MARYLAND
STATE CHILD FATALITY REVIEW TEAM

Child Deaths in Maryland

2004 Annual Report

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

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

MARYLAND STATE CHILD FATALITY REVIEW TEAM

Baltimore, Maryland 21201

Ms. Sally B. Dolch, MSW
Chairperson

Carolyn Fowler, Ph.D., M.P.H.
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 is pleased to submit the 2004 Annual Report on child deaths in Maryland which incorporates information about the work of local teams, training and advocacy efforts to prevent child deaths throughout the state. 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: S. Anthony McCann
Michelle A. Gourdine, M.D.
Robyn Elliott
Russell Moy, M.D., M.P.H.
Bonnie S. Birkel, C.R.N.P., M.P.H.

Enclosure

MARYLAND STATE CHILD FATALITY REVIEW TEAM

Baltimore, Maryland 21201

Ms. Sally B. Dolch, MSW
Chairperson

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

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

Dear President Miller and Speaker Busch:

Pursuant to Senate Bill 464 enacted during the 1999 legislative session, the Maryland State Child Fatality Review Team is pleased to submit the 2004 Annual Report on child deaths in Maryland which incorporates information about the work of local teams, training and advocacy efforts to prevent child deaths around the state. 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: S. Anthony McCann
Michelle A. Gourdine, M.D.
Robyn Elliott
Russell Moy, M.D., M.P.H.
Bonnie S. Birkel, C.R.N.P., M.P.H.

Enclosure

MARYLAND
STATE CHILD FATALITY REVIEW TEAM

Child Deaths in Maryland

2004 Annual Report

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

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

Acknowledgements

This Maryland State Child Fatality Review Team (State CFR Team) 2004 Annual Report required by Health-General Article §5-704 (b) (12) is the product of many hands.

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

The 2004 Annual Report includes:

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

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

Sally B. Dolch, MSW
Chairperson
sdolch@juno.com

TABLE OF CONTENTS

VISION, MISSION, AND GUIDING PRINCIPLES

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

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

Guiding Principles

1. We will work cooperatively with other state and local child fatality review systems.

2. We base our recommendations on findings from child fatality reviews.

3. Our understanding of child fatalities is based on both quantitative and qualitative information from child fatality reviews and observations.

4. Child fatality review 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 the children of Maryland.

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

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

INTRODUCTION

The purpose of the Maryland State Child Fatality Review Team (State CFRT) 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;

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

BACKGROUND

The 25 members Maryland State Child Fatality Review Team met for the first time in November 1999. Membership is comprised of the Secretaries or their designees of 12 state offices or departments, two pediatricians, and 11 members of the general public with interest 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 four times a year to address 13 statutorily prescribed duties.

Child Fatality Review (CFR) is a systematic, multi-agency, multi-disciplinary review of unexpected child deaths within a jurisdiction. This review process, which began in Los Angeles in 1978 as a mechanism to identify fatal child abuse and neglect, has grown into a national system to examine child fatalities within the context of prevention.

Detecting and preventing child abuse and neglect remain an important focus of CFR, the Department of Health and Mental Hygiene and the Department of Human Resources. Whatever the cause and manner of death, the majority of childhood deaths raise questions about the general child health system and warrant thorough systematic investigation. The overarching benefit of CFR is an examination of the system of service delivery and adequacy of services provided in order to prevent child deaths.

During calendar year 2004, the State CFRT conducted an all-day training on November 16 and held quarterly meetings on March 9, May 11, September 14.

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 DEATH."

In 2003 there were 944 deaths of 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 the deaths, 610 occurred in the first year of life and 334 occurred subsequently. All deaths are reported to the Department of Health and Mental Hygiene (DHMH), Vital Statistics Administration and are delineated in the annual reports produced by the Administration. The Office of the Chief Medical Examiner (OCME) studies child deaths that are considered sudden and unexpected. These cases and information concerning the death are referred to the local Child Fatality Review (CFR) Teams throughout the state. Local Fetal and Infant Mortality Review (FIMR) Teams receive notification of deaths of 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).

Information 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.

(2) "REVIEW REPORTS FROM LOCAL TEAMS."

Local teams reviewed over 300 cases during 2004. Each local CFR team was asked to report on their efforts and activities at the end of the year. A new computerized reporting form was developed for the 2004 reports to facilitate completion by the local teams. Among other things, teams were asked how many CFR meetings were held during the year and how many deaths were reviewed. 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."

In November 2004 an all-day statewide training was held which was organized by the State Child Fatality Review Team along with the Center for Maternal and Child Health. The day began with a review of the National Child Death Network by Maryland State CFR Team Chairperson Sally Dolch, MSW. Chief Medical Examiner David Fowler, M.D., gave an update of CFR in relation to the Medical Examiner's Office and addressed commonly asked questions. State Team member Carolyn Fowler, Ph.D., M.P.H., spoke on identifying opportunities for action and Susan De Francesco, J.D, M.P.H., presented on how data can be used for action and advocacy. The agenda for the training is provided in appendix D. All day trainings for State and local CFR members will be held once a year.

State CFR Team member Donna Becker is also Director of the Center for Infant and Child Loss. The Center distributed new Department of Health and Human Services booklets on SIDS and compassionate intervention to Local Child Fatality Review Teams (LCFRT). Center staff also presented bereavement training to approximately 40 health care professionals.

The Governor's Annual Conference on Child Abuse and Neglect was held in April 2004. State CFR Chairperson Sally Dolch, M.S.W, and Co-Chair Carolyn Fowler, PhD, M.P.H, presented along with Scott Krugman, M.D., on, "Child Fatality Review: Translating Tragedy into Action." Maureen Edwards, M.D., M.P.H, DHMH Center for Maternal Child Health (CMCH) Medical Director and State CFR Team member, and CMCH epidemiologist William Adih, M.D., Dr.P.H., presented on "Child Deaths in Maryland" along with CMCH intern Joylene Johns, M.D., M.P.H. Local CFR team members are encouraged to attend the conference each year.

(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."

The Maryland State Child Fatality Review Team initiated and developed a document entitled "Guidelines for Local Case Review" when child fatality reviews were first initiated. Each jurisdiction has a copy of the Guidelines. Numerous topics are addressed and the Guidelines serve as a comprehensive source of information for county teams. The Guidelines are modified as necessary and are made available to local teams and the public on the Child Fatality Review Web site 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."

A mechanism for the collection of data regarding child births and deaths currently exists through the Vital Statistics Administration of the Maryland Department of Health and Mental Hygiene.

The State Child Fatality Review Team and the Office of the Chief Medical Examiner (OCME) currently have in place a paper protocol for the collection of information regarding child deaths.

The State Child Fatality Review Team continues to work with the OCME to establish a highly secure computerized system for sending and retrieving data to and from the local Child Fatality Review teams. This system is expected to expedite data collection, making OCME information more readily available to the counties and the reporting of local data less burdensome.

As soon as the system is fully operational, training will be provided.

(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."

As can be found in Appendix C, each local CFR team provides information on their activities for the 2004 Annual Report. Local teams include recommendations for preventing child deaths. Some of these recommendations may imply policy and regulation initiation or change, both at the local level and State level. Local recommendations specific to the State CFR Team are included in Appendix F.

(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."

Each year the local CFR teams are asked to assess and describe their training needs in their annual report. The State CFR Team uses this feedback to plan training activities.

The year 2004 saw the implementation of a new format for the State CFR quarterly meetings that was developed in 2003. Each State Team meeting was hosted either by a state agency representative or an outside institution and included a training component. Presentations were made by State Team members from the University of Maryland Medical Center, and the Maryland State Department of Education. A representative of the Department of Juvenile Services and the State Fire Marshal's Office also presented at quarterly meetings. This educational component of the

State CFR meetings equips members with information to take back to their respective agencies.

A wide variety of agencies and disciplines are represented on the State CFR Team and quarterly meetings provide the opportunity for members from the different agencies to recognize and define cross-agency training needs and service gaps. This information base is then used to develop training ideas and plans. Holding meetings on a quarterly basis also addresses the significant distance and travel time required to convene a state meeting.

As mentioned above, The Governor's Annual Conference on Child Abuse and Neglect is a forum for meeting training needs. State CFR Chair, Sally B. Dolch and Co-Chair, Carolyn Fowler presented at this conference in 2004.

The State CFR administrative team routinely informs local CFR teams of available conferences and trainings which may be of interest. In 2004, besides the training conference presented by the State CFR Team, local teams were notified about the 11th Annual Governor's Conference on Abuse and Neglect and the Sixteenth Annual Conference on Suicide Prevention.

(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."

Access to information is vital to the assessment of child deaths and, in turn, vital to the development of policies impacting child safety. In the past, questions have been raised related to the sharing of information with other review teams and other agencies. In late 2003 the DHMH Center for Maternal and Child Health, in consultation with the Office of the Attorney General, sent a letter of clarification to all local Child Fatality Teams regarding the Health Insurance Portability and Accountability Act (HIPAA). This letter provided clarification and support for local teams in their efforts in 2004. The letter stated, "HIPAA permits disclosure of health information for public health surveillance and investigation activities. HIPAA permits disclosure of health information for public health surveillance and investigation activities. Child Fatality Review is a public health surveillance activity at both the State and local level. The authority of the Department of Health and Mental Hygiene to conduct analysis of child deaths is found in the Health-General, §5-707, Annotated Code of Maryland. CFR investigations are included under this HIPAA provision as outlined in the federal regulation (45CFR 164.512(b)). Therefore, "covered entities" (physicians and other providers) should make

available information requested by the local CFR Team as part of the case review process."

(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 RESPONSIBILITES IN ACCORDANCE WITH:

(1) THE STATE PLAN UNDER 42 U.S.C. §5106A(B);

(2) THE CHILD PROTECTION STANDARDS SET FORTH IN 42 U.S.C. §5106A(B); AND

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

Representatives of agencies providing Child Protective Services serve on the State Child Fatality Review Team and on most local Child Fatality Review Teams, enabling them to raise issues and heighten awareness about agency strengths and weaknesses. This involvement also serves to protect the siblings of children who have died who may be at an increased risk for abuse or neglect.

(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."

The State CFR Annual Report is available as a resource to the public in hard copy and via the Internet. The Annual Child Death Report and the report of activities by the local CFR teams are included.

Various local teams have taken steps to bring educational messages to the public. Examples include newspaper articles written about gun safety and swimming pool safety, distribution of gift packets on "Keeping Babies Safe" to pregnant women and new mothers to reduce the risk of Sudden Infant Death Syndrome and Shaken Baby Syndrome, and press conferences held to educate about proper infant sleeping practices and proper dosing of infant medications.

State Team member Donna Becker is Director of The Center for Infant and Child Loss. The Center conducts trainings for professionals and educates the public about the importance of safe sleeping practices in preventing Sudden Infant Death Syndrome. Besides the efforts on behalf of local Child Fatality Review Teams and local health departments mentioned above, in 2004 the Center for Infant and Child Loss provided training to approximately 1,172 day care providers, 143 health care professionals, 88 parents, 85 program staff, 155 public school students, and participated in six health fairs**.** Thousands of pieces of educational literature were distributed and a new partnership was established with a local television station to broadcast "back to sleep" messages.

A brochure entitled, "When Your Baby Won't Stop Crying" was developed by the DHMH Center for Maternal Child Health (CMCH), based on information from the Baltimore County Department of Health Injury Prevention Program. The brochure describes reasons babies may cry incessantly and offers instruction on handling such situations. The brochure stresses that a baby must never be shaken, and details how shaking may result in brain damage and even death.

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

Since 2003 the State has had a dedicated staff person responsible for coordinating the efforts of the State CFR Team. DHMH administrative staff provides support for the overall operation of the State CFR Team and State Team activities such as the State CFR Annual Report.

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

The State Child Fatality Review team has completed Annual Reports for 1999 through 2004. The Annual Reports are sent to the Governor and the General Assembly. They are posted on the Center for Maternal Child Health Web site to ensure public access. Included as well are Reports of Local Activities compiled by the local Child Fatality Review Teams detailing their efforts.

(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 they determined could have resulted in death. In jurisdictions with lesser number of deaths, reviewing "near fatalities" can help maintain the experience of the team, while at the same time identifying opportunities for the improvement for 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 185 admissions in 2003 in children less than 18 years, which met these criteria. A subcommittee of the State Team is working with representatives of the American Academy of Pediatrics (AAP) and the Maryland Institute for Emergency Medical Services Systems (MIEMSS) to identify appropriate data sources and will work with the local CFR teams to develop a process for review of these cases.

COORDINATION

The State Child Fatality Review Team is required to coordinate its activities with the State Citizen Review Board for Children and the State Council on Child Abuse and Neglect. Strategies undertaken to ensure this coordination were:

1. The Chairperson of the State CFR Team communicates with the State Citizen Review Board for Children and the State Council on Child Abuse and Neglect in order to avoid unnecessary duplication of effort.

2. Each year the State CFR Team participates in the Governor's Conference on Child Abuse and Neglect, an event that is planned and coordinated by the State Council on Child Abuse and Neglect. In 2004, the Chairperson and Vice-Chair of the State CFR Team as well as the Medical Director and an epidemiologist from the Center for Maternal and Child Health presented workshops and training on child fatality prevention in Maryland.

3. Chairpersons from the State CFR Team, the State Council on Child Abuse and Neglect and the State Citizen Review Board for Children met at the Annual State Conference on Child Abuse and Neglect in 2004 to work towards coordination of activities.

4. Some members of the State CFR Team also serve as members on the Citizen's Review Board for Children or the State Council on Child Abuse and Neglect.

CHILD FATALITY REVIEW – REPORT OF MARYLAND JURISDICTIONS

Each jurisdiction completes a report of activities every year and these reports are presented in Appendix C. The reports document the number of meetings held in the jurisdiction and the number of child deaths reviewed. The reports help to highlight the issues specific to the differing demographic regions of the state and show the efforts made to address those issues, whether through trainings conducted or attended, public education campaigns, or other advocacy endeavors.

Publication of the local CFR reports allows all local CFR teams to compare their efforts and trends with other jurisdictions. Contact lists are published to facilitate this, allowing them to build on one another's work and learn from each other. Should they so choose, local teams can work together on regional programs.

The local reports also highlight recommendations for State Team collaboration and describe how local teams see the State Team as contributing to efforts at the local level.

In 2004, State Team members began visiting local team meetings to learn about locale-specific issues and observe the different ways of conducting local meetings. Because the number and type of fatalities vary based on the demographics and geography of a region, such visitation allows State CFR Team members to see how different teams manage the needs of their jurisdiction. This information sharing helps to create a bridge between state and local efforts.

CHALLENGES AND GOALS

With four meetings a year, a significant turnover in membership and with the complexity of implementing some goals**,** it is more realistic to set long-term goals for the State Team rather than year-to-year short-term goals. The State Team will continue to work on the following goals in 2005:

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

    - There has been progress in efforts to computerize the data system. The Office of the Chief Medical Examiner contracted with Towson State University to employ master's level computer science students to develop, test and put into practice a system to collect data from Child Fatality Review Teams in accordance with a system developed by the National Center on Child Death Review. This system is nearing completion and will hopefully be in use by the summer of 2005.

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

    - There are ongoing efforts at the State and local level to understand a variety of health disparities, including child fatality. The Center for Maternal Child Health, the administrative home for the Child Fatality Review Team, is involved in the Association of Maternal & Child Health Programs (AMCHP) sponsored efforts to study perinatal health disparities.

- As required by law, collaborate with state and local panels reviewing child abuse and neglect to identify deaths and potential deaths associated with preventable child abuse and neglect.

    - Examination of these causal relationships has been an important part of Child Fatality Review from the very beginning and continues into 2005. With the development of the new data system, it may become easier to understand these relationships.

- In consultations with local teams, develop policy recommendations to reduce child deaths in Maryland.

    - In the local Child Fatality Reports completed every year, the local teams state their actions and recommendations based on their reviews. Some of these suggestions involve policy development or suggestions to prevent child fatalities or near fatalities. These suggestions are included in the State Child Fatality Annual Report, which by law is presented to the Governor and the Maryland General Assembly.

- Examine confidentiality and access to information laws.

    - HIPAA regulations have addressed these concerns in a uniform way. Each local CFR team received a letter from the Director of the Center for Maternal Child Health in 2003 discussing the impact of HIPAA on local CFR efforts. In addition, the Team pays attention to these concerns as they are presented on a list-serve managed by the National Child Death Review.

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

    - Efforts continue to develop a well-defined, comprehensive approach to near fatality. It seems important to understand that efforts to prevent child fatality are accomplished by understanding issues related to near fatality. The recommendations and suggestions that are made to prevent child fatalities will be successful by preventing the conditions and events that could be defined as possibly leading to a near fatality.

- A major training for local Child Fatality Review Teams is held one time per year and other training and educational opportunities are presented to the team as they become available.

    - Starting in December 2003, a training component was added to each quarterly meeting. Local CFR team members may attend as long as there is no specific case discussion. In addition, the Center for Maternal Child Health offered Child Fatality Review Team members the opportunity to attend the National Fetal and Infant Mortality Review Conference in the summer of 2004 and the Governor's Conference on Child Abuse and Neglect each year for the last several year, and again in 2005. Also in 2005, the Center for Infant and Child Loss will be offering a conference opportunity on the death of children, including Sudden Infant Death (SIDS) and the Sudden Unexpected Death of an Infant (SUDI).

APPENDICES

Appendix A

2004 State Child Fatality Review Team Membership

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

(1) THE ATTORNEY GENERAL – Eileen McInerney, J.D., designee
(2) THE CHIEF MEDICAL EXAMINER - David Fowler, M.D.
(3) THE SECRETARY OF HUMAN RESOURCES – Fran Pellerin, designee
(4) THE SECRETARY OF HEALTH AND MENTAL HYGIENE – Maureen Edwards, M.D., M.P.H., designee
(5) THE STATE SUPERINTENDENT OF SCHOOLS – Richard Steinke, designee
(6) THE SECRETARY OF JUVENILE SERVICES – Anne Fox, R.N., B.S., designee
(7) THE SPECIAL SECRETARY FOR CHILDREN, YOUTH AND FAMILITES – Twilah Shipley, J.D., designee
(8) THE SECRETARY OF THE STATE POLICE – Lt. Doug Wehland, designee
(9) THE PRESIDENT OF THE STATE'S ATTORNEY'S ASSOCIATION – Jonathan G. Newell, J.D. designee
(10) THE CHIEF OF THE DIVISION OF VITAL RECORDS – Hal Sommers, M.A., designee
(11) A REPRESENTATIVE OF THE STATE SIDS INFORMATION AND COUNSELING PROGAM, Donna Becker, RN, MSN, Director, Center for Infant and Child Loss
(12) THE DIRECTOR OF THE ALCOHOL AND DRUG ABUSE ADMINISTRATION – David Putsche, designee
(13) TWO PEDIATRICIANS WITH EXPERIENCE IN DIAGNOSING AND TREATING INJURIES AND CHILD ABUSE AND NEGLECT, APPOINTED BY THE GOVERNOR FROM A LIST SUBMITTED BY THE STATE CHAPTER OF THE AMERCAN ACADEMY OF PEDIATRICS
Nerita Estampador-Ulep, M.D., FAAP
Richard Lichenstein, M.D., FAAP
(14) ELEVEN MEMBERS OF THE GENERAL PUBLIC WITH INTEREST OR EXPERTISE IN CHILD SAFETY OR WELFARE, APPOINTED BY THE GOVERNOR, INCLUDING CHILD ADVOCATES, CASA VOLUNTEERS, HEALTH AND MENTAL HEALTH PROFRESSIONALS, AND ATTORNEY'S WHO REPRESENT CHILDREN –
Sally Dolch, MSW, Chairperson
Susan Daddio, MSW, Citizen Advocate for Children
Carolyn Fowler, Ph.D, M.P.H.,Vice-Chair, Citizen Advocate for Children
Patricia Kirby, Ph.D., Citizen Advocate for Children
Dorothy Marge, Ph.D., Citizen Advocate for Children
Pierre Mooney, MSW, Citizen Advocate for Children
Albert Rolle, M.D., FACS, Citizen Advocate for Children
John Rusinko, LCSW-C, Citizen Advocate for Children
Anntinette Williams, LICSW, Citizen Advocate for Children

Appendix B

Child Death Report 2004

Department of Health and Mental Hygiene

Family Health Administration

Russell W. Moy, M.D., M.P.H., Director
Joan H. Salim, Deputy Director

Center for Maternal and Child Health

CHILD DEATH REPORT
2004

Robert L. Ehrlich, Jr.
Governor

Michael S. Steele
Lt. Governor

S. Anthony McCann
Secretary
Department of Health and Mental Hygiene

ACKNOWLEDGEMENTS

This report was prepared by William K. Adih, M.D., Dr.PH., and the staff of the Department of Health and Mental Hygiene's Center for Maternal and Child Health. Maureen C. Edwards, M.D., M.P.H., Medical Director, Center for Maternal and Child Health, provided guidance. Isabelle Horon, Dr.P.H., Director, Vital Statistics Administration, and Robert L. Hayman, Ph.D., Manager, Data Production Unit, Vital Statistics Administration, provided the data. Thanks go to Drs. Edwards, Horon, Hayman, and Mr. Hal Sommers, Vital Statistics Administration, and Ms. Tracey Serpi, Center for Preventive Health Services, for reviewing the report.

For comments, please contact:

William K. Adih, M.D., Dr.P.H.
MCH Epidemiologist
Center for Maternal and Child Health
Maryland Department of Health and Mental Hygiene
Phone: 410-767-6715
E-mail: ***wadih@dhmh.state.md.us***

The report can be found at: ***http://www.fha.state.md.us/mch/html/cfr***

TABLE OF CONTENTS

INTRODUCTION

Childhood deaths are a major public health problem and many of these are preventable fatalities.

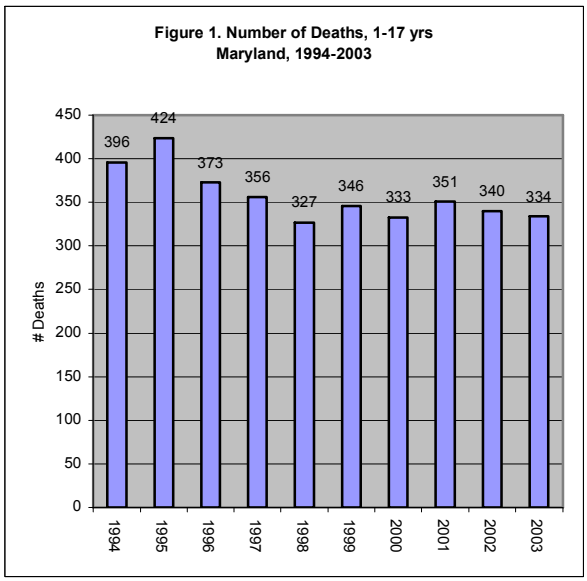
Surveillance of childhood deaths is one of the most important components of child death prevention. It helps to determine the magnitude of child mortality, the leading causes of death, and the population groups most affected. In addition, this data is crucial for evaluating the effectiveness of program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

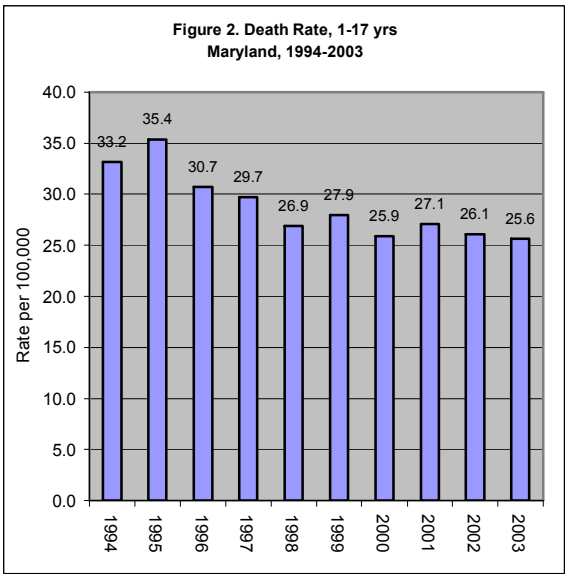
Injuries are the leading cause of death in children aged 1-17 years. In 2003, in Maryland, unintentional injuries comprised 33 percent of all deaths among children ages 1 to 17 years, followed by homicides, malignant neoplasms, cardiovascular diseases, congenital malformations, and suicides. Overall, childhood death rates have declined during the past decade in Maryland and the U.S.

This report is based on existing data from the Vital Statistics Administration, Department of Health and Mental Hygiene. In the future, the report will incorporate data from the new State Child Fatality Review database, which is currently being developed. This database will also include qualitative findings and recommendations from local Child Fatality Review Teams.

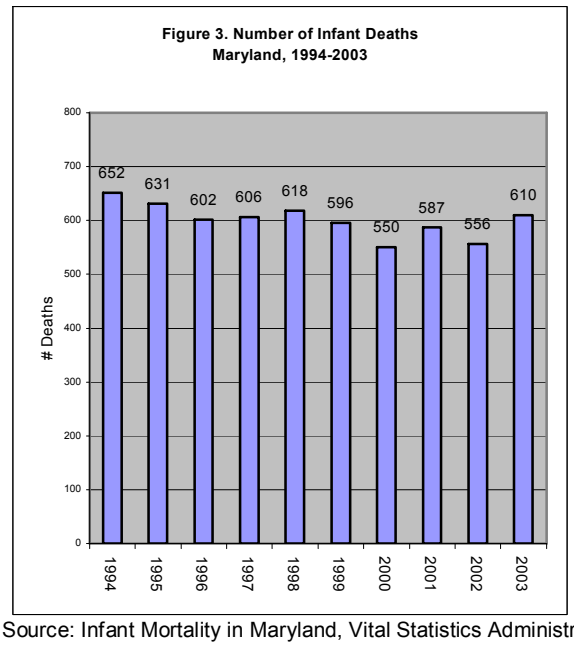
OVERALL TRENDS

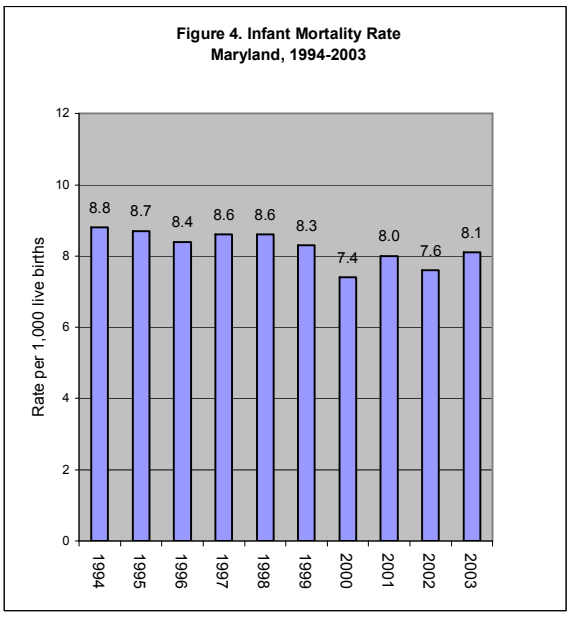
In 2003, there were 944 deaths of infants and children under the age of 18 years in Maryland. This age range was utilized for this report because it encompasses the ages for which the State Child Fatality Review Team has responsibility. Overall, there has been a gradual decrease in the number and rate of both infant and child deaths in the state over the past decade. The infant mortality rate, however, rose to 8.1 per 1,000 live births in 2003. (Figures 1, 2, 3 and 4). It is important to note that many of these deaths in childhood could be prevented with appropriate interventions in both the public and private sectors.





Source: Analysis of data from Vital Statistics Administration, DHMH





Source: Infant Mortality in Maryland, Vital Statistics Administration, DHMH

Mortality rates are expressed as the number of deaths per a population measure in a given time period. Infant mortality rates are traditionally expressed as the number of deaths in the first year of life per 1,000 live births during the same year. However, other mortality rates are expressed as the number of deaths per the number in the population, usually per 1,000 or 100,000. To overcome the problems associated with the statistical manipulation of small number of events, some of the information in this report is based on combined years of data (three or five years). The average mortality rate for infants less than one year of age has decreased by 8.6 percent between the five-year periods of 1994-1998 and 1999-2003. The neonatal mortality rate (deaths to infants under 28 days of age per 1,000 live births) and the postneonatal mortality rate (deaths from 28 days through 11 months per 1,000 live births) declined by 5.9 percent and 15.0 percent respectively (Table 1). Overall, for children ages 1 through 17 years, the mortality rate fell by 14.9 percent and there was also a decline in mortality rates for young children and adolescents (Table 2).

TABLE 1. NUMBER OF INFANT, NEONATAL AND POSTNEONATAL DEATHS BY RACE, DEATH RATES AND PERCENT CHANGE IN RATES FROM 1994-1998 TO 1999-2003, MARYLAND**

	Number of deaths		Death rates*		Percent change**	
	1994-1998	1999-2003	1994-1998	1999-2003		
Infant mortality*						
All races***	3109	2902	8.6	7.9	-8.6	****
White	1260	1156	5.7	5.2	-8.9	****
Black	1763	1655	15.3	13.7	-10.1	****
Neonatal mortality*						
All races***	2179	2095	6.1	5.7	-5.9	****
White	852	834	3.9	3.8	-2.8	
Black	1261	1193	10.9	9.9	-9.4	****
Postneonatal mortality*						
All races***	930	807	2.6	2.2	-15.0	****
White	408	322	1.9	1.5	-21.6	****
Black	502	462	4.4	3.8	-11.9	****

Source: Infant Mortality in Maryland, Vital Statistics Administration, DHMH
*Rate per 1,000 live births
**Percent change is based on the exact rates and not the rounded rates represented here
***Includes races other than White and African American
***Rates for 1994-1998 and 1999-2003 differ significantly (p<.05)

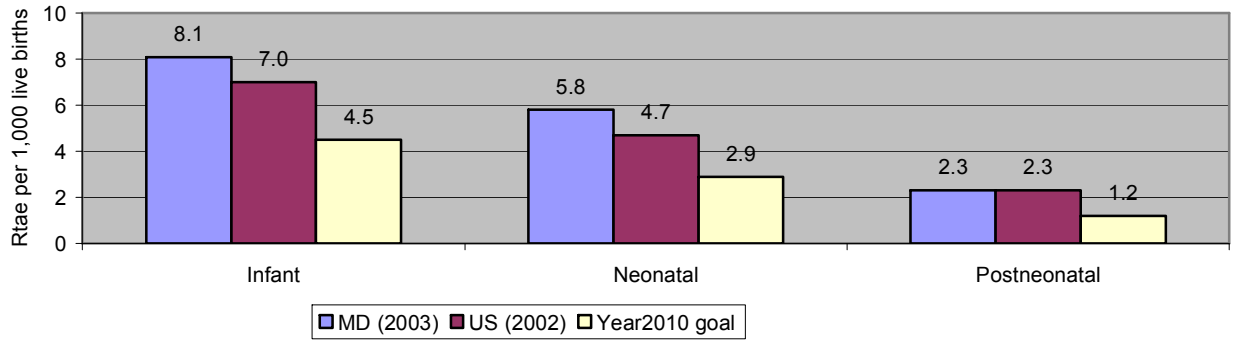
TABLE 2. NUMBER OF DEATHS, DEATH RATES AND PERCENT CHANGE IN RATES FOR CHILDREN UNDER 18 YEARS, MARYLAND, 1994-1998 AND 1999-2003

	Number of Deaths		Death Rates*		Percent
Age group	1994-1998	1999-2003	1994-1998	1999-2003	Change**
< 1 year	3,109	2902	868.2	792.1	-8.6***
1-17 years	1,876	1,704	31.1	26.5	-14.9***
1-4 yr	516	425	35.6	29.9	-16.1***
5-9 yr	315	282	17.0	14.8	-12.6
10-14 yr	392	367	22.6	18.5	-18.3***
15-17 yr	653	630	66.3	56.3	-15.1***

Source: Source: Analysis of data from Vital Statistics Administration, DHMH
*Per 100,000 population in specified age group
**Percent change is based on the exact rates and not the rounded rates presented here
***Rates for 1994-1998 and 1999-2003 differ significantly (p<.05)

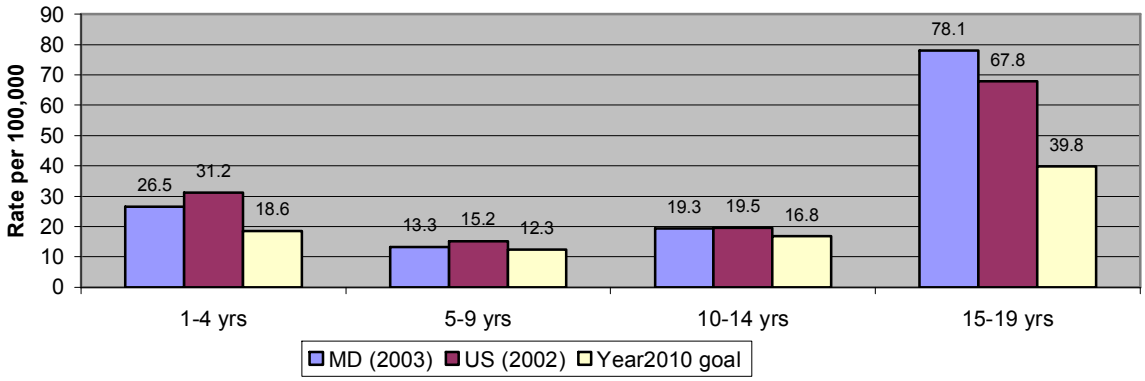
COMPARISION TO NATIONAL STATISTICS

Figure 5. Infant Deaths



Source: Analysis of data from Vital Statistics, Vital Statistics Administration, DHMH

Figure 6. Child/Adolescent Deaths



Source: Analysis of data from Vital Statistics Administration, DHMH

The absolute number of child deaths and mortality rates in Maryland decreased throughout the 1990s. The 2003 Maryland infant and neonatal mortality rates are higher than the 2002 national rate (the most current year for which national data is available). The Maryland postneonatal mortality rate, however, equals the national rate (Figure 5). In the age groups 1-4 years and 5-9 years, Maryland's mortality rates are lower than the national rates. In the older age groups, mortality rates approximate the national rate or are higher (Figure 6).

National objectives for infant and child mortality have been established in the Healthy People 2010 project of the United States Department of Health and Human Services. While Maryland is close to meeting several of these objectives, others remain a challenge. It is anticipated that progress will be realized now that jurisdictions have Child Fatality Review infrastructure and the improved surveillance system will identify areas for appropriate intervention (Figures 5 and 6).

DEMOGRAPHICS

In order to avoid preventable deaths in childhood, it is necessary to understand both the causes of death and which children are at particular risk. A breakdown of the age of death for children in Maryland in 2003 is presented in Table 3 and Figure 7.

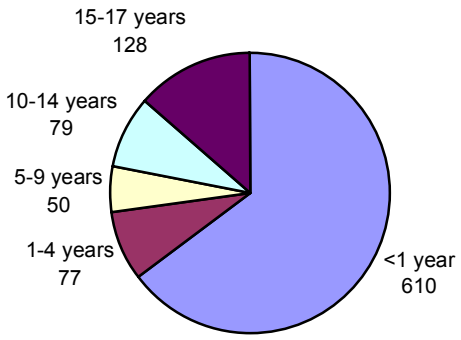
TABLE 3. CHILD DEATHS UNDER 18 YEARS, MARYLAND, 2003

Age group	# Deaths	% of Total
<1 year	610	64.6
<=28 days	*435*	*46.1*
29-365 days	*175*	*18.5*
1-4 years	77	8.2
5-9 years	50	5.3
10-14 years	79	8.4
15-17 years	128	13.6
Total	**944**	

Of the 944 deaths, 64.6 percent occurred in the first year of life with 46.1 percent of the total occurring in the first month of life. Therefore, efforts to lower overall child fatalities must be coordinated with activities specifically aimed at addressing infant deaths. Although mortality rates fall after infancy, they rise again during adolescence. Teens and young adults have approximately two or three times the number of fatalities as seen in younger children.

Source: Analysis of data from Vital Statistics Administration, DHMH

Figure 7. Number of Child Deaths, 2003



N=944

Source: Analysis of data from Vital Statistics Administration, DHMH

Gender and race also influence the number and rate of death. In 2003, of the 334 deaths among 1 to 17 year old children, 62.3 percent occurred in boys, representing a rate of 29.5 per 100,000. Among females, the death rate was 18.7 per 100,000 (Table 4).

This trend is also seen in infancy where 57.6 percent of the deaths were to boys.

TABLE 4. DEATHS, 1-17 YEARS, BY GENDER, MARYLAND, 2003

Gender	Number of Deaths	% of total	Rate*
Male	208	62.3	29.5
Female	126	37.7	18.7
Total	**334**		**24.2**

Source: Analysis of data from Vital Statistics Administration, DHMH
*Rate per 100,000 population

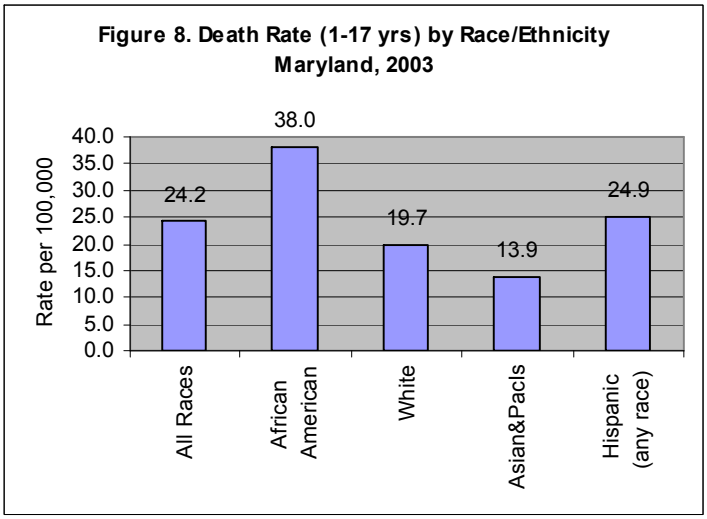
African-American children were at an increased risk of dying both in the first year of life and in later childhood. In 2003, African-American infants died at 2.7 times the rate of white infants. This ratio remained elevated at 1.9 in children 1 through 17 years of age (Table 5 and Figure 8). The basis of these associations is not completely understood but must be addressed to prevent childhood deaths.

TABLE 5. DEATHS, 1-17 YEARS, BY RACE, MARYLAND, 2003

	# of Deaths	Rate*
African-American	165	38.0
White	159	19.7
Am. Indian	1	15.9
Asian & Pac Is.	8	-
Other	1	-
Total	**334**	**24.2**
Hispanic (any race)	18	24.9
Ratio AA:W		1.9

Source: Analysis of data from Vital Statistics Administration, DHMH
*Rate per 100,000 population
-Rates based on fewer than five events in the numerator are not presented since rates based on small numbers are likely to be unstable.

Figure 8. Death Rate (1-17 yrs) by Race/Ethnicity Maryland, 2003



Source: Analysis of data from Vital Statistics Administration. DHMH

CAUSE OF DEATH

Understanding the underlying cause of death in childhood is necessary in order to develop strategies to prevent these events when possible. Specific causative factors vary significantly depending on the age of the child. In the first year of life, the leading causes of mortality relate to prematurity and low birthweight. In Maryland, compared to the U.S., excess numbers of preterm and low birthweight infants account for the higher infant mortality rate rather than excess mortality within birthweight groups. After the first month of life, Sudden Infant Death Syndrome (SIDS) and congenital anomalies are the leading causes of death in infancy. Table 6 presents the leading causes of infant mortality in 2003. The number of deaths is given in parenthesis. A more detailed review of infant mortality is presented in the Annual Infant Mortality Report prepared by the Department of Health and Mental Hygiene's Vital Statistics Administration. It can be found at *http://www.mdpublichealth.org/vsa*.

TABLE 6. LEADING CAUSES OF INFANT DEATH, MARYLAND, 2003

	Neonatal (435)	Postneonatal (175)	INFANT (610)
1	Short gestation, LBW (123)	SIDS (49)	Short gestation, LBW (138)
2	Congenital malformation (75)	Congenital malformation (24)	Congenital malformation (99)
3	Maternal complications (56)	Diseases of digestive tract (15)	Maternal complications (56)
4	Complications of placenta, cord (29)	Other sudden deaths (10)	SIDS (56)
5	Respiratory distress of newborn (23)	Assault (homicide) (9)	Complications of placenta, cord (29)
6	Bacterial Sepsis of Newborn (15)	Diseases of circulatory system (7) Necrotizing enterocolitis of newborn (7) Unspecified non-transport accident (7)	Respiratory distress of newborn (24)
7	Cardiovascular disorders originating in perinatal period (13)	Influenza & pneumonia (6)	Other sudden deaths (19)
8	Necrotizing enterocolitis of newborn (9) Other sudden deaths (9)	Septicemia (4) Bacterial sepsis of newborn (4) Metabolic disorders (4)	Diseases of digestive tract (17)
9	Intrauterine hypoxia & birth asphyxia (8) Intracranial non-traumatic hemorrhage of fetus & newborn (8)	Short gestation, LBW (3) Other infectious diseases (3)	Necrotizing enterocolitis of newborn (16)
10	Newborn affected by other complications of labor & delivery (7) SIDS (7)	Falls (accident) (2) Convulsion (2)	Cardiovascular disorders originating in perinatal period (13)

Source: Analysis of data from Vital Statistics Administration, DHMH

SUDDEN INFANT DEATH SYNDROME (SIDS)

SIDS is the sudden death of an infant under one year of age, which remains unexplained after a thorough case investigation, including performance of a complete autopsy, examination of the death scene, and review of the clinical history. SIDS remains the leading cause of death in the first year of life beyond the neonatal period. SIDS is of particular public health concern because it can be reduced through safe sleeping practices for infants and education regarding cultural practices for specific infant care issues. In Maryland, the number of deaths from SIDS has decreased throughout the 1990's with a 24.2 percent decrease between 1994-1998 and 1999-2003. In 2001-2003, there were 168 SIDS deaths. These deaths included other sudden infant deaths classified as Sudden Unexpected Deaths in Infancy (SUDI). SUDI includes cases where there is confirmation of bed-sharing and in which the possibility of asphyxia, due to unsafe sleeping surfaces, could not be ruled out.

Risk factors for SIDS include: 1) a physiological defect; 2) critical development period (SIDS risk peaks between two and four months of age); and 3) environmental stressors such as oxygen depletion while sleeping face down, exposure to prenatal or second-hand smoke, and overheating while wrapped in heavy blankets. Additionally, the mother's health and behavior during pregnancy and the infant's health before birth are important factors in the occurrence of SIDS.

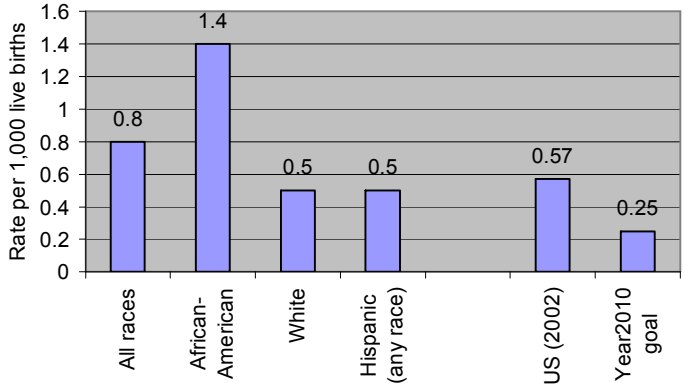
Of the 168 SIDS deaths between 2001 and 2003, 97 (57.7 percent) were boys and 71 (42.3 percent) were girls. Sixty-two white infants died from SIDS, a rate of 0.5 per 1,000 live births. Among African-Americans, there were 103 SIDS deaths, representing a rate of 1.4 per 1,000. Eight Hispanic infants (any race) died from SIDS, a rate of 0.5 per 1,000 live births (Table 7 and Figure 9). The findings of gender difference and racial disparity mirror national data. Maryland's average SIDS death rate is over two times higher than the 2002 national rate (the most current year for which national data is available). The Healthy People 2020 goal calls for reducing death from SIDS to no more than 0.25 per 1,000 live births.

TABLE 7. SIDS DEATHS, 1-17 YEARS, BY RACE/ETHNICITY, MARYLAND, 2001-2003

	# Deaths	Rate*
African American	103	1.4
White	62	0.5
American-Indian	0	-
Asian or Pacific Is.	1	-
Other	2	-
Total	**168**	**0.8**
Hispanic (any race)	8	0.5

Source: Analysis of data from Vital Statistics Administration, DHMH
*Rate per 1,000 population
-Rates based on fewer than five events in the numerator are not presented since rates based on small numbers are likely to be unstable.

Figure 9. SIDS Death Rate by Race/Ethnicity Maryland 2001-2003



CAUSES OF DEATH AMONG OLDER CHILDREN

Table 8 shows the causes of death among children 1-17 years in 2003 and for the period 2001-2003. Figure 10 demonstrates the graphical distribution of the causes of death in 2003.

TABLE 8. NUMBER OF DEATHS BY CAUSE
1-17 YEARS, MD, 2003 AND 2001-2003

Cause of Death	2003	2001-2003
Unintentional Injuries (Accidents)	111	340
Transport	77	242
Non-Transport	34	98
Homicide	54	156
Cancer	33	103
Suicides	13	45
Cardiovascular	16	52
Congenital Malformations	20	53
Other	87	276
Total	**334**	**1025**

Source: Analysis of data from Vital Statistics Administration, DHMH

Figure 10. Number of Deaths by Cause (1-17 years), Maryland, 2003

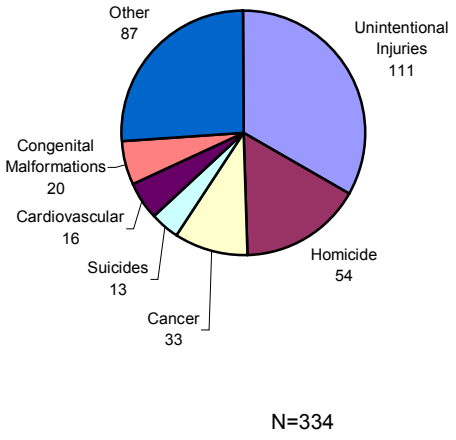


Table 9 shows the ranking by the number of deaths among the various childhood age groups (1-17 years) for the three-year period 2001-2003. The number of deaths is given in parenthesis.

TABLE 9. LEADING CAUSES OF DEATH BY AGE GROUP, MARYLAND, 2001-2003

Age	1-4 years	5-9 years	10-14 years	15-17 years
Rank	N=261	N=171	N=215	N=378
1	Unintentional Injury (63)	Unintentional Injury (61)	Unintentional Injury (62)	Unintentional Injury (154)
2	Malignant Neoplasms (28)	Malignant Neoplasms (26)	Malignant neoplasms (30)	Homicide (104)
3	Homicides (27)	Congenital malformations (11)	Homicide (18)	Suicide (29)
4	Congenital malformations (24)	Major Cardiovascular Diseases (10)	Suicide (16)	Malignant Neoplasms (19)
5	Major Cardiovascular Diseases (17)	Homicide (7)	Major Cardiovascular Diseases (9)	Major Cardiovascular Diseases (16)

INJURIES

Injuries were the leading cause of death in children aged 1-17 years, with unintentional injuries accounting for the most common etiologies of mortality in every age group (Table 9). Unintentional injuries constituted the leading cause of death (59.6) to children between 2001 and 2003. Homicide and suicide (intentional injuries) represented 27.4 percent and 7.8 percent respectively of all fatal injuries (Table 10 and Figure11). Many of these injury deaths are preventable. Undetermined intent refers to cases where information is insufficient to enable a medical or legal authority to a make a distinction between an accident, self-harm, and assault.

Vignette:
4-Year Old Girl Killed in Rowhouse Fire
Source: The Baltimore Sun,
October 18, 2004

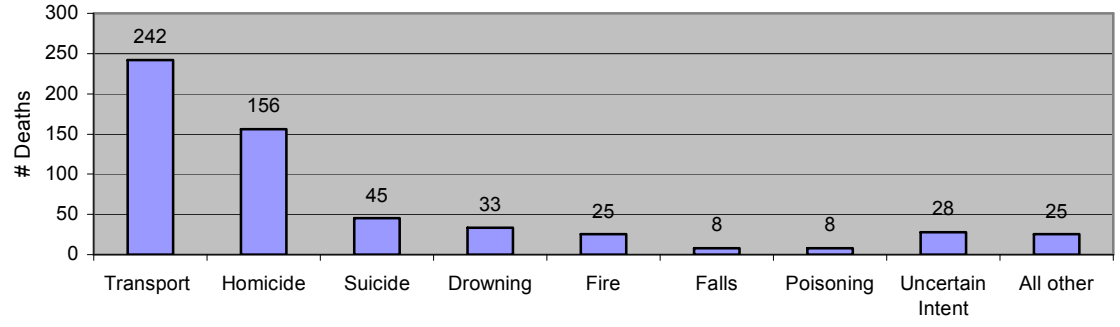
"A 4-year old girl was killed and several family members – including an infant – were injured in a rowhouse fire in West Baltimore, authorities said. Fire fighters responding to a call 12:30 a.m. found fire in the first floor and basement of the two storey brick rowhouse. The cause of the blaze remained under investigation."

TABLE 10. NUMBER OF INJURY RELATED DEATHS, 1-17 YEARS MARYLAND, 2001-2003

Type of Injury	2001-2003	% of Total
Unintentional	**340**	**59.6**
Transport	**242**	
-MVA	217	
-Other	25	
Non-Transport	**98**	
-Falls	8	
-Drowning	33	
-Fire	25	
-Poisoning	8	
-Other	24	
Homicide	**156**	**27.4**
-Firearm	96	
-Other	60	
Suicide	**45**	**7.8**
-Firearm	12	
-Other	33	
Legal intervention	**1**	**0.2**
Undetermined Intent	**28**	**4.9**

Source: Analysis of data from Vital Statistics Administration, DHMH

Figure 11. Injury Related Childhood Deaths (1-17 yrs) Maryland, 2001-2003



Source: Analysis of data from Vital Statistics Administration, DHMH

Motor Vehicle Accidents

Motor vehicle-related injuries are the leading cause of unintentional (accidental) injury death to children. Between 2001 and 2003, 217 children ages 1-17 years were killed in motor vehicle crashes (Table 11).

TABLE 11. CATEGORY OF PERSONS KILLED IN MVA, 1-17 YEARS, MARYLAND, 2001-2003

Person	Number	Percent
Driver of vehicle	31	14.3
Passenger	43	19.8
Pedestrian	44	20.3
Motorcycle rider	5	2.3
Pedal cyclist	10	4.6
Unspecified occupant of vehicle	22	10.1
Unspecified	62	28.6
Total	**217**	

Source: Analysis of data from Vital Statistics Administration, DHMH

TABLE 12. UNINTENTIONAL TRANSPORT INJURY DEATHS BY RACE, 1-17 YEARS, MARYLAND, 2001-2003

	MVA		Other Transport	
Race	**Number**	**Rate***	**Number**	**Rate***
African American	67	5.1	8	0.6
White	138	5.7	15	0.6
Am. Indian	1	-	0	-
Asian &Pac Is.	8	4.7	1	-
Other	3	-	1	-
Total	**217**	**5.6**	**25**	**0.6**
Hispanic (any race)	12	5.6	0	-

Source: Analysis of data from Vital Statistics Administration, DHMH
*Per 100,000 population
-Rates based on fewer than five events in the numerator are not presented since rates based on small numbers are likely to be unstable

TABLE 13. UNINTENTIONAL TRANSPORT INJURY DEATHS: NUMBER AND RATE BY AGE GROUP, 1-17 YEARS, MARYLAND, 2001-2003

	MVA		Other Transport	
Age group	**Number**	**Rate***	**Number**	**Rate***
1-4	24	2.8	1	-
5-9	36	3.2	6	0.5
10-14	39	3.2	2	-
15-17	118	17.2	16	2.3
Total	**217**	**5.6**	**25**	**0.6**

Source: Analysis of data from Vital Statistics Administration, DHMH
*Per 100,000 population
-Rates based on fewer than five events in the numerator are not presented since rates based on small numbers are likely to be unstable

The motor vehicle-related injuries included all deaths occurring to children who were drivers, passengers, pedestrians, or other types of occupants in a form of transport. For a fuller understanding of the circumstances surrounding cases listed as "unspecified," additional sources of information, such as police reports will be examined.

Of the 217 motor vehicle related deaths between 2001 and 2003, 144 (59.5 percent) were boys and 98 (40.5 percent) were girls. One hundred and thirty-eight white youths died in motor vehicle crashes, a rate of 5.7 per 100,000. Among African-American children, there were 67 motor vehicle-related deaths, representing a rate of 5.1 per 100,000 (Table 12). Older children bore the brunt of the cases, dying at the rate of 17.2 per 100, 000 in the 15-17 year age group (Table 13).

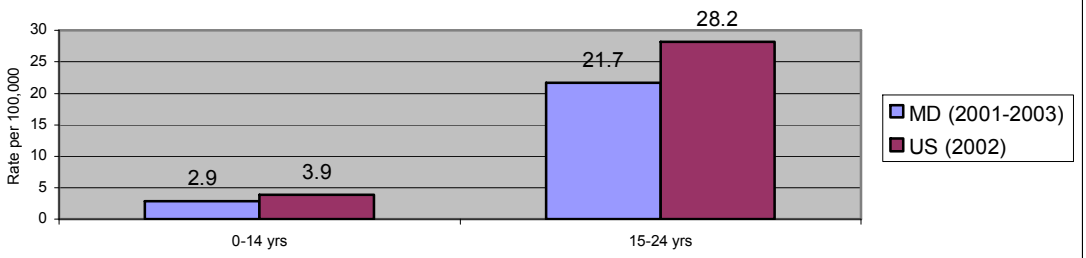
Vignette:
MD Teens Had Been Drinking, Police Say
Washington Post, September 29, 2004

"A 17-year motorist who died in a crash that also killed one of his teenage passengers had a blood-alcohol level of more than twice the legal limit for driving, Montgomery Police said. The car the decedent was driving at high speed spun out of control and slammed into a steel light pole. The dead passenger, also 17, was also under the influence of alcohol when the crash occurred. A total of five young people died and four injured in Montgomery in three weekend accidents, all of which involved excessive speed, police said. The victims were 16 to 19 years old."

Comparison to National Statistics: Motor Vehicle Accidents

Maryland's average mortality rates from motor vehicle accidents for children and young adults for 2001-2003 are higher than national rates (Figure 12; 2002, the most current year for which national data is available). The objective of the Healthy People 2010 goal is to reduce the mortality rate from motor vehicle crashes to no more than 9.2 per 100,000 in the general population (all races, all gender, all ages). In 2002, Maryland's total mortality rate from motor vehicle accidents (all ages) was 13.1 per 100,000 population.

Figure 12. Deaths from Motor Vehicle Accidents: Comparison to National Statistics



Source: MD data – Analysis of data from Vital Statistics Administration, DHMH
National data – National Center for Injury Prevention and Control

Homicides

There were 183 homicides in 2001-2003 among children aged 0 to 17 years. The numbers of homicide deaths among African-American and white children were 151 and 27 respectively, representing rates of 10.9 per 100,000 for African-American children and 1.1 per 100,000 for white children (Table 14). The greatest number of homicides occurred in older adolescents and involved the use of mostly firearms; 82 of the firearm-related deaths were in adolescents aged 15-17 years, representing a rate of 12.0 per 100,000 in this age group (Table 15). There were 27 homicides perpetrated against infants (under one year of age) during this three-year period. Of the 98 firearm-related deaths, 87 (88.8 percent) were among males and 11 (11.2 percent) among females (Table 16).

TABLE 14. HOMICIDE: TOTAL NUMBER AND AVERAGE RATE* BY RACE, 0-17 YEARS, MARYLAND, 2001-2003

	All homicides		By firearm		Other means	
	Number	Rate*	Number	Rate*	Number	Rate*
African American	151	10.9	90	6.5	61	4.4
White	27	1.1	8	0.3	19	0.7
Am. Indian	0	-	0	-	0	-
Asian & Pac. Is	4	-	0	-	4	-
Other	1	-	0	-	1	-
Total	**183**	**4.4**	**98**	**2.4**	**85**	**2.1**
Hispanic (any race)	8	3.5	0	-	8	3.5

Source: Analysis of data from Vital Statistics Administration, DHMH

* Per 100,000

-Rates based on fewer than 5 events in the numerator are not presented since rates based on small numbers are likely to be unstable.

TABLE 15. HOMICIDE: TOTAL NUMBER AND AVERAGE RATE* BY AGE GROUP, 0-17 YEARS, MARYLAND, 2001-2003

Age group	By Firearm		Other means	
	Number	Rate*	Number	Rate*
Under 1	2	-	25	11.1
1-4	2	-	25	2.9
5-9	2	-	5	0.4
10-14	10	0.8	8	0.7
15-17	82	12.0	22	3.2
Total	**98**	**2.4**	**85**	**2.1**

Source: Analysis of data from Vital Statistics Administration, DHMH
*Per 100,000 population
-Rates based on fewer than five events in the numerator are not presented since rates based on small numbers are likely to be unstable.

TABLE 16. MEANS OF HOMICIDE BY SEX, 0-17 YEARS, MARYLAND, 2001-2003

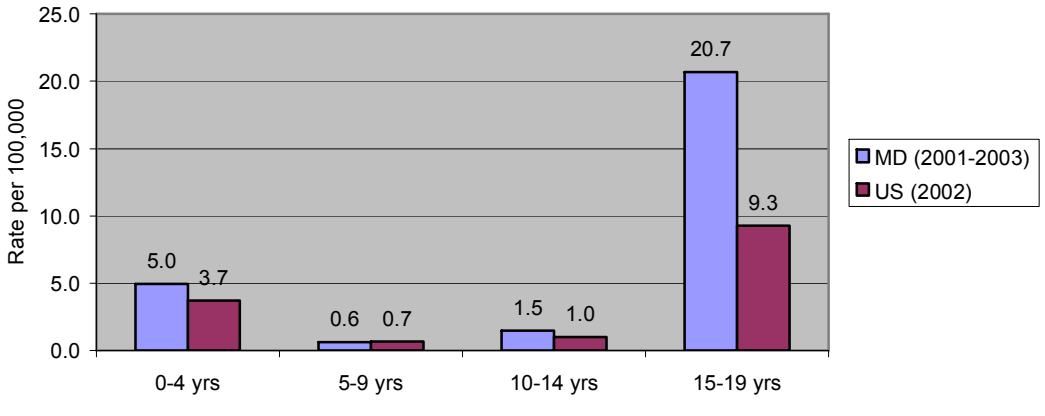
	Male	Female	Total
By firearm	87	11	98
Other means	49	36	85
Total	**136**	**47**	**183**

Source: Analysis of data from Vital Statistics Administration, DHMH

Comparison to National Statistics: Homicides

While in the 5-9 years and 10-14 years age groups, Maryland's average homicide rates for 2001-2003 are equal to the 2002 national rate or are slightly higher; the rates for the youngest and oldest children are higher than the national rate (Figure 13; 2002, the most current year for which national data is available). The Healthy People 2010 goal calls for reducing the homicide rate to no more than 3.0 per 100,000 (all races, all gender, all ages). In 2002, Maryland's total mortality rate from homicide (all ages) was 10 per 100,000 population.

Figure 13 Homicide Rates: Comparison to National Statistics



Source: MD data – Analysis of data from Vital Statistics Administration, DHMH
National data – National Center for Injury Prevention and Control

Vignette:
W. Baltimore teen fatally shot inside his residence
The Baltimore Sun, September 23, 2004

"A 16-year old drug dealer with an extensive juvenile arrest record was shot and killed inside his West Baltimore home, police said. Police said the decedent was dealing drugs through a slit in a window screen at his house. The shooter put the gun through the slit."

Vignette:
Couple Charged in Baby's Death
The Baltimore Sun, January 4, 2005.

"A couple was charged with crimes, including first-degree murder in the New Year's Day killing of their infant son. The baby suffered a broken skull, a broken right leg and back injuries, according to court documents. The baby's parents called 911 on New Year's Day to report that he wasn't breathing. The baby was taken by rescue workers from his bassinet in the couple's home to the hospital, where he was pronounced dead."

Vignette:
Woman sentenced for shaking toddler
The Baltimore Sun, September 4, 2004.

"A West Baltimore woman was sentenced to 14 years in prison – with all but five years suspended – for child abuse for shaking and nearly killing a 21-month-old girl in her care. The woman was accused of shaking the baby, resulting in the child's being hospitalized in critical condition at the hospital. Doctors told detectives that the child's injuries, which included severe head injuries and cigarette burns, were consistent with abuse and not from a fall down stairs, as claimed by the accused."

NATURAL CAUSES OF DEATH

In addition to being classified according to cause, death is also classified by manner as natural, accident (unintentional), homicide, suicide, and undetermined. Death from natural causes constituted a substantial proportion of mortality among children under 18 years of age in Maryland during the period 2001-2003. A death due to a natural cause can result from one of many serious health conditions. Congenital anomalies, genetic disorders, cancers, heart and cerebral problems, serious infections and respiratory disorders, such as asthma, can be fatal to children. Many of these conditions are not believed to be preventable to the same extent in which unintentional injuries, homicides or suicides are preventable. However, there are some illnesses such as asthma, infectious diseases and some screenable genetic disorders, in which under certain conditions, fatalities can and should be prevented.

CHILD DEATHS IN MARYLAND JURISDICTIONS

Many activities to avoid child deaths occur on the local level through public health and public policy interventions. Specific causes of death may also vary in different geographic locations. Information demonstrating the occurrence of infant and child deaths by jurisdiction is included in the following pages. In these tables and maps, an average rate over five years is used for comparison because a relatively low number of deaths in any jurisdiction in a single year may result in considerable variation which may not indicate an actual significant change. The tables also include an analysis of the change in the rate in jurisdictions over a ten-year period.

Maryland's average infant mortality rate declined by 8.6 percent between 1994-1998 and 1999-2003 (Table 17). However, statistically significant declines occurred only in Montgomery, Prince George's, and Queen Anne's Counties (Infant Mortality Report, Vital Statistics Administration, 2003). Figure 14 details how infant mortality in the jurisdictions compares with the Maryland average during the period 1999-2003.

For children ages 1-17 years, average mortality rate declined by 15.0 percent between 1994-1998 and 1999-2003 (Table 18). Statistically significant declines occurred, however, only in Baltimore City and Anne Arundel County. Changes in the sociodemographic characteristics of the population may also have contributed to changes in rates and percentage changes with respect to infant and child deaths.

The number of childhood deaths by jurisdiction (1999-2003) is shown in Appendix A.

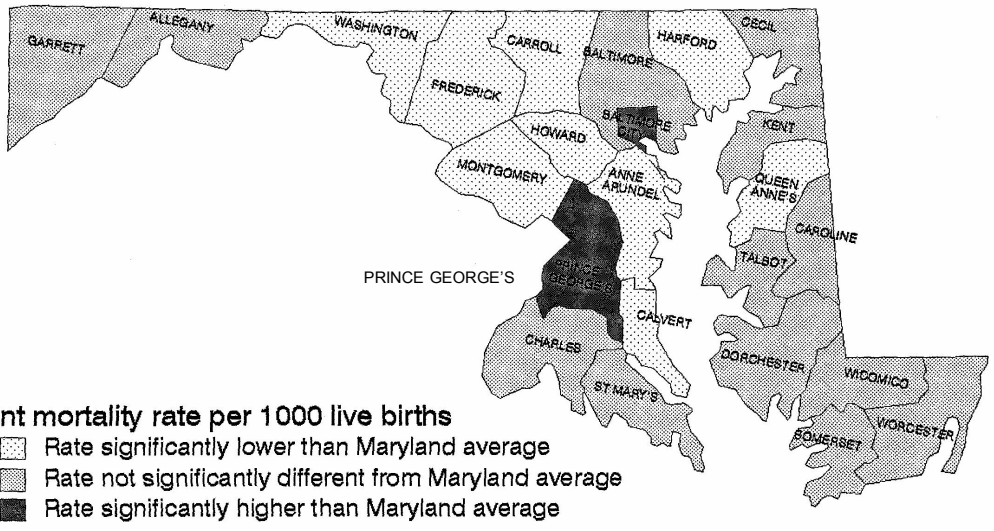
Figure 15 shows the difference between death rates for children ages 1-17 years in the jurisdictions and the Maryland average during the period 1999-2003.

TABLE 17. NUMBER OF INFANT DEATHS, INFANT MORTALITY RATES* AND PERCENT CHANGE IN RATES* BY REGION AND POLITICAL SUBDIVISION, MARYLAND, 1994-1998 AND 1999-20003

Region and Political Jurisdiction	Number of infant deaths		Average infant mortality rate*		Percent Change**	
	1994-1998	1999-2003	1994-1998	1999-2003		
Maryland	**3109**	**2902**	**8.6**	**7.9**	**-8.6**	***
Northwest Area	151	161	5.7	5.7	1.4	
Garrett	12	18	6.7	10.9	62.6	
Allegany	19	30	4.9	8.3	70.4	
Washington	56	45	7.2	5.5	-24.3	
Frederick	64	68	4.9	4.7	-3.5	
Baltimore Metro Area	**1450**	**1363**	**8.5**	**8.1**	**-5.1**	
Baltimore City	647	565	12.7	12.1	-4.6	
Baltimore County	355	348	7.8	7.6	-2.9	
Anne Arundel	211	230	6.5	6.8	3.2	
Carroll	60	40	6.3	4.2	-32.8	
Howard	75	105	4.4	6.0	34.0	
Harford	102	75	6.9	5.1	-25.3	
National Capital Area	**1182**	**1044**	**9.7**	**8.2**	**-15.3**	***
Montgomery	412	368	6.8	5.6	-17.3	***
Prince George's	770	676	12.6	11.0	-12.7	***
Southern Area	**139**	**137**	**7.4**	**6.8**	**-8.5**	
Calvert	27	26	5.9	5.2	-12.3	
Charles	55	63	6.8	7.2	5.8	
St. Mary's	57	48	9.3	7.4	-20.2	
Eastern Shore	**187**	**197**	**8.2**	**8.2**	**-0.1**	
Cecil	37	49	6.8	8.4	22.5	
Kent	5	10	5.0	11.2	125.5	
Queen Anne's	22	10	10.1	4.0	-60.1	***
Caroline	20	23	11.0	11.7	6.7	
Talbot	7	9	4.1	5.2	28.3	
Dorchester	13	14	7.8	8.6	9.5	
Wicomico	45	54	8.4	9.4	12.0	
Somerset	12	12	9.6	9.3	-3.3	
Worcester	26	16	10.9	6.5	-40.3	

Source: Infant Mortality in Maryland, Vital Statistics, Administration, DHMH
*Per 1000 live births
**Percent change is based on the exact rates and not the rounded rates presented here.
***Rates for 1994-1998 and 1999-2003 differ significantly (p<0.5)

Figure 14. Comparison of County Infant Mortality Rates With the State Average, Maryland, 1999-2003*



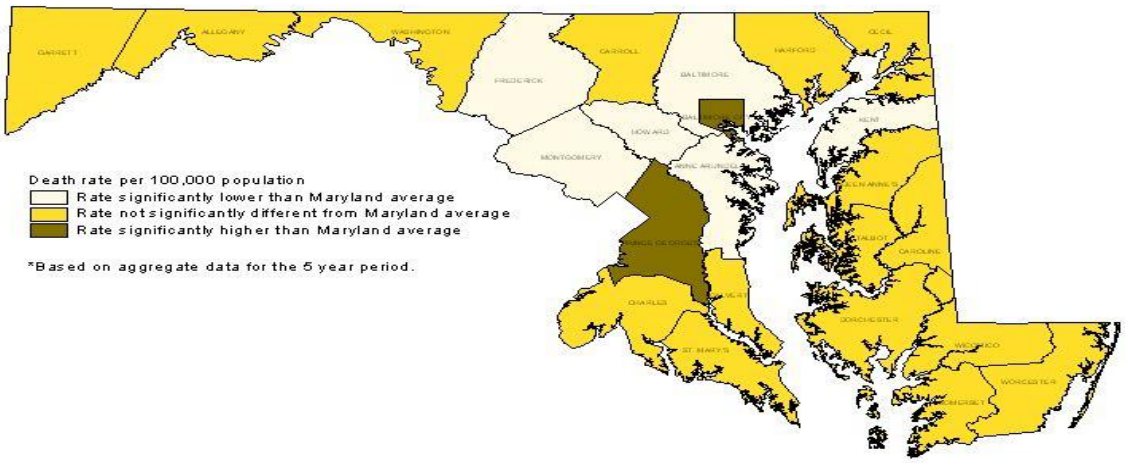
* Based on aggregate data for the 5 year period.

TABLE 18. NUMBER OF DEATHS, DEATH RATES AND PERCENT CHANGE IN RATES FOR CHILDREN 1-17 YEARS, MARYLAND, 1994-1998 AND 1999-2003

Region and	# Deaths*		Death Rates		Death Rates**	
Political Jurisdiction	1994-1998	1999-2003	1994-1998	1999-2003	Change***	
Maryland	**1,876**	**1,702**	**31.1**	**26.5**	**-15.0**	****
Northwest Area	**112**	**130**	**23.4**	**25.3**	**8.0**	
Garrett	12	12	33.0	33.8	2.5	
Allegany	20	23	26.1	31.5	21.0	
Washington	37	43	26.6	29.5	10.7	
Frederick	43	52	19.0	20	5.3	
Baltimore Metro Area	**1020**	**862**	**35.5**	**28.7**	**-19.0**	****
Baltimore City	493	382	59.8	50.6	-15.5	****
Baltimore County	200	180	25.4	21.6	-16.0	
Anne Arundel	147	124	27.3	21.1	-22.7	****
Carroll	50	41	28.1	20.5	-27.1	
Howard	52	65	18.4	19.7	7.0	
Harford	78	70	29.3	24.1	-17.9	
National Capital Area	**477**	**473**	**25.4**	**22.7**	**-10.5**	****
Montgomery	163	157	17.2	14.9	-13.3	
Prince George's	314	316	33.6	31.2	-7.2	
Southern Area	112	**101**	**31.2**	**25.6**	**-17.8**	
Calvert	**28**	27	30.4	25.3	-16.6	
Charles	51	43	32.8	25.3	-22.9	
St. Mary's	33	31	29.6	26.4	-10.8	
Eastern Shore	**155**	**136**	**36.1**	**29.8**	**-17.3**	
Cecil	27	39	26.0	34.2	31.7	
Kent	7	2	36.6	10.5	-71.2	
Queen Anne's	14	12	32.4	24.1	-25.4	
Caroline	9	9	25.2	23.7	-5.8	
Talbot	8	6	24.6	17.3	-29.8	
Dorchester	17	10	50.2	29.8	-40.7	
Wicomico	41	33	42.6	33.5	-21.4	
Somerset	13	6	56.8	27.1	-52.3	
Worcester	19	19	44.9	41.0	-8.8	

*Source of data: Analysis of death data from Vital Statistics Administration
**Per 100,000 population
***Percent change is based on the exact rates and not the rounded rates presented here
****Rates for 1994-1998 and 1999-2003 differ significantly (p<.05)

Figure 15. Comparison of County Death Rates for Children ages 1-17 Years with the State Average, Maryland, 1999-2003*



CLOSING

Although child deaths and death rates are declining in Maryland, there is still room for improvement. The most common causes of death in children and adolescents are frequently related to preventable factors. Provision of data that describes the extent, distribution and risk factors of childhood deaths is vital to policy makers, health professionals and communities to enable them to make decisions about allocation of resources and institution of effective strategies to prevent future child fatalities, and to monitor progress. The data presented here supplements the review process of local Child Fatality Review teams (CFR) to gain understanding of the circumstances surrounding the death of children in their jurisdictions. Because CFR teams are multi-disciplinary and multi-agency, they are uniquely qualified to understand what no single agency or group working alone can: how and why children are dying in their communities. In many cases, this review provides important information, which can direct appropriate prevention initiatives by local authorities. In addition, state and federal initiatives are important in avoiding preventable deaths in children.

In the future, when the new state CFR database becomes operational to allow for its data to be analyzed, the report will incorporate findings and recommendations of local CFR teams.

APPENDIX A: NUMBER OF CHILDHOOD DEATHS, 1-17 YEARS, BY JURISDICTION
MARYLAND, 1993-2003

Regional and Political Jurisdiction	1999	2000	2001	2002	2003	Total
Maryland	**346**	**333**	**351**	**340**	**332**	**1702**
Northwest Area	31	24	25	18	32	130
Garrett	2	5	3	0	2	12
Allegany	6	4	5	2	6	23
Washington	8	7	10	6	12	43
Frederick	15	8	7	10	12	52
Baltimore Metro Area	**180**	**169**	**165**	**183**	**165**	**862**
Baltimore City	84	69	60	93	76	382
Baltimore	43	37	38	31	31	180
Anne Arundel	27	25	26	23	23	124
Carroll	10	9	7	7	8	41
Howard	6	16	16	12	15	65
Harford	10	13	18	17	12	70
National Capital Area	**88**	**96**	**108**	**90**	**91**	**473**
Montgomery	26	38	35	27	31	157
Prince George's	62	58	73	63	60	316
Southern Area	**24**	**20**	**15**	**18**	**24**	**101**
Calvert	7	5	5	2	8	27
Charles	11	4	6	13	9	43
St. Mary's	6	11	4	3	7	31
Eastern Shore	**23**	**24**	**38**	**31**	**20**	**136**
Cecil	5	10	11	9	4	39
Kent	1	0	0	1	0	2
Queen Anne's	1	1	5	2	3	12
Caroline	1	2	1	4	1	9
Talbot	1	1	1	1	2	6
Dorchester	2	2	3	2	1	10
Wicomico	5	6	9	8	5	33
Somerset	2	0	3	1	0	6
Worcester	5	2	5	3	4	19

Source: Analysis of data from Vital Statistics Administration, DHMH

Appendix C

2004 Report of Local CFR Team Activities

CHILD FATALITY REVIEW
Report of Local Team Activities, 2004
Jurisdiction: Allegany County

	(Answers in this Column)
1. Number of CFR meetings held in 2004:	2
2. What resources do you use to make sure you identify <u>all</u> deaths of children that occur in your community?	OCME Vital Statistics
3. Of all these deaths, what factors do you use to select cases for review at CFR meetings?	All OCME cases reviewed unless natural with known chronic medical condition as cause of death. Others as group determines appropriate.
4. Number of cases reviewed at Local CFR team meetings in 2004, regardless of year of death: *(Number should include cases from OCME, Vital Statistics and other sources).*	2
5. Number of cases in which child abuse or neglect was **substantiated** (i.e. homicide):	2
6. Number of cases in which the team felt abuse or neglect **contributed** to the death:	2
7. Does your team have guidelines for determination of abuse/neglect? If so, what are they?	DSS Criteria
8. Recommendations made by team for Local action:	Family Preservation Services
a. Possible state-local advocacy:	Campaign similar to Parent's Eyes Save Children's Lives
b. Other:	Local increase in awareness campaign Parent's Eyes Save Children's Lives
9. Actions taken in/by your Jurisdiction *(Briefly highlight special activities).*	Increase awareness of need for parental supervision. Community working on "Got Hope" to help prevent and treat drug addiction.
10. Recommendations from Local team to the State CFR team:	See 8.
11. Attach Membership List *(Role/Affiliation/address/phone/e-mail for Chair/ Co-Chair/Contact only. All others, name and Agency affiliation only).*	See attached.

Your Ideas and Input:	
What training events would the team leadership and/or the team members find helpful?	
Team Leaders:	Dr. Carolyn Fowler to come in March to provide training for team on evaluation of situation and ways to develop recommendations.
Team Members:	
What training events have been **conducted** by your team during 2004?	None planned, 3/05
What training events have been **attended** by your team during 2004?	Injury Prevention Networking Meeting
Does your team have a need for Technical Assistance for CFR? Describe.	Not at this time

Parent's Eyes Save Children's Lives

- Developed by the Child Abuse Task Force
- Funded by LMB dollars
- Multi-agency campaign to make adults aware of high-risk situations faced by children and how they can prevent or avoid harm.
  - Billboards
  - Radio spots
  - Incentive items
  - Bus signs
  - Posters

  Radio spots highlighted different agencies area of expertise, i.e., Health Department, DSS, Police, State's Attorney's office

Allegany County 2004 Child Fatality Review Board

Dr. Sue Raver, Chair/Facilitator
Allegany County Health Department (ACHD)
P. O. Box 1745
Cumberland, MD 21501-1745
301-777-5657 phone
301-777-5674 fax
sraver@dhmh.state.md.us

Jim Brenneman
Outpatient Addictions
ACHD

Deloris Gingerich
Mental Health System's Office (CSA)
ACHD

Janie Hutcherson
Prevention
ACHD

Diane Rice
Child Health
ACHD

Lisa Swauger
Mental Health
ACHD

Harry Grove
Department of Juvenile Service

Bill Hardy, EMS
Western Maryland Health System

Christina Hamilton
State's Attorney's Office

Jim Koon, EMS
Alternative School

Ruth Lafferty
Child Care Administration

Dr. Michael Levitas
Children's Medical Group

Tim Miller
Board of Education

Jim Pyles, Detective Sergeant
C3I/Maryland State Police

Carol Sangiovanni
Child Abuse Task Force

John Sangiovanni
Department of Social Services

Dr. Paul Snow
Medical Examiner

R. Anne Sheetz, L.C.P.C., R.N.
(Zealand Psychological Associates)

Other agencies are represented when appropriate, i.e., police and C3I officers, pediatricians, fire and ambulance responders.

CHILD FATALITY REVIEW
Report of Local Team Activities, 2004
Jurisdiction: Anne Arundel County

	(Answers in this Column)
1. Number of CFR meetings held in 2004:	4
2. What resources do you use to make sure you identify <u>all</u> deaths of children that occur in your community?	Death Certificates. FIMR, Newspaper
3. Of all these deaths, what factors do you use to select cases for review at CFR meetings?	All Referrals from OCME. Do not present most deaths from congenital disorders to the full team
4. Number of cases reviewed at Local CFR team meetings in 2004, regardless of year of death: *(Number should include cases from OCME, Vital Statistics and other sources).*	24
5. Number of cases in which child abuse or neglect was **substantiated** (i.e. homicide):	0
6. Number of cases in which the team felt abuse or neglect **contributed** to the death:	1
7. Does your team have guidelines for determination of abuse/neglect? If so, what are they?	Rely on input from DSS, schools, police & State's Attorney's Office
8. Recommendations made by team for Local action:	To school health to make it routine to check blood pressure and other vital signs on children who make multiple Health Room visits complaining or headache or migraine.
a. Possible state-local advocacy:	None
b. Other:	None
9. Actions taken in/by Jurisdiction *(Briefly highlight special activities).*	None
10. Recommendations from Local team to the State CFR team:	None
11. Attach Membership List *(Role/Affiliation/address/phone/e-mail for Chair/ Co-Chair/Contact only. All others, name and Agency affiliation only).*	See attached

Your Ideas and Input:	
What training events would the team leadership and/or the team members find helpful?	1. Interventions to recommend pertaining to death from motor vehicle accidents or bicycles. 2. Criteria for determining abuse or neglect
Team Leaders:	
Team Members:	
What training events have been **conducted** by your team during 2004?	None
What training events have been **attended** by your team during 2004?	State CFR Training
Does your team have a need for Technical Assistance for CFR? Describe.	No

.

ANNE ARUNDEL COUNTY
CHILD FATALITY REVIEW TEAM
MEMBERS
2004

C. Earl Hill, M.D.
Chairman
1677 Thrope Road
Pasadena, MD 21122
410-255-9529
cearlhill@earthlink.net

Frances Feldman
Regional Manager
Child Care Administration,
Region I

Susan Crosby, R.N., M.P.H.
Deputy Director, Community Outreach
Anne Arundel County Department of Health

Laura Kiessling
Office of the State's Attorney

Barbara Schwartz, PhD.
Coordinator, Psychological Services
Anne Arundel County Public Schools

Alice Harris
Acting Executive Director
Anne Arundel County Local
Management Board

Linda Fassett, Ed.D
Director, Mental Health and Addictions
Anne Arundel County Department of Health

David Ladd, L.C.S.W.C.
Anne Arundel County
Department of Social
Services

Frank Stamm
Battalion Chief
Anne Arundel County Fire Department

Lt. Alan Marshall
Annapolis Police
Department

Jo D Straub
Juvenile Counselor Supervisor
Anne Arundel County Dept of Juvenile Justice

Alice Murray, R.N., M.P.H.
Private Citizen

Sgt. David Waltemeyer
Anne Arundel County Police Department

Frank Pecukonis, Ph.D.
Anne Arundel County
Mental Health and
Addictions

Mary Ann Woodzelle, R.N., M.A.
Director, Community Outreach
Anne Arundel County Department of Health

Susan Hogan, M.D.
Assistant Medical Examiner
OCME

Katherine Farrell, M.D., M.P.H.
Deputy Health Officer, Public Health
Anne Arundel County Department of Health

Ann Jackson
Local Management Board
Anne Arundel County

Jennifer Schroeder, R.N., BSN
Program Manager, Community Health
Anne Arundel County Department of Health

Lani Wheeler, M.D.
Pediatric Consultant
Anne Arundel County
Department of Health

CHILD FATALITY REVIEW
Report of Local Team Activities, 2004
Jurisdiction: Baltimore City

(Answers in this Column)

1. Number of CFR meetings held in 2004:	8
2. What resources do you use to make sure you identify all deaths of children that occur in your community?	OCME.
3. Of all these deaths, what factors do you use to select cases for review at CFR meetings?	We review all cases sent to us by the OCME.
4. Number of cases reviewed at Local CFR team meetings in 2004, regardless of year of death: *(Number should include cases from OCME, Vital Statistics and other sources)*.	95
5. Number of cases in which child abuse or neglect was **substantiated** (i.e. homicide):	7
6. Number of cases in which the team felt abuse or neglect **contributed** to the death:	7
7. Does your team have guidelines for determination of abuse/neglect? If so, what are they?	No guidelines per se. The CFR Team relies on the ME's findings and reports from DSS.
8. Recommendations made by team for Local action:	
a. Possible state-local advocacy:	None.
b. Other:	See actions taken.

9. Actions taken in/by your Jurisdiction *(Briefly highlight special activities)*.	• Wrote a letter to Northwood principal to discuss water safety following a drowning death reviewed at CFR. The recommendation to write the letter was broadened to include water safety for all schools – Dr. Beilenson spoke with all principals during summer meeting. • An Infant Safety Meeting was held to develop strategies to address the recurring issue of co-sleeping and SUDI deaths. • Prevention activities relating to the three most prevalent causes of death reviewed in the CFR process: 1.SIDS/SUDI cases, a public education approach emphasizing safe sleeping; 2.for juvenile homicide, DJS was asked to identify the highest risk kids for referral to Operation Safe Kids; and 3. for cases involving child abuse and neglect, the recommendation was for temporary or permanent removal with monitoring of the placement for access by the perpetrators. • Sought funding from the Abell Foundation to make and distribute infant sleepwear with a safe sleeping message. • Dr. Beilenson informed the team that he had met with Secretary McCabe who had agreed to join him in presenting information on DSS services and referral process during Grand Rounds at city hospitals. • A summary of information regarding non-prescription cold medications and children was created. This came as a follow-up to cases reviewed by CFR where young children died as a result of overdoses of combination cold medicines and a non-fatal case treated at Johns Hopkins where a child was accidentally given infant Tylenol that is more concentrated than the children's formulation. Input from pediatricians at Johns Hopkins was received on the summary and comments were given. • A press conference was held on Wednesday, October 27, 2004 at Healthy Start to inform the public of infant deaths in Baltimore City due to unsafe sleep environments. Dr. Beilenson described safe sleep practices that reduce the risk of these deaths and announced the Infant Safe Sleep Campaign and the onesie and brochure that are part of the campaign. • On November 12, 2004 Dr. Beilenson held a press conference to call on parents and medical professionals to monitor the type and dosage of cold medications given to sick children. • Created "Speaker Series" to occur following normal CFR case reviews. Start date is January 2005.

10. Recommendations from Local team to the State CFR team:	None.
11. Attach Membership List *(Role/Affiliation/address/phone /e-mail for Chair/ Co-Chair/Contact only. All others, name and Agency affiliation only).*	

NAME	TITLE AND ORGANIZATION
Angelici, Karen	Baltimore City Health Department – Director, Infant Survival Initiative
Allan, Carol	Office of the Chief Medical Examiner
Bassin, Lucy J.	University of Maryland Baltimore School of Social Work
Becker, Donna C.	UMSM, Center for Infant And Child Loss
Beilenson, Peter	Commissioner of Health, Baltimore City Health Department
Bogrov, Michael Arthur	Sheppard Pratt Hospital
Bridgeforth, Keith	Department of Juvenile Services
Doyle, Tracy	Baltimore City Health Department, Div. of Maternal and Child Health
Drake, Julie	Felony Family Violence Division Baltimore City State's Attorney Office
Duncan-Wilson, Dorenzer	Baltimore Mental Health Systems
Fine, Catherine	Operation Safe Kids
Firth, Lisa	Division of Maternal and Child Health, Baltimore City Health Department
Gainers, Jocelyn	Baltimore Substance Abuse Systems
Glass-Siegel, Marcia	Baltimore Mental Heatlh Systems
Green, Kamala T.	Mayor's Office for Children, Youth & Families
Greenberg, Tasha	Office of the Chief Medical Examiner
Holzer, Dave	Supervising Attorney Baltimore City Dept. of Social Services
Kinkopf, Kristen Stamile	DSS Commission
Layman, Leyla	Operation Safe Kids
Morrison, Michael	Regional Child Care Administration – DHR
O'Keefe, Gena	Baltimore City Health Department, Health Projects Director
Rowe, Sgt. Scott	Baltimore City Police – Homicide Section
Saunders, Ted (Chief)	Baltimore City Fire Marshal
Shubin, Charles	Children's Health Center Mercy Family Care
Smith, Jane	Maryland Department of Human Resources
Spaccarelli, Arianne	Baltimore City Health Department
Spears, Tina	Baltimore City Public School System
Strohminger, Nancy M.	Turn Around, Inc.
Walker, Allen	Pediatric Emergency Medicine – Johns Hopkins Hospital
Wilson, Dan	Baltimore City Department of Social Services

Your Ideas and Input:	
What training events would the team leadership and/or the team members find helpful?	
Team Leaders:	• Understanding how the cases are chosen. • Presentation by State CFR team with updates on State actions and action taken by other local CFR teams.
Team Members:	• Presentation by Medical Examiners office regarding death investigation. (A presentation was given by the ME's office to the Baltimore City CFR regarding pediatric death investigation in January 2005). Other team members such DSS will be presenting in 2005.
What training events have been **conducted** by your team during 2004?	None.
What training events have been **attended** by your team during 2004?	State CFR training.
Does your team have a need for Technical Assistance for CFR? Describe.	Not at this time but we are always open to ideas from the State CFR.

www.co.ba.md.u

Baltimore County
Child Fatality Review Team
Phone: 410-887-2738
Fax: 410-887-2737

CHILD FATALITY REVIEW
Report of Local Team Activities, 2004
Jurisdiction: Baltimore County

	(Answers in this Column)
1. Number of CFR meetings held in 2004:	7
2. What resources do you use to make sure you identify <u>all</u> deaths of children that occur in your community?	We rely primarily on referrals from OCME but team members inform us of deaths that have happened so that we can ensure they are referred. We crosscheck with an OCME case printout regularly. We also review the newspaper for reports of child deaths.
3. Of all these deaths, what factors do you use to select cases for review at CFR meetings?	We review all OCME referrals. We plan to review a small number of "near-fatalities" in 2005.
4. Number of cases reviewed at Local CFR team meetings in 2004, regardless of year of death: *(Number should include cases from OCME, Vital Statistics and other sources).*	Total = 41 5 deferred from 2003 36 new referrals [3 other cases were referred in error (not Baltimore County cases) and referred back to OCME]
5. Number of cases in which child abuse or neglect was **substantiated** (i.e. homicide):	3 infant deaths
6. Number of cases in which the team felt abuse or neglect **contributed** to the death:	2 children, with negative autopsy findings, had a positive history of abuse/neglect. Both were signed out as SUDI/UNDETERMINED
7. Does your team have guidelines for determination of abuse/neglect? If so, what are they?	We review CPS involvement for all cases as well as ME file data. Where available, we review public health nursing case management information.
8. Recommendations made by team for Local action:	We have two priority areas this year: sleep safety and male caretaker training. We are also concerned about deaths in young drivers (16 years) and/or their young passengers.

a. Possible state-local advocacy:	Graduated licensing laws for teenagers: restricted passengers in first year.
b. Other:	
9. Actions taken in/by your Jurisdiction *(Briefly highlight special activities).*	*Our Shaken Baby flier has been adopted by the State for use in Mayland. *As a CFR, we applied for grant funding to establish a child safety network in the Essex area of the county. This was successful. The multidisciplinary grant-funded project begins in March 2005. * We are planning a CFR "page" on the county website
10. Recommendations from Local team to the State CFR team:	1. Pursue the issue of funding for CFR aggressively. Recommend that all local teams document the hours contributed by various members so that we could calculate the $ value of "in-kind" hours contributed to CFR teams. Valuable information for advocacy. 2. Provide a directory of all local team coordinators to every team. If possible add other important local contacts such as SAFE KIDS or Injury Prevention Coordinator, Community Traffic Safety Planner, ME assigned to team (if relevant), etc. 3. Focus capacity development activities on action planning. We need to move beyond data collection.
11. Attach Membership List *(Role/Affiliation/address/phone/e-mail for Chair/ Co-Chair/Contact only. All others, name and Agency affiliation only).*	Attached

Your Ideas and Input:	
What training events would the team leadership and/or the team members find helpful?	We are fortunate to have several very skilled team members who share knowledge with us.
Team Leaders:	Training on the new CFR database data entry protocols
Team Members:	Training on the new CFR database data entry protocols
What training events have been **conducted** by your team during 2004?	1. In May 2004, we held a one-day Child Safety Strategy Conference in Baltimore County. 40 people who represented numerous county organizations/agencies as well as state agencies attended this. 2. Team members were involved in presenting at the State CFR meeting. 3. Team members presented at Governor's Child Abuse Conference and CFR Training Conference 4. Training on childhood injury prevention for all Baltimore County school nurses and school health aids.
What training events have been **attended** by your team during 2004?	State CFR conference, Governor's Child Abuse Conference, Baltimore County Child Safety Strategy Conference
Does your team have a need for Technical Assistance for CFR? Describe.	No. Funding for the coordinator is a major issue as FIMR is funded but not CFR.

NAME	AGENCY
Mary Beckenholdt	BC Health Department (FIMR Coordinator)
Capt. Glenn Blackwell	Baltimore County Fire Department (alt. for Capt. Korn)
Lt. Craig Bowers	BC Police Department (Homicide Unit)
Paula Boykin (as available)	BC Health Department (WIC and Infants and Toddlers)
Ann Brobst	BC Office of the State's Attorney (as available; alt. for John Cox and Jason League)
Capt. Tom Busch	BCPD and BCPS Safe Schools Program
John Cox*	BC Office of the State's Attorney (*until September 2004)
Dr. Carolyn Fowler	BC Health Department (Injury Prevention Program)
Colleen Freeman	BC Health Department (MCH; Child Advocacy Center)
Dr. Tasha Greenberg	Office of the Chief Medical Examiner
Rose Marie Hayes	Child Care Licensing Administration
Sheila Johnson	BC Health Department (Public Health Nursing)
Capt. Jim Korn	BC Fire Department (EMS)
Dr. Scott Krugman	Franklin Square Hospital and AAP
Jason League**	BC Office of the State's Attorney (**from September 2004)
Laurel Moody	BC Public Schools
John Rusinko	Catholic Charities
Don Schlimm	BC Local Management Board
John Stallard	BC Health Department (Developmental Disabilities)
Jane Talbott	Citizen Member
Mark Vidor	DHR (Family Services)
Dawn Zulauf	Chief Forensic Investigator (OCME) – as available

Prepared by Carolyn Fowler (cfowler@co.ba.md.us)

CHILD FATALITY REVIEW
Report of Local Team Activities, 2004
Jurisdiction: Calvert County

(Answers in this Column)

1. Number of CFR meetings held in 2004:	4
2. What resources do you use to make sure you identify <u>all</u> deaths of children that occur in your community?	Death certificates
3. Of all these deaths, what factors do you use to select cases for review at CFR meetings?	Death in county of children 18 and under.
4. Number of cases reviewed at Local CFR team meetings in 2004, regardless of year of death: *(Number should include cases from OCME, Vital Statistics and other sources).*	6
5. Number of cases in which child abuse or neglect was **substantiated** (i.e. homicide):	None
6. Number of cases in which the team felt abuse or neglect **contributed** to the death:	None
7. Does your team have guidelines for determination of abuse/neglect? If so, what are they?	State of Maryland Child Protection Laws and Family Law Statute.
8. Recommendations made by team for Local action:	
a. Possible state-local advocacy:	
b. Other:	Outcomes include: Heightened interagency communication. Increased awareness of child fatality issues within agencies.
9. Actions taken in/by your Jurisdiction *(Briefly highlight special activities).*	Women's Shelter has instituted multiple protocol changes to enhance infant & child safety. Local law enforcement is more closely scrutinizing crime scene details involving infants & children.
10. Recommendations from local team to the State CFR team:	None
11. Attach Membership List *(Role/Affiliation/address/phone/e-mail for Chair/ Co-Chair/Contact only. All others, name and Agency affiliation only).*	

Your Ideas and Input:	
What training events would the team leadership and/or the team members find helpful?	Münchausen's Syndrome
Team Leaders:	
Team Members:	
What training events have been **conducted** by your team during 2004?	
What training events have been **attended** by your team during 2004?	OCME presented State Child Fatality Review Training Conference November 16, 2004. OCME presented Investigation of SIDS deaths in Maryland on December 8, 2004 at Calvert Memorial Hospital.
Does your team have a need for Technical Assistance for CFR? Describe.	No

2004 Calvert County Child Fatality Review Team

David L. Rogers, M.D., Health Officer
Chairman
Calvert County Health Department
Prince Frederick, MD 20678
410-535-5400
e-mail: dlrogers@dhmh.state.md.us

Barbara Buchheister, RN
Facilitator
Calvert County Health Department
P O Box 980
Prince Frederick, MD 20678
410-535-5400
e-mail: bbuchheister@dhmh.state.md.us

Mrs. Phyllis Baker
Attorney-At-Law

Ms. Susan Copsey
Regional Representative
Child Care Administration

Ray D'Arienzo, Ed.D.
Superintendent of Student Services &
Hearing Officer
Calvert County Public Schools

Sheriff Michael Evans
Calvert County Sheriff's Office

Mrs. Barbara Fenwick, RN
Director, Emergency Service
Calvert Memorial Hospital

Ms. Laura Martin
Calvert County State's Attorney's Office

Mrs. Doreen McKenzie
Calvert County Department of Social
Services

Ms. Donna Millar
County Supervisor
Department of Juvenile Services

Mr. John Mitchell
Director, Substance Abuse Program
Calvert County Health Department

Detective Sgt.Michael Moore
Calvert County Sheriff's Office

Lt. Homer Rich
Commander, Maryland State Police
Barrack U

James Richardson
Coordinator, Fire Rescue EMS
Calvert County Government

Mary G. Ripple, M.D.
Deputy Chief Medical Examiner

Osama Saleh, M.D.
Child Psychiatrist
Mental Health Division
Calvert County Health Department

Mr. Douglas Weems
Director, Core Service Agency
Calvert County Health Department

CHILD FATALITY REVIEW
Report of Local Team Activities, 2004
Jurisdiction: Caroline County

1. Number of CFR meetings held in 2004:	4
2. What resources do you use to make sure you identify <u>all</u> deaths of children that occur in your community?	Vital records, Obituaries, Death certificates, FIMR, Case Referral for Local Review from Maryland Child Fatality Review
3. Of all these deaths, what factors do you use to select cases for review at CFR meetings?	Full CFR review is performed on all referrals from the OCME
4. Number of cases reviewed at Local CFR team meetings in 2004, regardless of year of death: *(Number should include cases from OCME, Vital Statistics and other sources).*	6 (4 completed and 2 continued into 2005)
5. Number of cases in which child abuse or neglect was **substantiated** (i.e. homicide):	1
6. Number of cases in which the team felt abuse or neglect **contributed** to the death:	1
7. Does your team have guidelines for determination of abuse/neglect? If so, what are they?	Utilize CPS criteria
8. Recommendations made by team for Local action:	
a. Possible state-local advocacy:	Teen driving restricting passengers until age 18
b. Other:	

9. Actions taken in/by your Jurisdiction *(Briefly highlight special activities).*	▪ Collaboration with Delaware Medical examiner ▪ Promoted a variety of safety messages ▪ Cases were reviewed on more than 1 occasion ▪ High School Assembly addressing behavioral risks ▪ Hosted QA Co. Coordinator/State CFR team member ▪ Initiated Counseling Services for survivors ▪ LMB grant for Hospice counselor to provide services for sibling survivors ▪ New partnerships/collaboration ▪ Review of all child deaths ▪ Press releases ▪ Uniform reporting – completion of case reports ▪ Child Assessment Center-LMB
10. Recommendations from Local team to the State CFR team:	▪ Teen driving restricting passengers until age 18
11. Attach Membership List *(Role/Affiliation/address/phone/e-mail for Chair/ Co-Chair/Contact only. All others, name and Agency affiliation only).*	

Your Ideas and Input:	
What training events would the team leadership and/or the team members find helpful?	
Team Leaders:	Incorporating Regional FIMR data and findings
Team Members:	▪ Understanding Initial Police Investigation ▪ Moving from Investigation to Support Services ▪ Making Timely Team Recommendations
What training events have been **conducted** by your team during 2004?	▪ Child Health - Back to Sleep/SIDS –Judy Center and Family Support Center parents and staff ▪ Child Health- Newborn Parents instruction in Back to sleep/SIDS
What training events have been **attended** by your team during 2004?	▪ Governor's Child Abuse & Neglect Conference ▪ Moving to Action ▪ High Risk Adolescent Behaviors-MSDE ▪ Adolescent Health Issues in the 21st Century ▪ Summit for Clinical Excellane-2nd National Adolescent Conference ▪ Critical Issues for Adolescent Drug Court
Does your team have a need for Technical Assistance for CFR? Describe.	▪ Data collection and reporting ▪ Determining abuse/neglect in CFR case review

2004 CAROLINE COUNTY CHILD FATALITY REVIEW TEAM

Representing:	Name:
Health Officer	Dr. Leland Spencer Caroline County Health Dept.
Deputy Health Officer	Rebecca Loukides CCHD
Appointed Member	Jennie Glime Caroline County Health Dept. 410-479-8015 410-479-4871 fax jennieg@dhmh.state.md.us
Medical Examiner	Dr. Christian Jensen
Director DSS	Dina Gomes Daly
State's Attorney	Jonathan Newell
Superintendent/Schools	Dr. Edward Shirley
Director of Pupil Svcs.	Mary Ann Adkins
Law Enforcement	Sidney Pinder
Law Enforcement	Dan Nelson MD. State Police TFC John Branham Sgt. Joe Gambrill Lt. Gary Foster
Director of Substance Abuse Psychologist experienced in child abuse and neglect.	Dr. Betty Malkus
Attorney representing DSS Child welfare proceedings	Millicent Maloney
Reg. Rep. of Child Care Adm.	Price Shuler
Dir. of Caroline Co. Service Agency	Mike Campbell

Pediatrician, experienced in diagnosing/treating injuries and child abuse and neglect	**Dr. Denise Kyle**
Pediatricians Cont'd.	**Dr. Moore** **Dr. Riddle**
General Public	**Renee Woodworth**
Local Management Board w/interest or expertise in prevention and treatment	
Transportation Safety	**Sgt. Merl Evans**

CHILD FATALITY REVIEW

Report of Local Team Activities, 2004
Jurisdiction: Carroll County

1. Number of CFR meetings held in 2004:	4
2. What resources do you use to make sure you identify <u>all</u> deaths of children that occur in your community?	Reports from OCME Death Certificates Newspaper Obituaries
3. Of all these deaths, what factors do you use to select cases for review at CFR meetings?	Cases reviewed by OCME
4. Number of cases reviewed at Local CFR team meetings in 2004, regardless of year of death: *(Number should include cases from OCME, Vital Statistics and other sources).*	12
5. Number of cases in which child abuse or neglect was **substantiated** (i.e. homicide):	1
6. Number of cases in which the team felt abuse or neglect **contributed** to the death:	1
7. Does your team have guidelines for determination of abuse/neglect? If so, what are they?	No - Follow guidelines of DSS
8. Recommendations made by team for Local action:	
a. Possible state-local advocacy:	Disseminate information on teen depression/suicide
b. Other:	
9. Actions taken in/by your Jurisdiction *(Briefly highlight special activities).*	Newspaper articles regarding gun safety/pool (swimming) safety Special meeting with CCPS personnel regarding teen suicide. Discussion of teen suicide at Carroll County School Health Council
10. Recommendations from Local team to the State CFR team:	What guidelines does the State CFR use in determining abuse/neglect?
11. Attach Membership List *(Role/Affiliation/address/phone/e-mail for Chair/ Co-Chair/Contact only. All others, name and Agency affiliation only).*	

Your Ideas and Input:	
What training events would the team leadership and/or the team members find helpful?	
Team Leaders:	
Team Members:	
What training events have been **conducted** by your team during 2004?	None
What training events have been **attended** by your team during 2004?	State CFR Training (3 attended)
Does your team have a need for Technical Assistance for CFR? Describe.	

2004 CARROLL COUNTY HEALTH DEPARTMENT
CHILD FATALITY REVIEW TEAM MEMBERS

Child Fatality Member List

Contact Person:		
	Dr. Elizabeth Ruff	
	Carroll Co. Health Dept	
	290 S. Center Street	
	P.O. Box 845 Westminster, MD 21158	
	Phone:	(410) 876-4927
	FAX:	(410 876-4959
	E-Mail:	eruff@dhmh.state.md.us
Penny Bramlett		Carroll County Health Dept.
Natasha Byus		State's Attorney's Office
Dianna Davis		Carroll County Health Dept.
Howard Held		Carroll Co. Health Dept. - Addictions Bureau
Bill Knight		Carroll Co. Dept. of Social Services
Cyndy Little		Pupil Personnel - Carroll County Public Schools
Robert Wack, M.D.		Carroll Co. General Hospital
Jeffrey Moffatt		Dept. of the County Attorney
Amy (Blank) Ocampo		State's Attorney's Office
Lieut. David Reichenbaugh		MD State Police
Barb Rodgers/Kim Spangler		Carroll Co. Health Dept. - Health Education
Lynn Wisner		Carroll Co. Dept. of Social Services
Dr. Bill Woodward		Carroll Co. Health Dept.

CHILD FATALITY REVIEW
Report of Local Team Activities, 2004
Jurisdiction: Cecil County

(Answers in this Column)

1. Number of CFR meetings held in 2004:	3
2. What resources do you use to make sure you identify <u>all</u> deaths of children that occur in your community?	Identification of all deaths of children is obtained from local newspaper obituaries and funeral directors and by receipt of notification from the Maryland Medical Examiner's office and Maryland Vital Statistics.
3. Of all these deaths, what factors do you use to select cases for review at CFR meetings?	All child death cases are reviewed.
4. Number of cases reviewed at Local CFR team meetings in 2004, regardless of year of death: *(Number should include cases from OCME, Vital Statistics and other sources).*	8
5. Number of cases in which child abuse or neglect was **substantiated** (i.e. homicide):	0
6. Number of cases in which the team felt abuse or neglect **contributed** to the death:	0
7. Does your team have guidelines for determination of abuse/neglect? If so, what are they?	The Department of Social Services, Child Protective Services representative consistently attends board meetings and assists in the determination of abuse/neglect.
8. Recommendations made by team for Local action:	▪ To provide educational literature on infant safety. ▪ To make a resource list of both Internet and local community support groups in Cecil County to distribute to families who have had a recent fetal, infant or child loss. ▪ To hold a "First Responder" Conference for law enforcement, medical and legal personnel involved in the investigation of the child's death.
a. Possible state-local advocacy:	None at this time.
12. Other:	None at this time.

9. Actions taken in/by your Jurisdiction *(Briefly highlight special activities).*	▪ The Cecil County Health Department in partnership with the Cecil County CAT conducted the "Keeping our Babies Safe" campaign for new and expecting mothers to reduce the risk of Sudden Infant Death Syndrome and Shaken Baby Syndrome in Cecil County. Five hundred "Keeping Babies Safe" campaign gift packets were distributed at the Cecil County Pregnancy Center and the Family Education Center that provide services to new and expecting mothers. ▪ The CAT obtained a resource list for distribution to families who have had a recent child loss. ▪ Convened an ad hoc committee for the purpose of planning a "First Responder" Conference for Cecil County.
10. Recommendations from Local team to the State CFR team:	None at this time.
11. Attach Membership List *(Role/Affiliation/address/phone/e-mail for Chair/ Co-Chair/Contact only. All others, name and Agency affiliation only).*	(Attachment 1)

Your Ideas and Input:	
What training events would the team leadership and/or the team members find helpful?	The identification and explanation of the functions performed by legal, medical and other personnel involved in the investigation of the death of a child.
Team Leaders:	Maintaining the attendance of members of the CFR board.
Team Members:	Identification of modifiable system issues.
What training events have been **conducted** by your team during 2004?	The Cecil County Maternal and Child Health Improved Pregnancy Outcomes Systems Issues Update Luncheon was held on February 5, 2004. Issues were reviewed related to maternal and child health in Cecil County. An overview of local and state infant and child mortality statistics were presented. The identified barriers/systems issues and efforts used to address these concerns were reported. Members of the teams will work on developing an action plan to reduce the incidence of fetal, infant and child death for the upcoming year.
What training events have been **attended** by your team during 2004?	Carol King RN-C, BSN, the IPO coordinator attended the National Fetal and Infant Mortality Review Conference in August 2004 and the Annual Maryland Child Fatality Review Conference in November 2004.
Does your team have a need for Technical Assistance for CFR? Describe.	None at this time

2004 Cecil County Child Fatality Review Board Members

TFC Susan Smith CFR Chairperson	Maryland State Police North East Barracks 2433 Pulaski Highway North East, Maryland 21901 410-996-7800
Dong Park, M.D.	Cecil County Pediatrics
Cheryl Vogel, RN	Union Hospital of Cecil County Utilization Management Office
Sue Bailey, Assistant Director	Department of Social Services
Dereck Chapman, DSFM	State Fire Marshall Office
Laura Young RN Coordinator of School Nurses	Cecil County Public Schools
Major George Tarr Director of Law Enforcement	Cecil County Sheriff's Department
Mike Browne Chief	Cecil County Emergency Management
Richard Achuff Investigator	State Attorney's Office
Virginia Bailey, MD, MPH Health Officer	Cecil County Health Department
Douglas C. Sommer Director	Cecil County Health Department Division of Special Populations
Norma Dempsey, RN, MSN Child Health Program Supervisor	Cecil County Health Department
Barbara Brueckner RN Director of Nursing	Advanced Treatment Systems Methadone Clinic
Michelle Meaders	Forensic Investigator Emergency Medical Services
Matthew Donnelly Sergeant	Elkton Police Department
Holly Smith Sergeant	Elkton Police Department
CPL. David Wong Investigator	Maryland Natural Resources Police
Christine Barclay RN, BSN Supervisor	Cecil County Health Department Division of Health Promotion
Carol King RN-C, BSN CFR Facilitator	Cecil County Health Department Division of Health Promotion

CHILD FATALITY REVIEW
Report of Local Team Activities, 2004
Jurisdiction: Charles County

(Answers in this Column)

1. Number of CFR meetings held in 2004:	This forum convenes monthly and discusses cases as soon as we receive information
2. What resources do you use to make sure you identify <u>all</u> deaths of children that occur in your community?	DSS is notified by the ME office and local sheriff's office
3 Of all these deaths, what factors do you use to select cases for review at CFR meetings?	We try to review all deaths
4. Number of cases reviewed at Local CFR team meetings in 2004, regardless of year of death: *(Number should include cases from OCME, Vital Statistics and other sources).*	4
5. Number of cases in which child abuse or neglect was **substantiated** (i.e. homicide):	0
6. Number of cases in which the team felt abuse or neglect **contributed** to the death:	0
7. Does your team have guidelines for determination of abuse/neglect? If so, what are they?	Team uses the same guidelines that you use to report abuse of neglect
8. Recommendations made by team for Local action:	Concerns have been voiced about driver education programs
a. Possible state-local advocacy:	
b. Other:	
9. Actions taken in/by your Jurisdiction *(Briefly highlight special activities).*	Community Response: Parent dinners for transitional school years Back to Sleep Program continues
10. Recommendations from Local team to the State CFR team:	
11. Attach Membership List *(Role/Affiliation/address/phone/e-mail for Chair/ Co-Chair/Contact only. All others, name and Agency affiliation only).*	Wanda Collins DSS 301-392-6731 Phylis Reinard CCHD 301-609-6866

Your Ideas and Input:	
What training events would the team leadership and/or the team members find helpful?	
Team Leaders:	
Team Members:	
What training events have been **conducted** by your team during 2004?	
What training events have been **attended** by your team during 2004?	State meeting
Does your team have a need for Technical Assistance for CFR? Describe.	

Charles County had four child fatalities in 2004.

CHILD FATALITY REVIEW
Report of Local Team activities, 2004
Jurisdiction: Dorchester County

No report available.

CHILD FATALITY REVIEW
Report of Local Team Activities, 2004
Jurisdiction: Frederick County

(Answers in this Column)

1. Number of CFR meetings held in 2004:	3
2. What resources do you use to make sure you identify <u>all</u> deaths of children that occur in your community?	Medical Examiner reports, police, team members, and local newspapers
3. Of all these deaths, what factors do you use to select cases for review at CFR meetings?	We review all cases with the exception of natural cause deaths where the child was under a doctor's care for the illness and there were no suspicious factors present.
4. Number of cases reviewed at Local CFR team meetings in 2004, regardless of year of death: *(Number should include cases from OCME, Vital Statistics and other sources).*	8
5. Number of cases in which child abuse or neglect was **substantiated** (i.e. homicide):	0
6. Number of cases in which the team felt abuse or neglect **contributed** to the death:	0
7. Does your team have guidelines for determination of abuse/neglect? If so, what are they?	No. Abuse determined by police and CPS investigation. We do not believe it is the mission of CFR to determine abuse. We look at systemic causes of the deaths. We do not place blame we are looking for problems in an effort to improve the system and prevent future deaths.
8. Recommendations made by team for Local action:	We continue to work with school system to identify students at risk and provide intervention.
a. Possible state-local advocacy:	N/A
b. Other:	N/A
9. Actions taken in/by your Jurisdiction *(Briefly highlight special activities).*	Continue to meet on a formalized schedule pending caseload.
10. Recommendations from Local team to the State CFR team:	None

11. Attach Membership List *(Role/Affiliation/address/phone/e-mail for Chair/ Co-Chair/Contact only. All others, name and Agency affiliation only).*	see attached list
Your Ideas and Input:	
What training events would the team leadership and/or the team members find helpful?	None at this time
Team Leaders:	N/A
Team Members:	N/A
What training events have been **conducted** by your team during 2004?	None. Currently there is no need.
What training events have been **attended** by your team during 2004?	N/A
Does your team have a need for Technical Assistance for CFR? Describe.	No. We have a very diversified group of professionals from the medical, social, and law enforcement fields.

CHILD FATALITY REVIEW PANEL

Name	Agency	Address	Phone #	Fax #
Sharon Boettinger/ Donna Piper	CPS			
Tom Chase/Bruce DeGrange	CPD			
Corporal Jeff Kessler	Brunswick Police			
Kate English	AO			
Mary Howser	Heartly House			
CHAIR Lt.. Dave Reichenbaugh, Chair	SP	1125 National Highway Cumberland, MD 21502	301-729-2101	301-729-3128
Tom Graf/Katherine Shriver	CHD Substance Abuse			
Deb Hubbell	Mental Health Clinic			
Madeline Morey	FC Office of Children and Families			
Bob Pitcher	HMA			
Lt. Ted Nee /Chuck Jenkins	CSD			
Cam Smith/Singy Golden	CDJJ			
Michael Morrissette	Office of Public Defender			
Pam McCormick	Frederick Co. Head Start			
Brenda Williamson	Dev. Disabilities Admin.			
Chuck McCaan	Brooklane Health Services			

Name	Agency	Address	Phone #	Fax #
Fran Freire	The Institute for Family Centered Services			
CO-CHAIR Dr. Deborah Frye, Ph.D	Frederick County Health Department – School Health	350 Montevue Lane Frederick, MD 21702	301-631-3116	301-631-3308
Dr. John Molesworth, M.D./Kim Day, R.N.	Frederick Memorial Hospital			
Dr. Jack Titus, M.D.	Medical Examiners Office			
Cynthia Harne Coordinator/ Facilitator	Frederick Co. Dept. of Social Services	100 E. All Saints St. Frederick, MD 21701	301-694-4536	301-631-2639
Deborah Ramelmeier	Frederick Co. Dept. of Social Services			
Janice Kisbert	Child Advocacy Center			
MAILED COPIES OF THE AGENDA ARE SENT TO THE FOLLOWING:				
Eileen Spangler, Citizen Member				
Dr. Charles Wright, M.D. Citizen Member				

REVISED 2/05 MAM

CHILD FATALITY REVIEW
Report of Local Team activities, 2004
Jurisdiction: Garrett County

	(Answers in this Column)
1 Number of CFR meetings held in 2004:	0
2. What resources do you use to make sure you identify all deaths of children that occur in your community?	Reports from state coroner
3. Of all these deaths, what factors do you use to select cases for review at CFR meetings?	We review all that come from state review
4. Number of cases reviewed at Local CFR team meetings in 2004, regardless of year of death:*(Number should include cases from OCME, Vital Statistics and other sources).*	0
5. Number of cases in which child abuse or neglect was **substantiated** (i.e. homicide):	0
6. Number of cases in which the team felt abuse or neglect **contributed** to the death:	0
7. Does your team have guidelines for determination of abuse/neglect? If so, what are they?	State DHR guidelines and States attorney and local law enforcement.
8. Recommendations made by team for Local action:	none
a. Possible state-local advocacy:	
b. Other:	
9. Actions taken in/by your Jurisdiction *(Briefly highlight special activities).*	none
10. Recommendations from Local team to the State CFR team:	none
11. Attach Membership List *(Role/Affiliation/address/phone/e-mail for Chair/ Co-Chair/Contact only. All others, name and Agency affiliation only).*	

Your Ideas and Input:	
What training events would the team leadership and/or the team members find helpful?	How to have an active team with no reported deaths
Team Leaders:	
Team Members:	
What training events have been **conducted** by your team during 2004?	none
What training events have been **attended** by your team during 2004?	none
Does your team have a need for Technical Assistance for CFR? Describe.	Not at this time.

CHILD FATALITY REVIEW
Report of Local Team Activities, 2004
Jurisdiction: Harford County

(Answers in this Column)

1. Number of CFR meetings held in 2004:	3
2. What resources do you use to make sure you identify <u>all</u> deaths of children that occur in your community?	Local health dept. weekly death certificate reviews, OCME referrals, Inter-county communications, local and Baltimore newspapers, local public school system, FIMR program matched birth-death certificates, local hospital social work referrals, Center for Infant and Child Loss, Healthy Start Home Visiting Program, Child Care Administration, Foster Care Administration, Local Highway Safety Reports, WIC
3. Of all these deaths, what factors do you use to select cases for review at CFR meetings?	Unexplained deaths, Motor Vehicle Accidents, OCME referrals, SIDS. Due to the county's environmental hazard concerns (MTBE, Perchlorate and nearby nuclear power plant) the CFR team is tracking cancer and congenital anomaly related deaths.
4. Number of cases reviewed at Local CFR team meetings in 2004, regardless of year of death: *(Number should include cases from OCME, Vital Statistics and other sources).*	9 cases formally presented for case review by CFR Team
5. Number of cases in which child abuse or neglect was **substantiated** (i.e. homicide):	Zero (One case is still in the process of being litigated)
6. Number of cases in which the team felt abuse or neglect **contributed** to the death:	1case SUDI
7. Does your team have guidelines for determination of abuse/neglect? If so, what are they?	Team uses DHR guidelines
8. Recommendations made by team for Local action:	
a. Possible state-local advocacy:	

b. Other:	Include local government representative and highway safety for meetings. Develop a way for CPS to "flag" or monitor a high-risk behavior (drugs/homelessness/lack of support) mother for subsequent pregnancy/birth in those cases where SUDI occurred and the family has been known to CPS. Advocate for health classes to be included in the middle schools so that all students will be exposed to suicide prevention curriculum.
9. Actions taken in/by your Jurisdiction *(Briefly highlight special activities)*.	For at-risk infants and children: developed a communication link and direct referral system between local hospital social work/discharge planning and Health Department Healthy Start Case management team. Grant application for education staff in-service on suicide prevention
10. Recommendations from Local team to the State CFR team:	
11. Attach Membership List *(Role/Affiliation/address/phone/e-mail for Chair/ Co-Chair/Contact only. All others, name and Agency affiliation only).*	See attached page

Your Ideas and Input:	
What training events would the team leadership and/or the team members find helpful?	To have a regional training day (similar to the Annual CFR meeting) where all of the team members would be invited to attend.
Team Leaders:	
Team Members:	
What training events have been **conducted** by your team during 2004?	Media Event (televised by the local cable network) Health Officer presented Infant Mortality Report to the County Council Board of Health Meeting, October 2004
What training events have been **attended** by your team during 2004?	*2 team members: Annual State CFR Meeting *1 team member: Attended the National FIMR Conference in DC in August 2004
Does your team have a need for Technical Assistance for CFR? Describe.	Effective methods of putting recommendations into action; A cook-book approach for forming work groups for specific problems i.e.: resource manual.

Harford County CFR Membership List 2004

Chair: **John Rusinko**
Director of Child and Family Services
Villa Maria/Catholic Charities
2300 Dulaney Valley Road
Timonium, MD 21093
(410) 252-4700, Ext.102
FAX: (410) 252-3040
E-mail: jrusinko@cc.md.org

CFR Coordinator: **Judy D. Churn, MS, RN-C.**
FIMR and CFR Coordinator
Harford County Health Department
Aberdeen Community Service Building
34 N. Philadelphia Blvd., Rm. 211
Aberdeen, MD 21001
(410) 273-5626
FAX: (410) 272-5467
E-mail: jchurn@dhmh.state.md.us

Mary Jo Beach, MS, RN, Cm, LCCE
Director of Nursing Services
Harford County Health Department
Sandra L. Bell, RN
Drug Abuse Services
Harford County Health Department

Andrew Bernstein, MD, MPH
Health Officer
Harford County Health Department

Wilbur W. Bolton, III, JD
Attorney for Dept. of Social Services

Mary-Claire Brett
Director of Alcohol Services
Harford County Health Dept.

Gary Kosyjana
Regional Manager
Child Care Administration

M. Paul Lomonico, M.D.
Board Certified Pediatrician

Carolyn McQuiston
Assistant Director of Services
Harford County Dept. of Social Services

Gregory Smith, MA, LCPC
Child and Adolescent Coordinator
Harford County Core Service Agency

Cynthia Spath
Licensing Specialist
Child Care Administration

Christopher Taylor
Legal Assistant
Harford County State's Attorney's Office

Cydney Wentsel
Supervisor of Counseling and Guidance
Harford County Public Schools

Major Rick Williams, Bureau Commander
Investigative Services
Harford County Sheriff's Office

CHILD FATALITY REVIEW
Report of Local Team Activities, 2004
Jurisdiction: Howard

(Answers in this Column)

1. Number of CFR meetings held in 2004:	2
2. What resources do you use to make sure you identify <u>all</u> deaths of children that occur in your community?	-Death certificates sent to HCHD -Reports from OCME -News items
3. Of all these deaths, what factors do you use to select cases for review at CFR meetings?	-All children up to age 18 not reviewed by FIMR -Selected deaths ages 18 and over in whom risk factors were likely in childhood
4. Number of cases reviewed at Local CFR team meetings in 2004, regardless of year of death: *(Number should include cases from OCME, Vital Statistics and other sources).*	14
5. Number of cases in which child abuse or neglect was **substantiated** (i.e. homicide):	2
6. Number of cases in which the team felt abuse or neglect **contributed** to the death:	0
7. Does your team have guidelines for determination of abuse/neglect? If so, what are they?	No
8. Recommendations made by team for Local action:	-Improve lighting at community pools to deter trespassing -Promote CPR for teens and young adults -Strengthen bullying prevention education
a. Possible state-local advocacy:	Legislation to limit passengers when teens drive
b. Other:	
9. Actions taken in/by your Jurisdiction (Briefly highlight special activities).	Initiative to reduce under age 21 deaths in MV crashes announced 1/12/05 by HC Police chief
10. Recommendations from Local team to the State CFR team:	State team presentation to our Local team demonstrating the importance of our work in improving outcomes.

11. Attach Membership List *(Role/Affiliation/address/phone/e-mail for Chair/ Co-Chair/Contact only. All others, name and Agency affiliation only).*	See attached
Your Ideas and Input:	
What training events would the team leadership and/or the team members find helpful?	See item 10 above
Team Leaders:	
Team Members:	
What training events have been **conducted** by your team during 2004?	None
What training events have been **attended** by your team during 2004?	State CFRT Annual Conference 11/16/04 attended by Chair
Does your team have a need for Technical Assistance for CFR? Describe.	Not at the present time

Howard County Child Fatality Review Team
Membership 2004-2005

Cynthia M. Lipsitz, MD, MPH
Medical Director, Howard County Health Department
Chair, Howard County Child Fatality Review Team
7178 Columbia Gateway Drive
Columbia, MD 21046
410-313-6168
clipsitz@co.ho.md.us

Penny E. Borenstein, MD, MPH
Howard County Health Officer

Wayne Livesay
Chief, Howard County Police Department

Joseph Herr
Chief, Howard County Department of Fire and Rescue

Catherine Busch
Clinical Director
Sexual Trauma Treatment, Advocacy and Recovery Center

Jeannie Meece
Executive Director
Sexual Trauma Treatment, Advocacy and Recovery Center

Tim McCrone
Howard County State's Attorney

Robert Castor
Howard County Police Department
Child Advocacy Center

Chris Keane
Howard County Office of Law

Marilyn Manson Fauntleroy
Director, Bureau of Addictions
Howard County Health Department

Susan Rosenbaum
Director

Howard County Department of Citizens' Services

Dr. Mary Ripple
Office of the Chief Medical Examiner

Donna Wells
Executive Director
Howard County Mental Health Authority

Dr. Wendy Lane
Pediatrician
Howard County Child Advocacy Center

Dr. David Monroe
Howard County General Hospital Emergency Department

Doris Mason
Acting Director
Howard County Department of Social Services

Deborah Fleischmann
Howard County General Hospital Emergency Department

Barbara McCready
Licensing Supervisor
Child Care Administration
Maryland Department of Human Resources

Pamela Blackwell
Student Services Coordinator
Howard County Public School System

Jurisdiction: Kent County Child Fatality Review for Calendar Year 2004

Kent County met in January, July and October 2004. The sessions were to review deaths and one planning session. In January, the death had occurred in 2002 and the October meeting, the death had occurred in August of 2004. If needed, we touch base quarterly by e-mail or phone, but we come together as a group at least once a year following CPS meeting which was in July. We reviewed our cases and everyone felt they knew their purpose.

Goals for future of CFR: Meeting every six months and e-mailing or calling the other two quarters. This will be amended if we have a death or need to physically meet.

Current membership: Kent Co Health Department-Chair
Mary Adda Moore, RN, BSN
Kent County Health Department
125 S. Lynchburg Street
Chestertown, Md. 21620
410-778-1350 ext:7040

Dept. of Social Services-Paula Gish, LSW
Local Board of Education-Gail Vucci, RN
Local Hospital- Katherine Neff, RN-facilitator
State Police-Capt. Marty Knight
County EMS-Serenity Ernest
Dept of Juvenile Justice- William Clark
State's Attorney- Robert H. Strong-Attorney
Local Pediatrician-Freddie Araujo, MD
Regional Child Care Administration- Price Schulyer

Case Review: Two reviews of deaths that occurred to children this year.

Recommendations:

-Talk to public schools
-Juvenile drinking and substance abuse (talk to county liquor inspector and case manager for drug and alcohol).
-Check on enforcing of seat belts
-Communications between agencies needs coordination.

Actions taken: Initial discussions with the groups to make action plan.

CHILD FATALITY REVIEW
Report of Local Team Activities, 2004
Jurisdiction: Montgomery County

(Answers in this Column)

1. Number of CFR meetings held in 2004:	10
2. What resources do you use to make sure you identify <u>all</u> deaths of children that occur in your community?	ME Reports Newspaper Articles Information from participating agencies
3. Of all these deaths, what factors do you use to select cases for review at CFR meetings?	We review all child deaths between birth and through age 17 years which are "medical examiner cases", as defined by Health-General Article, Section 5-309. That is: deaths that occur by violence, by suicide, by casualty, or suddenly, if the deceased was in apparent good health or unattended by a physician, or in any suspicious manner
4. Number of cases reviewed at Local CFR team meetings in 2004, regardless of year of death: *(Number should include cases from OCME, Vital Statistics and other sources).*	27
5. Number of cases in which child abuse or neglect was **substantiated** (i.e. homicide):	2
6. Number of cases in which the team felt abuse or neglect **contributed** to the death:	2 (This does not include the two cases from question 5.)
7. Does your team have guidelines for determination of abuse/neglect? If so, what are they?	MD Family Law 5-701 Criminal Law Section 3-601 of the Annotated Code of Maryland

8. Recommendations made by team for Local action:	1). Driving: Circumstances around the deaths in automobiles lead us to believe that a better job must be done in educating young drivers. This is particularly evident in the unusual and emergency situations. Also evident are risk taking behavior in and around cars. 2) Suicide: Suicide prevention training needs to be more extensively performed in schools for teachers and students. Signs of deepening severity of depression need to be better understood and steps that can lead to therapeutic intervention supported in both groups. 3) Bullying: Bullying led to deaths by homicide and suicide. The anti-bullying program of the County Schools needs to be supported and strengthened. 4) Arrhythmia: Four deaths followed arrhythmia caused by congenital cardiac disease. Early warning signs and appropriate diagnostic procedures need to be emphasized to health care providers and coaches. 5) Other: One pedestrian death supports the continued and renewed effort to emphasize safe pedestrian practice. Child abuse prevention efforts need to be continually focused on the immature and borderline caregivers. The increase of risk to infants from parental smoking needs to be a part of prenatal education. Employers of youth need to be especially diligent in training youth who may work around dangerous equipment.
a. Possible state-local advocacy:	Support enhanced driver education and anti-bullying programs.
b. Other:	

9. Actions taken in/by your Jurisdiction (Briefly highlight special activities).	1) Training for the CFRT by Donna Becker of the Center for Infant & Child Loss on SIDS 2) Several members attended the State Fatality Conference. 3) The Team identified trends for the year and planned to focus on suicide as a major issue. 4) Student Nurses from Columbia Union College were allowed to attend three meetings as part of their Public Health Nursing rotation. 5) Team Member, Beverly Byron on February 25, 2004, testified before the House in Annapolis with Delegate Kathleen Dumais about HB715 which mandated a statewide hospital based Shaken Baby Syndrome (SBS) awareness/prevention program, which was based on the very successful New York State SBS-hospital based education program which provides one-on-one RN discharge teaching with every patient that leaves a postpartum unit with a newborn. The bill passed through the House but was held up in the Senate. The opponent was the Maryland Hospital Association. The Senate wanted the MHA to create a new workgroup whose task was to create a new hospital based SBS and Postpartum Depression Awareness program. Beverly Byron was a member of this team which produced a new SBS brochure and an updated Postpartum depression brochure along with a video to be sent to every hospital CEO/ Nurse Manager in the state.
10. Recommendations from Local team to the State CFR team:	1) Develop a standard list of questions for suicide review in order to standardize the reporting of such deaths by triggers, therapy, supervision, etc. 2) Review the State's child fatality reports for the past 3 to 5 years to get a better incidence of arrhythmia induced deaths in preparation for the training of sports trainers and medical practitioners. 3) Add classifications to all reports that use current medical injury terminology. 4) Consider funding for local teams for technical support and advocacy efforts.

11. Attach Membership List *(Role/Affiliation/address/phone/e-mail for Chair/* *Co-Chair/Contact only. All others, name and* *Agency affiliation only).*	**Barbara Bonnin, L.C.S.W-C Co-Chair** **Montgomery County Dept of Health & Human Services** Child Welfare Services 1301 Piccard Drive Rockville, MD 20850 Tel: 240-777-3551 Fax: 240-777-3534 E-Mail: barbara.bonnin@montgomerycountymd.gov **Dr. Carl Margolis –Co- Chair** **Deputy Medical Examiner, Montgomery County Maryland** 11125 Rockville Pike Rockville, MD 20852 Tel: 301-770-3660 Fax: 301-770-1344 E-Mail: cimargolis@pol.net **Patty Ryan Coordinator** Major Crimes Division/Police Headquarters, MCPD 2350 Research Boulevard Rockville, MD 20850 Tel: 240-773-5070 Fax: 240-773-5117 E-Mail: patricia.ryan@montgomerycountymd.gov **Carol W. Garvey, M.D.** **Brenda Botchway, R.N., CHN** Injury Prevention Coordinator Montgomery County Department of Health & Human Services **Heidi Bresse, CRNP-Coordinator** SAAC Shady Grove Adventist Hospital **Beverly Byron, RN, MSN Nurse Educator/Program Manager** DHHS Health Promotion Program **Laura Chase** Montgomery County State's Attorney's Office **Captain Nancy Demme** Director, Major Crimes Division, MCPD **Nerita Estampador-Ulep, M.D.** M.D., F.A.A.P. Physician, Montgomery County Department of Health & Human Svcs. **Lorne K. Garrettson, M.D., F.A.A.P.** Professor Emeritus Emory University **Anne Hoffman, L.C.S.W.-C** Montgomery County Department of Health & Human Services Child Welfare Services **Julia Lajoie, MD, FACEP, FAAP** Shady Grove Adventist Hospital Medical Director, Sexual Assault & Abuse Center **Min Leong** Student Services Montgomery County Public Schools **Judy Madden, Acting Director** Student Services Montgomery County Public Schools **Detective Sally Magee** Family Crimes Division, MCPD **Cpt. Kimonti Oglesby** Montgomery County Quality Assurance Officer **Lieutenant Philip C. Raum** Major Crimes Division Montgomery County Police Department **Karen Riibner,** L.C.S.W.-C Montgomery County Department of Health & Human Services Addiction Services

Your Ideas and Input:	
What training events would the team leadership and/or the team members find helpful?	Teen suicide prevention Teen driving
Team Leaders:	
Team Members:	
What training events have been **conducted** by your team during 2004?	SBS Training
What training events have been **attended** by your team during 2004?	State Fatality Conference Team member Beverly Byron attended the National SBS conference in Montreal in Sept.2004 and gave the updated info to the group. She was also a guest lecturer at the August 2nd, 2004 APSAC conference and presented a training for health care professionals on "SBS is 100% preventable" Team member, Brenda Botchway attended the 13th Annual Summer Institute: Principles & Practice of Injury Prevention in July 2004 @ Johns Hopkins School of Public Health and the SAFE KIDS Leadership Conference in Wash., D.C.
Does your team have a need for Technical Assistance for CFR? Describe.	Administrative/clerical support

CHILD FATALITY REVIEW
Report of Local Team Activities, 2004
Jurisdiction: Prince George's County

(Answers in this Column)

1. Number of CFR meetings held in 2004:	3 (March 31st; July 21st and October 20th, 2004)
2. What resources do you use to make sure you identify <u>all</u> deaths of children that occur in your community?	The Prince George's County Child Fatality Review Team receives data on fatalities from the Office of the Chief Medical Examiner; Prince George's Fire/EMS Department and from team members.
3. Of all these deaths, what factors do you use to select cases for review at CFR meetings?	The Prince George's County Fatality Review Team reviews all known child deaths in the county.
4. Number of cases reviewed at Local CFR team meetings in 2004, regardless of year of death: *(Number should include cases from OCME, Vital Statistics and other sources).*	46
5. Number of cases in which child abuse or neglect was **substantiated** (i.e. homicide):	6
6. Number of cases in which the team felt abuse or neglect **contributed** to the death:	2
7. Does your team have guidelines for determination of abuse/neglect? If so, what are they?	The Prince George's County Fatality Review Team utilizes the expertise from the Department of Social Services and social work clinicians and the information from the data collection forms to determine abuse/neglect in a case.

8. Recommendations made by team for Local action:	The team's recommendations for 2004 are: (1) to educate the community about the importance of smoke detectors within the household and the proper use of space heaters; (2) The need for additional in-patient psychiatric facilities for children within the state; (3) To educate staff and students within the school system about the impact of harassment on children due to sexual identity issues; (4) To educate the community about the hazards of teenage driving (i.e. drinking, stolen vehicles, usage of seat belts; etc.) ; (5) To improve the communication between the Police Department (Homicide Division) and the Department of Social Services in the reporting of possible child abuse/neglect cases; (6) To explore the feasibility of developing a standardized checklist to be used by the police and fire departments in the reporting of child deaths; (7) To implement a campaign in clinics, schools and hospitals about the danger of co-sleeping and the importance of placing babies on their backs during sleeping ; (8) To educate the public about the appropriate age of children in car seats and the proper installation of car seats; (9) To increase the public's awareness of SIDS/SUDI cases within the county; and (10) To continue to keep the public informed of the on-going number of violent deaths to children due to homicide and suicide.
a. Possible state-local advocacy:	The issue of teenage driving deaths has increased substantially within the county, as well as, in the state. Deaths resulted from high speeds, intoxication and non-usage of seat belts.
b. Other:	Another issue is co-sleeping and/or placing babies on their backs during sleep.

9. Actions taken in/by your Jurisdiction (Briefly highlight special activities).	The Prince George's County Child Fatality Review Team has discussed the possibility of issuing public service announcements on teenage driving and proper sleeping conditions for children.
10. Recommendations from Local team to the State CFR team:	The following are recommendations from the Prince George's County Fatality Team to the State Team: (1) Funding for local team activities are needed; (2) Review process for submission of data to local teams. The Prince George's Fatality Review Team has identified many cases that were classified as declined cases that were not forwarded to the local team for review. This creates a "glitch" in the team's ability to review all child death cases within the county; (3) Revision of the current forms used by the teams and/or implementation of the Internet system. The current forms are not relevant to many of the cases that are reviewed and causes some data to be improperly completed; 4) Increase the number of training opportunities for the local teams; and (5) Development of an interim means of communication for the local teams (i.e. newsletter) until the internet system is completed.
11. Attach Membership List *(Role/Affiliation/address/phone/e-mail for Chair/ Co-Chair/Contact only. All others, name and Agency affiliation only).*	

Your Ideas and Input:	
What training events would the team leadership and/or the team members find helpful?	The team would find helpful training in the areas of: (1) networking and collaboration with private and public partners and (2) identification of funding sources (via grant writing, etc.) to enable local teams to provide community activities and support.
Team Leaders:	Anntinette D. Williams, LICSW, Chair Virginia Beisler, Co-Chair
Team Members:	See attachment.
What training events have been **conducted** by your team during 2004?	None.
What training events have been **attended** by your team during 2004?	Prince George's County Team Members have attended the Maryland State Team's Annual Training; the Governor's Conference on Child Abuse and Neglect and the National Association of Black Social Workers Conference.
Does your team have a need for Technical Assistance for CFR? Describe.	The technical assistance that the team needs is in the area of having a database developed to track the cases reviewed over the past three years.

PRINCE GEORGE'S COUNTY

CHILD FATALITY REVIEW TEAM

MEMBERSHIP ROSTER

PAULETTE JACKSON-AUSTIN, LICSW, LCSW-C
Assistant Bureau Chief
PG County Department of Social Services
E-mail: Pjackso2@dhr.state.md.us

VIRGINIA BEISLER, Co-Chair
Assistant Director, Prince George's County Health Department
Division of Maternal and Child Health
E-mail: vmbeisler@co.pg.md.us
Office: 301-883-7858 Fax: 301-883-7897

LT. ANDREW BLUESTEIN
EMS Quality Assurance Coordinator
Prince George's County Fire/EMS Department
E-mail: abluestein@co.pg.md.us

JOANN WOODSON-BRANCHE
Assistant State's Attorney
Office of the State's Attorney
E-mail: jwbranche@co.pg.md.us

DR. FLORENCE FOREMAN
Prince George's County Public Schools
Psychological Services
E-mail: florenc.foreman@PGCPS.org

LT. LAWRENCE GORDON, Commander
Prince George's County Homicide Section
Criminal Investigations Division
E-mail: LtGordon@co.pg.md.us

PHIL NEWSOM, Acting Deputy Director
Prince George's County Department of Social Services
E-mail: Pnewsom@dhr.state.md.us

DR. ALBERT ROLLE
Medical Examiner's Office
E-mail: arolmd@aol.com

LINDA VAN NESS, Systems Analyst
Prince George's County Fire/EMS Department
E-mail: llvanness@co.pg.md.us

BEVERLY VAYHINGER
Prince George's County Health Department/CAP
E-mail:bvayhinger@co.pg.md.us

ANNTINETTE D. WILLIAMS, LICSW, Co-Chair
Maryland State Child Fatality Review Team
E-mail: ADWilliams@cfsa-dc.org
Office: 202-727-7333 Fax: 202-727-3348

CHILD FATALITY REVIEW
Report of Local Team Activities, 2004
Jurisdiction: Queen Anne's County

	(Answers in this Column)
1. Number of CFR meetings held in 2004:	3
2. What resources do you use to make sure you identify <u>all</u> deaths of children that occur in your community?	Review of death certificates through the Health Dept.
3. Of all these deaths, what factors do you use to select cases for review at CFR meetings?	Age of child
4. Number of cases reviewed at Local CFR team meetings in 2004, regardless of year of death: *(Number should include cases from OCME, Vital Statistics and other sources).*	4
5. Number of cases in which child abuse or neglect was **substantiated** (i.e. homicide):	0
6. Number of cases in which the team felt abuse or neglect **contributed** to the death:	0
7. Does your team have guidelines for determination of abuse/neglect? If so, what are they?	DSS guidelines
8. Recommendations made by team for Local action:	
a. Possible state-local advocacy:	Need for community mental health services, Need for conflict resolution education
b. Other:	Need for asset building for children Importance of parent support programs such as Healthy Families Need for bereavement programs for survivors Promotion of completion of high school
9. Actions taken in/by your Jurisdiction *(Briefly highlight special activities).*	Discussion regarding consideration of regional meetings to review issues common to several counties on the Mid-Shore
10. Recommendations from Local team to the State CFR team:	None

11. Attach Membership List *(Role/Affiliation/address/phone/e-mail for Chair/ Co-Chair/Contact only. All others, name and Agency affiliation only).*	See attached
Your Ideas and Input:	
What training events would the team leadership and/or the team members find helpful?	
Team Leaders:	Orientation to CFR team guidelines and completion of forms
Team Members:	Orientation and purpose of CFR, etc.
What training events have been **conducted** by your team during 2004?	None
What training events have been **attended** by your team during 2004?	Annual Child Fatality Review Conference
Does your team have a need for Technical Assistance for CFR? Describe.	CMCH State CFR administrative team assisted in 2004.

Queen Anne's County
Child Fatality Review Team, 2004

1) Mary Ann Thompson, RN - Chair
   Q.A. Co. Health Dept.
   206 North Commerce St.
   Centreville, MD
   410-758-0720
   mat@dhmh.state.md.us

2) Capt. Martin Knight
   Maryland State Police

3) John Heddinger/Matt Kempel
   Queen Anne's Co. Sheriff's Office

4) Frank Kratovil
   Q.A. Co. State's Attorney's Office

5) Denise Whitely
   Q.A. Co. Juvenile Justice

6) Cathy Dougherty
   Q.A. Co. Dept. of Social Services

7) Cheryl Peguese
   Dept. of Parole and Probation

8) Ben Cohey
   Centreville Town Police

9) Dominic Romano
   Q.A. Co. Board of Education

10) Price Shuler
    Child Care Administration

11) Mike Clark
    Local Management Board

12) Kathy Wright
    Q.A. Co. Drug and Alcohol Services

13) Pat Deitz
    Q.A. Co. Health Dept.

CHILD FATALITY REVIEW
Report of Local Team Activities, 2004
Jurisdiction: St. Mary's County

Highlights of Local CFR Team for 2004:
Dr. Robert Konkol resigned from team
Dr. Jeffrey Cole resigned from team
Kerry Klear, Leonardtown Volunteer Rescue Squad was appointed to committee

Social or Health Impact of CFR in your county since its inception:
Working together as a community

Goals:
Increase public awareness regarding preventive measures

Membership:
See attached list

Meeting:
There was no meeting held in 2004 due to some committee members resigned and we only had two deaths due to auto accident. We held a meeting in March 2005.

Case Review:
None

Recommendations:
To recruit someone from the local rescue squad to sit in on the committee.

Actions:
a. Review material on " Leadership to Keep Children Alcohol Free"
b. Sit in on teleconference on "Child Passenger Safety"

LOCAL CITIZEN CHILD FATALITY REVIEW PANEL
ST. MARY'S COUNTY, MARYLAND

St. Mary's County Health Department 301-475-4330
William Icenhower, M.D.,M.P.H., Health Officer
P.O.Box 316 Leonardtown, MD 20650
icenhowerw@smhd.com

St. Mary's County Health Department
Nancy Luginbill, R.N.,B.S.
Luginbilln@smhd.com

St. Mary's County Department of Social Services
Ella May Russell, Director
erussel@dhr.state.md.us

Office of State's Attorney
Michael Stamm, Assistant State's Attorney
Michael_stamm@co.saint-marys.md/us

St. Mary's County Public Schools
Dr. Lorraine Fulton, Acting Superintendent
lrfulton@smcps.org

Maryland State Police
Bryan Cedar, Barrack Commander

St. Mary's County Sheriff's Office
David Zylak, Sheriff
David_zylak@co.saint-marys.md.us

Walden-Sierra
Kathy O'Brien, Executive Director
Kathleen@waldensierra.org

St. Mary's County Department of Social Services Attorney
Daniel Armitage, Assistant County Attorney
darmitag@dhr.state.md.us

Mental Health Authority
Alexis Zoss, Executive Director
azoss@mhasm.com

Pediatrician
I.V. Shah, M.D.,F.A.A.P.

Leonardtown Volunteer Rescue Squad
Kerry Klear

Community Representative
Elizabeth Osborne, PHD St. Mary's College

CHILD FATALITY REVIEW
Report of Local Team Activities, 2004
Jurisdiction: Somerset County

	(Answers in this Column)
1. Number of CFR meetings held in 2004:	One meeting was held and due to scheduling difficulties our team meets to review cases only or when a special need arises.
2. What resources do you use to make sure you identify <u>all</u> deaths of children that occur in your community?	OCME referrals; Birth/death cert. matches from Vital Records; Local death data; local obituaries
3. Of all these deaths, what factors do you use to select cases for review at CFR meetings?	We review all cases on children 1 month-17 years of age.
4. Number of cases reviewed at Local CFR team meetings in 2004, regardless of year of death: *(Number should include cases from OCME, Vital Statistics and other sources).*	4
5. Number of cases in which child abuse or neglect was **substantiated** (i.e. homicide):	0
6. Number of cases in which the team felt abuse or neglect **contributed** to the death:	In one case it is possible that neglect contributed to the death of the infant.
7. Does your team have guidelines for determination of abuse/neglect? If so, what are they?	Utilize guidelines from the Dept. of Social Services to determine abuse/neglect.
8. Recommendations made by team for Local action:	County-wide educational campaign on safe sleep and safe bedding for infants that includes the Back-to-Sleep info. as well.
a. Possible state-local advocacy:	
b. Other:	

9. Actions taken in/by your Jurisdiction *(Briefly highlight special activities)*.	The HD is in the process of instituting a "Pack N Play" program for eligible families to provide a safe/adequate bed for infants who otherwise would not have one. Also, the HD is developing a brochure about safe bedding that emphasizes the Back-to-Sleep campaign as well. At the present time the HD is exploring the use of a billboard to convey this same message as above.
10. Recommendations from Local team to the State CFR team:	None at this time.
11. Attach Membership List *(Role/Affiliation/address/phone/e-mail for Chair/ Co-Chair/Contact only. All others, name and Agency affiliation only)*.	See attached.
Your Ideas and Input:	
What training events would the team leadership and/or the team members find helpful?	.
Team Leaders:	It would be helpful to have a standard worksheet to use during the actual case reviews as a guide for all case reviews
Team Members:	
What training events have been **conducted** by your team during 2004?	None but note activities of the team as a result of the case reviews.
What training events have been **attended** by your team during 2004?	The state CFR and FIMR meetings.
Does your team have a need for Technical Assistance for CFR? Describe.	Not at this time.

2004 SOMERSET COUNTY CHILD FATALITY REVIEW TEAM

Colleen Parrott, Chair
Health Officer
Somerset Co. Health Dept.
7920 Crisfield Highway
Westover, MD 21871
443-523-1700

Suzanne Ruark
Child Care Administration

Patti Mannion
Director, Somerset Co. Dept. of Social Services

Dr. Karen Lee-Brofee
Superintendent, Somerset Co. Board of Education

Logan Widdowson
Somerset County State's Attorney

H.P. Ketterman
Maryland State Police
Barracks X

Craig Stofko, Director
Addictions
Somerset Co. Health Dept

Dr. Ephrem Daniel
Pediatrician
Three Lower Counties Community Services

Lisa Hartman
Core Service Agency
Somerset Co. Health Dept.

Chris Bozick, Therapist
Three Lower Counties Community Services, Mental Health

Lee Ann Grosky
Somerset Co. Health Dept.
7920 Crisfield Highway
Westover, MD 21871
443-523-1764
E-mail: LeeAnn@dhmh.state.md.us

CHILD FATALITY REVIEW
Report of Local Team Activities, 2004
Jurisdiction: Talbot County

	(Answers in this Column)
1. Number of CFR meetings held in 2004:	Three
2. What resources do you use to make sure you identify <u>all</u> deaths of children that occur in your community?	Newspaper and reports from the OCME
3. Of all these deaths, what factors do you use to elect cases for review at CFR meetings?	We review each death.
4. Number of cases reviewed at Local CFR team meetings in 2004, regardless of year of death: (Number should include cases from OCME, Vital Statistics and other sources).	One vehicle related death.
5. Number of cases in which child abuse or neglect was **substantiated** (i.e. homicide):	None
6. Number of cases in which the team felt abuse or neglect **contributed** to the death:	One.
7. Does your team have guidelines for determination of abuse/neglect? If so, what are they?	No
8. Recommendations made by team for Local action:	A brochure was circulated to DMV, police concerning the need to watch toddlers in a yard of a residence especially if big trucks are going to be on the property. It was felt that truck back up "beeping sounds" be mandatory and that the sound becomes louder the nearer the truck is to an object. Additionally, it was felt that adequate visibility via mirrors is needed for all corners of a truck or other vehicle.
a. Possible state-local advocacy:	DMV and Truck drivers training programs.
b. Other:	
9. Actions taken in/by your Jurisdiction *(Briefly highlight special activities).*	Brochure Again discussed ATV dangers, believing a picture on the front page of the local paper showing happy children riding in an ATV was not appropriate. A telephone call to the local paper was made. Hopefully,

	no more pictures of this nature will appear
10. Recommendations from Local team to the State CFR team:	Need more time to allow visibility for our recommendations. 1. Truck manufacturers install adequate visibility for truck drivers. 2. Need sensing equip to detect imminent collision in backup situations. 3. Teach parents to always be alert when there are construction vehicles/trucks on their residential property.
11. Attach Membership List	
Your Ideas and Input:	
What training events would the team leadership and/or the team members find helpful?	The State program is always enlightening. We don't have the time to devote to this very important program.
Team Leaders:	Ann H. Webb, M.D., MPH Deputy Health Officer – Talbot County
Team Members:	- See enclosed list
What training events have been **conducted** by your team during 2004?	We incorporate them into our regular meetings
What training events have been **attended** by your team during 2004?	The one that is given by the State CFR Team. In Dec '04
Does your team have a need for Technical assistance for CFR? Describe.	We would like help with advertising our recommendations. We do not have time to follow through with our suggestions. All recommendations from the various counties should be compiled and sent to the appropriate agency that can enact some of the recommendations.

Talbot County CFR Committee
Membership List
July 9, 2004

Ann H. Webb, M.D., M.P.H., Chairman
Deputy Health Officer
Talbot County Health Department
100 S. Hanson Street
Easton, MD 21601

410-819-5600 or

annwebb@dhmh.state.md.us

Membership:

Deputy State's Attorney, Talbot County

Talbot County Public Schools

Criminal Investigation Unit
Maryland State Police

Clinical Director
Talbot County Health Department Addictions

Attorney for Talbot Co. Dept. of Social Services

Regional Manager
Child Care Administration

Detective
Easton Police Department

Executive Director
Mid-Shore Mental Health Systems, Inc

Community Health Nurse
Talbot County Health Department

Director
Talbot Dept. of Social Services

Prevention Coordinator
Talbot County Health Department

CHILD FATALITY REVIEW
Report of Local Team Activities, 2004
Jurisdiction: Washington County

	(Answers in this Column)
1. Number of CFR meetings held in 2004:	4
2. What resources do you use to make sure you identify <u>all</u> deaths of children that occur in your community?	Fatality Review Members, OME, Health Officer, Physicians, Child Protective Services
3. Of all these deaths, what factors do you use to select cases for review at CFR meetings?	All child deaths between ages 1 and 18 are reviewed by the Fatality Review Panel in Washington County.
4. Number of cases reviewed at Local CFR team meetings in 2004, regardless of year of death: *(Number should include cases from OCME, Vital Statistics and other sources).*	Twelve cases were reviewed during 2004.
5. Number of cases in which child abuse or neglect was **substantiated** (i.e. homicide):	2 cases
6. Number of cases in which the team felt abuse or neglect **contributed** to the death:	2 cases
7. Does your team have guidelines for determination of abuse/neglect? If so, what are they?	Yes, Child Protective Services Maryland COMAR Regulations.
8. Recommendations made by team for Local action:	Community Education on the misuse of adult equipment by children (farm equipment, ATV). More information to adolescents regarding the Maryland Youth Crisis Hotline.
a. Possible state-local advocacy:	Statewide education regarding misuse of adult equipment used by children (Farm equipment, ATV). Gun Safety program. Media Campaign regarding the Maryland Youth Crisis Hotline.
b. Other:	

9. Actions taken in/by your Jurisdiction *(Briefly highlight special activities)*.	Working with Washington County Health Department regarding community education/prevention education. Invited Maryland Youth Crisis Hotline educator to present to Panel. Posters and cards were given to all middle and high schools as well as community agencies for distribution. Maryland Youth Crisis Hotline Number is in local newspaper. Coordinated with the local police department regarding gun safety lock distribution within the community. Two articles were in the local newspaper regarding gun safety locks and where to get them.
10. Recommendations from Local team to the State CFR team:	Statewide education on Maryland Youth Crisis Hotline, Misuse of equipment, Gun Safety.
11. Attach Membership List *(Role/Affiliation/address/phone/e-mail for Chair/ Co-Chair/Contact only. All others, name and Agency affiliation only)*.	See Attachment
Your Ideas and Input:	
What training events would the team leadership and/or the team members find helpful?	What changes are occurring across the state due to reviews by county Panels. How are Panels effecting change.
Team Leaders:	Teresa Thorn, Staff Washington County William Christoffel, Chair Jenny Taylor-Grey, Facilitator
Team Members:	See Attached.
What training events have been **conducted** by your team during 2004?	Maryland Youth Crisis Hotline
What training events have been **attended** by your team during 2004?	Maryland Youth Crisis Hotline Annual Fatality Review Training
Does your team have a need for Technical Assistance for CFR? Describe.	

January 2005

The following people have agreed to serve on the combined CFRT/CRP:

William Christoffel, Washington County Health Officer, Washington County Health Department, 1302 Pennsylvania Avenue, Hagerstown, MD 21742

Teresa Thorn, Program Director, Washington County Child Advocacy Center

Jody Bishop, RN, Clinical Nurse Manager, Family Birthing Center, Washington County Hospital

Edward Ditto, III, MD, Washington County Medical Examiner

Stephanie Stone, Director, Office for Children and Youth/LMB

Dolores Harmon, Regional Manager, Child Care Administration

Charles Strong, Washington County State's Attorney

Millie Lowman, Executive Director, Parent-Child Center

Markella Budesky, Director, Healthy Families, Washington County Health Department,

Melanie Reinke, Children's Therapist, CASA

Christina Keyser, MD, Chairman Pediatrics Department, Washington County Hospital,

Tim Gordon, Esq., Washington County Department of Social Services (Attorney who represents local department of social services in child welfare proceedings)

Carrol Lourie, LCSW-C, Assistant Director, Adult, Child and Family Services, Washington County Department of Social Services

Joyce Williams, RN, Washington County Medical Examiners Office

Spence Perry

June Scheer

Rebecca Hogaimier, Director of Addictions, Washington County Health Department

Jenny Taylor-Gray, Washington County Health Department

Shane Blankenship, Hagerstown City Police

Melissa Cline, CPS Program Manager, Washington County Department of Social Services

Michael Markoe, Washington County Board of Education

1st Sgt. Randy Wilkenson, Washington County Sheriff's Office

CHILD FATALITY REVIEW
Report of Local Team Activities, 2004
Jurisdiction: Wicomico County

	(Answers in this Column)
1. Number of CFR meetings held in 2004:	Four
2. What resources do you use to make sure you identify <u>all</u> deaths of children that occur in your community?	CFR staff review all fetal, infant and child death certificates issued by local health dept. as well as any deaths reported from the local hospital's Perinatal Bereavement Coordinator. Staff also monitors obituaries published in local newspaper.
3. Of all these deaths, what factors do you use to select cases for review at CFR meetings?	Cases referred by the OCME are reviewed unless the cause of death is listed as natural. Any deaths by natural causes are referred to the CFR Chairperson who determines whether the case will be reviewed by the full committee based on the circumstances of the death and medical complications.
4. Number of cases reviewed at Local CFR team meetings in 2004, regardless of year of death: *(Number should include cases from OCME, Vital Statistics and other sources).*	Six
5. Number of cases in which child abuse or neglect was **substantiated** (i.e. homicide):	None
6. Number of cases in which the team felt abuse or neglect **contributed** to the death:	Two
7. Does your team have guidelines for determination of abuse/neglect? If so, what are they?	The team utilizes LDSS as the resource in the determination of child abuse/neglect.

8. Recommendations made by team for Local action:	1. All newborns should be seen earlier than the standard two week appointment. It should not be limited to first time parents and breastfed babies. This would allow for earlier identification of any potential feeding problems. 2. Pediatricians are encouraged to refer families experiencing newborn feeding problems or other concerns to the local Healthy Start program. A Community Health Nurse from Healthy Start will see any family regardless of insurance status when referred by the pediatrician. 3. Local Obstetricians need education on what constitutes rape and child abuse and when it is required to refer to LDSS. 4. Local hospital ER staff is reminded to notify law enforcement with any unattended death. 5. Recommendations by law enforcement after the investigation of a school bus accident should be shared with members of the Board of Education. It was also recommended that motion detectors be considered for possible use on school buses.
a. Possible state-local advocacy:	See above – numbers one and three
b. Other:	none
9. Actions taken in/by your Jurisdiction *(Briefly highlight special activities)*.	1. On 6/25/04, the local health department sponsored training on child abuse/neglect. Forty-five professionals including six CFR team members attended the training. 2. Three team members attended the state CFR training on 11/16/04.

10. Recommendations from Local team to the State CFR team:	1. Develop a national registry to track SIDS/SUDI and child abuse/neglect cases. 2. Establish a procedure to investigate SIDS/SUDI cases at the scene which includes taking photographs demonstrating the infant's position at time of sleep and at death utilizing a model (doll).
11. Attach Membership List *(Role/Affiliation/address/phone/e-mail for Chair/ Co-Chair/Contact only. All others, name and Agency affiliation only).*	See attached
Your Ideas and Input:	
What training events would the team leadership and/or the team members find helpful?	
Team Leaders:	
Team Members:	1.SIDS training 2.Community Collaboration to address gaps found as result of the reviews 3.Roles of respective CFR members
What training events have been **conducted** by your team during 2004?	See # 9.
What training events have been **attended** by your team during 2004?	See # 9. In addition, one member attended the seminar, "When A Child Dies."
Does your team have a need for Technical Assistance for CFR? Describe.	As also identified under training needs, training on how to move from the review process to community collaboration would be helpful.

2004 Wicomico County Child Fatality Review Team	
Wicomico CFR Chair	Judith Sensenbrenner, MD Health Officer Wicomico County Health Department 108 East Main Street Salisbury MD 21801 ERIC@dhmh.state.md.us Phone: (410) 543-6930 Fax: (410) 543-6975
Wicomico CFR Staff	Rose Johnson Program Manager, Maternal Child Health Wicomico County Health Department 108 East Main Street Salisbury MD 21801 ROSE@dhmh.state.md.us Phone: (410) 543-6958 Fax: (410) 543-6568

Wicomico CFR Membership		
Michelle	Bailey	Wicomico County Health Dept - Mental Health
Lt. J.	Bennett	Salisbury EMS
Dr. Charlene	Cooper-Boston	Superintendent, Wicomico County Board of Ed
Maryrose	Custer	PRMC / NICU/Bereavement
Debra	Davis	Director, Child Advocacy Center
Kimberly	Dumpson	Life Crisis Center
Becky	Griffin	Wicomico County Health Dept - Maternal Child Health
Linda	Hardman	Director, Wicomico Partnership
Donna	Hoch	Wicomico County Board of Ed
Liz	Ireland	State's Attorney's Office
Chief Paul	Jackson	Fruitland Police Dept
Cpt. Marty	Keorner	Maryland State Police

Wicomico CFR Membership		
Sgt. Stephen	Matthews	WCSD – Child Advocacy Center
Sherriff Hunter	Nelms	Wicomico County Sheriff
Sgt. David	Owens	Maryland State Police
Joe	Rando	Assistant Director for Services, Wicomico County DSS
Lisa	Renegar	Wicomico County Health Dept - CSA
Suzanne	Ruark	Wicomico County Childcare Administration
Davis	Ruark	State's Attorney's Office
Chief Hal	Saylor	Delmar Police Dept
Christopher	Snyder, DO	County Medical Examiner , PRMC
Tammy	Stewart	Wicomico County Health Dept - Health Promotions
Pam	Thompson	CPS Supervisor, Wicomico County DSS
Capt. Mark	Tyler	Salisbury Police Dept.
Chief Allan	Webster	Salisbury Police Dept.
Jennifer	Wimbrow	Wicomico County Juvenile Justice
Deborah	Winder	Wicomico County Parole & Probation

CHILD FATALITY REVIEW
Report of Local Team Activities, 2004
Jurisdiction: Worcester County

	(Answers in this Column)
1. Number of CFR meetings held in 2004:	3
2. What resources do you use to make sure you identify <u>all</u> deaths of children that occur in your community?	Medical Examiner reports sent to health department; obituaries in local newspaper
3. Of all these deaths, what factors do you use to select cases for review at CFR meetings?	Reviewed all deaths of Worcester County residents unless death was due to natural causes
4. Number of cases reviewed at Local CFR team meetings in 2004, regardless of year of death: *(Number should include cases from OCME, Vital Statistics and other sources).*	3 (Two Worcester residents, one case Wicomico County resident, representative from Wicomico County Child Fatality Review Team participated in review)
5. Number of cases in which child abuse or neglect was **substantiated** (i.e. homicide):	0
6. Number of cases in which the team felt abuse or neglect **contributed** to the death:	0
7. Does your team have guidelines for determination of abuse/neglect? If so, what are they?	Utilize expertise of DSS staff who participate in the team review.
8. Recommendations made by team for Local action:	
a. Possible state-local advocacy:	Development of a County Child Advocacy Center
b. Other:	
9. Actions taken in/by your Jurisdiction *(Briefly highlight special activities).*	Sheriff's office sent letter to highway administration requesting signage for curve in road. Ocean City Beach Patrol provides public education regarding rip currents. DSS sought opinion of AG's office for clarification related to disclosure of information between agencies under the auspices of Multi-D Team in response to concerns raised in a near-fatality review. School is evaluating effectiveness of anonymous reporting of student concerns in the middle school as a result of a near-fatality review.
10. Recommendations from Local team to the State CFR team:	

11. Attach Membership List *(Role/Affiliation/address/phone/e-mail for Chair/ Co-Chair/Contact only. All others, name and Agency affiliation only).*	Attached
Your Ideas and Input:	
What training events would the team leadership and/or the team members find helpful?	
Team Leaders:	
Team Members:	
What training events have been **conducted** by your team during 2004?	Maryland State Police Accident Reconstruction Team representative gave a presentation at the January 2004 meeting. *Maryland State Child Fatality Review Team Child Death in Maryland 2002 Annual Report* was reviewed in the January 2004 meeting.
What training events have been **attended** by your team during 2004?	Two team members attended the State Child Fatality Review Training in November 2004
Does your team have a need for Technical Assistance for CFR? Describe.	

Worcester County Child Fatality Review Team
Members List – 2005

Member	Agency
Deborah Goeller **Chairperson** **Health Officer**	**Worcester County Health Department** **P.O. Box 249** **Snow Hill, Maryland 21863** **410-632-1100 Fax: 410-632-0906**
*** Rebecca Shockley** **Director of Nursing**	**Worcester County Health Dept.** **P.O. Box 249** **Snow Hill, Maryland 21863** **410-632-1100 Fax: 410-632-0906**
Doris Moxley **Addictions Director**	**Worcester County Health Dept.**
Lynne Boyd **Mental Health Director**	**Worcester County Health Dept.**
Debbie Farlow **Nursing Program Supervisor**	**Worcester County Health Dept.**
Paula Erdie **Director**	**Worcester County Department of Social Services**
Jeff Cropper **Attorney**	**Worcester County Department of Social Services**
Peter Buesgens **Assistant Director**	**Worcester County Department of Social Services**
Charles Martin **Sheriff**	**Worcester County Sheriff**
Dr. Jon Andes **Superintendent of Schools**	**Worcester County Board of Education**
Joel Todd **State=s Attorney**	**State=s Attorney=s Office**
Suzanne Ruark **Regional Manager**	**Child Care Administration** **Social Services Administration**
Linda Busick	**Resident of Worcester County**
Dr. Glenn Arzadon **Physician**	**Atlantic General Health Services**

**** Contact Person for Worcester County***

Appendix D

Agenda
2004 State Child Fatality Review Training Conference

9:00 - 10:00
Registration

10:00 – 10:30
Welcome
The National Network: Keeping Kids Alive
Sally B. Dolch, MSW
Chair, State Child Fatality Review Team

10:30 – 11:15
CFR Updates and Frequently Asked Questions (FAQ's)
David Fowler, MD
Chief Medical Examiner of the State of Maryland

11:15 – 12:30
Identifying Opportunities for Action: Case Reviews and Discussion
Carolyn J. Fowler, PhD, MPH
Vice-Chair, State Child Fatality Review Team

12:30 – 1:30
Lunch (provided) and Networking
(Meet your CFR counterparts. Name tags are color-coded to assist you in meeting others from or near your region).

1:30 - 3:15
Social Math: Using Data for Action and Advocacy
Susan De Francesco, J.D., MPH

3:15 - 3:30
Next Steps for Maryland's Child Fatality Review
Evaluation of Training

Appendix E
Child Fatality Review
Resource List

1. www.aap.org (American Academy of Pediatrics)
2. www.medem.com (Search Child Fatality)
3. www.seatcheck.org (Safety Seats—1-866-seat-check)
4. www.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/advocacy_tools.shtml (Advocacy tools. Working with elected officials)
8. www.baltimorecity.gov/government/mocyf/mission.html (Youth Violence Reduction Initiative)
9. www.firemarshal.state.md.us (Fire Safety Issues.)
10. www.nfpa.org/riskwatch (National Fire Protection Association)
11. www.nfpa.org/riskwatch/kids.html (Risk Watch: Make Time for Safety
12. www.nfpa.org/riskwatch/about.html (Overview of the Risk Watch program.)
13. www.nfpa.org/riskwatch/teacher.html (Teacher's tools to use in the Risk Watch program.)
14. www.infography.com (Search on Farm Safety)
15. www.fs4jk.org (Kids safety messages, games, coloring book, crossword puzzles etc.)
16. 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)
17. http://www.cdc.gov/health/default.htm (A list of Health Topics A-Z)
18. 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.)
19. http://mova.missouri.org/childab.htm (Missouri Victims Assistance Network, Child Abuse Victims Resources. Click on Child Abuse Prevention Network.)
20. www.child-abuse.com (Click on ICAN-NCFR Child Fatality Review)
21. www.marylandcasa.org (Maryland CASA Programs, Maryland Facts. FAQs
22. www.nationalcasa.org (Services and health tips)
23. www.agnr.umd.edu/MCE/Publications/index.cfm (Maryland Cooperative Extension Service)
24. http://safety.coafes.umn.edu/ (University of Minnesota, Farm Safety and Health Information Clearinghouse)
25. www.connectforkids.org (Click of "Topics A-Z. Click on "Health". Click on "Safety and Injuries". Explore other aspects of this web site.)
26. www.nichd.nih.gov/sids/ (SIDS Back To Sleep Campaign)
27. www.nichd.nih.gov/publications/pubskey.cfm?from=sids (Ordering information for SIDS material in Spanish and English.)

28. www.nichd.nih.gov/strategicplan/cells/SIDS_Syndrome.pdf (Targeting Sudden Infant Death Syndrome (SIDS): A Strategic Plan—June 2001, 40 pages).
29. www.mdpublichealth.org/mch (Click on Child Fatality Review)
30. www.infantandchildloss.org (The Center for Infant and Child Loss)
31. www.drada.org/ (Depression and Related Affective Disorders Association)
32. http://www.suicidehotlines.com/maryland.html (Suicide hotlines in Maryland)
33. http://www.mentalhealth.org/suicideprevention/stateprograms/Maryland.asp
34. http://www.familytreemd.org (Child Abuse information for Maryland)
35. http://www.childwelfare.net/CFR/ (Child Fatality Review in Georgia)
36. http://www.hs.state.az.us/cfhs/azcf/ (Child Fatality Review in Arizona)
37. http://www.tdprs.state.tx.us/child_protection/about_child_abuse/cfrt.asp (Child Fatality Review in Texas)
38. http://www.cdphe.state.co.us/pp/cfrc/cfrchom.asp (Child Fatality Review in Colorado)
39. http://www.dss.state.mo.us/stat/mcfrp.htm (Child Fatality Review in Missouri)
40. http://www.keepingkidsalive.org/ (Child Fatality Review in Michigan)

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

Appendix F
2004 Recommendations to State CFR from Local CFR Teams
LCFR Issues for Statewide Consideration

Allegany

Possible collaboration on local program "Parents Eyes Save Children's Lives" which is a multi-agency campaign to increase adult awareness of high-risk situations faced by children and how they can be avoided or prevented. Media vehicles included billboards, bus signs, posters, radio spots, incentive items.

Baltimore County

1. Pursue the issue of funding for CFR aggressively. Recommend that all local teams document the hours contributed by various members so that we can calculate the monetary value of "in-kind" hours contributed to CFR teams. Valuable information for advocacy.
2. Provide a directory of all local team coordinators to every team. If possible, add other important local contacts such as SAFE KIDS or Injury Prevention Coordinator, Community Traffic Planner, Medical Examiner assigned to team (if relevant), etc.
3. Focus capacity development activities on action planning. We need to move beyond data collection.

Caroline

Teen drivers – restrict passengers until age 18.

Carroll

Clarification of guidelines used by State to determine abuse/neglect.

Howard

State Team presentation to our local team demonstrating the importance of our work in improving outcomes.

Montgomery

1. Develop a standard list of questions for suicide review in order to standardize the reporting of such deaths by triggers, therapy, supervision, etc.

2. Review the State's child fatality reports for the past 3 to 5 years to get a better incidence of arrhythmia induced deaths in preparation for the training of sports trainers and medical practitioners.

3. Add classifications to all reports that use current medical injury terminology.

4. Consider funding for local teams for technical support and advocacy efforts.

Prince George's County

1. Funding for local team activities.

2. Review the process of data submission to local teams. If "declined" cases are not submitted to the local teams, the teams are not able to review all child deaths in the county.

3. Revise current CFR data collection forms/tools as they are not relevant to many of the cases being reviewed. This causes some data to be improperly completed.

4. Increase the number of training opportunities for the local teams.

5. Development of an interim means of communication for the local teams (i.e. newsletter) until the Internet system is completed.

Talbot

1.Need more time to allow visibility for our recommendations.
2.Truck manufacturers install adequate visibility for truck drivers.
3.Need sensing equipment to detect imminent collision in back-up situations.
4. Teach parents to always be alert when there are construction vehicles/trucks on their residential property

Washington County

Statewide education on Maryland Youth Crisis Hotline, misuse of equipment and gun safety.

Wicomico

1.Develop a national registry to track SIDS/SUDI and child abuse and neglect cases.
2. Establish a procedure to investigate SIDS/SUDI cases at the scene which includes taking photographs demonstrating the infant's position at the time of death utilizing a model (doll).

Appendix G
TALLY OF 2004 LOCAL CFR RECOMMENDATIONS TO STATE CFR

Abuse/Neglect Issues (2 jurisdictions had recommendations on this topic)

Clarify the guidelines used by the state to determine abuse and neglect.

Develop a national registry to track down child abuse and neglect cases.

Commercial/Construction Vehicles (1)

Truck manufacturers need to design trucks with adequate visibility.

Trucks should be equipped with sensing equipment which detects imminent collision while backing-up.

Communication (3)

State Team presentation to local teams on the importance of local team efforts in improving outcomes.

Develop an interim means of communication for local teams (i.e. newsletter) until the Internet system is completed.

Provide directory of all local team coordinators to every team. If possible, add other local contacts such as SAFE KIDS or Injury Prevention Coordinator, Community Traffic Planner, Medical Examiner assigned to team (if relevant).

Data Issues (2)

Add classifications to all reports that use current medical injury terminology.

Review all CFR reports for the last 3-5 years to determine the incidence of deaths from arrhythmia. Use the findings in preparation to train sports trainers and medical professionals.

Review process of data submission to local teams. If "declined" cases are not submitted to local teams, then the local CFR team is not able to review all child deaths in the county.

Revise current CFR data collection forms/tools as they are not relevant to many of the cases being reviewed. This causes some data to be improperly completed.

Funding of Local CFR Team (3)

Consider and work towards statewide funding of local teams for technical support and advocacy efforts.

Public Education (3)

Teach parents to remain vigilant when construction vehicles are on their property.

Increase parental awareness of situations that are high risk to children and how they can be avoided through "Parents Eyes Save Children's Lives" campaign.

Local recommendations need on-going promotion over time.

Promote statewide education about:

- the Maryland Crisis Youth Hotline
- misuse of equipment
- gun safety

SIDS/SUDI (2)

Develop national registry to track SID /SUDI cases.

Work to standardize investigative procedures at the scene of SIDS/SUDI cases and include photographs demonstrating the infant's position at the time of sleep and at time of death, using a model.

Suicide Prevention (1)

Develop a standard list of questions for review after suicides in order to standardize the reporting of such deaths by triggers, therapy and supervision.

Teen Drivers (1)

Restrict passengers of teen drivers until age 18.

Training (2)

Increase the number of training opportunities for local teams.

Focus activities on action planning.