MARYLAND STATE CHILD FATALITY REVIEW TEAM

Baltimore, Maryland 21201

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

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

SEP 2 4 2007

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

RE: Senate Bill 464 (Ch. 355) of the Acts of 1999
2006 Legislative Report of the State Child Fatality Review Team

Dear Governor O'Malley:

Pursuant to Senate Bill 464 enacted during the 1999 legislative session, the Maryland State Child Fatality Review (CFR) Team is pleased to submit this 2006 annual report on its progress and accomplishments. The report incorporates information about the work of local CFR teams, training and advocacy efforts to prevent child deaths throughout the State, and 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, MDiv, M.S.W.
Chairperson

Enclosure

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

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

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

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MARYLAND STATE CHILD FATALITY REVIEW

2006 Annual Legislative Report

Martin O'Malley Governor	Anthony G. Brown Lt. Governor	John M. Colmers Secretary, Department of Health and Mental Hygiene

The purpose of the Maryland State Child Fatality Review (CFR)Team is to prevent child deaths by: (1) understanding of the causes and incidence of child deaths; (2) implementing changes within the agencies represented on the State CFR Team to prevent child deaths; and (3) advising the Governor, the General Assembly, and the public on changes to law, policy, and practice to prevent child deaths. The State CFR Team envisions the elimination of preventable child fatalities by successfully using the child fatality review process to understand the circumstances around those fatalities and to recommend strategies for prevention.

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

Child Fatality Review was established in Maryland statute in 1999. The 25 member Maryland State CFR Team is comprised of the Secretaries (or their designees) of 12 State offices or departments, two pediatricians, and 11 members of the general public with interest and expertise in child safety and welfare who are appointed by the Governor. (2006 membership is presented in Appendix A.) The State CFR Team meets at least four times a year to address 13 statutorily prescribed duties. One of the meetings is used for education and training on a variety of topics.

In Maryland, there is the State CFR Team and local jurisdictions have CFR Teams. These local CFR teams convene regular meetings to review unexpected deaths of child residents living within their geographic borders. These local CFR teams concentrate on issues specific to area deaths that may be impacted by changes in systems, policies, or practices at the local level.

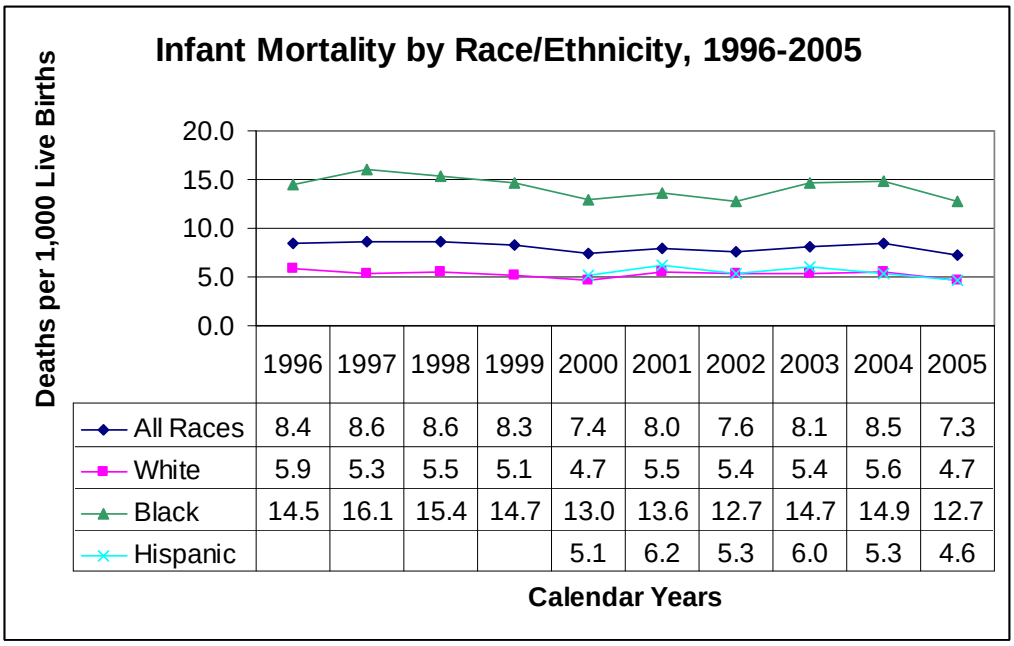
Detecting and preventing child abuse and neglect remain an important focus of CFR, the Department of Health and Mental Hygiene (DHMH) and the Department of Human Resources (DHR). Whatever the cause and manner of death, the majority of childhood deaths raise questions about the general child health system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

Summary of the Maryland Child Death Report

Surveillance of childhood deaths is important because it helps to measure the magnitude of the problem and assess the causes and the population groups most affected. The data is crucial for identifying trends and designing interventions to reduce childhood mortality.

The Child Death Report focuses on deaths in children under age 18. In 2005, there were 545 infant deaths and 301 deaths to children between the ages of one and 17 years. Deaths to infants (less than one year of age) are analyzed separately from deaths of children between one to 17 years of age. The three leading causes of death in infants for 2005 were disorders related to preterm birth or low birth weight (24.2 percent), congenital abnormalities (14.7 percent), and sudden infant death syndrome (10.1 percent). After increasing for two straight years, the infant mortality rate dropped in 2005, to 7.3 per 1,000 live births (Figure 1). Consistently, there are

substantial racial disparities in infant mortality rates. In 2005, the infant mortality rate for whites was 4.7 per 1,000 live births compared to 12.7 per 1,000 live births for African-Americans.



	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005
All Races	8.4	8.6	8.6	8.3	7.4	8.0	7.6	8.1	8.5	7.3
White	5.9	5.3	5.5	5.1	4.7	5.5	5.4	5.4	5.6	4.7
Black	14.5	16.1	15.4	14.7	13.0	13.6	12.7	14.7	14.9	12.7
Hispanic					5.1	6.2	5.3	6.0	5.3	4.6

Figure 1
Data Source: Vital Statistics Administration, DHMH

In 2005, the child death rate (one -17 years of age) declined, to 22.7 per 100,000 population (Figure 2). The child death rate for whites was 20.1 per 100,000 population compared to 28.2 per 100,000 population for African-Americans and 24.5 per 100,000 population for Hispanics.

The causes of death are best assessed through aggregate data because of enhanced stability. Among children aged one to 17 years, the three leading causes of death were unintentional injuries, homicide, and neoplasms (i.e., tumors and cancer) in 2003 through 2005 (Table 1). For the injury- related deaths, 41.3 percent were due to motor vehicle collisions (Tables 2 and 3) and 61.3 percent of motor vehicle deaths occurred in males. The greatest proportion of motor vehicle-related injury deaths occurred in children aged 15 to 17 years (56.8 percent). The rates for motor vehicle related deaths by race and ethnicity were 6.0 for whites, 5.3 for African-Americans, and 4.3 for Hispanics per 100,000 population.

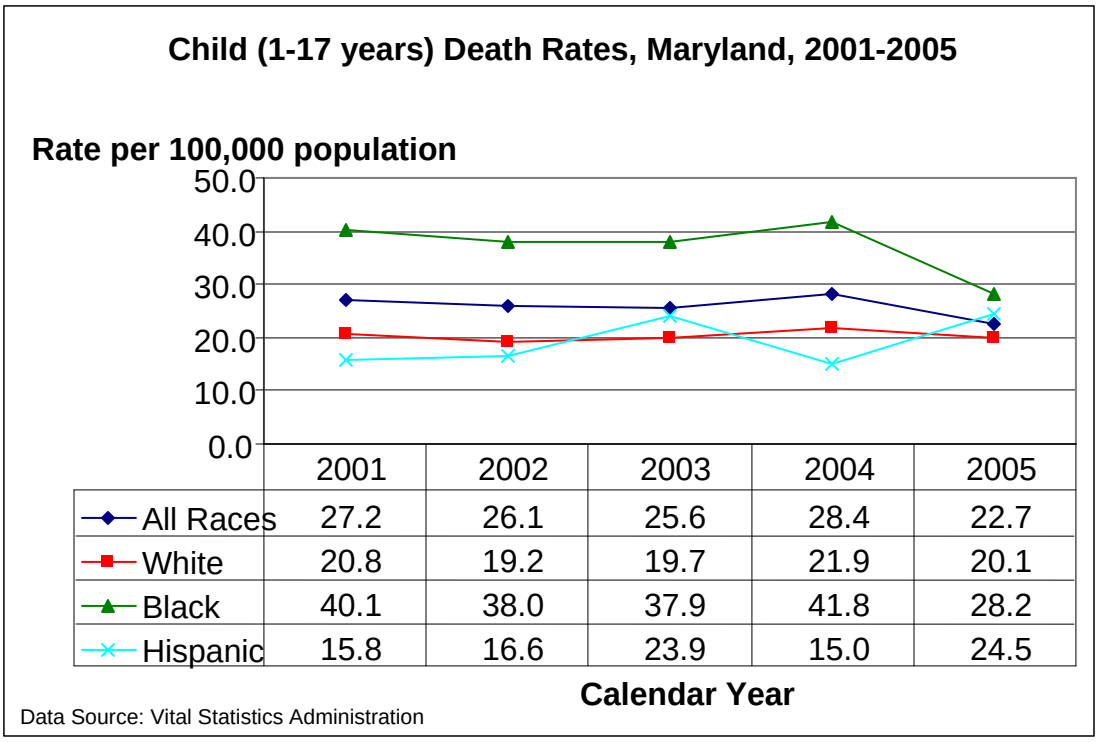


Figure 2

Children's death by homicide continues to be a significant public health problem in Maryland. Between 2003 and 2005 there were 21 homicides of infants and 143 homicides among children aged one to 17 years. The rate of homicides among children aged one to 17 is substantially higher among African-Americans, at 8.1 per 100,000 population, compared to 1.3 per 100,000 population for whites. Approximately 60.8 percent of the homicides of children aged one to 17 years involved firearms. The age group with the highest homicide rate was that of children between 15 to 17 years (14.2 per 100,000 population). The group with the next highest rate was that of infants (9.3 per 100,000). Males were victims of homicide at a much higher rate than females, 5.7 versus 2.1 per 100,000 population respectively.

There were 47 suicides among children from 2003 to 2005. The rate of suicide was greatest among those aged 15 to 17 years (4.4 per 100,000 population). Suicides occurred less frequently among younger children aged 10 to 14 years (1.2 per 100,000 population). Among children 10 to 17 years, males committed suicide more frequently than females (3.9 compared to 0.8 per 100,000 population, respectively). The suicide rates varied by race from 5.9 among Asian or Pacific Islanders, to 2.6 among whites, and 1.6 among African-Americans per 100,000 population. There were no suicides reported among Hispanic children during this time period.

Table 1. Leading Causes of Death by Age Group, Maryland, 2003-2005					
Rank	Age Group				
		1-4 years	5-9 years	10-14 years	15-17 years
1	Cause of Death	Unintentional Injury	Unintentional Injury	Unintentional Injury	Unintentional Injury
	# of Deaths	54	59	67	154
	% of Deaths in Age Group	23.1%	37.6%	29.9%	39.1%
2	Cause of Death	Neoplasms	Neoplasms	Neoplasms	Homicide
	# of Deaths	29	32	39	103
	% of Deaths in Age Group	12.4%	20.4%	17.4%	26.1%
3	Cause of Death	Congenital Malformations	Diseases of the Respiratory System	Diseases of the Nervous System	Suicide
	# of Deaths	27	11	16	32
	% of Deaths in Age Group	11.5%	7.0%	7.1%	8.1%
4	Cause of Death	Homicide	Congenital Malformations	Suicide	Neoplasms
	# of Deaths	20	10	15	26
	% of Deaths in Age Group	8.6%	6.4%	6.7%	6.6%
5	Cause of Death	Diseases of the Circulatory System	Diseases of the Nervous System	Diseases of the Circulatory System	Diseases of the Circulatory System
	# of Deaths	19	10	15	19
	% of Deaths in Age Group	8.1%	6.4%	6.7%	4.8%

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

Table 2. Child (1-17 years) Injury Related Deaths by Type of Injury and Gender, Maryland, 2003-2005				
Type of Injury	Male	Female	Total Deaths	Percent of Total Injury Deaths
Motor Vehicle Collision	136	86	222	41.3%
Other Transport Injury	9	7	16	3.0%
Falls	1	2	3	0.6%
Drowning	26	6	32	5.9%
Fire	25	7	32	5.9%
Poisoning	4	5	9	1.7%
Other Non-Transport Injury	16	4	20	3.7%
Homicide by Firearm	76	11	87	16.2%
Homicide by Other Means	35	21	56	10.4%
Suicide by Firearm	14	0	14	2.6%
Suicide by Other Means	25	8	33	6.1%
Undetermined Intent	5	9	14	2.6%

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

Table 3. Child (1-17 years) Injury Related Deaths by Type of Injury and Race, Maryland, 2003-2005					
Type of Injury	White	African-American	Other	Total Deaths	Percent of Total Injury Deaths
Motor Vehicle Collision	143	72	7	222	41.3%
Other Transport Injury	13	3	0	16	3.0%
Falls	1	1	1	3	0.6%
Drowning	16	15	1	32	5.9%
Fire	12	20	0	32	5.9%
Poisoning	4	5	0	9	1.7%
Other Non-Transport Injury	12	8	0	20	3.7%
Homicide by Firearm	13	74	0	87	16.2%
Homicide by Other Means	19	36	1	56	10.4%
Suicide by Firearm	11	2	1	14	2.6%
Suicide by Other Means	20	9	4	33	6.1%
Undetermined Intent	10	3	1	14	2.6%

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

State CFR Team Activities

The State CFR Team conducts educational and training events in response to the needs of local CFR teams. Each year the State CFR Team collects reports on activities from the local CFR teams in which the teams describe their previous year activities, their training needs, and their recommendations for State CFR Team action. State CFR Team members review these local reports and respond through educational opportunities with local teams.

Educational Opportunities

Topics of special interest are covered in depth, either by CFR Team members with expertise or invited guests, including:

"The Department of Health and Mental Hygiene Violence Reporting System"
State CFR Team member:
George Thorpe, MD, Project Director, Maryland Violent Death Reporting System
Center for Preventive Health Services
The Maryland Department of Health and Mental Hygiene

"The Safety of Children in Child Care"
Guest Speakers:
Lisa McDonald, Assistant Program Manager
Cheryl Hall, Nurse Consultant
Office of Child Care
The Maryland State Department of Education

"The History of Fetal and Infant Mortality Review (FIMR)"
Guest Speaker:
Jeanne L. Brinkley, MPH, CNM, Chief, Systems Improvement
Center for Maternal and Child Health
The Maryland Department of Health and Mental Hygiene

The annual educational training typically focuses on several specific health or risk issues, and the needs of the local CFR teams related to their team operation. In 2006, the annual training was conducted in collaboration with the Maryland Department of Human Resources (DHR). Because of the common goal of keeping children safe, the two agencies worked together to bring their shared perspective to the conference.

A full-day training session was held to inform participants about the CFR process by Sally Dolch, MDiv. M.S.W. and protocol by Chief Medical Examiner, David Fowler, M.D. Educational information was presented about identifying deaths through a presentation by Assistant Medical Examiner Tasha Greenberg, MD, entitled "The Changing Landscape: Sudden Infant Death Syndrome (SIDS) and Sudden Unexpected Death in Infancy (SUDI)." CFR also discussed turning recommendations into advocacy and preparing for future technology advancements that will enhance efficiency.

Networking amongst the local CFR teams, as well as the securing of the relationship between DHR and the State CFR Team, has helped to foster collaboration among these groups. Specifically, Dan Wilson, LCSW-C and Mark Vidor, LCSW-C, discussed how CFR teams and DHR can join efforts to improve the safety of Maryland's children. The session was moderated by Dr. Rebecca Bright, the Acting Director of DHR's Social Services Administration. At all annual training events, CFR team leaders are encouraged to interact with the team leaders of other jurisdictions with similar characteristics. Examples include those with a predominantly

rural or urban population, or a high death rate in a particular area, such as automobile deaths or suicides. Because similar regions often share risk profiles, they can benefit from joint communication, efforts, and public education campaigns.

Another source of networking and education has been the newsletter, written by State CFR Team Chair Sally B. Dolch, which provides an update for local team members concerning relevant legislation, training opportunities, State CFR Team membership changes, and other important information. The newsletter was the outgrowth of recommendations by a communications subcommittee of the State CFR Team and local CFR teams, as a way of improving communication and increasing the ability of the State CFR Team to provide information and education. The newsletter provides an update on the activities of the State CFR Team and local CFR teams. It often focuses on a special topic and emphasizes advocacy skills needed to address a particular area of concern. When applicable, a legislative update is given. A calendar of upcoming meetings, trainings, Webcasts, and other related events is always included. The newsletter has been an excellent addition to the efforts of the State CFR Team. Copies can be viewed at *http://www.fha.state.md.us/mch/cfr/* under "What's New."

Defining Near Fatality

During 2006, a subcommittee of the State CFR Team continued on-going efforts to make it possible for local CFR teams to receive notification of near fatalities occurring in their jurisdiction and obtain the necessary information to review them. The cases of near fatalities will necessitate a point of initiation other than the Office of the Chief Medical Examiner, which now conveys information on fatal cases under its auspices. Although the process for review of near fatalities will be similar to that of fatal cases, near fatality cases will likely be identified through arrangements with hospitals or the Emergency Medical System. The State CFR Team continues to work to clarify these issues to make a workable system of notification and review. Once developed, the State CFR Team will work with local teams that want to review near fatalities, to ease the new effort into operation.

State CFR Team Future Activities

The State CFR Team will continue to work toward the prevention of child deaths, especially as related to child abuse and neglect. Implementing and strengthening future activities, however, requires additional resources. Currently, there are no funds allocated for CFR. While some local teams are able to acquire necessary funds, a comprehensive, Statewide or regional approach is necessary. Specifically, additional resources to serve the many high-risk 15-17 year old adolescents are necessary in order to prevent deaths and ensure that these children are ready to enter adulthood.

Appendix A: 2006 State Child Fatality Review Team Members

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

(1) THE ATTORNEY GENERAL – Amanda Scott, J.D., designee (pending)
(2) THE CHIEF MEDICAL EXAMINER – Tasha Greenberg, M.D., designee
(3) THE SECRETARY OF HUMAN RESOURCES – Kathleen Harrison, designee
(4) THE SECRETARY OF HEALTH AND MENTAL HYGIENE – George Thorpe, M.D., designee
(5) THE STATE SUPERINTENDENT OF SCHOOLS - Pending
(6) THE SECRETARY OF JUVENILE SERVICES – Anne Fox, R.N., B.S., designee

(7) THE SECRETARY OF THE STATE POLICE – Tina Becker, designee
(8) THE PRESIDENT OF THE STATE'S ATTORNEY'S ASSOCIATION – Jonathan G. Newell, J.D., designee
(9) THE CHIEF OF THE DIVISION OF VITAL RECORDS – Hal Sommers, M.A., designee
(10) A REPRESENTATIVE OF THE STATE SIDS INFORMATION AND COUNSELING PROGAM, Donna Becker, R.N., M.S.N., Director, Center for Infant and Child Loss
(11) THE DIRECTOR OF THE ALCOHOL AND DRUG ABUSE ADMINISTRATION – David Putsche, designee
(12) 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
(13) ELEVEN MEMBERS OF THE GENERAL PUBLIC WITH INTEREST OR EXPERTISE IN CHILD SAFETY OR WELFARE, APPOINTED BY THE GOVERNOR, INCLUDING CHILD ADVOCATES, CASA VOLUNTEERS, HEALTH AND MENTAL HEALTH PROFESSIONALS, AND ATTORNEYS WHO REPRESENT CHILDREN –
Sally Dolch, MDiv, MSW, Chairperson
Susan Daddio, MSW, Citizen Advocate for Children
Carolyn Fowler, Ph.D, M.P.H.,Vice-Chair, Citizen Advocate for Children
Mary C. Gentile, LCSW-C, 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: Summary of Local Reviews

Summary of Local Case Review Meetings and Findings – Maryland Jurisdictions* *Five counties not included due either to no deaths, no case reviews, or no report	
	Total
1. Total Number of CFR meetings held in 2006.	75
2. In how many jurisdictions were all Medical Examiner cases reviewed by the team?	17
3. Total number of cases reviewed at local CFR team meetings in 2006, regardless of year of death.	233
4. Of all the cases reviewed by all teams in 2006, in how many was abuse or neglect confirmed; e.g., there was a finding of "indicated abuse" or "indicated neglect" by Child Protective Services (CPS) or a positive police investigation?	18
5. Not including those children counted in number 4 above; what is the total number of cases that teams *subjectively* felt abuse or neglect may have contributed to the death?	24
6. Of the total cases reviewed in 2006, in how many was there a previous history of child abuse, as determined by CPS?	10
7. How many had a previous history of child neglect, as determined by CPS?	9
8. How many had a history of involvement with the Department of Juvenile Services (formerly Dept. of Juvenile Justice)?	3

Appendix C: Local CFR Team Recommendations for State CFR Team

1. ATVs/Dirt Bikes

Help make dirt bike safety instruction easily available and affordable.

- Recommend the State CFR Team consider supporting the AAP position on ATVs and propose legislation in Maryland.
- Develop a Statewide ATV Awareness campaign.
- Develop ATV safety recommendations. Safety training course prior to purchase. No one under 16 years allowed to drive the ATV. Promote legislation regarding recommendations.

2. Assist with Prevention Programs/Education/Materials – by and for local CFR Teams

- Focus on teen suicide - Work with schools, clergy and other sources to help identify warning signs of depression and suicide.
- Focus on teen drinking - Educate parents about the dangers. Some parents prefer teens to drink at home rather than outside the home.
- Continue the Annual Training Conference.
- Present information on best and promising practices for relevant local issues.
- Provide outreach materials and speakers to the locals on subjects locals request.
- Present evaluations findings from other states.
- Organize a Medical Examiner and Fatality Prevention Conference.
- Provide grant writing instruction to get funding for local CFR team activities/projects.
- Aid in networking with other teams to discuss accomplishments and issues.
- Provide training on how to move from review process to community collaboration.

3. Communication

- Continue the State CFR Team Newsletter.
- Develop a communication check to be sure information is received.
- Inform local CFR teams of concerns beyond the immediate cause of death.
- Provide feedback on local CFR team recommendations made to the State CFR Team.

4. Data Collection/Reporting/Synthesis

- Establish database system that compiles information for the local CFR teams.
- Revise current reporting forms used by local teams, including the data collection tool.
- Evaluate contributing factors (i.e., a lack of seat belt use in auto accidents) relating to causes of death for adolescents. Trending cause of adolescent deaths over a five year period to identify areas of concern for Statewide prevention efforts.
- Add information/statistics to local Web sites.
- Assist in data collection.
- Involve interested local CFR teams in piloting the new data system, when available.

5. Funding

- Provide money to support local outreach/educational programs, i.e., Risky Business Program.
- Explore funding resources for local CFR teams.

6. Home Schooling

- Modify/tighten current home schooling laws to require stricter on-site student supervision of pupils for evidence of grade appropriate skill mastery. Additionally, require all home-schooled children to provide proof of initial (and periodic) medical assessment/physical exams to include nutritional, growth and development and immunization status.

7. Near Fatality

- Define near fatality and reporting guidelines.

8. Promote Available Programs and Conduct Media Campaigns

- Support Cribs for Kids.
- Educate about co-sleeping dangers through a media campaign.
- Educate people about the Safe Haven Program via a media campaign.

9. Collaborate with other Safety Commissions/Programs

- Provide input to other product safety commissions.
- Provide more involvement with Consumer Protection and/or Occupational Health and Safety, when appropriate.