MARYLAND STATE CHILD FATALITY REVIEW TEAM

2008 Annual Legislative Report

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

http://fha.maryland.gov/mch/cfr_home.cfm

Overview of the Maryland State Child Fatality Review Team

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

The purpose of the Maryland State Child Fatality Review (CFR) Team is to prevent child deaths by: (1) understanding the causes and incidence of child deaths; (2) implementing changes within the agencies represented on the State CFR Team to prevent child deaths; and (3) advising the Governor, the General Assembly, and the public on changes to law, policy, and practice to prevent child deaths. The State CFR Team envisions the elimination of preventable child fatalities by successfully using the child fatality review process to understand the circumstances around those fatalities and to recommend strategies for 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) and representatives of 12 State agencies or offices, two pediatricians, and 11 members of the general public with interest and expertise in child safety and welfare who are appointed by the Governor (See Appendix A for 2008 State CFR Team membership). The State CFR Team meets at least four times a year to address 13 statutorily-prescribed duties (See Appendix B for State CFR Team duties). One of the quarterly meetings is designed as an all-day training on select topics, to enhance specialized knowledge.

In Maryland, besides the State CFR Team, each local jurisdiction has a CFR Team. These local CFR teams convene regular meetings to review unexpected deaths of child residents living within their geographic borders. The teams concentrate on issues specific to each area, reviewing deaths in order to determine beneficial changes in systems, policies, or practices at the local level. Administrative support for the State CFR Team and the local child fatality review teams is provided by the Center for Maternal and Child Health within the Department of Health and Mental Hygiene (DHMH).

Detecting and preventing child abuse and neglect remain an important focus of CFR, 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.

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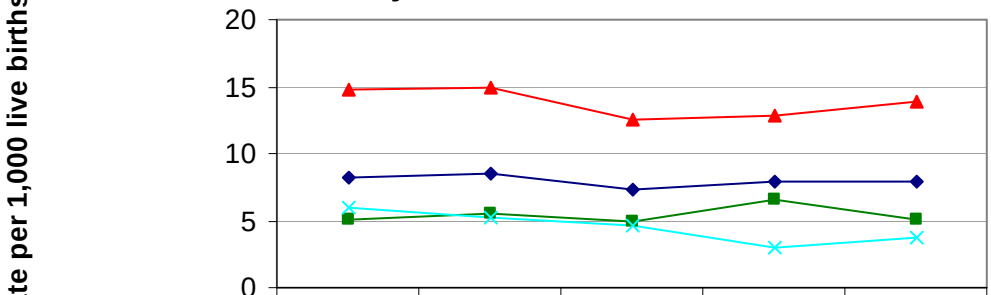
Summary of the Maryland Child Death Report 2008
Reflecting Deaths Occurring 2003-2007

Childhood deaths are a major public health problem and many of these deaths are preventable. Surveillance of childhood deaths is important because it helps to measure the magnitude of the problem, and to assess the causes and the population groups most affected. The data is crucial for identifying trends and targeting interventions to reduce childhood mortality.

The Child Death Report focuses on deaths in children below the age of 18. In 2007, there were 622 infant deaths and 366 deaths to children between the ages of 1 and 17. Deaths to infants (< 1 year of age) are usually analyzed separately from deaths to children between 1 to 17 years of age. The three leading causes of death in infants for 2007 were disorders related to preterm birth or low birth weight (24.0%), congenital abnormalities (14.3%), and sudden infant death syndrome (10.0%). The infant mortality rate increased in 2007, to 8.0 per 1,000 live births (Figure 1).

Figure 1. Infant Mortality Rates by Race/Ethnicity, Maryland, 2003-2007



	2003	2004	2005	2006	2007
All Races/Ethnic	8.1	8.5	7.3	7.9	8.0
White non-Hisp	5.1	5.6	4.9	6.5	5.1
Black non-Hisp	14.7	15.0	12.6	12.8	13.9
Hispanic	6.0	5.3	4.6	3.0	3.8

Calendar Year

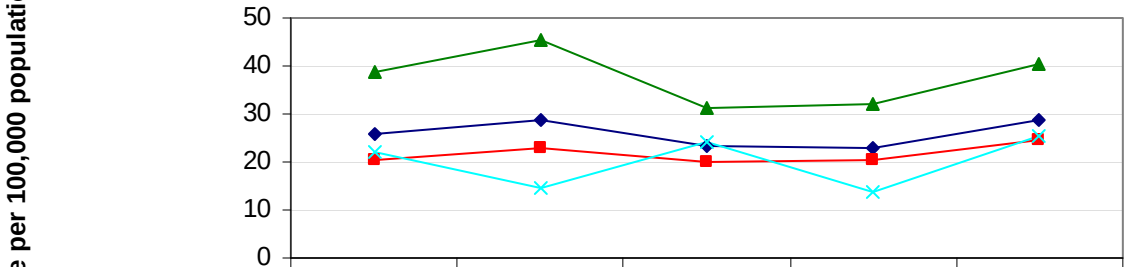
Data Source: MD DHMH, Vital Statistics Administration

There were substantial racial disparities in infant mortality rates in 2007. The infant mortality rate for White non-Hispanics was 5.1 per 1,000 live births compared to 13.9 per 1,000 live births for Black non-Hispanics. The rate was lowest among Hispanics at 3.8 deaths per 1,000 live births.

In 2007, the overall child death rate (1-17 years of age) increased to 28.6 per 100,000 population (Figure 2). In 2007, the child death rate for White non-Hispanics was 24.5 per 100,000 population compared to 40.6 per 100,000 population for Black non-Hispanics. The child death rate for Hispanics in 2007 was 25.3 per 100,000 population. Among children aged 1-17, the three leading causes of death were unintentional injuries,

homicide, and malignant neoplasms during the years 2005 through 2007. (Note: data are aggregated over a three year period to provide more stability.) Table 1 shows the leading causes of death by age group. For the injury related deaths, 37.4% were due to motor vehicle collisions (Tables 2, 3). Sixty-one percent of motor vehicle deaths occurred in males. The greatest proportion of motor vehicle related injury deaths occurred in children aged 15 to 17 (56.5%). The rates for motor vehicle-related deaths by race and ethnicity were 5.0 per 100,000 population for White non-Hispanics, 5.6 per 100,000 population for Black non-Hispanics, and 4.4 per 100,000 population for Hispanics.

Figure 2: Child (1-17 years) Death Rates by Race/Ethnicity, Maryland, 2003-2007



	2003	2004	2005	2006	2007
All Races	25.6	28.7	23.1	22.9	28.6
White non-Hisp	20.3	23.1	19.8	20.5	24.5
Black non-Hisp	38.7	45.2	31.3	31.9	40.6
Hispanic	21.9	14.7	24.0	13.6	25.3

Calendar Year

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

Death by homicide among children continues to be a significant public health problem in Maryland. In the period 2005 through 2007, there were 16 homicides of infants and 129 homicides of children aged 1-17 years. The rate of homicides among children aged 0-17 is substantially higher among Black non-Hispanics, at 7.8 per 100,000 population, compared to 5.0 per 100,000 population for Hispanics, and 1.3 per 100,000 population for White non-Hispanics. Fifty-nine percent of the homicides of children aged 0-17 involved firearms. The age group with the highest homicide rate was children between 15 to 17 years old (12.2 per 100,000 population). The group with the next highest rate was infants (7.1 per 100,000). Seventy-seven percent of the child victims of homicide (aged 0-17 years) were male.

There were 46 suicides among children over the period from 2005 to 2007. The rate of suicide was greatest among those aged 15 to 17 years (4.7 per 100,000 population). Suicides occurred less frequently among younger children aged 10 to 14 years (1.0 per

100,000 population). Among children aged 10 to 17, 73.9% of suicides were committed by males. The suicide rates were similar among White non-Hispanic (2.6 per 100,000 population) and Black non-Hispanic children (2.2 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, MD, 2005-2007

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	60	44	64	139
	% of Deaths in Age Group	24.8%	31.2%	31.7%	36.8%
2	**Cause of Death**	Congenital Malformations	Malignant Neoplasms	Malignant Neoplasms	Homicide
	# of Deaths	33	26	27	90
	% of Deaths in Age Group	13.6%	18.4%	13.4%	23.8%
3	**Cause of Death**	Homicide	Congenital Malformations	Diseases of the Circulatory System	Suicide
	# of Deaths	21	11	16	35
	% of Deaths in Age Group	8.7%	7.8%	7.9%	9.3%
4	**Cause of Death**	Malignant Neoplasms	Diseases of the Nervous System	Diseases of the Nervous System	Malignant Neoplasms
	# of Deaths	21	11	15	22
	% of Deaths in Age Group	8.7%	7.8%	7.4%	5.8%
5	**Cause of Death**	Diseases of the Circulatory System	Infectious Diseases	Homicide	Undetermined Intent
	# of Deaths	17	10	13	20
	% of Deaths in Age Group	7.0%	7.1%	6.4%	5.3%

* Data Source: MD DHMH, Vital Statistics Administration

Table 2. Child (1-17 years) Injury Related Deaths by Type of Injury and Gender, Maryland, 2005-2007				
Type of Injury	**Male**	**Female**	**Total Deaths**	**% of Total Injury Deaths**
Motor Vehicle Collision	118	75	193	37.4%
Homicide by Firearm	76	9	85	16.5%
Homicide by other Means	25	19	44	8.5%
Drowning	29	9	38	7.4%
Fire	28	7	35	6.8%
Suicide by other Means	22	11	33	6.4%
Undetermined Intent	26	6	32	6.2%
Other Non-Transport Injury	12	9	21	4.1%
Suicide by Firearm	12	1	13	2.5%
Other Transport Injury	6	3	9	1.7%
Falls	4	4	8	1.6%
Poisoning	1	2	3	0.6%
Legal Intervention	2	0	2	0.4%

* Data Source: MD DHMH, Vital Statistics Administration

Table 3. Child (1-17 years) Injury Related Deaths by Type of Injury and Race/Ethnicity, Maryland, 2005-2007					
Type of Injury	**White non-Hispanic**	**Black non-Hispanic**	**Hispanic**	**Other**	**Total Deaths**
Motor Vehicle Collision	105	71	13	4	193
Homicide by Firearm	10	70	5	0	85
Homicide by other Means	8	24	12	0	44
Drowning	18	17	2	1	38
Fire	16	18	1	0	35
Suicide by other Means	18	12	0	3	33
Undetermined Intent	21	8	2	1	32
Other Non-Transport Injury	10	8	3	0	21
Suicide by Firearm	9	2	0	2	13
Other Transport Injury	5	4	0	0	9
Falls	2	2	2	2	8
Poisoning	1	2	0	0	3
Legal Intervention	0	1	0	1	2

* Data Source: MD DHMH, Vital Statistics Administration

2008 State CFR Team Activities

Training and Education

One of the statutory duties of the State CFR Team is to conduct educational and training events in response to the needs of local CFR teams. Each year, the State CFR Team collects reports from the local CFR teams (See Appendix C for Summary of Local CFR Team case reviews meetings and findings). In these reports the local teams describe their activities of the previous year, their training needs, and their recommendations for State CFR Team action (See Appendix D for local CRF team training needs and recommendations). State CFR Team members review these local reports and respond by providing technical assistance, training, and education directed at the needs described.

Topics of special interest are covered in depth at the State CFR Team quarterly meetings and at the annual training meeting held at the end of each year. Presentations are made by expert State CFR Team members and invited guests.

In 2008, special presentations at quarterly State CFR meetings included:

Teri Covington, MPH
Director, National Center for Child Death Review
"Data Systems Collaboration for Child Death Review"

Tasha Greenberg, MD
Vice-Chair, Maryland State Child Fatality Review Team
Assistant Medical Examiner, Office of the Chief Medical Examiner
"Infant Investigation Protocol: CDC, SUIDI Investigation &
Infant Scene Re-enactments"

Richard Lichenstein, MD
Chair, Maryland State Child Fatality Review Team
Director, Pediatric Emergency Department
University of Maryland Medical Center
"Teen Driving"

David R. Morgan, JD
Assistant Attorney General
Office of the Attorney General
"Legal Issues Involved When Considering Data Collaboration with the
National Child Death Review Center"

Training and education are also the focus of the State CFRT annual meeting, where specific health or risk areas are highlighted. The 2008 annual meeting included a presentation on pediatric death investigation in Maryland by the Chief Investigator for the

Office on the Chief Medical Examiner. Also included was a discussion of coming changes to the Office of the Chief Medical Examiner, and a practice case review session conducted by a local CFR team. The full agenda for the 2008 annual meeting is in Appendix E.

At all annual training events, CFR team leaders are encouraged to interact with the team leaders of other jurisdictions with similar demographics. Examples include those with a predominantly rural or urban population, or a high death rate due to a particular cause, such as homicides or automobile related deaths. Because similar regions often share risk profiles, they can benefit from joint communication, effort, and public education campaigns.

Newsletter

In 2008, as in previous years, an excellent source of communication, networking, and education has been the quarterly State CFR Team newsletter, which is edited by State CFR Team members Donna Mazyck and Laurel Moody. The newsletter provides a regular update for local team members regarding relevant legislation, training opportunities, State CFR Team membership changes, helpful Web sites, and other valuable information.

The newsletter also focuses on special timely topics. In 2008 information was provided on passenger safety, boating safety, suicide prevention, and poison control, among other topics.

Copies of the newsletter can be viewed at http://fha.maryland.gov/mch/cfr_home.cfm

Electronic Data System

The National Center for Child Death Review (NCCDR) is funded by the Health Resources Services Administration (HRSA), an agency of the federal government. Together these organizations offer a system of electronic data collection and analysis to all states with child fatality review programs. In states that use the electronic system, the local CFR teams enter the data obtained from case review meetings onto a Web-based standardized form. They then send the information electronically to the NCCDR and it is entered into a database with information from other states. Individual state summaries are made available to CFR teams from participating states, as is national data. The entire system is free to states. The NCCDR offers free training to state and local child fatality review teams to ensure proper initiation and use of the system over time.

2008 saw the State CFR Team make substantial progress toward establishing the NCCDR electronic data system in Maryland. This will provide a much improved capacity for collecting child fatality review data. To that end, DHMH in consultation with the State CFR Team provided technical assistance in the development of House Bill 705/Senate Bill 862 (2009) (Child Fatality Review – Child Death Review Case Reporting System). The new legislation amends the statute governing CFR to allow Maryland to participate

in the electronic data system offered by the NCCDR. The enactment of this legislation and the promulgation of related regulations under COMAR 10.11.05 (Child Death Review Case Reporting System) will allow the data system to be implemented in 2009.

Defining Near Fatality

Currently, official case reviews are performed only on child fatalities, not near fatalities, in accordance with statute. In 2007, the State CFR Team developed the following definition of near fatality:

> **"A child requiring professional health care for a life-threatening event or a serious or critical condition as a result of a potentially preventable injury or illness**."

Development of a definition of near fatality was the first step towards enabling local CFR teams to do formal case reviews of near fatalities. The next step will be to work out a system for local CFR teams to be notified about the near fatalities that occur to child residents of their jurisdiction.

Currently, the Office of the Chief Medical Examiner (OCME) sends information on recent child fatalities to each local jurisdiction every month. Receipt of this information from the OCME initiates the review process by the local child fatality review teams. However, because the OCME does not have information on near fatalities, another system of notification will need to be developed before the local CFR teams can review near fatalities. Near fatality notification will most likely be accomplished through an arrangement with local hospitals or the Emergency Medical System, but the exact process is yet to be determined.

Collaboration Efforts

Collaborative efforts between the State Child Fatality Review Team, the State Council on Child Abuse and Neglect (SCCAN), and the Citizens' Review Board for Children (CRBC) continued in 2008, with members of the "sister" teams meeting together, and several attending State CFR meetings. Health-General Article §5-704(c) requires these three groups to coordinate activities. The statute provides that, "The State Team shall coordinate its activities under this section with the State Citizens' Review Board for Children, local citizen review panels, and the State Council on Child Abuse and Neglect in order to avoid unnecessary duplication of effort."

State CFR Team Future Activities

The State CFR Team will continue to work in partnership with local CFR teams toward the prevention of child deaths. A primary focus of the State CFR Team in 2009 will be the implementation of the data system described above, in collaboration with the National Center for Child Death Review. The system will streamline efforts of local child fatality

review teams and significantly improve the ability to analyze child deaths in Maryland, as well as nationally.

The State CFR Team will continue to promote safe sleep efforts, working with the Center for Infant and Child Loss to increase training for professionals, and education and awareness for the general public. In 2009 the State CFR Team is also looking at increasing efforts for suicide prevention through a program of preliminary analysis of psychiatric visit data in hospital emergency departments.

Training and education efforts in other areas of prevention, and in CFR review itself, will continue as well, as will efforts to find more resources for CFR in general. There are no funds currently allocated for CFR. A comprehensive, Statewide or regional approach is necessary if the State and local CFR teams are to have the ability to make significant change over the long term. Any child's death is a tragedy and the state and local CFR teams will continue to work to understand why unexpected child deaths occur and how their number can be reduced.

Appendix A: 2008 State Child Fatality Review Team Members

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

(1) THE ATTORNEY GENERAL – Amanda Scott, J.D., designee
(2) THE CHIEF MEDICAL EXAMINER – Tasha Greenberg, M.D., designee
(3) THE SECRETARY OF HUMAN RESOURCES – Rosalind McDaniel, designee
(4) THE SECRETARY OF HEALTH AND MENTAL HYGIENE – George Thorpe, M.D., designee
(5) THE STATE SUPERINTENDENT OF SCHOOLS – Donna Mazyck, RN, BSN, designee
(6) THE SECRETARY OF JUVENILE SERVICES – Jenny Maehr, M.D., designee
(7) THE SPECIAL SECRETARY FOR CHILDREN, YOUTH, AND FAMILIES – * Permanent Vacancy due to the sunset of the Office for Children, Youth, and Families in 2005.
(8) THE SECRETARY OF THE STATE POLICE – Michael Mann, JD, designee
(9) THE PRESIDENT OF THE STATE'S ATTORNEYS' 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, R.N., M.S.N., Director, Center for Infant and Child Loss
(12) THE DIRECTOR OF THE ALCOHOL AND DRUG ABUSE ADMINISTRATION – David Putsche, designee
(13) TWO PEDIATRICIANS WITH EXPERIENCE IN DIAGNOSING AND TREATING INJURIES AND CHILD ABUSE AND NEGLECT, APPOINTED BY THE GOVERNOR FROM A LIST SUBMITTED BY THE STATE CHAPTER OF THE AMERICAN ACADEMY OF PEDIATRICS –
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 PROFESSIONALS, AND ATTORNEYS WHO REPRESENT CHILDREN –
Akin Akintola, MD, 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
Roger Lerner, JD, Citizen Advocate for Children
Dorothy Marge, Ph.D., Citizen Advocate for Children
Laurel Moody, RN, MS, 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
(Two pending general public vacancies)

Appendix B: The 13 Duties of the State Child Fatality Review Team

Health-General Article, §5-704 (b), sets forth the State CFR Team's 13 duties as follows:

1. Undertake annual statistical studies of the incidence and causes of child fatalities in the State, including an analysis of community and public and private agency involvement with the decedents and their families before and after the deaths.

2. Review reports from local teams.

3. Provide training and written materials to the local teams established under §5-705 of this subtitle to assist them in carrying out their duties, including model protocols for the operation of local teams.

4. In cooperation with the local teams, develop a protocol for child fatality investigations, including procedures for local health departments, law enforcement agencies, local medical examiners, and local departments of social services, using best practices from other states and jurisdictions.

5. Develop a protocol for the collection of data regarding child deaths and provide training to local teams and county health departments on the use of the protocol.

6. Undertake a study of the operations of local teams, including the State and local laws, regulations, and policies of the agencies represented on the local teams, recommend appropriate changes to any regulation or policy needed to prevent child deaths, and include proposals for changes to State and local laws in the annual report required by paragraph (12) of this subsection.

7. Consider local and Statewide training needs, including cross-agency training and service gaps, and make recommendations to member agencies to develop and deliver these training needs.

8. Examine confidentiality and access to information laws, regulations, and policies for agencies with responsibility for children, including health, public welfare, education, social services, mental health, and law enforcement agencies, recommend appropriate changes to any regulations and policies that impede the exchange of information necessary to protect children from preventable deaths, and include proposals for changes to statutes in the annual report required by paragraph (12) of this subsection.

9. Examine the policies and procedures of the State and local agencies and specific cases that the State team considers necessary to perform its duties under this section, in order to evaluate the extent to which State and local agencies are effectively discharging their child protection responsibilities in accordance with:
   (i) The State plan under 42 U.S.C. §5106a(b):
   (ii) The child protection standards set forth in 42 U.S.C. § 5106a(b); and

(iii) Any other criteria that the State Team considers important to ensure the protection of children.

10. Educate the public regarding the incidence and causes of child deaths, the public role in preventing child deaths, and specific steps the public can undertake to prevent child deaths.

11. Recommend to the Secretary any regulations necessary for its own operation and the operation of the local teams.

12. Provide the Governor, the public, and subject to §2-1246 of the State Government Article, the General Assembly with annual written reports, which shall include the State Team's findings and recommendations.

13. In consultation with local teams:
    (i) Define "near fatality;" and
    (ii) Develop procedures and protocols that local teams and the State Team may use to review cases of near fatality.

Appendix C: Summary of Local CFR Team Case Reviews

2008 Summary of Local Case Review Meetings and Findings Maryland Jurisdictions	
	Total
1. Total Number of CFR meetings held in 2008.	80
2. In how many jurisdictions were all Medical Examiner cases reviewed by the team?	Yes 15 No 6 N/A 3
3. Total number of cases reviewed at local CFR team meetings in 2008, regardless of year of death.	311
4. Of all the cases reviewed by all teams in 2008, 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?	25
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?	26
6. Of the total cases reviewed in 2008, in how many was there a previous history of child abuse, as determined by CPS?	20
7. How many had a previous history of child neglect, as determined by CPS?	19
8. How many had a history of involvement with the Department of Juvenile Services?	26

Appendix D

2008 Local CFR's Recommendations for State CFR Team by Topic Area

Administrative: (3 Counties made suggestions in this category)

-Finalize the State CFR Policy and Procedure manual (Cecil).
-Forge greater connection with Child Protective Services (CPS) as this collaboration is experienced as helpful in local CFR meetings (Kent).
-Consider adopting the CDC recommended tools for Statewide use in the investigation of sudden infant deaths (Wicomico).

Advocacy/Publicity (4 Counties)

-Promote the Kids for Cribs program throughout the State (Carroll).
-Promote public awareness about safe sleep practices (Wicomico).
-Promote public education and outreach targeting mental health service availability and suicide prevention (Howard).
-Help promote the airing of PSAs, from midnight to 4AM, targeting teen drivers. Explain the terrible physical consequences of high speed crashes, especially when there is no seat belt use (Montgomery).

ATVs/Mopeds (1 County)

-Provide Statewide ATV safety campaign (Caroline County).

Autopsy/Forensics (1 County)

-Provide counties with full autopsy reports to help determine future actions (Frederick).

Communication/Feedback (5 Counties)

-Provide more information on local CFR recommendations that are sent to the State CFR (Anne Arundel).
-Provide more information on CFRT activities around the State (Anne Arundel).
-Please provide written guidance regarding sharing of CFR and FIMR information within a jurisdiction (Anne Arundel).
-Communicate new strategies/programs/grant opportunities to the local CFR teams (Caroline).
-Share what other jurisdictions are doing (Frederick).
-More assistance with information sharing/communication, when cases involve two jurisdictions (Howard).
-Continue on-going communication between the State and local teams via newsletters, conferences, etc. (Prince George's).

Data Systems Reporting and or Training on Electronic System (4 Counties)

-Support efforts to improve data reporting capabilities. Gain permission for participation in and training on the National Child Death Reporting System. (Baltimore County)
-Need electronic reporting of case review information, rather than current hard copies (Frederick).

- Revise current reporting forms to better capture needed data and implement training on the child death database (Prince George's).
-Train LCFRs in data analysis and grant writing (Prince George's).
-We look forward to the new data collection tool (Worchester).

Funding (1 County)
-Provide funding scholarships for local CFRT members to attend/participate in training conferences (Caroline).
-Identify funding sources to enable implementation of CFR recommendations (Caroline).

MVA/Teen Driving (1 County)
-Promote special PSAs between midnight and 4AM directed at teens, describing the dangers of speeding and not wearing seat belts (Montgomery).

Newsletter (2 Counties)
-Continue the State Newsletter (Anne Arundel).
-Continue on-going communication between State and local CFR teams via newsletter, conferences, etc. (Prince George's).

Safe Sleep (2 Counties)
-Promote safe sleep practices (Wicomico).
-Promote "Kids for Cribs" programs throughout the State (Carroll).

Suicide (1 County)
-Help to increase public education and outreach targeting mental health service availability and suicide prevention (Howard).
-Conduct or promote trainings that address teen suicide (Howard).

Training (8 Counties) and/or Technical Assistance (3 Counties) Requests
-Provide additional mock reviews with a focus on recommendation for different manner and causes of death (Anne Arundel).
-Provide information reviewing the purpose and function of CFR committees and what happens at the State level (Frederick).
-Central region trainings are not convenient (Garrett).
-Provide training on conducting joint LCFR meetings when cases involve two jurisdictions, e.g., when the child dies in a county where they do not reside (Montgomery).
-Provide trainings that addresses suicide among adolescents and the State's suicide prevention plan as it relates to school age children (Howard).
-Provide training on current data collection and reporting (Caroline).
-Provide training when the new electronic data system becomes operational (Baltimore County & Worchester).
-Training in the area of data analysis and grant writing would be helpful (Prince George's).

Appendix E

Agenda
Annual State Child Fatality Review Team Meeting
December 9, 2008
Location: Maryland Department of Transportation
7201 Corporate Center Dr.
Hanover, Maryland 21076
888-713-1414

9:00 Registration

9:30 Welcome and Introductions
Tasha Greenberg, MD, Vice-Chair, State Child Fatality Review Team
Assistant Medical Examiner
Office of the Chief Medical Examiner (OCME)

Presentation: Pediatric Pathology and Autopsies in Maryland

11:00 Case Review Practice Session by a Local CFR Team
The Prince George's County Child Fatality Review Team
Anntinette Williams, LICSW, Co–Chair, Prince George's County CFR Team and Member of the State CFR Team, with members of the
Prince George's Child Fatality Review Team

12:00 Lunch (Regional Networking)

1:00 Pediatric Death Investigation in Maryland
Dawn Zulauf
Chief Investigator for the Office of the Chief Medical Examiner

2:30 The Future of the Office of the Chief Medical Examiner
Tasha Greenberg, MD, Vice-Chair, State Child Fatality Review Team
Assistant Medical Examiner
Office of the Chief Medical Examiner

2:45 Wrap-up
Joan Patterson, LCSW-C
Coordinator, Maryland State Child Fatality Review

3:00 Adjournment