MARYLAND
STATE CHILD FATALITY REVIEW TEAM

Child Deaths in Maryland

2003 Annual Report

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

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

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Acknowledgements

This Maryland State Child Fatality Review Team (State CFR Team) 2003 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 2003 Annual Report includes:

- State CFR Team membership and accomplishments.
- Reports from twenty-three jurisdictions discussing local efforts and findings from 266 child fatality reviews conducted in 2003.
- The Child Death Report - 2003 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
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VISION, MISSION, AND GUIDING PRINCIPLES

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

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

Guiding Principles

1. We 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 quarterly to address 13 statutorily prescribed duties.

Child Fatality Review (CFR) is a systematic, multi-agency, multi-disciplinary review of all unexpected child deaths within a jurisdiction. This review process, which began in Los Angeles 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 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 2003, the State CFRT conducted an all-day training on March 6 and held quarterly meetings on June 9, September 9, and December 15.

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 2002 there were 898 deaths in infants and children under the age of 18 throughout the state of Maryland. The age of 18 is selected as the upper limit for the review since it is the age specified in the enabling legislation for the Child Fatality Review Team. Of the deaths, 557 occurred in the first year of life and 341 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 266 cases during 2003. Each local CFR team was asked to report on their efforts and activities at the end of the year. 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 March 2003 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 and Med Chi, the State Medical Society. Topics included an overview of the Child Fatality Review process in Maryland by State CFR Team Chairperson Sally Dolch, and a retrospective of information regarding child fatalities by Dr. Maureen Edwards, Medical Director of the Center for Maternal and Child Health. The training also included a review of forensic investigations by Chief Medical Examiner, Dr. David Fowler and Lt. Douglas Wehland of the Maryland State Police. Several panel discussions were held. The first was entitled "Challenges for Local Child Fatality Review" presented by Laura Chase, Rose Johnson, Nancy Luginbill and Dawn Zulauf. A second panel on "Infant Safety" was conducted by Dr.Scott Krugman, Beverly Byron and Dr. Carolyn Fowler. The agenda for the training and some of the materials provided are in appendix D. Such day long 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. Center staff presented bereavement training to approximately 20 nurses in local health departments. The Center also distributed sample materials on SIDS risk reduction to Local Child Fatality Review Teams (LCFRTs), including some materials which were translated into three different languages. Also sent to the LCFRTs was an article on co-sleeping and a co-authored letter from Donna Becker and Dr. David Fowler (OCME) addressing police interaction with parents when a child is taken to a hospital ER during a crisis.

The Governor's Annual Conference on Child Abuse and Neglect was held in April 2003. State CFR Team member Anntinette Williams gave a presentation at the conference titled "The Maryland State Child Fatality Review Process."

(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 Boards. 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 2003 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 E.

(7) "CONSIDER LOCAL AND STATEWIDE TRAINING NEEDS INCLUDING CROSS AGENCY TRAINING AND SERVICE GAPS, AND MAKE RECOMMENDATIONS TO MEMBER AGENCIES TO DEVELOP AND DELIVER THESE TRAINING NEEDS."

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.

In 2003 a new format was developed for the State CFR quarterly meetings to include a training component in each State CFR meeting. Members can then take the information back to their respective agencies. Local team members are welcome to attend.

A wide variety of agencies 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. Quarterly meetings also address the significant distance and travel time required to convene a state meeting.

The Annual Governor's Conference on Child Abuse and Neglect is a forum to meet training needs and one State CFR member presented at this conference in 2003.

Additionally, the State CFR administrative team informs local CFR teams of available conferences and trainings which may be of interest. In 2003 these included a conference offered in October by the Washington D.C. Medical Examiners Office entitled "Putting Recommendations into Action," another DHMH sponsored conference entitled "Suicide Prevention in a Time of National Crisis," and the National Center for the Prosecution of Child Abuse conference, "Investigation and Prosecution of Child Abuse: Equal Justice for Children."

(8) "EXAMINE CONFIDENTIALITY AND ACCESS TO INFORMATION LAWS, REGULATIONS, AND POLICIES FOR AGENCIES WITH RESPONSIBILITIES FOR CHILDREN, INCLUDING HEALTH, PUBLIC WELFARE, EDUCATON, 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. This year the DHMH Center for Maternal and Child Health, in consultation with the Assistant Attorney General's Office, sent a letter of clarification to all local Child Fatality Teams regarding the Health Insurance Portability and Accountability Act (HIPAA). The letter stated, "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.

(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 Team has supported various local teams who have taken steps to bring education to the public. Examples include newspaper articles written on All-Terrain Vehicle (ATV) accidents and drowning prevention, distribution of information about the "Back to Sleep" campaign, distribution of gift packets containing infant t-shirts which say "Make sure I'm on my back to sleep," and posters for the public which describe what constitutes child neglect.

In February 2003 the State CFR Team Chair Sally B. Dolch and Team member Lt. Douglas Wehland of the Maryland State Police issued a press release as the result of a rash of carbon monoxide related child deaths. The press release warned parents about the dangers of leaving children unattended in running vehicles. In several incidents the exhaust pipe had been blocked by high snow. This information was carried on television channels throughout the metropolitan Baltimore/Washington area and received national coverage on the three major networks.

Besides the efforts on behalf of local Child Fatality Review Teams and local health departments mentioned above, in 2003 the Center for Infant and Child Loss provided training to approximately 200 day care providers, 100 professionals, 40 agency staff, 300 public school students, and participated in eight health fairs and two statewide conferences**.**

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

In 2003 the State hired a dedicated staff person to assume responsibility for coordinating the efforts of the State CFR Team. Administrative staff have provided support for the overall operation of the State CFR Team.

(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 2003. The Annual Reports are sent to the Governor and the General Assembly. They are posted on the CMCH web site to ensure public access. Included as well are Annual Reports compiled by the local Child Fatality Review Teams.

(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" helps maintain the experience of the team, 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 2002 in children less than 18 years which met these criteria. Discharge of a child under 18 years from an acute care hospital following an admission for an injury to a sub-acute or chronic care facility provides another potential operational definition of "near fatality." The HSCRC database contains approximately 102 cases that met this definition. Review of cases of "near fatality" will require not only defining cases but also developing a method of identifying cases and an approach to review.

COORDINATION

The State Child Fatality 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. The organizations exchange copies of their Annual Reports.

3. Each year the State 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 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 in Maryland.

4. The Chairpersons of both the Citizen's Review Board for Children and the State Council on Child Abuse and Neglect have been invited to meet with the State Child Fatality Review Team.

5. Some members of the State Child Fatality Review 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 help to highlight the issues specific to the differing demographic regions of the state and show the efforts made to address them. Publication of these local reports allows all local CFR teams to compare trends in other areas with their own, seek information or guidance from other jurisdictions, and learn from one another.

CHALLENGES AND GOALS

With four meetings a year, a significant turnover in membership and with the complexity of implementing some goals without a budget**,** it is more realistic to set long term goals for the Team rather than year-to-year short term goals. The Team will continue to work on the following goals in 2004:

- 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 and it has moved into the testing phase. Students from a local university will be working to refine the system during 2004.

- Examine factors which may contribute to the disproportionate burden of child deaths in the African American community.
  - Analysis of available data should be completed in 2004.

- 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 will be emphasized starting in 2004.

- In consultations with local teams, develop policy recommendations to reduce child deaths in Maryland.
  - To be introduced in anticipation of November 2004 training with local teams.

- Examine confidentiality and access to information laws.
  - HIPAA regulations have addressed these concerns in a uniform way and each local CFR team received a letter from DHMH discussing the impact of HIPAA on local CFR efforts.

- Define near fatality and develop protocols for review of these situations.
  - Efforts continue to develop a well-defined, comprehensive approach to near fatality.

- Training for local Child Fatality Review Teams is held one time per year and other training opportunities are presented to the team as they become available.
  - Starting in December of 2003 a training component was added to each quarterly meeting. Local team members may attend.

APPENDICES

Appendix A

State Child Fatality Review Team
Membership 2003

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, designee
(2) THE CHIEF MEDICICAL EXAMINER - David Fowler, M.D.
(3) THE SECRETARY OF HUMAN RESOURCES – Tom Grazio, designee
(4) THE SECRETARY OF HEALTH AND MENTAL HYGIENE – Carol Garvey, M.D., designee
(5) THE STATE SUPERINTENDENT OF SCHOOLS – Richard Steinke, designee
(6) THE SECRETARY OF JUVENILE JUSTICE – Lee Towers, designee
(7) THE SPECIAL SECRETARY FOR CHILDREN, YOUTH AND FAMILITES – Donna Behrens, designee
(8) THE SECRETARY OF THE STATE POLICE – Lt. Doug Wehland, designee
(9) THE PRESIDENT OF THE STATE'S ATTORNEY'S ASSOCIATION – Joel Todd, designee
(10) THE CHIEF OF THE DIVISION OF VITAL RECORDS – Geneva Sparks, designee
(11) A REPRESENTATIVE OF THE STATE SIDS INFORMATION AND COUNSELING PROGAM, Donna Becker, 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.
(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
Jennifer Bodine, Citizen Advocate for Children
Carolyn Fowler, Ph.D, M.P.H, Vice-Chair
Pierre Mooney, Citizen Advocate for Children
Barbara Roque, R.N., J.D., Citizen Advocate for Children
Anntinette Williams, LICSW, Citizen Advocate for Children

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
2003

Robert L. Ehrlich, Jr.
Governor of Maryland

Michael S. Steele
Lt. Governor of Maryland

Nelson J. Sabatini
Secretary of the Department of
Health and Mental Hygiene

ACKNOWLEDGEMENTS

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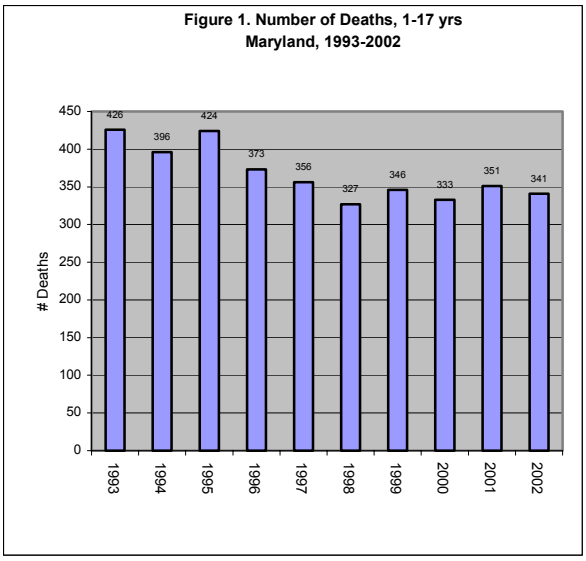
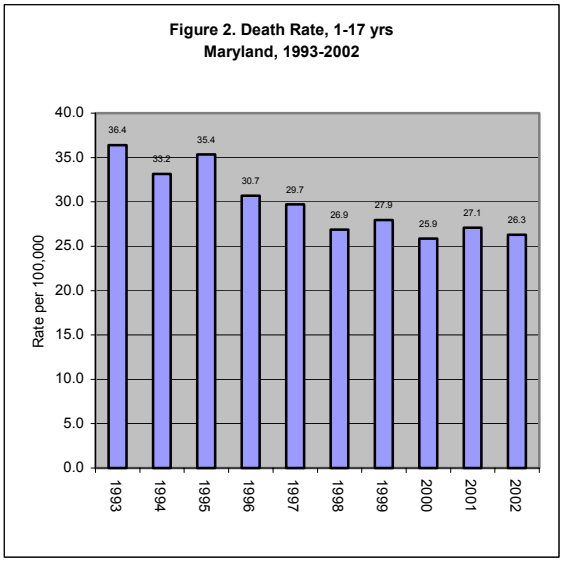
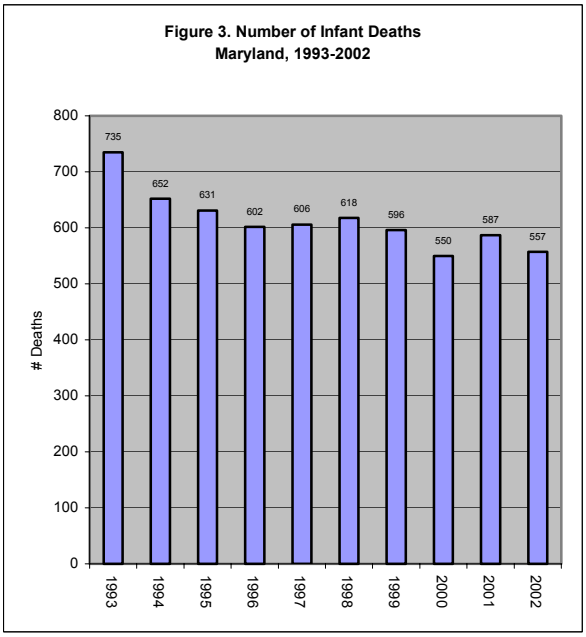
OVERALL TRENDS

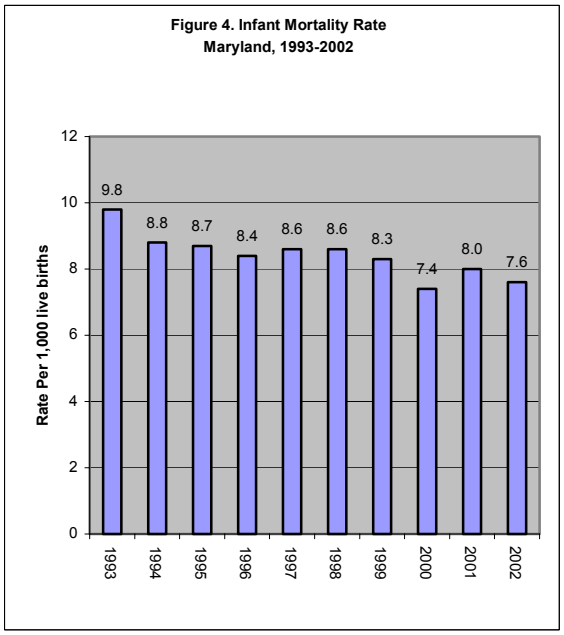
In 2002, there were 898 deaths of infants and children under the age of 18 years in Maryland. This age range was utilized for this report because it encompasses the ages for which the State Child Fatality Review Team has responsibility. Overall there has been a gradual decrease in the number and rate of both infant and child deaths in the State over the past decade (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. The average mortality rate for infants less than one year of age has decreased by 10.2% between the five-year periods of 1993-1997 and 1998-2002. Neonatal mortality rate (deaths to infants under 28 days of age per 1,000 live births) and postneonatal mortality rate (deaths from 28 days through 11 months per 1,000 live births) declined by 6.0% and 19.8% respectively (Table 1). For children ages 1 through 17 years, the decline in mortality rates was 18.9% (Table 2).

Table1. NUMBER OF INFANT, NEONATAL AND POSTNEONATAL DEATHS BY RACE, DEATH RATES AND PERCENT CHANGE IN RATES FROM 1993-1997 TO 1998-2002, MARYLAND**

	Number of deaths		Death rates*		Percent	
	1993-1997	1998-2002	1993-1997	1998-2002	change**	
Infant mortality*						
All races***	3226	2908	8.9	8.0	-10.2	****
White	1313	1155	5.9	5.3	-10.4	****
Black	1827	1664	15.7	13.9	-11.9	****
Neonatal mortality*						
All races***	2235	2109	6.2	5.8	-6.0	****
White	875	843	3.9	3.8	-1.8	
Black	1297	1200	11.2	10.0	-10.5	****
Postneonatal mortality*						
All races***	992	799	2.7	2.2	-19.8	****
White	439	312	2.0	1.4	-27.6	****
Black	530	464	4.6	3.9	-15.3	****

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 1993-1997 and 1998-2002 differ significantly (p<.05)

TABLE 2. NUMBER OF DEATHS, DEATH RATES AND % CHANGE IN RATES FOR CHILDREN UNDER 18 YEARS, MARYLAND, 1993-1997 AND 1998-2002

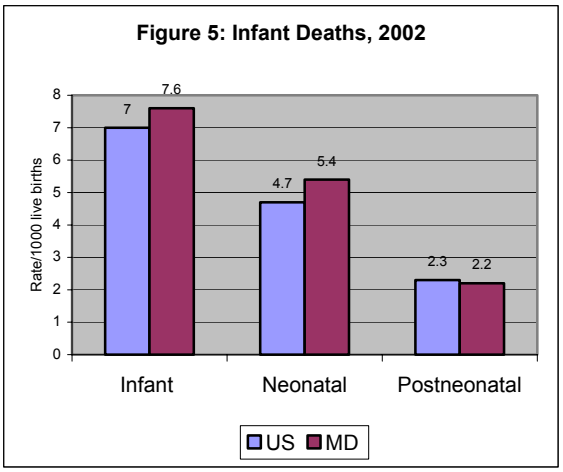
	Number Deaths		***Death Rates****		
Age group	**1993-1997**	**1998-2002**	**1993-1997**	**1998-2002**	**Percent change****
< 1 year	**3,226**	**2,908**	**888.2**	**814.0**	**-8.4*** **
1-17 years	**1,975**	**1,698**	**33.0**	**26.8**	**-18.9*** **
1-4 yr	566	434	38.1	31.0	-18.6***
5-9 yr	333	283	18.2	14.8	-18.5***
10-14 yr	413	353	24.3	18.3	-24.8***
15-17 yr	663	628	69.1	57.5	-16.8***

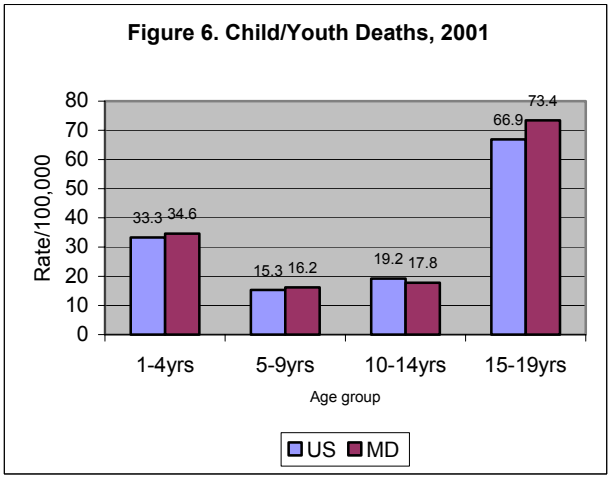
Source: Source: Analysis of data from Vital Statistics Administration, DHMH

*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 1993-1997 and 1998-2002 differ significantly (p<.05)

COMPARISION TO NATIONAL STATISTICS

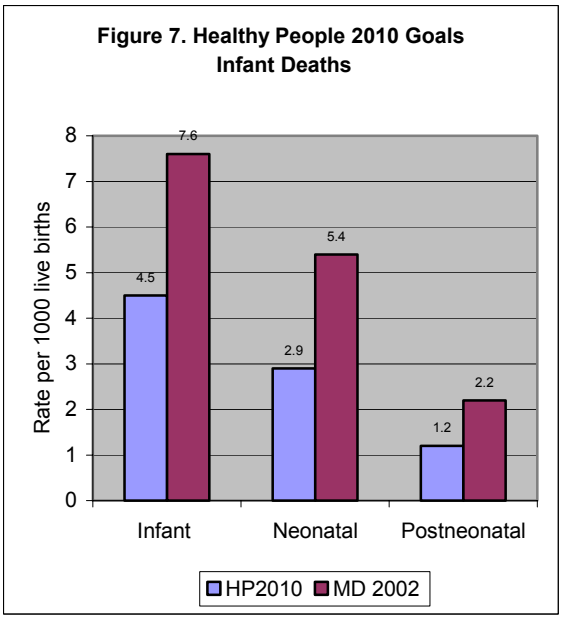
The absolute number of child deaths and mortality rates in Maryland decreased throughout the 1990's. Maryland infant mortality rate, along with neonatal mortality rate are higher than that of the nation as a whole in 2002. The Maryland postneonatal mortality rate is, however, slightly lower than the national rate (Figure 5). In 2001, in the age group 10-14 years, Maryland's rate is slightly better than the national rate. In the other child/youth age groups mortality rates approximate the national rate or are slightly higher (Figure 6).

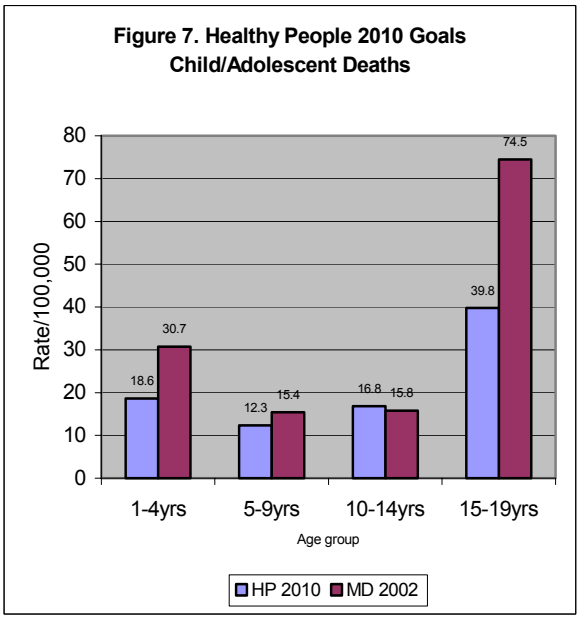




Source: Analysis of data from Vital Statistics Administration, DHMH

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. It will require considerable progress for Maryland to reach these objectives particularly for the youngest children and adolescent population (Figures 7 and 8).





Source: Analysis of data from Vital Statistics Administration, DHMH

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 2002 is represented in Table 3 and Figure 9.

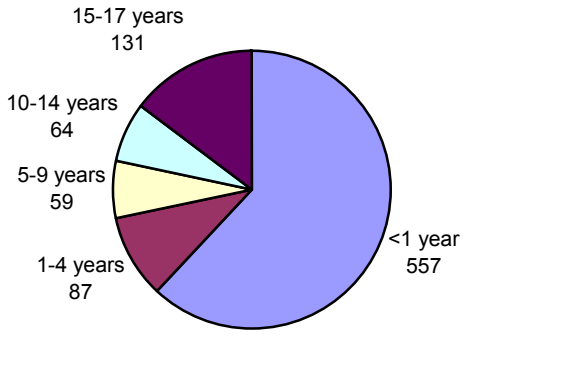
TABLE 3. CHILD DEATHS UNDER 18 YEARS, MARYLAND, 2002

Age group	# Deaths	% of Total
<1 year	557	62.0
<=28 days	*401*	*44.7*
29-365 days	*156*	*17.4*
1-4 years	87	9.7
5-9 years	59	6.6
10-14 years	64	7.1
15-17 years	131	14.6
Total	**898**	

Of the 898 deaths, 62.0% occurred in the first year of life with 44.7% 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 2 to 3 times the number of fatalities as seen in younger children.

Source: Analysis of data from Vital Statistics Administration, DHMH

Figure 9. Number of Child Deaths, Maryland, 2002



Source: Analysis of data from Vital Statistics Administration, DHMH

Gender and race also influence the number and rate of death. In 2002, of the 341 deaths among 1 to 17 year old children, 60.4% occurred in boys, representing a rate of 31.1 per 100,000. Among females the death rate was 21.3 per 100,000 (Table 4).

This trend is also seen in infancy where 55% of the deaths were to boys.

African American children were at an increased risk of dying both in the first year of life and in later childhood. In 2002, African American infants died at 2.4 times the rate of white infants. This ratio remained elevated at 2.0 in children 1 through 17 years of age (Table 5 and Figure 10). The basis of these associations is not completely understood but must be addressed to prevent childhood deaths.

TABLE 4. DEATHS, 1-17 YEARS, BY GENDER, MARYLAND, 2002

Gender	Number of Deaths	% of total	Rate*
Male	206	60.4	31.1
Female	135	39.6	21.3
Total	**341**		**26.3**

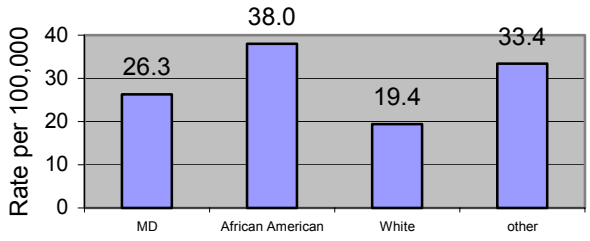
Source: Analysis of data from Vital Statistics Administration, DHMH
*Rate per 100,000 population

TABLE 5. DEATHS, 1-17 YEARS, BY RACE, MARYLAND, 2002

	Number of Deaths	Rate*
African American	166	38.0
White	155	19.4
Other	20	33.4
Total	**341**	**26.3**
Ratio AA:W		2.0

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

Figure 10. Death Rate (1-17 yrs) by Race, Maryland, 2002



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 infant mortality 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 2002. 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 DHMH Vital Statistics Administration. It can be found at http://www.mdpublichealth.org/vsa.

TABLE 6. LEADING CAUSES OF INFANT DEATH, MARYLAND, 2002

Neonatal (400)	**Postneonatal (156)**	**INFANT (556)**
Short gestation, LBW (136)	SIDS (53)	Short gestation, LBW (137)
Congenital malformation (65)	Congenital malformation (37)	Congenital malformation (102)
Maternal complications (41)	Diseases of circulatory system (8)	SIDS (57)
Complications of placenta, cord (28)	Sepsis of newborn (3)	Maternal complications (41)
Respiratory distress of newborn (26)	Necrotizing enterocolitis of newborn (3)	Complications of placenta, cord (28)

Source: Analysis of data from Vital Statistics Administration, DHMH

SIDS

SIDS is the sudden death of an infant under 1 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 is of particular public health concern because it can be reduced through safe sleeping practices for infants. In Maryland, the number of deaths from SIDS has decreased throughout the 1990's with a 30.2% decrease between 1993-1997 and 1998-2002. In 2000-2002, there were 162 SIDS deaths.

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.

CAUSES OF DEATH AMONG OLDER CHILDREN

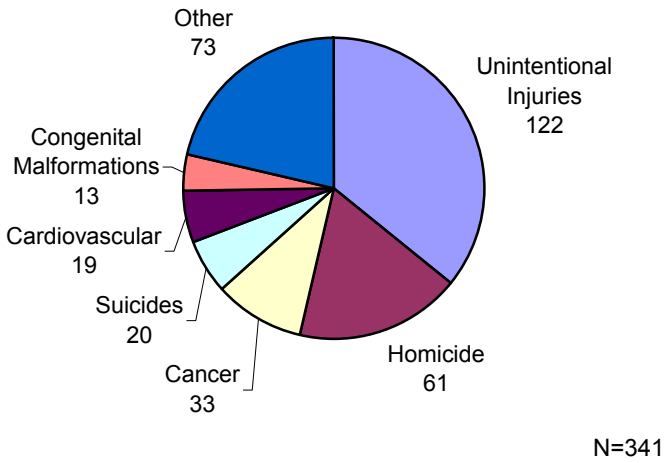
Table 7 demonstrates the causes of death among children 1-17 years in 2002 and for the period 2000-2002. Figure 11 shows the graphical distribution of the causes of death in 2002

TABLE 7. NUMBER OF DEATHS BY CAUSE, 1-17 YEARS, MARYLAND, 2002 AND 2000-2002

Cause of Death	2002	2000-2002
Unintentional Injuries (Accidents)	122	319
Transport	80	229
Non-Transport	42	90
Homicide	61	135
Cancer	33	112
Suicides	20	57
Cardiovascular	19	55
Congenital Malformations	13	52
Other	73	295
Total	**341**	**1025**

Source: Analysis of data from Vital Statistics Administration, DHMH

Figure 11. Number of Deaths by Cause (1-17 years), Maryland, 2002



Source: Analysis of data from Vital Statistics Administration, DHMH

A ranking of the total deaths for the three year period 2000-2002 is shown below in Table 8. The number of deaths is given in parenthesis.

TABLE 8. LEADING CAUSES OF DEATH BY AGE GROUP, MARYLAND, 2000-2002

Age	1-4 years	5-9 years	10-14 years	15-17 years
Rank				
1	Unintentional Injury (63)	Unintentional Injury (56)	Unintentional Injury (57)	Unintentional Injury (143)
2	Malignant Neoplasms (29)	Malignant Neoplasms (36)	Malignant Neoplasms (29)	Homicide (87)
3	Congenital Malformations (26)	Major Cardiovascular Diseases (12)	Homicide (19) Suicide (19)	Suicide (36)
4	Homicides (23)	Congenital Malformations (10)	Major Cardiovascular Diseases (12)	Malignant Neoplasms (18)
5	Major Cardiovascular Diseases (18)	Septicemia (5)	Congenital Malformations (8) Events of Undetermined Intent (8)	Major Cardiovascular Diseases (13) Events of Undetermined Intent (13)

Source: Analysis of data from Vital Statistics Administration, DHMH

INJURIES

In childhood, injuries resulting from external causes are the most common etiologies of death in every age group. Many of these injuries are preventable. These include unintentional injuries as well as homicides and suicides (Table 9).

TABLE 9. NUMBER OF INJURY DEATHS, 1-17 YEARS, MARYLAND, 2000-2002

Type of Injury	2000-2002
Unintentional	**319**
Transport	**229**
-MVA	200
-Other	29
Non-Transport	**90**
-Falls	8
-Drowning	25
-Fire	31
-Poisoning	2
-Other	24
Suicide	**57**
-Firearm	21
-Other	36
Homicide	**135**
-Firearm	90
-Other	45
Uncertain Intent	**34**

Source: Analysis of data from Vital Statistics Administration, DHMH

Vignette:
Infant Boy Dies After Two-story Fall
Source: The Montgomery Journal, June 26, 2003

"OCEAN CITY - An 11- month old baby died after falling from a second-story balcony, police said. The child was seen by witnesses squeezing between the guard rails of the balcony just before he fell 21 feet onto the asphalt below. The next-door neighbor saw the boy slip his leg through the railing and reached for him, but he fell to the ground. The sliding glass door was left open. While investigation is continuing, the incident is being ruled an accident."

Motor Vehicle Accidents

Motor vehicle crashes are the leading cause of unintentional (accidental) injury death to children. Between 2000 and 2002, 200 children ages 1-17 years were killed in motor vehicle crashes (Table 10).

TABLE 10. CATEGORY OF PERSONS KILLED IN MVA, 1-17 YEARS, MARYLAND, 2000-2002

Person	Number	Percent
Driver of vehicle	29	14.5
Passenger	39	19.5
Pedestrian	36	18.0
Motorcycle rider	6	3.0
Pedal cyclist	8	4.0
Unspecified	82	41.0
Total	**200**	

Source: Analysis of data from Vital Statistics Administration, DHMH

This included all deaths occurring to children who were drivers, passengers, pedestrians or other types of occupants in a form of transport.

TABLE 11. UNINTENTIONAL TRANSPORT INJURY DEATHS BY RACE, 1-17 YEARS, MARYLAND, 200-2002

	MVA		Other Transport	
Race	**Number**	**Rate***	**Number**	**Rate***
African American	60	4.7	12	0.9
White	130	5.6	14	0.6
Other	10	3.6	3	-
Total	**200**	**5.2**	**29**	**0.7**

Source: Analysis of data from Vital Statistics Administration, DHMH
*Per 100,000 population
-Rates based on fewer than 5 events in the numerator are not presented since rates based on small numbers are likely to be unstable

Of the 200 motor vehicle related deaths between 2000 and 2002, 124 (62%) were to boys and 76 (38%) to girls. One hundred and thirty white youths died in motor vehicle crashes, a rate of 5.6 per 100,000. Among African-American children, there were 60 motor vehicle-related deaths, representing a rate of 4.7 per 100,000 (Table 11). Older children bore the brunt of the cases, dying at the rate of 16.2 per 100, 000 in the 15-17 year age group (Table 12).

TABLE 12. UNINTENTIONAL TRANSPORT INJURY DEATHS: NUMBER AND RATE BY AGE GROUP, 1-17 YEARS, MARYLAND, 2000-2002

	MVA		Other Transport	
Age group	**Number**	**Rate***	**Number**	**Rate***
1-4	24	2.8	1	-
5-9	30	2.6	6	0.5
10-14	37	3.1	5	0.4
15-17	109	16.2	17	2.5
Total	**200**	**5.2**	**29**	**0.7**

Source: Analysis of data from Vital Statistics Administration, DHMH
*Per 100,000 population
-Rates based on fewer than 5 events in the numerator are not presented since rates based on small numbers are likely to be unstable

Vignette:
Car Wreck Kills Annapolis Girl, 17
Source: The Baltimore Sun, June 17, 2003

"An Annapolis teenager was killed after being partially ejected through the sunroof of a car which was being driven by another teen, 16 years old, police said. The decedent was in the back of the car when it ran off the road, hit a tree and rolled over."

Homicides

There were 158 homicides in 2000-2002 among children aged 0 to 17 years. The numbers of homicide deaths among African-American and white children were 129 and 24 respectively, representing rates of 9.5 and 1.0 per 100,000 respectively (Table 13). The greatest number of homicides occurred in older adolescents; seventy-six of the firearm related deaths were in adolescents aged 15-17 years, representing a rate of 11.3 per 100,000 in this age group (Table 14). There were 23 homicides perpetrated against infants (under 1 year of age) during this three-year period. The majority of the homicides in older children involved firearms. Of the 90 firearm related deaths in the 1-17 year olds, 81 (90%) were among males and 9 (10%) among females (Table 15).

TABLE 13. HOMICIDE: TOTAL NUMBER AND AVERAGE RATE* BY RACE, 0-17 YEARS, MARYLAND, 2000-2002

	All homicides		By firearm		Other means	
	Number	Rate*	Number	Rate*	Number	Rate*
African American	129	9.5	84	6.2	45	3.3
White	24	1.0	7	0.3	17	0.7
Other	5	1.7	1	-	4	-
Total	**158**	**3.9**	**92**	**2.2**	**66**	**1.6**

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 14. HOMICIDE: TOTAL NUMBER AND AVERAGE RATE* BY AGE GROUP, 0-17 YEARS, MARYLAND, 2000-2002

	By Firearm		Other means	
Age group	Number	Rate*	Number	Rate*
Under 1	2	-	21	9.8
1-4	2	-	21	2.5
5-9	1	-	5	0.4
10-14	11	0.9	8	0.7
15-17	76	11.3	11	1.6
Total	**92**	**2.4**	**66**	**1.7**

Source: Analysis of data from Vital Statistics Administration, DHMH

*Per 100,000 population

-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. MEANS OF HOMICIDE BY SEX, 1-17 YEARS, MARYLAND, 2000-2002

	Male	Female	Total
By firearm	81	9	90
Other means	24	21	45
Total	**105**	**30**	**135**

Source: Analysis of data from Vital Statistics Administration, DHMH

Vignette:
Slain Boy Worked Hard at School, Had Lofty Goals
Source: The Baltimore Sun, July 10, 2003

"A 14- year old boy who pushed himself at school, earning awards for spelling and perfect attendance and dreamed of becoming a professional football player or a police detective, was killed – shot in the head at a neighborhood playground. The decedent was standing near a playground in East Baltimore, when someone approached and opened fire, police said."

Vignette:
Mother's Boyfriend Indicted in Death of Frederick Baby
Source: Washington Post, May 5, 2003

"A 25-year old man accused of sexually assaulting and beating to death his girlfriend's 9-month-old baby has been indicted on first-degree murder charges, Frederick County prosecutors said. The perpetrator is accused of battering the deceased with such force that he cracked her skull, snapped her back and shattered bones in her arms and legs."

NATURAL CAUSES OF DEATH

In addition to being classified according to cause, death is also classified by manner as natural, accident, homicide, suicide, and undetermined. Death from natural causes constituted the leading cause of mortality among children under 18 years of age in Maryland during the period 2000-2002. 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 will and do 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 10.2 percent between 1993-1997 and 1998-2002 (Table 16). However, statistically significant declines occurred only in Montgomery, Prince George's and Worcester Counties (Infant Mortality Report, Vital Statistics Administration, 2002). Figure 12 details how infant mortality in the jurisdictions compares with the Maryland average during the period 1998-2002.

For children ages 1-17 years, average mortality rate declined by 18.7 percent between 1993-1997 and 1998-2002 (Table 17). Statistically significant declines occurred, however, only in Baltimore City, Anne Arundel and Talbot counties. Population changes may also have contributed to changes in rates and percentage changes in respect of infant and child deaths.

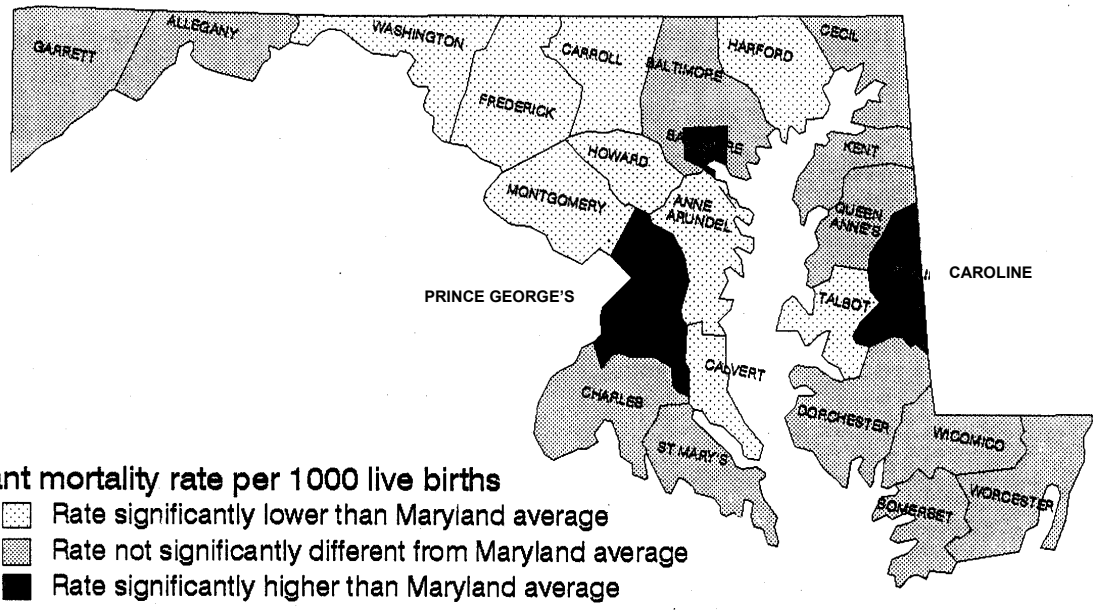
Figure 13 shows the difference between death rates for children ages 1-17 years in the jurisdictions and the Maryland average during the period 1998-2002.

TABLE 16. NUMBER OF INFANT DEATHS, INFANT MORTALITY RATES* AND PERCENT CHANGE IN RATES* BY REGION AND POLITICAL SUBDIVISION, MARYLAND, 1993-1997 AND 1998-20002

Region and	Number of infant deaths		Average infant mortality rate*		Percent
Political Jurisdiction	1993-1997	1998-2002	1993-1997	1998-2002	Change**
Maryland	**3226**	**2908**	**8.9**	**8.0**	**-10.2** ***
Northwest Area	170	158	6.4	5.7	-10.5
Garrett	10	18	5.4	10.8	99.5
Allegany	27	27	6.7	7.3	8.8
Washington	56	44	7.2	5.4	-25.1
Frederick	77	69	5.9	4.9	-17.7
Baltimore Metro Area	**1496**	**1350**	**8.7**	**8.0**	**-7.7** ***
Baltimore City	704	563	13.1	11.9	-9.2
Baltimore County	355	350	7.8	7.7	-1.4
Anne Arundel	213	214	6.7	6.3	-5.2
Carrol	55	45	5.8	4.8	-18.4
Howard	76	98	4.5	5.6	24.9
Harford	93	80	6.4	5.4	-14.7
National Capital Area	**1231**	**1058**	**10.0**	**8.5**	**-15.8** ***
Montgomery	424	385	7.0	6.0	-14.3 ***
Prince George's	807	673	13.0	11.0	-15.2 ***
Southern Area	**137**	**146**	**7.3**	**7.4**	**0.8**
Calvert	24	26	5.3	5.3	0.2
Charles	51	71	6.3	8.2	30.8
St. Mary's	62	49	10.1	7.7	-23.2
Eastern Shore	**192**	**196**	**8.3**	**8.3**	**-0.4**
Cecil	43	43	7.9	7.5	-5.4
Kent	5	10	4.9	11.0	126.2
Queen Anne's	20	13	9.4	5.3	-43.5
Caroline	20	25	10.8	13.3	23.1
Talbot	7	8	4.0	4.7	18.2
Dorchester	16	14	9.3	8.8	-4.7
Wicomico	44	56	8.0	9.9	24.5
Somerset	9	13	7.2	10.2	41.8
Worcester	28	14	11.6	5.6	-51.6 ***

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 1993-1997 and 1998-2002 differ significantly ($p<0.5$)

Figure 12. Comparison of County Infant Mortality Rates With the State Average, Maryland, 1998-2002*.



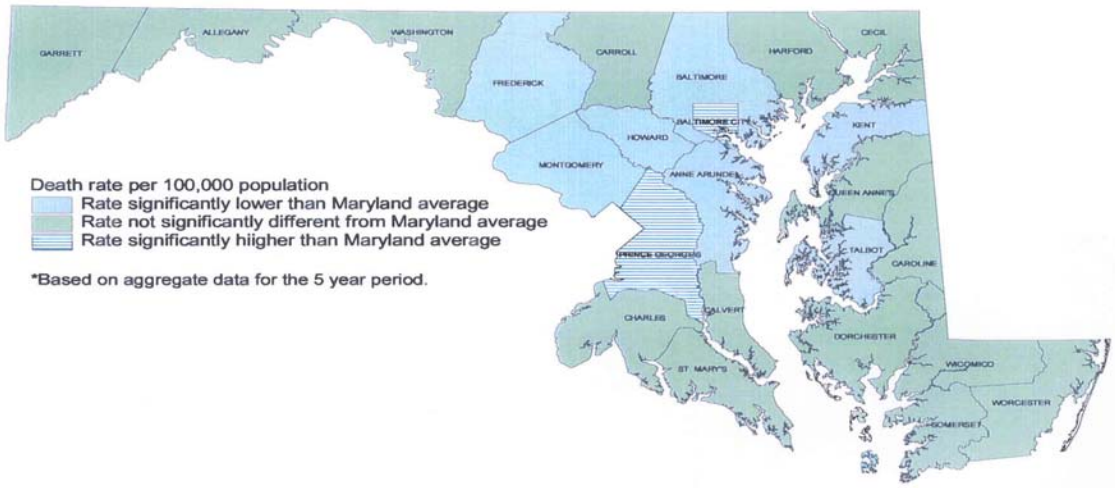
* Based on aggregate data for the 5 year period.

TABLE 17. NUMBER OF DEATHS, DEATH RATES AND % CHANGE IN RATES FOR CHILDREN 1-17 YEARS, MARYLAND, 1993-1997 AND 1998-2002

Region and	Number Deaths*		Death Rates**		Percent
Political Jurisdiction	1993-1997	1998-2002	1993-1997	1998-2002	Change***
Maryland	**1,975**	**1,698**	**33.0**	**26.8**	**-18.7 ******
Northwest Area	**113**	**123**	**24.0**	**24.1**	**0.5**
Garrett	16	10	44.3	27.5	-38.0
Allegany	17	25	22.1	33.5	51.4
Washington	38	37	27.5	25.6	-7.0
Frederick	42	51	19.1	20.1	5.0
Baltimore Metro Area	**1083**	**873**	**37.8**	**29.4**	**-22.1 ******
Baltimore City	535	385	63.8	50.3	-21.1 ****
Baltimore County	212	187	26.9	23.0	-14.4
Anne Arundel	154	125	29.1	21.5	-26.2 ****
Carroll	54	46	31.3	23.1	-26.1
Howard	50	61	18.1	19.1	5.3
Harford	78	69	30.0	24.0	-20.0
National Capital Area	**499**	**462**	**26.7**	**23.0**	**-13.9 ******
Montgomery	176	156	18.7	15.3	-18.2
Prince George's	323	306	34.7	30.9	-11.1
Southern Area	**107**	**101**	**30.8**	**25.8**	**-16.2**
Calvert	25	24	28.2	23.0	-18.4
Charles	49	46	32.3	27.2	-15.7
St. Mary's	33	31	30.7	26.1	-15.0
Eastern Shore	**173**	**139**	**40.8**	**30.6**	**-25.2 ******
Cecil	33	40	32.4	35.5	9.7
Kent	7	2	37.3	10.3	-72.3
Queen Anne's	11	13	26.2	26.6	1.2
Caroline	16	9	45.3	23.6	-47.8
Talbot	12	4	37.1	11.6	-68.8 ****
Dorchester	15	13	44.1	38.6	-12.5
Wicomico	43	34	45.1	34.5	23.5
Somerset	13	6	57.9	26.1	-54.9
Worcester	23	18	55.7	39.2	-29.9

*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 1993-1997 and 1998-2002 differ significantly (p<.05)

Figure 13. Comparison of County Death Rates for Children ages 1-17 Years with the State Average, Maryland , 1998-2002*.



CLOSING

Although child deaths and death rates are declining in Maryland, there is still ample room for improvement. The most common causes of death in children and adolescents are frequently related to preventable factors. In many cases, reviewing the circumstances surrounding the death can provide important information which can direct prevention initiatives. Local authorities can take the most appropriate action after a child's death is thoroughly investigated by the local team. In addition, state and federal initiatives are important in avoiding preventable deaths in children.

Appendix C

Child Fatality Review

Report of Local Team Activities, 2003

Allegany County
Child Fatality Review
2003 Report of Local Team Activities

Highlights and successes of local CFR Team for 2003:
CFR Team meets to discuss all cases referred to them by OME office. Of the six cases receiving full review four deaths were in children one month to eight months of age. Improper beds, bedding and sleeping position were at least contributing factors in all cases. The CFR worked with the local FIMR Board to help distribute pamphlets developed by the FIMR on sleep to hospitals, Healthy Start clients, and doctor's offices.

Social or Health Impact of CFR in your county since its inception:
CFR has helped promote a variety of safety measures in community, e.g., increased education on railroad safety, increased numbers of persons CPR trained in the schools, and distribution of information to decrease SIDS deaths.

Goals for the future of the CFR Team:
To make individual agencies more aware of safety issues that can be promoted to help decrease morbidity and mortality in children.

Membership and leadership of Team:
See attached list.

Meetings in 2003:
Three meetings were held 4/23/03, 9/3/03, and 12/3/03.

Case Reviews:
Six cases received full team review in 2003. One additional case was screened by the team but they felt by using the OME report that this case was completely medical so full review was not completed.

One case required CPS investigation. The other children were removed. The death was SUDI.

Recommendations and actions taken by CFR Team:
CFR team has recommended increased distribution of information on safest sleeping positions and safe bed and bedding be gotten out to pregnant women and those with infants. The FIMR has developed information and it has been given to the hospital, doctor offices, and distributed by the health department.

Issues referred by Local Team to State Team for statewide consideration:
The whole issue of when it is safe for a child to be returned to a home from foster care needs to be looked at.

The CFR felt one case listed as SIDS had evidence of URI (upper respiratory infection) that may have contributed to the death.

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Allegany Child Fatality Review Board

Dr. Sue Raver, Chair/Facilitator
Allegany County Health Department
P. O. Box 1745
Cumberland, MD 21501-1745
301-777-5657 phone
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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 Justice

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

Barbara Roque, R.N., J.D.
Allegany College

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, 2003
Anne Arundel County Child Fatality Review Team

Highlights and successes of local CFR Team for 2003: With the assistance of Dr. David Fowler, Chief Medical Examiner of Maryland, we were able to improve our access to reports from the OCME and to add a new member from his office to our team. This has materially improved our ability to review cases more thoroughly, efficiently, and in a timely manner.

Dr. Fowler attended one meeting of the Team and provided members with an overview of the processes used by the OCME to determine, if possible, the cause of death of an individual and challenges to accomplish this role.

Social or Health Impact of CFR in your county since its inception: There has been improved attention by the local Child Care Association to educate child care providers regarding surveillance for signs of child abuse among those in their care. The regional manager of that Administration now sits as a member of the Team.

A letter regarding "co-sleeping" hazards (children in beds other than those designed for this age group) was written to the Editor of *The Baltimore Sun* and was published.

The Team has made recommendations to the State Team to:

- improve public awareness of the importance of screening for and recognition of Sickle Cell Trait/Disease;
- encourage the Center for Infant Loss to resume its public awareness campaign through the use of its "Back To Sleep" program; and
- suggest that the Maryland Department of Education include the "Back To Sleep" program in the health curriculum.

Goals for the future of the CFR Team: The goal of the Team is the reduction in the number of preventable deaths among children.

In order to achieve this goal, the Team will:

- encourage members to provide and respond to suggestions for improvement in the process of identification of at-risk children;
- monitor actions taken by various member agencies;
- add members to the Team as needed;
- make recommendations to applicable agencies/groups for correction of deficiencies in services to these children; and
- distribute pertinent information and educational materials/opportunities to Team members.

Membership and leadership of Team: See attached list.
Meetings in 2003: There were four meetings of the Team: March, June, September, and December. Reminders are mailed one month before each meeting. Attendance level, on

average was 65%. Confidentiality statement signature forms are collected at each meeting and serve to document attendance as well.

Case Reviews: There were 15 cases reviewed and discussed by the Team. Additionally, the team chair and one team member reviewed eight cases determined by the OCME to have been death due to natural causes and did not require full Team review.

One case was determined to be a homicide as a result of child abuse.

Recommendations by your CFR Team for local action: None this year.

Actions taken in or by your jurisdiction: None.

Issues referred by Local Team to State Team for statewide consideration: None.

C. Earl Hill, M.D.
Chairman
Anne Arundel County Child Fatality Review Team

ANNE ARUNDEL COUNTY
CHILD FATALITY REVIEW TEAM
MEMBERS

C. Earl Hill, M.D.
Chairman
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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 States Attorney

Barbara Schwartz, Ph.D.
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 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

Child Fatality Review
Report of Local Team Activities, 2003
Baltimore City

Highlights and Successes of Local CFR Team for 2003:
This year, Baltimore City Health Commissioner and CFR Chair, Peter Beilenson, M.D., held three press conferences to educate the public on child death prevention measures, per recommendations from the CFR Team.

In mid July, Dr. Beilenson held a press conference, together with the Baltimore's Mayor O'Malley, announcing the city's lowest infant mortality in history, and took the opportunity to educate parents on the importance of placing babies to sleep on their backs in their own cribs to prevent future deaths. Later that month, Dr. Beilenson conducted a press conference to raise awareness among parents of children with asthma about the importance of reducing disease risks and the need for regular doctor visits, in response to recent asthma deaths reviewed.

In December, Dr. Beilenson conducted a press conference to inform the public of recent SIDS, SUDI and infant suffocation deaths. He again reminded parents that infants need their own beds without comforters, pillows and stuffed toys, and should be placed on their backs to sleep.

Social or Health Impact of CFR in Your County Since its Inception:
CFR has increased knowledge among providers and the public on causes of child mortality and on means to prevent future child deaths.

Goals for the Future of the CFR Team:
1. Invite new team members to join with Child Welfare expertise, and other areas of expertise, which may be underrepresented on the team.
2. Continue to find opportunities to reduce co-sleeping and suffocation deaths among infants.
3. Develop guidelines for determination of when abuse/neglect contribute to death.
4. Continue to foster greater collaboration among agencies on child welfare issues.
5. Collaborate with community agencies/organizations to develop strategies for reducing teen homicide.
6. Continue to identify and advocate for policies that will reduce child abuse and neglect and improve child welfare.

Membership and Leadership of Team:
Current membership with affiliations—see attached list.

Chair:
Peter Beilenson, M.D., M.P.H.
Commissioner of Health
Baltimore City Health Department
210 Guilford Avenue
Baltimore, MD 21202
PH: 410-396-4387
Fax: 410-396-1571
E-mail: peter.beilenson@baltimorecity.gov

Facilitator for CFR meetings: Peter Beilenson, M.D., M.P.H.
Lisa Firth, M.B., M.P.H, serves as alternate

Staff Coordinator for CFR meetings: Karen Angelici, M.P.P.

Meetings in 2003:
Eight CFR meetings were held in 2003. Meetings are scheduled for the third Monday of each month, but were cancelled in April, June, October and December due to lower caseloads.

Case Reviews:
Eighty-four cases were reviewed in 2003. There were five cases in which child abuse or neglect was substantiated. The team reviewed 29 infant death cases, including 11 SUDI, four SIDS and four asphyxia deaths. A total of 14 cases were reviewed in which co-sleeping or inappropriate sleeping conditions were noted.

Recommendations by Your CFR Team for Local Action:

1. Asthma
   - BHCD should develop a press release and conduct a press conference on the importance of asthma treatment and prevention.
   - BHCA should talk to MCOs about the importance of properly caring for asthmatic children.

2. Safe Infant Sleeping
   - Education about the importance of putting an infant to sleep in its own crib on its back, without comforters, pillows and stuffed toys should continue through the press and providers.
   - Education about the risks of co-sleeping should continue though the press and providers.

3. Water Safety
   - Parents should be reminded by the press and providers to watch their children at swimming pools, even if a lifeguard is on duty.
   - Teachers and providers should emphasize water safety.

4. Investigations/Follow-up
   - A home study should be conducted before a child is placed with a previously non-custodial parent or with a guardian.
   - Police and OCME investigators should continue to conduct detailed questioning at a child death scene.
   - DSS should plan to follow up with other siblings in a home where a child dies and the team feels abuse/neglect may have been a factor.

5. Other
   - Education on the importance of smoke detectors in the home should be stressed.
   - An open dialogue with obstetricians at local hospitals concerning providing tubal ligations (if requested) after delivery should be initiated.
   - The Maternal and Infant Nursing Program should send a letter to hospitals in the counties to let them know that they should refer high-risk infants and pregnant women who live in the Baltimore City.
   - Parents should be educated about the need to continue "well child" visits when their children reach adolescence to ensure that potentially life-threatening conditions in teens are detected and treated. Information about publicly funded services for teens should also be made widely available.

Actions Taken in or by Your Jurisdiction:

1. In July, Baltimore City Health Commissioner and CFR Chair, Dr. Peter Beilenson, held a press conference to educate parents of children with asthma about the importance of

getting timely treatment, and reducing disease triggers.

2. In July, Baltimore City Health Commission and CFR Chair, Dr. Peter Beilenson, held a press conference with the Mayor to announce the city's lowest infant mortality rate in history. He also took the opportunity to raise awareness of the leading causes for child death and the importance of continued prevention.

3. In August, several team members participated in a DHMH conference on a CDC-led cluster investigation of child asthma deaths in Baltimore.

4. In December, City Health Commissioner and CFR Chair, Dr. Peter Beilenson, held a press conference to inform the public of recent SIDS, SUDI and suffocation deaths, and to educate parents on safe infant sleeping.

5. The Maternal and Infant Nursing Program sent letters to hospitals in surrounding counties asking them to refer Baltimore City residents to the program.

6. CFR members participated in a DHMH conference on a CDC-led cluster investigation of child asthma deaths in the city.

7. DSS is closely following siblings where a death has occurred in the family, and where the team feels abuse/neglect was contributory.

8. Baltimore City Health Commissioner and CFR Chair, Dr. Peter Beilenson, met with directors from Johns Hopkins and Sinai Hospitals and the University of Maryland Medical Center to discuss the importance of providing tubal ligations to clients immediately after delivery, if requested by their clients.

Issues Referred by Local Team to State Team for Statewide Consideration:

1. Guidance for determination of abuse/neglect in a CFR case review.

2. State recommendations for tackling co-sleeping and asphyxia issue.

3. OCME should have investigators gain more information from families on the circumstances surrounding asthma deaths

4. Cases from across the state should be examined to determine the degree to which coming from a "chaotic family" influences the risk of a child dying.

5. Interventions should be developed to target young, 11-12 year-old kids, who are referred to DJS.

BALTIMORE CITY
CFR TEAM

NAME	TITLE AND ORGANIZATION	ADDRESS	TELEPHONE	
Abraham, M.P.H., Meena	Med-Chi, MCH Program Director			Stet
Angelici, M.P.P., Karen	Baltimore City Health Department – Division of Maternal and Child Health	210 Guilford Avenue (21202)	410-396-3769	22
Bassin, LCSW-C, Lucy J.	University of Maryland Baltimore School of Social Work			
Ariano, Bonnie	Mayor's Office for Children, Youth & Families			
Becker, Donna C.	UMSM, Center for Infant And Child Loss			
Beilenson, M.D., Peter	Commissioner of Health Baltimore City Health Department	210 Guilford Avenue (21202)	410-396-4387	
Bogrov, M.D., Michael Arthur	Sheppard Pratt Hospital			5
Cox, Elaine (for Bishop Robinson)	Secretary Department of Juvenile Services			
Crowel, M.D., Raymond (for Steve Baron)	Baltimore Mental Health Systems			
Drake, Julie (for Patricia Jessamy)	Felony Family Violence Division Baltimore City State's Attorney Office			
Duncan-Wilson, Dorenzer	Baltimore Mental Health Systems			
Evan, Karen	Will and Jada Smith Foundation			3
Firth, M.D., Lisa	Division of Maternal and Child Healh, Baltimore City Health Department	210 Guilford Avenue (21202)	410-396-1834	410
Gottschalk Sgt. (Alternate: Det/Sgt. William Furlong)	Baltimore City Police Dept. – Child Abuse Unit			
Holzer, Dave	Supervising Attorney Baltimore City Dept. of Social Services			
Johnson, Claudietta B. (Kenneth Hendricks Alternate)	Baltimore City Dept. of Social Services			
Ling, M.D., Li (for Dr. David Fowler)	Office of the Chief Medical Examiner			
Mainor, Peggy	Baltimore Child Abuse Center			
Mattison, Rita (for Bonnie Cypull)	Baltimore Substance Abuse Systems			
Moran, Heather	Med-Chi			
Morrison, Michael	Regional Child Care Administration – DHR			
Moses, Jamaal (Alt: Denise Parker)	Mayor's Office for Children, Youth & Families			
Rowe, Sgt. Scott	Baltimore City Police – Homicide Section			

Saunders, Ted (Chief)	Baltimore City Fire Marshall			
Shubin, M. D., Charles	Children's Health Center Mercy Family Care			
Spaccarelli, Arianne	Baltimore City Health Department			
Spear, Tina (for Carmen V. Russo)	Baltimore City Public School System			
Walker, M.D., Allen	Pediatric Emergency Medicine – Johns Hopkins Hospital			
Walker, Sheryl	Secretary to Fowler OCME			
Wilson, Dan	Baltimore City Department of Social Services			
Zemrus, M.D., Tasha	Office of the Chief Medical Examiner			

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Baltimore County
Child Fatality Review Team
Phone: 410-887-2738
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REPORT OF LOCAL TEAM ACTIVITIES, 2003

Highlights and successes of local CFR Team 2003:

- The Baltimore County Child Fatality Review Team (BCCFRT) is now in its third year. It has been privileged to retain the support and active participation of its members. In 2003, we lost three members (who left their current work positions), but were fortunate to gain other valuable team members (membership list attached).
- In November 2003, three members of the BCCFRT were asked to present a workshop at the American Academy of Pediatrics Annual Meeting in New Orleans. The topic of the 3-hour workshop was: *Child fatality review: the contribution of pediatrics, forensic pathology, and injury epidemiology.* Evaluation of the session indicates that it was well received.
- In December 2003, two senior colleagues from the HRSA Maternal Child Health Bureau joined us for the case review meeting. Both are working on various issues related to CFR at the national level. Their purpose was to observe a well-functioning local CFRT to identify issues pertinent to training and development of CFRT capacity in the USA. We had a very productive discussion.
- Two members of the team submitted an abstract with Sally Dolch (Chair of the State CFRT) to present a workshop at the Governor's Child Abuse and Neglect Conference April 29, 2004. The session, which has since been accepted, for presentation is called: *Child Fatality Review - Translating Tragedy into Advocacy.*

Social or Health Impact of CFR in Baltimore County since the inception of the CFR Team:
Although it is premature to claim significant impact on the health status of children in Baltimore County, the existence of the team has made an important social impact on participating members and agencies. Enhanced communication between agencies is a key benefit of CFRT. In addition, participating agencies have embarked on collaborative prevention projects beyond CFRT.

Membership and leadership of BCCFRT:

- Currently, the BCCFRT has 17 members. A membership list is attached. In addition, 4 visitors attended review meetings in 2003.
- The leadership structure of the BCCFRT is informal, and meetings are relaxed and very interactive. The Chair, Dr. Carolyn Fowler, also serves as co-coordinator. Team members alternate responsibility for leading case review discussions.
- Responsibility for follow-up communications with other colleagues or agencies in other jurisdictions is shared. Our policy has been to encourage colleague-to-colleague calls. For example, if a Baltimore County child has died in another

jurisdiction and that jurisdiction's police department is investigating the death, our team's police department representative will talk with his colleague and report back to the team. During 2003 we have successfully followed this procedure with almost all disciplines involved in the team.

Meetings in 2003:
Meetings are scheduled routinely for the fourth Tuesday of each month but held or canceled based on caseload.
Six case review meetings were held in 2003 (January, April, June, August, October, and December). In addition, team members communicate regularly by e-mail to discuss follow-up that is deemed necessary during review meetings.

On December 15, 2003, seven CFR Team members attended the State CFRT meeting to discuss the roles, and special contributions that various agencies make to CFR. Participating members represented the following agencies: Fire/EMS, Health Department/Injury Prevention, Hospital-based pediatrics/child abuse specialists, Office of the Chief Medical Examiner, Police, Social Services.

Case Reviews:
In 2003, thirty (30) new cases were referred to our team by the OCME. Twenty-four (24) of these were reviewed in 2003. Six (6) were deferred for review at the first meeting of 2004. Many cases are reviewed on more than one occasion; several remain open pending follow-up information that has been requested.

Categories of Child Deaths Reviewed by Baltimore County CFRT Review Year 2003		
Manner of Death	**Number of Cases**	**Concerns about abuse and/or neglect involving family or caregivers**
Accident	9	1
Homicide	4	2 (infant homicides)
Natural		
❑ SIDS	3	1
❑ SUDI	2	1
❑ Other	2	0
Suicide	2	2
Pending	2	2
Deferred to 2004	6	N/A
TOTAL	30	9

Recommendations by BCCFRT for local action:
1. Team members agreed to develop the team's outreach activities, while exploring the potential for policy-related action and advocacy. To build the visibility of the CFR in Baltimore County, we decided that materials and activities arising from team discussions, such as the need to train childcare providers, will be attributed to the Child Fatality Review Team.

2. The team is participating in a strategy conference to be held in Towson, MD, on May 25, 2004. This conference, organized by the Department of Health's Injury Prevention Program, will bring together 50 people from various agencies and organizations that, in some way, promote and protect the health and well-being of children in Baltimore County. The CFRT is committed to supporting activities that draw attention to the need for coordinated community action.

Actions taken in/by jurisdiction:
Discussions during case reviews led to concerns about pregnancies resulting from relationships between young women and older men that, technically, qualify as statutory rape. It became apparent that communication gaps about recommended referral issues, policies and procedures existed between police, pediatric/hospital providers, the States Attorney's Office and Social Services. Team discussions resulted in enhanced information being distributed among agencies.

Issues referred by Local Team to State Team for statewide consideration:

- The team looks forward to the development of the State CFR database at the Office of the Chief Medical Examiner. We thank the OCME for their support of our review activities in 2004.
- Our visitors from HRSA MCHB encouraged us to promote and contribute to training and support for local CFR Teams. Their comments focused on issues of team management, and moving to action rather than exclusively on the review process.

We thank Fran Pellerin for her careful screening and referral of cases to our team. Ms. Pellerin is an invaluable resource to CFR.

www.co.ba.md.u

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

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	BC Health Department (WIC and Infants and Toddlers)
Ann Brobst	BC Office of the State's Attorney (as available; alt. for John Cox)
Capt. Tom Busch	BCPD and BCPS Safe Schools Program
John Cox	BC Office of the State's Attorney
Dr. Carolyn Fowler	BC Health Department (Injury Prevention Program)
Colleen Freeman	BC Health Department (MCH; Child Advocacy Center)
Sheila Johnson	BC Health Department (Public Health Nursing)
Capt. Jim Korn	BC Fire Department (EMS)
Dr. Scott Krugman	Franklin Square Hospital and AAP
John Stallard	BC Health Department (Developmental Disabilities)
Jane Talbott	Citizen Member
Mark Vidor	DHR (Family Services)
Dr. Tasha Greenberg	Office of the Chief Medical Examiner
Dawn Zulauf	Chief Forensic Investigator (OCME) – as available

Prepared by Carolyn Fowler (cfowler@co.ba.md.us)
Updated: January 2, 2004

Child Fatality Review
Report of Local Team Activities, 2003
Calvert County

Highlights and Successes:

Child Fatality Review (CFR) has promoted interagency communication and resulted in vigorous participation around child fatality issues.

Social or Health Impact Since Inception:

The CFR meetings have heightened awareness of child fatality issues, such as Sudden Infant Death and high-risk adolescent behaviors.

Goals:

An on-going goal is to offer professional training around social and medical issues identified in the case reviews.

Membership:

See attached list.

Meetings:

Two meetings were held in 2003 and two cases were reviewed.

Case Reviews:

Calvert County Forensic Investigator presented an overview of unexpected infant death and Munchausen by proxy to the Board.

Recommendations:

Team recommendations have focused on systems' changes within agencies involved in child fatality cases.

Actions:

a. Sudden Infant Death training will be scheduled early in 2004 for interested health department and hospital staff and CFR team members.

b. Adolescent health issues remain a community priority and the focus of various endeavors.

Issues:

It would be beneficial for Child Fatality at the state level to facilitate and expedite acquisition of autopsy reports and investigative files for local jurisdiction.

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

Mr. Ray D'Arienzo
Superintendent of Student Services
Calvert County Public Schools

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

Ms. Susan Copsey
Regional Representative
Child Care Administration

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

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

David L. Rogers, M.D.
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Health Officer
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Ms. Susan Dohony
Vice President, Quality Management
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Sheriff Michael Evans
Calvert County Sheriff's Office

Detective Sgt.Michael Moore
Calvert County Sheriff's Office

Lt. Homer Rich
Commander, Maryland State Police
Barrack U

Mrs. Doreen McKenzie
Department of Social Services

Mrs. Phyllis Baker
Attorney-At-Law

Mr. Troy Smith
Forensic Investigator

Ms. Donna Millar
County Supervisor
Department of Juvenile Services

James Richardson
Coordinator, Fire Rescue EMS

Caroline County Child Fatality Review
Annual Report
Calendar Year 2003

Meetings and agency representation

- Quarterly
- See attached member listing

Causes and Incidence of all child deaths (include those not reviewed by multi-disciplinary team, comparison with state data)

- Vital records review of all resident child deaths

  In calendar 2003, one infant death was reported. This case was not selected for review to date by the Fetal Infant Mortality Review Team (FIMR) due to new guidelines prioritizing selection of cases for review. It has been requested that since there is only one for the county that this case be placed on the agenda for early in calendar year 2004.
- Full multi-disciplinary review of child deaths to county residents which were Medical Examiners cases

  The team has finalized two reviews of deaths from 2002, as well as reviewing two for 2004.
- Discretionary review of records or multidisciplinary review of other resident or non-resident child deaths and non-fatal sentinel events, as the team defined them.

  Four deaths to young adults (aged 18, 2 residents, 2 non-residents) were not fully reviewed, due to the guidelines for age and residency that the team adopted.

State and Local recommendations for preventing morbidity and mortality

- Recognition that oxycotin, methadone, and heroin use exists in Caroline County among children and young adults, resulting in abuse and overdose.
- Support funding needed to address treatment for increasing drug abuse.
- Raise awareness of the outcomes of inexperienced teen drivers.
- Recommend standard curriculum for health class, which addresses a variety of topics and preventive measures, reflective of Maryland's data on child deaths.
- Develop guidelines for reviewing a case that is being prosecuted.
- Assistance in merging data from a Regional FIMR into specific county CFR reporting.
- State reporting to local CFR, how the CFR process has affected change in mortality rates.
- Assist in establishing a database for required recording of child death statistics.
- Continue promotion of parent responsibilities regarding supervision of children.
- Support public awareness of the danger of children left unattended.
- Support safe storage for firearms and ammunition.
- Alert the public on how and when to report suspected abuse or neglect.

Recommended changes to local or state law, policy, and practice

- Promote longer driving training through parent education and enhanced driving school curriculum.
- Explore the impact of linking school graduation and attendance with a license to drive.
- Support proposed legislation regarding teen driving and transporting other teens.
- Fund the Child Fatality review mandate.
- Establish guidelines which restrict the number of passengers in a vehicle in line with the number of seat belts approved for that vehicle.

Evaluation of the extent to which state and local agencies are effectively discharging their child protection responsibilities in accordance with the state plan under 42 U.S.C. 5106A (B), and standards it sets forth.

- The Director of the Department of Social Services is a participating member of the Caroline County CFR team. She has come prepared with a review of the incident and a history of the case, if any, with the department. She has been able to identify whether neglect or abuse was suspected and whether any other children in the family unit are at risk.

Actions taken by the team (e.g. implementation of the recommendations or advocacy for them)

- Sharing of the Resource List, March 6, 2003 (Web listings)
- Literature Review of *Morbidity and Mortality Weekly Report (MMWR), source of Firearms Used by Students in School-Associated Violent Deaths*
- Training: Participated in West Virginia CFR Annual Conference: *Investigation & Prosecution of Child Fatalities: How Looking Back Can Help*
- Training: Reviewed Wicomico County's CFR Power Point presentation
- Agreement for "out of county" Pediatrician to participate in reviews for those children for whom she was the provider
- Recommended determination of airbag deployment
- Recommended determination of teen driver's history
- Advocated that infant death be reviewed by FIMR, although not meeting initial criteria for selection
- Recommended determination of any known negative impact of cruise control affecting driving, stopping or applying brakes during precipitation
- Recommended teen peers be contacted/counseled for their similar risky behaviors
- Recommended drug treatment for teen peers
- Recommended grief counseling for survivors
- Recommended questioning car availability to unlicensed teens
- Recommended further questioning to determine lack of supervision and underage consumption of alcohol
- Questioned relationship of time of accident to the teens daily routine
- Advocated for release of records from Maryland State Police
- Approval of firearm safety education in home visiting

Child Fatality Review
Report of Local Team Activities, 2003
Caroline County

Highlights and successes

- Literature review of *Morbidity and Mortality Weekly Report (MMWR), Source of Firearms Used by Students in School-Associated Violent Deaths*
- Disseminated Resource List (Web listings)
- *Attended West Virginia CFR annual conference: Investigation & Prosecution of Child Fatalities: How Looking Back Can Help*
- Reviewed Wicomico County CFR Team's Power Point Presentation
- Willingness of Pediatrician to participate in CFR, although the practice is in another county

Social or Health Impact of CFR in the community since its inception

- Raised awareness of SB 464 among agencies and community key players and team members
- Increased public awareness regarding preventive measures
- Increased awareness of team responsibilities and recommendations to county elected officials
- Considerations and changes made in policy/curriculum/practices
- Additional support services utilized
- Enhanced communication at multiple levels
- More comprehensive approach to address child death

Membership and leadership of Team

Current membership consists of the following:

Health Officer	Dr. John Grant
Deputy Health Officer	Rebecca Loukides
Medical Examiner	Dr. Christian Jensen
Director DSS	Jane Conlin
State's Attorney	Jonathan Newell
Superintendent of Schools	Larry Lorton (2002-3 school year) Edward Shirley (2003-4)
Director of Pupil Services	Tina Brown

Law Enforcement	Sidney Pinder H. P. Ketterman John Branham
Director of Substance Abuse Program	Dr. Betty Malkus
Attorney representing DSS in Child Welfare proceedings	Millicent Maloney
Regional Representative of the Childcare Administration	Price Shuler
Director of Mental Health Pediatrician	Mile Campbell Dr. Denise Kyle
Human Services Council Director Child Health Services	Helen Spinelli Jennie Glime

In 2002, the team elected Rebecca Loukides as Chairperson, Betty Malkus as recorder and the Human Services Council as facilitator. Jennie Glime has served as the team contact person and has acted as facilitator during 2003.

Rebecca Loukides, Deputy Health Officer, can be reached at Caroline County Health Department, 403 South Seventh Street, Denton, Maryland 21629, phone 410-479-8035, and fax 410-479-0554, email bloukides@dhmh.state.md.us

Meetings

Quarterly (January,April, July and October)

Case Reviews

Two cases from 2002 were finalized and two for 2003 were reviewed fully.

Recommendations by Team for local action

- Recommended determination of airbag deployment
- Recommended determination of teen driving history
- Recommended determination of any know negative impact of cruise control affecting driving/stopping/applying brakes during precipitation
- Recommended teen peers be contacted/counseled for risky behaviors
- Recommended drug treatment for teen peers
- Recommended grief counseling for survivors

- Recommended questioning car availability to unlicensed teens
- Recommended further questioning re: no supervision and drinking
- Questioned relationship of time of car accident to teens routine
- Training opportunity-Governor's Counsel in Abuse/Neglect Prevention attended by Addictions Program staff

Actions taken in/by local jurisdiction

- Advocated for release of records from State Police
- Approval of firearm safety education in home visiting

Issues referred by Local team to State Team for statewide consideration

- Changing direction of FIMR places emphasis on Community Action initiatives presently, not case/systems review. This, along with it being a regional approach makes it difficult to extrapolate any meaningful data.

Child Fatality Review
Report of Local Team Activities, 2003
Carroll County

Highlights and successes of local CFR Team for 2003: Dissemination of information in the local media concerning water safety, A.T.V.s, farm safety, and dangers resulting from heavy snowfalls.

Social or Health Impact of CFR in your county since its inception: Public education concerning issues that impact child safety.

Goals for the future of the CFR Team: To be discussed at next meeting.

Membership and leadership of Team: see attached list.

.**Meetings in 2003: Two meetings were held, on 4.25.03 and 7.25.03.**

Case Reviews: Three cases were reviewed. A total of 3 cases were referred to the O.C.M.E. in 2003. In no cases was abuse or neglect a contributory factor.

Recommendations by your CFR Team for local action:
1. **Media coverage concerning issues of carbon monoxide poisoning and cars, in heavy snow-falls.**
2. **The possibility of placement of carbon monoxide detectors in cars was discussed.**

Actions taken in or by your jurisdiction:
1. **Articles placed in the local media.**
2. **Information about "Back to Sleep" campaign distributed in the community.**

Issues referred by Local Team to State Team for statewide consideration: None.

CARROLL COUNTY HEALTH DEPARTMENT
CHILD FATALITY REVIEW TEAM MEMBERS

Amy Blank – State's Attorney's Office

Natasha Byus – State's Attorney's Office

Penny Bramlett (Carroll County Health Dept.)

Dianna Davis (Carroll County Health Dept.)

Howard Held (Carroll Co. Health Dept. - Addictions Bureau)

Linda Holmes

Jeffrey Moffatt
Dept. of the County Attorney

Bill Knight - Carroll Co. Dept. of Social Services

Cyndy Little - Pupil Personnel - Carroll County Public Schools

1st Sgt. Dean Richardson - State Police Barracks
(or Keith Papi)

Barb Rodgers/Kim Spangler
(Carroll Co. Health Dept. - Health Education)

Dr. Elizabeth Ruff (Carroll Co. Health Dept.)

Robert Wack, M.D. (Carroll Co. General Hospital)

William Woodward, M.D. (Carroll Co. Health Dept.)

Chairperson: Elizabeth M. Ruff, M.D., Carroll County Health Department
Telephone: 410-876-4927 Fax: 410-876-4959
E-mail: eruff@dhmh.state.md.us

Facilitator: Carroll County Health Department, 290 S. Center Street, Westminster, MD 21157

Cecil County FY03 Child Fatality Review
Report of Local Team Activities

Highlights and Successes of Local CFR Team for 2003:
Cecil County has developed an Access database program to retrieve and analyze data related to fetal and infant morbidity and mortality. The Cecil County Fetal and Infant Mortality Review and Child Fatality Review Data Analysis Report consists of results of all fetal and infant deaths occurring within the Cecil County population from 1996 through 2002.

Social or Health Impact of CFR in your County Since its Inception:
Since 1996, the Cecil County Child Fatality Review (CFR) Board has evolved into a community-based committee that has made a commitment to review all child fatalities and recommend strategies to prevent future child fatalities. The CFR Board identifies system issues and recommends strategies to the Perinatal/Child Death Community Action Team (CAT) in order to resolve system problems in the community. The CAT uses these recommendations to develop an action plan to address these system issues.

Goals for the Future of the CFR Team:
The Cecil County CFR Board has a unique and diverse membership. The identified system issues and recommendations from the CFR Board are reviewed by CAT in order to complete a community action plan. A report back to the CFR Board will be presented each year at a joint meeting.

Membership and Leadership of Team:

Dong Park MD	Cecil County Pediatrics
Cheryl Vogel RN	Union Hospital of Cecil County Utilization Management Office
TFC Susan Smith CFR Chairperson	Maryland State Police North East Barracks
Sue Bailey, Assistant Director	Department of Social Services
Dereck Chapman, DSFM	State Fire Marshall Office
Sergeant Matthew Donnelly	Elkton Police Department
Laura Young RN Coordinator of School Nurses	Cecil County Public Schools
Detective Sergeant Barry Chiominto Supervisor of the Detective Unit	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
Jacqueline S. McMichael PhD Clinical Manager-Child Adolescent Mental Health Services	Cecil County Health Department Mental Health Core Services Agency
Norma Dempsey RN, MSN Child Health Program Supervisor	Cecil County Health Department Community Health Services
Barbara Brueckner RN Director of Nursing	Advanced Treatment Systems Methadone Clinic
Susan Ewing Forensic Investigator	Cecil County Emergency Medical Services

STAFF

Christine Barclay RN, BSN Community Health Nurse Program Supervisor	Cecil County Health Department Division of Health Promotion
Robin Chase	Cecil County Health Department Division of Health Promotion
Carol King RN-C, BSN CFR Facilitator	Cecil County Health Department Division of Health Promotion

Meetings in 2003:
One review board meeting was convened in 2003. The Improved Pregnancy Outcome (IPO) Coordinator, Carol King RN-C., BSN, attended statewide training meetings on March 6, 2003 and October 31, 2003. At the October meeting, Ms. King facilitated a roundtable discussion entitled "Working Across State Lines".

Case Reviews:

During 2003, four Cecil County children died. Three of these cases were reviewed at the 2003 CFR Board meeting. One child died in Harford County. The Harford County Review Board is responsible for reviewing the case. All cases of a child fatality in Cecil County receive a complete review. The Department of Social Services, Child Protective Services representatives attend board meetings and assist in the determination of abuse/neglect. There were no cases in which child abuse or neglect was substantiated or contributory toward the death of a child.

Recommendation by Your CFR Team for Local Action:
One of the recommendations of the CFR has been to educate parents about the importance of placing their babies on their backs to sleep.

Actions Taken in or by Your Jurisdiction:
In 2002, the Cecil County Perinatal/Child Death Community Action Team (CAT) developed and initiated a countywide educational campaign about infant sleep safety. In 2003, CAT partnered with the Cecil County Health Department in order to conduct the "Back to Sleep" Campaign for new and expectant mothers in order to reduce the risk of Sudden Infant Death Syndrome in Cecil County. The Injury Prevention Coordinator will continue to collaborate with the Cecil County CAT to identify potential community sites to conduct the campaign. Gift packets will include an infant T-shirt imprinted with the message "This side up. Every time I fall asleep, make sure I'm on my back to sleep." Other educational materials will also be included in the gift packets. The gift packets will be distributed at community sites, which include doctors' offices, clinics, Family Education Center, Union Hospital, and the Women, Infants & Children Program at Cecil County Health Department.

Issues Referred by Local Team to State Team for Statewide Consideration:
Cecil County has requested the State Team to facilitate a process for obtaining access to other state medical records for review, when a death occurs in a neighboring state.

Cecil County Child Fatality Review Membership F2004

Name	**Agency/Organization**				**E-mail**
Dong Hee Park, MD	Cecil County Pediatrics				none
Cheryl Vogel, RN	Union Hospital Utilization Management Office				
TFC Susan Smith Chairperson (Captain Kreiner)	Maryland State Police				None
Sue Bailey Assistant Director	Department of Social Services				sbailey@dhr.state.md.us
Sgt Matthew Donnelly					
Dereck Chapman, DSFM	State Fire Marshall Office				
Laura Young RN Coordinator of School Nurses	Cecil County Public Schools				
Detective Sergeant Barry Chiominto Supr. Det. Unit	Cecil County Sheriff's Office				
Mike Browne, Chief	Emergency Management				mbrowne@ccgov.org
Richard Achuff Investigator	State's Attorney's Office				
Jacqueline S. McMichael, PhD Clinical Manager-Child & Adolescent Services	Core Service Agency Cecil County Health Dept.				drsonya@iximd.com
Nancy Hardy Executive Director	Cecil Partnerships for Children, Youth & Families				family@dol.net
Barbara Brueckner RN Director of Nursing	Advanced Treatment Systems				
Susan Ganal Forensic Investigator	Emergency Medical System				
Virginia R. Bailey, MD, MPH Health Officer	Cecil County Health Department				
Norma Dempsey, RN, MSN Child Health Program Supr.	Cecil County Health Department				ndempsey@cecilcountyhealth.org
					jpatterson@dhmh.state.md.us
Staff					
Christine Barclay, RN, ,BSN Supervisor	Cecil County Health Department Division of Health Promotion	401 Bow Street Elkton, MD 21921	410-996-5168 x228	410-99-5168	cbarclay@cecilcountyhealth.org
Carol King, RN-C, BSN CFR Coordinator	Cecil County Health Department Division of Health Promotion	401 Bow Street Elkton, MD 21921	410-996-5168 x 152 ext. 152	410-996-5169	cking@cecilcountyhealth.org

Child Fatality Review
Report of Local Team Activities, 2003
Charles County, MD

Highlights and successes of local CFR Team for 2003:

A joint determination was made between the local FIMR and CFR team that a focus would be infant deaths from rollovers by parents. Child Protection/CFR Team used some of its funding to purchase pack and plays to give to new parents without cribs.

The public schools and mental health providers are looking at the number of teen suicides and vehicular deaths in the county.

Social or health impact of CFR in your county since its inception:

Public Schools and mental health providers are looking at the response to teen suicides and deaths. Support services to living siblings are under review for enhancement.

Goals for the future of the CFR Team:

We are trying to look for trends in the community and determine intervention strategies.

Membership and leadership of Team:

Meetings in 2003:

We met a total of 4 times to review deaths in the community and talk about issues.

Case Reviews:

4 deaths reviewed
1 was attributed to abuse.

We use the preliminary findings of the OME from DHR, police reports, and child protective services findings to determine abuse. We explore elements of family law and clinical and medical definitions of abuse to make a final finding.

Recommendations by your CFR Team for local action:
None.

Actions taken in or by your jurisdiction:
None.

Issues referred by Local Team to State Team for statewide consideration:

The team finds that with many of the reviews only the schools have prior contact with the families, so information is very limited.

We also have to conduct the reviews without having the final autopsy or finding, which is frustrating.

We believe some of our deaths may not be reviewed because the deaths occur in Prince George's County and Washington D.C which is where children are flown for critical care. Deaths that are investigated by the police and child protective services are not included in this population of children.

Child Fatality Review
Report of Local Team Activities, 2003
Frederick County

Highlights and successes of local CFR Team for 2003:

- High membership attendance
- Increased communication and coordination of service delivery between community partners
- Reviewed eleven child fatalities in calendar year 2003
- CFR Team made recommendations for increased traffic surveillance and an additional traffic sign to Frederick County law enforcement regarding vehicle fatalities
- Solicited Buckle Up Program through Frederick County Health Department in partnership with Frederick County Public Schools and law enforcement
- CFR Team members participated in training on gang philosophy and Wicken Movement's impact on adolescent behavior
- Dr. Kenneth Saad resigned as Chair in September 2003
- Lt. Dave Reichenbaugh elected Chair December 2003

Social or Health Impact of CFR in your county since its inception:

- CFR Team continues to identify case specific issues and make recommendations regarding systemic impact to community. For instance, CFR invited local motel/hotel businesses to provide cribs for infants without additional fee, addressing SIDS deaths in county. CFR also requested law enforcement to increase traffic surveillance on two specific roads in county with increased vehicle fatalities.
- CFR Team applauded and encouraged continued coordination of case activity between Frederick County Child Welfare Services and Frederick County Health Department Maternal Child Health.
- Identified need for better reporting of child fatalities and automatic system/database link between Frederick County Health Department, Child Protective Services and law enforcement.

Goals for the future of the CFR Team:

- CFR Team attendance and cooperation from members.
- Decrease number of child fatalities in Frederick County.
- Establish a better system of reporting child fatalities from the Office of the Medical Examiner to CFR Team.

Membership and leadership of Team:

Lt.. Dave Reichenbaugh, Chair	Maryland State Police 110 Airport Dr. East Frederick, Maryland 21701 301-644-4151 Reichenbaugh@mdsp.org
Deborah Frye, PhD, Co-Chair	Frederick County Health Dept. School Health
Anne E. Walker, Co-Chair	Frederick County Dept. of Social Services
Cynthia Harne, Coordinator	Frederick County Dept. of Social Services
Sharon Boettinger	Frederick County Public School
Lt. Tom Chase	Frederick City Police Department
Sgt. Bruce DeGrange	Frederick City Police Department
Corporal Jeff Kessler	Brunswick Police Department
Kate English, JD	Frederick County State's Attorney's Office
Mary Howser	Heartly House
Tom Graf	Frederick County Substance Abuse
Katherine Shriver	Frederick County Substance Abuse
Deb Hubbell	Frederick County Mental Health
Madeline Morey	Frederick County Office of Children and Families
Bob Pitcher	Mental Health Management
Lt. Ted Nee	Frederick County Sheriff's Office
Cam Smith	Department of Juvenile Service
Singy Golden	Department of Juvenile Services
Michael Morrissette	Office of Public Defender
Pam McCormick	Frederick County Head Start
Brenda Williamson	Developmental Disabilities Administration
Chuck McCaan	Brooklane Health Services
Ellen Ristocelli	Frederick County Health Dept. Nursing Division
John Molesworth, MD	Frederick Memorial Hospital
Kim Day	Frederick Memorial Hospital
Jack Titus, MD	Maryland Office of the Medical Examiner
Eileen Spangler	Citizen Member
Charles Wright, MD	Citizen Member

Meetings in 2003:	January 6, 2003 April 7, 2003 July 7, 2003 September 8, 2003 December 1, 2003

Presentation/ Training for Members:

- Department of Juvenile Services conducted presentation on gang related philosophy and the Wicken Religion movement's impact on adolescents.

Case Reviews: Frederick County reviewed a total of eleven child fatalities this year, seven of which were referred from the Maryland Office of the Medical Examiner.

The cases reviewed are as follows:

- Two cases had an indicated finding of child abuse and were deemed a homicide by law enforcement.
- Two cases (an adolescent and her infant) were deemed a homicide by law enforcement and did not meet the criteria for investigation by Child Protective Services.
- One case had a ruled out finding for child neglect.
- One case was a child who was placed in foster care and died as a result of a chronic/terminal medical condition.
- One case was an accidental drowning.
- Four of the cases were car fatalities.

Recommendations by your CFR Team for local action:

- CFR Team recommended increased traffic surveillance and an additional traffic sign to Frederick County law enforcement on two specific county roads to address child car fatalities.
- CFR Team recommended partnership between Frederick County Health Department, Frederick County Public Schools and law enforcement for soliciting and enforcement of the Buckle Up Program to address car safety for children.

Action taken in or by your jurisdiction:

- Law enforcement enforced child seat belt laws.
- Law enforcement increased traffic surveillance on two county roads.

Issues referred by Local team to State Team for statewide consideration:

- CFR Team requested a better system of reporting child fatalities to the CFR Team from the Maryland Office of the Medical Examiner

Child Fatality Review
Report of Local Team Activities, 2003
Garrett County

Highlights of local CFR Team for 2003:

We did not review any cases of child fatality because there were no cases to review. The CFR Team is in place in case a review is needed.

Social or Health Impact of CFR in your county since its inception:

Working together as a community.

Membership and leadership of Team:

Brook Schneider, Garrett County Health Department, Mental Health
Daniel Miller, Doctor of Osteopathy
Karl Schwalm, Garrett Medical Group
Jay Resh, Maryland State Police
Phil Lauver, Garrett county Board of Education
Lisa Thayer Welch, State's Attorney's Office
Rodney Glodfelty, Health Officer
Erica Mowbray, Garrett County Department of Social Services
Larry Bruch, Garrett County Department of Social Services, Chair of the CFR Team

Meetings in 2003:

We have not had a Child Fatality Review since March 2002.

Case Reviews:

No case reviews in 2003 because there were no child fatalities that needed to be reviewed.

There were no child fatalities attributed to child abuse or neglect.

Recommendations by Team for local action:
N/A
Actions taken in/by Jurisdiction:
N/A
Recommendations by Local Team to State Team:
N/A

Child Fatality Review
Report of Local Team Activities, 2003
HARFORD COUNTY CFR TEAM

Highlights and successes of local CFR Team for 2003:

In cooperation with the FIMR program and the county hospital, Harford County CFR staff assisted in the planning, training and implementation of a perinatal bereavement program available to parents. Historically, perinatal bereavement support groups were available only at metro Baltimore facilities, which are often travel prohibitive. A monthly parental support group began meeting locally in March 2003. The group is open to parents who have experienced the death of a child through miscarriage, stillbirth, newborn death, or infant death (up to one year of age.)

Social or Health Impact of CFR in your county since its inception:
CFR meetings have increased awareness of county agencies' roles and responsibilities with limited resources and resulted in improved cooperation in shared case investigation.

Goals for the future of the CFR Team:
Representation of the actual responding law enforcement officer/OCME investigating officer for case review meetings.

Membership and leadership of Team:

Chair: Christopher M. Tabone
Assistant State's Attorney for Harford County Board
101 South Main St., Suite 303
BelAir, MD 21014
(410) 638-3231
FAX: (410) 638-3195
E-Mail: cmtabone@co.ha.md.us

Assistant Chair: John Rusinko
Harford County Local Management Villa Maria/Catholic Charities
2300 Dulaney Valley Road
Timonium, MD 21093
(410) 252-4700, Ext. 102
FAX: (410) 252-3040)

Judy D. Churn, MS, RN-C.
FIMR and CFR Coordinator
Harford County Health Department

Wilbur W. Bolton, III, JD
Attorney At Law

Mary Jo Beach, MS, RN, Cm, LCCE
Director of Nursing
Harford County Health Department

Sandra Geiger, RN
Drug Abuse Services
Harford County Health Department

Mary-Claire Brett
Director of Alcohol Services
Harford County Health Department

Gary Kosyjana, Regional Manager
Cynthia Spath, Licensing Specialist
Child Care Administration

M. Paul Lomonico, MD
Board Certified Pediatrician
Pediatric Partners

Gregory Smith, MA, LCPC
Harford County Dept. of Social Services

Carolyn McQuiston
Child and Adolescent Coordinator
Core Service Agency

Beverly J. Stump, MD
Acting Health Officer
Harford County Health Dept.

Cydney Wentsel
Supervisor of Counseling and Guidance
Harford County Public Schools

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

Meetings in 2003: (4 Case Review Meetings)

January 15, 2003	4 cases reviewed
April 16, 2003	3 cases reviewed
September 10, 2003	3 cases reviewed
November 19, 2003	2 cases reviewed

The CFR Team formally reviewed 12 cases in calendar year 2003.

Referral Source: (cases may have multiple sources)
(Number of cases from OCME, from Vital Statistics and/or other sources.)

Health Dept. review of death certificates:	24
OCME referral:	11
Vital Statistics Birth/ Death Matches:	11
Center for Child/Infant Loss:	3
County public schools:	5
Other CFR jurisdictions:	3
Local Newspaper Obituary as only source:	3

Number of Cases Screened in 2003:	**14**
Previable births referred to FIMR:	10
Discussion Cases:	2
MVA fatalities of non-county residents:	2

The cases are screened as they are received by the coordinator. It has been the policy of the Team to screen all of the county's child deaths, regardless of OCME referral. Neonatal deaths due to previability are sent to the FIMR Board for review. Fatality cases involving congenital anomalies and childhood cancers are "discussion cases" as the Team is interested in the patterns of defects and possible links to hazardous chemicals. Two motor vehicle accident fatalities have occurred in the county involving out of county children. Harford's CFR Team has decided to review these cases in 2004.

Number of cases in which child abuse or neglect was substantiated (homicide): 1
The case is in the process of being litigated.

Number in which the team felt abuse and/or neglect were contributory:	**5**
Past history or current open file for DSS/ child protective service referral:	3
Non-compliance with medical plan of care for diagnosed physical/mental condition:	1
Lack of adequate supervision due to parental substance abuse:	1

Recommendations by your CFR Team for local action:

1. Research and obtain a copy of the current bicycle safety education information (if any) that is utilized in the Harford County Public School System.

2. Restrict newly licensed teen drivers from transporting passengers.

3. Review all child fatalities involving transfers to tertiary facilities.

Actions taken in or by your jurisdiction:

Assisted in the establishment of local perinatal bereavement resources for parents.

Issues referred by Local Team to State Team for statewide consideration:

1. Elevator safety compliance in Maryland. This issue was a carryover from 2002, as the civil case was settled in 2003 which included safety equipment changes.

2. Encourage trauma centers to cooperate with local CFR medical requests.

Child Fatality Review
Report of Local Team Activities, 2003
Howard County

Highlights and successes of local CFR team for 2003: The team disseminated and discussed relevant public health literature on risk factors for some of the causes of death this year.

Social or health impact of CFR in your county since its inception: The CFR team and the Howard County Injury and Violence Prevention Coalition have several members in common. As a result, non-confidential information about causes of death and their risk factors is beginning to be shared as sentinel indicators of potentially more widespread problems. The Coalition can use the data to recommend interventions that its members and others can implement to address these problems.

Goals for the future of the CFR team: The team will continue to review and discuss literature on causes of death, risk factors, and prevention.

Membership and leadership of team, current membership with affiliations, chair and other officers: see attached. Cynthia M. Lipsitz, MD, MPH, Medical Director, Howard County Health Department is the chairperson. There are no officers.

Facilitator for CFR meetings: Chairperson with assistance of the Program Manager, Howard County Child Advocacy Center

Number of CFR meetings and any special presentations/activities: **4 meetings held**

Case reviews:
Number of case reviews in 2003 (regardless of year of death): **13**
Number of cases in which child abuse or neglect was substantiated: **0**
Number of cases in which abuse and/or neglect were felt to be contributory: **1**

Of the 13 cases reviewed, four were ages 18 – 21. These were included at the discretion of the chairperson because there were risk factors for these deaths originating in childhood.

Recommendations by CFR team for local action:

Substance abuse:

1. Physicians diagnosing and treating depression should ensure that patients are seen in follow-up within an appropriate time period for reevaluation.
2. Schools should continue to provide crisis counseling and should enhance counseling team's skills with regular training.

3. The latter half of senior year in high school appears to be a time when students are more likely to engage in risky behaviors: partying, substance abuse, reckless driving, etc. Education during this time period targeted to graduating seniors should be enhanced.
4. Increase parent education about the progression of substance abuse from single drug experimentation to multiple drug dependence.
5. Consider a county-wide public education campaign with billboards similar to the "Heroin Kills" messages in Carroll County.

Suicide by gunshot:

1. Public education about gun purchasing laws.
2. Recognition of suicide risk factors.
3. Develop a program for high school seniors about dangers of transition period between high school and college or work.
4. Include an area in college health forms for information about a student's mental health history.
5. Train college resident assistants to recognize symptoms of depression.
6. Adolescent suicide prevention should place equal emphasis on medical therapy and counseling.
7. Public education about adolescent gangs, with special attention to ethnic differences; focused articles in Korean, Latino news media.

Vehicular:

1. Drivers' education programs should include more emphasis on judgment and parental knowledge.
2. Modifications to roadways and speed indicators should be implemented.

Drowning:

Health department to review, disseminate prevention educational materials in English and other languages.

Actions taken in or by your jurisdiction:

1. Department of Public Works examining ways to calm traffic in a specific area of the county and the Police are installing speed cameras in this same location.
2. Poster for public about what constitutes child neglect and pertinent law revised.
3. "Back to Sleep" SIDS prevention talk given to Injury Prevention Coalition by HCHD community health nurse.

Issues referred by local team to state team for statewide consideration:

1. There should be a mandatory waiting period for the purchase of ALL guns.
2. Pass a law restricting minors from riding in a vehicle driven by a minor.

CFRT Membership List 2004-2005

First Name	*Last Name*	*Agency*
Chris	Keane	Office of Law Geo Howard Bldg
Dale	Jackson	Howard County Child Advocacy Center
Deborah	Fleischmann	Howard Co General Hospital- Pediatric
Donna	Wells	Howard County Mental Health Authority
Janice	Burris	Child Care Administration
L. Jeannie	Meece	STTAR Center, Inc.
Marilyn	Manson	Howard County Health Department- Addictions
Pamela	Blackwell	Howard County Public Schools
Samuel	Marshall	Howard County Dept of Social Services
Susan	Rosenbaum	Howard Co Dept of Citizens' Serv
Tim	McCrone	State Attorney's Office-Carroll

First Name		*Last Name*	*Agency*				
Chief	Joseph	Herr	Fire and Rescue				
Chief	Wayne	Livesay	Howard County Police Department				
Dr.	Catherine	Busch					
Dr.	Cynthia	Lipsitz	Howard Co Health Department	10630 Little Patuxent Pkwy-Ste 400	Columbia	Maryland	21044
Dr.	David	Monroe	Howard County Gen Hospital-ER				
Dr.	Mary	Ripple	Medical Examiner's Office				
Dr.	Penny	Borenstein	Howard County Health Dept	6751 Columbia Gateway Dr-Ste 300	Columbia	Maryland	21046
Dr.	Wendy	Lane	Howard County Child Advocacy Center				

Kent County Child Fatality Review For Calendar Year 2003

Kent County met in January 2003 to review a death, which occurred in the fall of 2002. Since then we have been fortunate that we have not any more deaths. If needed we touch base quarterly by e-mail or phone, but we come together as a group once a year which is in January. We reviewed our only case since this process started 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
DSS
Local Board of Education
Local Hospital-facilitator
Local police
State Police
County EMS
DDJ
States Attorney
Local Pediatrician
Regional Child Care Administration

Case Review: One review of a child whose death was the result of an unintentional injury.

Recommendations: None at this time.

Actions taken: None at this time.

Kent County Child Fatality Review Membership List

Kent County Health Department
Mary Adda Moore, RN, BSN
Chair, Kent County Child Fatality Review Team
125 S. Lynchburg Street
Chestertown, MD 21620
410-778-3550

Kent County Department of Social Services
Paula Gish
Vice-Chair, Kent County Child Fatality Review Team

Chester River Hospital Center
Katherine Neff, RN
Facilitator, Kent County Child Fatality Review Team

Pediatrician – Dr. Freddie Araujo
Sheriff's Department – Sheriff John Price
State's Attorney's Office – Robert H. Strong, Attorney at Law
Juvenile Justice – William Clark
Board of Education - Gail Vucci, RN
Child Care Administrator – Price Schuler
County Paramedic - Keith Bennett

Montgomery County, Maryland

Child Fatality Review Team

Report of Findings and Activities 2003

Introduction:
Montgomery County initiated a Child Fatality Review Team (CFRT) in May 1997. In April 1999, the State passed legislation which mandated the establishment of a State Fatality Review Team and local teams in each county. The Child Fatality Review Process examines unexpected deaths of children to determine whether there are opportunities for action to prevent future deaths. Using a formal systematic approach, a multidisciplinary committee considers deaths and the circumstances surrounding them to determine whether the deaths might have been prevented, and makes recommendations for changes.

Mission of Montgomery County Review Team:

- To achieve a better understanding of why and how children die in Montgomery County.
- To find ways to improve the capacity of local agencies to work individually and collaboratively in responding to, effectively addressing, and preventing child fatalities.
- To formulate recommendations that address the issues raised by child deaths.
- To recommend system improvement strategies for preventing child deaths and enhancing safety for all children.

Highlights:
Early in the year, a Montgomery County representative served on a panel at the State training on CFRTs, and in September we hosted a State CFRT meeting. A member of a local victim's program observed one of our meetings due to an interest in setting up an Adult Fatality Review Team. Also a Montgomery County CFRT member, Beverly Byron, presented at the Governor's Conference on Child Abuse and Neglect on the topic of Shaken Baby Syndrome (SBS).

Presentations at the CFRT meetings included the following topics: the D.C. Child Fatality Review process, the Center for Infant and Child Loss, Shaken Baby Syndrome, SIDS/SUDI, the Red Flag Program at Montgomery County Public Schools that targets depression, the "Draw the Line" initiative that focuses on teenage drinking, the SAFE KIDS Montgomery County Coalition whose purpose is to reduce childhood death and disability due to unintentional injuries, the recent legislation on child car seats and proposed legislation to mandate that all parents of newborns have education on shaken baby syndrome.

Membership:

Co-Chair: Carol Garvey, M.D., MPH
Health Officer
Montgomery County Department of Health and Human Services

Co-Chair: Barbara Bonnin, MSW, LCSW-C
Child Welfare Services
Montgomery County Department of Health and Human Services

Coordinator: Susan Dudley
Senior Legal Assistant
Montgomery County State's Attorney's Office

Membership included representatives from Health, CPS, Schools, Law Enforcement, State's Attorney, Pediatricians, Hospitals, Fire and Rescue, Assistant Medical Examiners, Mental Health, Injury Prevention and Addiction Services.

The full membership is listed at the end of this document.

Impact of CFRT since Inception:

The Montgomery County CFRT process has facilitated a greater understanding about the work and scope of many agencies which address the needs of children and has enhanced communication and coordination between departments. There has been a sharing of information and expertise as each agency articulates its role and function and periodically provides informal presentations on different topics as well as lively debate on issues. The team is well established and provides a well-rounded forum for discussion of child deaths, the involvement of different agencies, and how the deaths could have been prevented. Discussions also include tertiary issues relating to how the death was handled, the need for grief counseling or debriefing for family members, school children at the same school as the deceased and/or other community residents.

The Team has written letters to Montgomery County Public Schools regarding safety around a school's boundaries, and to the State Highway Administration about unsafe intersections; the Montgomery County Health Officer issued press releases about safety practices, and one member of the team, Dr Nerita Estampador-Ulep, wrote an article on Shaken Baby Syndrome.

The Babies Sleep Safely Campaign:

Data from the Montgomery County Child Fatality Review Team in 1999-2000 indicated the majority of the infant deaths had been due to unsafe sleeping situations. Many of the cases involved bed sharing with family members. The Team recommended a Safe Sleeping Awareness Campaign to provide access to affordable cribs that meet safety standards. The Babies Sleep Safely Campaign started in 2003, through a $ 20,000 Community Development Block Grant. The campaign is to educate the public about safe

sleeping practices to reduce infant mortality and to provide new infant cribs that meet safety standards to low-income Montgomery County families.

Meetings in 2003:
The team met eight times in 2003. Meetings were monthly except January and February (inclement weather), August (summer break) and December (insufficient cases).

Case Reviews:
The CFRT reviewed 22 cases in 2003. Four deaths occurred in infancy and 18 were children over the age of one year. One-half of the deaths (11) were caused by trauma – homicide, suicide or accidents. Approximately one-half of the children were African American which is an over-representation for Montgomery County where African Americans comprise 15% of the population (Census 2000).

Deaths in Infancy:
There were four deaths in the first year of life which were all ruled "natural" and resulted from serious medical conditions: One premature child of 23 weeks gestation was stillborn; one premature baby died of myocarditis; one had pneumonia due to a metabolic disorder; and one baby died in a playpen without toys or objects. This was ruled SIDS.

Of the four deaths, three were female and one male; two were Black, one White and one Asian. One baby's death may have been prevented by prenatal care. It appears that none of the other three deaths were preventable.

Deaths in Children:
Unintentional injuries remained the leading cause of death after a child's first birthday and in 2003 accounted for eight of the18 non-infant deaths. Motor vehicle accidents accounted for four of these. In all four accidents the children/youth were wearing seat belts and there was no alcohol involved.

Two deaths resulted from drowning. Homicide and suicide resulted in three deaths.

One death was a result of "undetermined" cause.

Preventability:
Some of these child deaths may have been caused by actions or conditions that could have been prevented. Possible contributing factors such as driver error, speeding, and poor judgment might have been eliminated by closer adherence to safety rules. Increased adult supervision may also have improved outcome in certain circumstances. The use of alcohol as well as mental health issues may have contributed to the death toll and are obvious areas to examine for prevention education.

Recommendations/Issues Referred to State Team:
In its efforts to focus on preventability, the CDC has replaced the "accident" category for deaths with "unintentional injuries". This has become standard public health terminology and should be used in classifying deaths and in performing child fatality reviews.

Actions Taken:
Dr. Garvey the Health Officer and Co-Chair of this team issued a press release at the time of the last CFRT Report highlighting steps parents can take to ensure child safety and thereby reduce the occurrence of accidental injuries and deaths.

The Montgomery County Team has decided to institute an expanded tracking system for the reviewed cases which captures contributing factors and general comments. This will enhance our review process with regard to the salient factors in a case.

2003 Data Summary

Total Reviewed: 22

Deaths with autopsy reports: 20
Deaths without autopsy reports: 2

By gender:	Male	10	
	Female	12	
By age:	< 1 year	4	
	1-4 years	6	
	5-9 years	3	
	10-14 years	2	
	15-17 years	7	
By race/ethnicity:	White		10
	Black		10
	Other		2

By Means of Death:

Accident	8
Homicide/Suicide	3
Natural	10
Undetermined	1

Table 1:
Montgomery County Childhood Deaths by Age and Manner 2003

	< 1 year	1-4	5-9	10-14	15-17	Total
Accidental	0	1	2	1	4	**8**
Homicide/Suicide	0	1	0	0	2	**3**
Natural	4	3	1	1	1	**10**
Undetermined	0	1	0	0	0	**1**
Total	**4**	**6**	**3**	**2**	**7**	**22**

Table 2:
Montgomery County Deaths by Race/Ethnicity and Manner 2003

	White	Black	Asian	Hispanic	Total
Accidental	4	4	0	0	**8**
Homicide/Suicide	2	1	0	0	**3**
Natural	4	4	1	1	**10**
Undetermined	0	1	0	0	**1**
Total	**10**	**10**	**1**	**1**	**22**

MONTGOMERY COUNTY MULTI-DISCIPLINARY CHILD FATALITY REVIEW TEAM

2003 Membership List

Carol W. Garvey, M.D. – Co-Chair
Health Officer,
Montgomery County Department of Health and Human Services

Barbara Bonnin, L.C.S.W.-C.- Co-Chair
Accreditation Manager
Child Welfare Services
Montgomery County Department of Health and Human Services

Susan Dudley, Coordinator
Office of the State's Attorney for Montgomery County

Dr. Carl Margolis
Deputy Medical Examiner
Montgomery County, Maryland

Brenda Botchway, R.N., B.S.N.
Community Health Nurse II
Injury Prevention Coordinator
Montgomery County Department of Health & Human Services
Public Health Svcs/Health Promotion & Substance Abuse Prevention Program

Beverly Byron, R.N., M.S.N.
Nurse Educator/Program Coordinator, Mont. Cty. Shaken Baby/Family Violence Prevention Program

Laura Chase, Esq.
Sr. Assistant State's Attorney
Office of the State's Attorney for Montgomery County

Nerita Estampador-Ulep, M.D. F.A.A.P.
Physician
Community and School Health Services and Child Protective Services
Montgomery County Department of Health & Human Services

Lorne K. Garrettson, M.D., F.A.A.P.
Professor Emeritus Emory University
Department of Pediatrics

Anne Hoffman, L.C.S.W.-C.
Supervisor
Child Welfare Services
Montgomery County Department of Health & Human Services

Julia Lajoie, M.D., F.A.C.E.P., F.A.A.P.
Medical Director, Sexual Assault & Abuse Center
Shady Grove Adventist Hospital

Min Leong
Student Services
Montgomery County Public Schools

Detective Sally Magee
Family Crimes Division
Montgomery County Police Department

Michael McAdams
Montgomery County Fire & Rescue

Lieutenant Philip C. Raum
Deputy Director
Major Crimes Division
Montgomery County Department of Police

Karen Riibner, L.C.S.W.-C.
Addiction Services
Montgomery County Department of Health & Human Services

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Child Fatality Review
Report of Local Team Activities, 2003
Prince George's County

Highlights and successes of local CFR Team for 2003:

The Prince George's (PG) Child Fatality Review Team successfully conducted two fatality review team meetings during calendar year 2003. This was inspite of several administrative changes within the team's composition. During the past calendar year the team has appointed a new co-chair and has re-located the quarterly team meetings to the PG Health Department. The PG Child Fatality Review Team have a very committed and professional team that will continue to review fatality cases within PG County in a timely and efficient manner in order to provide recommendations to assist families and agencies in preventing future child fatalities.

Social or Health Impact of CFR in your county since its inception:

Through the efforts of several of the fatality team members, the PG Child Fatality Review Team have provided information to several local agencies on fetal infant deaths and several child –related illnesses (i.e. asthma). The team has also developed strategies of what services can be provided to schools and other child servicing agencies to assist professionals in addressing these issues.

The PG Child Fatality Review Team anticipates that during 2004, the team will develop brochures and pamphlets to highlight the team's activities and frequent causes of death of the children within the county. This information will alert the citizen's of the county to the issue of child fatality and what impact this issue has on our community.

Goals for the future of the CFR Team:

The PG County Child Fatality Review Team has established the following goals for 2004:

(1) To continue to meet quarterly to review all child deaths in PG County;
(2) To secure additional citizen participation on the local team;
(3) To encourage representatives from several county departments to identify individuals that will be able to attend fatality meetings for the entire year;
(4) To inform the broader PG community of the work of the fatality review team through workshops, community meetings, etc.; and
(5) To solicit support from the professionals within the county to assist in educating parents and families in the proper care of children, especially in those areas that the team have identified as causes of child deaths;

Membership and leadership of Team:

Facilitator for CFR meetings: Anntinette D. Williams, L.I.C.S.W.

Meetings in 2003:
The PG County Child Fatality Review Team held two meetings during March and October 2003**.**

Case Reviews:
The PG County Review Team reviewed 30 cases during 2003. All cases were referred from the OCME. The PG County Team does not review cases from any other source. During the review process the team was only able to substantiate that approximately 25% of the cases had some previous contact with the Department of Social Services prior to the death occurring. Many of these cases the team found that the family had been known to the Department of Social Services, but the neglect case may have been on another child within the family or the family had been involved with the agency several years prior to the death of the child.

Recommendations by your CFR Team for local action:
The team strongly believes that the recommendations from the 2003 fatality reviews could impact the number of child deaths within the county and should be implemented as follow:

- Teen parents and young adults need to be provided more education in the proper care and supervision of children. This educational support can be offered through the schools, local clinics, physician offices and social services agencies.
- Public service announcements and educational seminars need to focus on the hazards of teen driving. Several deaths within 2003 were due to reckless teen driving.
- County officials need to develop positive outlets for teens, such as recreation centers, to combat the increase homicide of teens within the county due to gangs and drugs.
- County agencies that have the responsibility of providing care for children need to continue working cooperatively together to ensure that appropriate services are delivered to families in a timely manner.
- Support for families that have experienced the death of a child should be readily available and accessible.

Actions taken in or by your jurisdiction:

The recommendations for 2003 have not been submitted to the county administration as of the submission of this report.

Issues referred by Local Team to State Team for statewide consideration:

- **On-going training for local team members;**
- **Funding for local team activities;**
- **Improved accountability of cases referred to local teams, as well as, cases reviewed by local teams;**
- **Dissemination of information from the State team to the local teams in a timely manner; and**
- **Revision of fatality review forms to ensure accuracy and timely completion of information.**

PRINCE GEORGES' COUNTY CHILD FATALITY REVIEW TEAM

VIRGINIA BEISLER, Assistant Director
PG County Health Department
Division of Maternal and child Health
Co-Chair, PG County Child Fatality Review Team
1701 McCormack Drive, Suite 100
Largo, Md. 20774
(301) 883-7858 (Office) Fax #: (301) 883-7897
E-mail: vmbeisler@co.pg.md.us

DR. FLORENCE FOREMAN
Psychological Services, PGCPS

LT. LAWRENCE GORDON, Commander
Homicide Section, Criminal Investigations Division

PHIL NEWSOM, Acting Deputy Director
PG County Department of Social Services

DR. ALBERT ROLLE
Medical Examiner's Office

ANNTINETTE D. WILLIAMS, LICSW
Member, Maryland State Child Fatality Review Team
Co-Chair, PG County Child Fatality Review Team
3906 Donnell Drive
Forestville, Md. 20747
(202) 727-7333 (Office) Fax#: (202) 727-7706
E-mail: ADWilliams@cfsa-dc.org

Child Fatality Review
Report of Local Team Activities, 2003
Queen Anne's County

Highlights and successes of local CFR Team for 2003:
New chair of CFR team, Mary Ann Thompson, attended training in March, 2003. We reviewed our first cases this year.

Social or Health Impact of CFR in your county since its inception:
Provides a mechanism for professionals and citizens of many disciplines to discuss circumstances surrounding the deaths of children in our county, share their expertise, look for trends, and make recommendations, when appropriate to help prevent other deaths.

Goals for the future of the CFR Team:
- Review cases as soon as possible
- Active participation of team members
- Improve investigations and inter-agency coordination
- Recommend changes in legislation, policy and practice to improve the safety of children

Membership and leadership of Team:
Current membership with affiliations (attach list): See attachment
Chair and other officers:

Mary Ann Thompson, RN
Queen Anne's County Health Department
206 North Commerce Street
Centreville, MD 21617
Phone: 410-758-0720, Ext. 324
Fax: 443-262-9357
E-mail: MAT@DHMH.STATE.MD.US

There are no other officers of the CFR Team.
Facilitator for CFR meetings: Mary Ann Thompson

Meetings in 2003:
The Multi-D Team met monthly. There was one meeting of the Child Fatality Review Team in conjunction with Multi-D on July 23, 2003

Case Reviews:
Two cases were reviewed this year.
In neither case were child abuse and neglect substantiated as contributing factors.

Recommendations by your CFR Team for local action:
Continue to have Health Department home visiting staff stress the importance of putting babies to sleep on their back.

Actions taken in or by your CFR Team for local action:
None

I**ssues referred by Local Team to State Team for statewide consideration:**
None

Queen Anne's County
Child Abuse/Neglect Multi-Disciplinary Team
Child Fatality Review Team, 2003

1) Pat Deitz, LCSW-C
2) Mary Ann Thompson, RN
   Q.A. Co. Health Dept.

3) Capt. Martin Knight/Cpl. Mark McGuire/
   Cpl. April Wilson
   Maryland State Police

4) Det/Sgt. John Heddinger/Matt Kempel
   Q.A. Co. Sheriff's Office

5) Frank Kratovil/Lance Richardson
   Q.A.Co. State's Attorney's Office

6) Denise Whitley
   Q.A.Co. Juvenile Justice

7) Chief Ben Cohey
   Centreville Town Police

8) Dominic Romano
   Q.A. Co. Bd. Of Ed.

9) J. Price Shuler
   Mid-Shore Child Care Ad.

10) Mike Clark
    Local Management Bd.

11) Kathy Wright
    Drug & Alcohol Services

12) Barbara Kelly
    Q.A. Co. Mental Health

13) Cathy Dougherty
    Q.A. Co. Social Services

14) Les Hill
    Mid-Shore Council on Domestic Violence

15) Cheryl Peguese
    Parole and Probation

Child Fatality Review
Report of Local Team Activities, 2003
St. Mary's County

Highlights and successes of local CFR Team for 2003:

This year saw the St. Mary's CFR fully functional.

Social or Health Impact of CFR in your County since its inception:

There has been increased awareness among the participant agencies about factors that may contribute to child fatalities – or adverse events.

Goals for the future of the CFR Team:

To meet at least once a year on an as needed basis. Recruit someone from the local rescue squad to join the committee.

Membership and Leadership of Team:

See attached list.

Meetings in 2003:

We met once on March 14, 2003 and reviewed (5) cases. The appointed members of the Child Fatality Review Committee were given the confidentiality agreement to sign.

Case Reviews:

A meeting was held on March 14, 2003 and (5) cases were reviewed. In the cases reviewed (2) were from Natural Causes, (2) were Accidents and (1) is still pending. In (1) Accident case possible criminal charges are pending. One of the Natural death cases is still pending.

Recommendations by your CFR Team for local action:

None

Actions taken in or by your jurisdiction:

None

Issues referred by Local Team to State Team for statewide consideration:

None

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

St. Mary's County Department of Social Services
Ella May Russell, Director

Office of State's Attorney
Michael Stamm, Assistant States Attorney

St. Mary's County Public Schools
Dr. Patricia M. Richardson, Superintendent

Maryland State Police
Bryan Cedar, Barrack Commander

St. Mary's County Sheriff's Office
Richard J. Voorhaar, Sheriff

Walden-Sierra
Kathy O'Brien, Executive Director

St. Mary's County Department of Social Services Attorney
Daniel Armitage, Assistant County Attorney

Mental Health Authority
Alexis Zoss, Executive Director

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

Psychiatrist
Dr. Robert Konkol, Chief of Psychiatry
St. Mary's Hospital

Community Representative
Elizabeth Osborne, Ph.D., St. Mary's College

St. Mary's Hospital Center
Dr. Jeffrey Cole, Chief, Emergency Room

Child Fatality Review
Report of Local Team Activities, 2003
Somerset County

Highlights and successes of local CFR Team for 2003:
Due to time constraints of all committee members, Somerset's CFR Team has not met outside meetings scheduled for actual case reviews. However, these case meetings have been productive and successful in identifying county needs.

Social or Health Impact of CFR in your county since its inception:
Identified the need to educate the community, especially parents and caregivers of infants about the dangers imposed upon these babies when placed in unsafe sleeping situations.

Goals for the future of the CFR Team:
To identify needs of the community and through collaboration with multiple agencies develop plans to meet them in order to prevent future childhood fatalities.

Membership and leadership of Team:
See attached membership list.
Chair and Facilitator: Colleen Parrott, RN MS
Health Officer
Somerset County Health Department
7920 Crisfield Highway
Westover, MD 21871
Phone: 443-523-1700 Fax: 410-651-5680
E-mail: Colleen@dhmh.state.md.us

Meetings in 2003:
One meeting was held this year on November 14, 2003.

Case Reviews:
Two case reviews completed, one of which was a homicide.

Recommendations by your CFR Team for local action:
Explore possibilities to expand education to new parents regarding the safety of infants while sleeping.

Actions taken in or by your jurisdiction:
Plans include contact with the regional medical center where the vast majority of Somerset County babies are born. Also, the LHD will incorporate this education to parents through the home visiting programs provided by the health department.

Issues referred by Local Team to State Team for statewide consideration:
None

Somerset County 2003 Child Fatality Review Team Member

Colleen Parrott
Health Officer
Somerset County Health Department

Suzanne Ruark
DHR Child Case Administrator

Patti Mannion
Director, Somerset County Department
of Social Services

Renee McLaughlin
Somerset County Board of Education

Logan Widdowson
Somerset County States Attorney

Vanessa Pinder
Maryland State Police

Craig Stofko, Director
Addictions
Somerset County Health Department

Dr. Ephrem Daniel
Pediatrician, TLC

Lisa Hartman
Core Service Agency
Somerset County Health Department

Chris Bozick
Therapist, TLC
Mental Health Services

Lee Ann Grosky
Somerset County Health Department

Child Fatality Review
Report of Local Team Activities, 2003
Talbot County, Maryland

Highlights and successes of local CFR Team for 2003: We met three times in 2003. Twice we met to bring the membership or contact information up-to-date. The third time was to do a death review. This was done on 10-21-03.

Social or Health Impact of CFR in your county since its inception: Increased awareness that each child death needs to be reviewed in an effort to prevent similar deaths.

Goals for the future of the CFR Team: Goals will remain the same. Perhaps since we are a small county and do not have many deaths, we should consider combining our team with CFR Teams from neighboring counties.

Membership and leadership of Team: See attached list.
Chairman is: Ann H. Webb, M.D., M.P.H., 410-819-5600 or email annwebb@dhmh.state.md.us
Our members include representatives from DSS, a deputy from the State Attorney's Office, Supervisor of Student Services at the Public Schools, a detective, a representative from the addictions program at the Talbot County Health Department, an attorney for the Dept. of Social Services, a retired pediatrician, the regional manager from the Child Care Administration, a police person from the Easton Police Dept., a registered nurse form FIMIR program, the Director of the Department of Social Services, a member of the Mid Shore Mental Health Systems as well as a member from the State CFR Team.

Meetings in 2003:
Number of CFT meetings and any special presentations/activities: We did not have any special presentations. We met one time to do a death review.

Case Reviews:
Number of case reviews in 2003 regardless of year of death.

We reviewed one case that involved a John Deere Gator, which is a form of an all terrain vehicle (ATV). No drugs, alcohol, or child abuse was uncovered by our investigation.

Recommendations by your CFR Team for local action:
1. We recommended that parents as well as students be made aware of the dangers of all ATV-like vehicles.

2. We recommend that the ATV laws be expanded to include mandatory safety training for all users.

3. We recommend that since the ATVs are used in farming and for commercial uses that the dangers of OTHER people using these vehicles AFTER hours be stressed to the farmer as well as to their children.

4. ATVs should not be used as a social mechanism for children "after farming hours."

5. Grief counseling for students and siblings may be necessary.

Actions taken in or by your jurisdiction: Published an editorial in our local paper.

Issues referred by Local Team to State Team for statewide consideration: The use and abuse of ATVs.

TALBOT COUNTY CFR COMMITTEE
Membership List
October 2003

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
410-819-5627
annwebb@dhmh.state.md.us

April Sharp, L.C.S.W.-C., Chairman
Talbot County Child Protection Team
Talbot County Department of Social Services

Marie Hill, Esq.
Deputy State's Attorney, Talbot County

Lynne Duncan
Supervisor of Student Services
Talbot County Public Schools

H. P. Ketterman
Detective Sergeant
Maryland State Police

Lauren Carter, Clinical Director
Talbot County Health Department Addictions

Patrick J. Palmer, Esq.
Attorney for Talbot Co. Dept. of Social Services

Price Shuler, Regional Manager
Child Care Administration

Yvonne Freeman, Detective
Easton Police Department

Nancy Zinn, M.S., R.N., Executive Director
Mid-Shore Mental Health Systems, Inc.

Kathy Foxwell, R.N.
Talbot County Health Department

Lou Collard, MPH, MPAC
Memorial Hospital at Easton

Cathy Mols, LCSW-C, Director
Talbot Dept. of Social Services

A. George Gilfillan, MD (Guest)

Child Fatality Review
Report of Local Team Activities, 2003
Washington County, Maryland

Highlights and successes of local CFR Team for 2003:

- Speakers from the Washington County Health Department presented on the "I Ask" program and gave updated information on community education plans regarding gun safety.
- The Panel contacted Compassionate Friends, Inc. and explored Grief Counseling options for Washington County residents.
- Washington County Department of Social Services presented on Child Protective Service and COMAR regulations.
- A speaker from the Regional Youth Crisis Hotline located in Frederick, MD has been asked to attend the February 2004 meeting, to ensure Washington County youth have access to the Crisis Hotline Number and so the Panel can take action on publicizing the information.

Social or Health Impact of CFR in your county since its inception:

Planning of the Washington County Child Fatality Review Team began during the years of 1995-1996 prior to the Senate Bill 464 Mandate. The first review was held on October 6, 1997. Reviews have been held quarterly since that time. The review team consists of members from police, fire department, department of social services, state's attorney, board of education, hospital, mental health authority, medical community and medical examiner.

Communication has improved between agencies over the years. The Panel is very action oriented. Each meeting consists of approximately 20 members with great participation from all members present.

Goals for the future of the CFR Team: Follow-up on trends and issues identified in the community. Overall goal of the CFR is to reduce child deaths in the community when possible.

Membership and leadership of Team:
Current membership with affiliations (attach list): The 2003 membership is comprised of 25 individuals from various government, agency, non-profit and volunteer status. (list Attached.)
Chair and other officers: (Please include address, phone number, fax number and e-mail address for the chair of the CFR Team.) Washington County Health Officer, William Christoffel is the chair and Teresa Thorn, Program Director, Child Advocacy Center, serves as staff for the County.
Facilitator for CFR meetings: Jenny Taylor-Grey is the facilitator.

Meetings in 2003:

Number of CRF meeting and any special presentations/activities:

Quarterly meetings were held during 2003 on the following dates:
February 13, 2003
May 8, 2003
August 7, 2003
November 6, 2003

Case Reviews
Number of case reviews in 2003 regardless of year of death. (Number of cases from OCME, from Vital Statistics and/or other sources.) Indicate the number of team reviews but also include the number of cases screened if there is an additional mechanism for other than a complete team review.

Eight cases were reviewed during 2003. Information was received through the OCME office.

Include the number of cases in which child abuse or neglect was substantiated (homicide) and the number in which the team felt abuse and/or neglect were contributory. If the team has guidelines for determination of abuse/neglect, please indicate and include.

One case had history of indicated physical abuse and unsubstantiated neglect. The Washington County Department of Social Services holds membership on the Panel and completes a history on the child and family when a review is scheduled.

Recommendations by your CFR Team for local action:

- **Grief Counseling for parents and siblings.**
- **Youth Crisis Hotline information.**
- **Follow-up on Gun Safety issues from 2002.**

Actions taken in or by your jurisdiction:

- **Speakers from Washington County Health Department presented on the "I Ask" program and gave updated information on the Gun Safety action plans for 2003.**
- **The Panel contacted Compassionate Friends, Inc. and explored Grief Counseling options for Washington County residents.**
- **Washington County Department of Social Services presented on Child Protective Service and COMAR regulations.**
- **A speaker from the Regional Youth Crisis Hotline located in Frederick, MD has been asked to attend the February 2004 meeting. To ensure Washington County youth have access to the Crisis Hotline Number and so the Panel can take action on publicizing the information.**

Issues referred by Local Team or State Team for statewide consideration:
Public awareness: Gun Safety
Suicide Hotline
Grief Counseling
Genetic Counseling

2004

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, 24 North Walnut Street, Suite 206, Hagerstown, Maryland 21740

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

Ken Long, Washington County State's Attorney

Millie Lowman, Executive Director, Parent-Child Center

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

Tim Gordon, Esq., Washington County Department of Social Services (Attorney who represents local department 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 DSS

Cheryl Strong, Washington County Board of Education

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

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

Melanie Reinke, Children's Therapist, CASA

Wicomico County Health Department
108 East Main Street
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410-749-1244
FAX: 410-543-6975
TDD: 410-543-6952
JUDITH A. SENSENBRENNER M.D., M.P.H.
HEALTH OFFICER

Child Fatality Review
Report of Local Team Activities, 2003
Wicomico County Child Fatality Review Team

Highlights and successes of local CFR Team for 2003:
◆ Staff for the county CFR team presented "Challenges for Local Child Fatality Review" at the annual state CFR meeting held in March 2003.
◆ During 2003, the team added an Injury Prevention Specialist from the local health department to assist in developing strategies to increase public awareness and/or education about issues found as a result of the reviews.
◆ During the fourth quarter, the team invited the local medical examiner to attend the reviews. His participation has been valuable in identifying system issues from both a county and regional perspective.

Social or Health Impact of CFR in your county since its inception:
The main impact of the CFR process has been to improve communication and collaboration among agencies in the investigation of child deaths.

Goals for the future of the CFR Team:
1. Improve agency communication and collaboration.
2. Examine findings, determine trends and recommend prevention strategies for child deaths.
3. Develop a protocol for standard investigation of Child Deaths across all jurisdictions.
4. Develop a comprehensive database for FIMR & CFR.

Membership and leadership of Team:
Membership includes representation from Local Department of Social Services, the Local Board of Education, the Child Advocacy Center, Parole and Probation, six law enforcement agencies, the Local Management Board, Life Crisis Center, the Local Health Department, Injury Prevention Program, the State's Attorney Office, the regional medical center, Department of Juvenile Justice, Regional Child Care Administration, Core Service Agency and the local medical examiner. See attached list.

The Chair is:
Judith A. Sensenbrenner, M.D., M.P.H.
Health Officer
Wicomico County Health Department
108 East Main Street
Salisbury, MD 21801
410-749-1244
Fax 410-543-6972
ERIC@dhmh.state.md.us

Facilitator for CFR meetings:
Rose E. Johnson, R.N., M.S.

Meetings in 2003:
The CFR team conducts quarterly luncheon meetings depending on the status of the case(s). During CY 03, the team met in January, April, July and October. Maternal/ Child Health staff from the local health department presented an overview of infant/child deaths in the county for 2000 – 2002.

Case Reviews:
In 2003, the team reviewed a total of seven cases. All cases were referred by the OCME. There was one case (homicide) in which child abuse was substantiated and two cases (one homicide and one sudden unexplained death) in which the team felt neglect/abuse was a contributory factor. Two cases were reviewed again as additional information was obtained from a joint meeting with the Worcester County CFR team. Revised report forms were submitted for those two cases.

The department staff screened a total of 35 fetal and infant/child deaths from death certificates as well as deaths reported by the local hospital. The same staff also screens death certificates for Somerset and Worcester counties as a part the regional Fetal Infant Morality Review (FIMR) project.

Recommendations by your CFR Team for local action:
1. The team has recommended that the Child Advocacy Center be notified by law enforcement of all child deaths. The center has a team of law enforcement and Child Protective Services staff that jointly interview and investigate the cases. At times multiple investigators from different agencies have interviewed the parents/caregivers numerous times resulting in less than a cohesive approach to the investigation. It has been recommended that the Child Advocacy Center be the lead in investigating child deaths.
2. The team recommended that the 911 Operator notify law enforcement of all child injuries/deaths so that immediate investigation may be initiated.
3. The team recommended that training and education of health care providers on the classic warning signs of child abuse be offered locally or regionally.
4. The team recommended that for single occupant accidents involving teen drivers that the Maryland State police conduct a reconstruction review of the accident. Typically, reconstruction review is not conducted for single occupant accidents.
5. The team recommended that when the death of a county resident occurs in another jurisdiction, a representative from the team might participate in the review of that case in the other county.

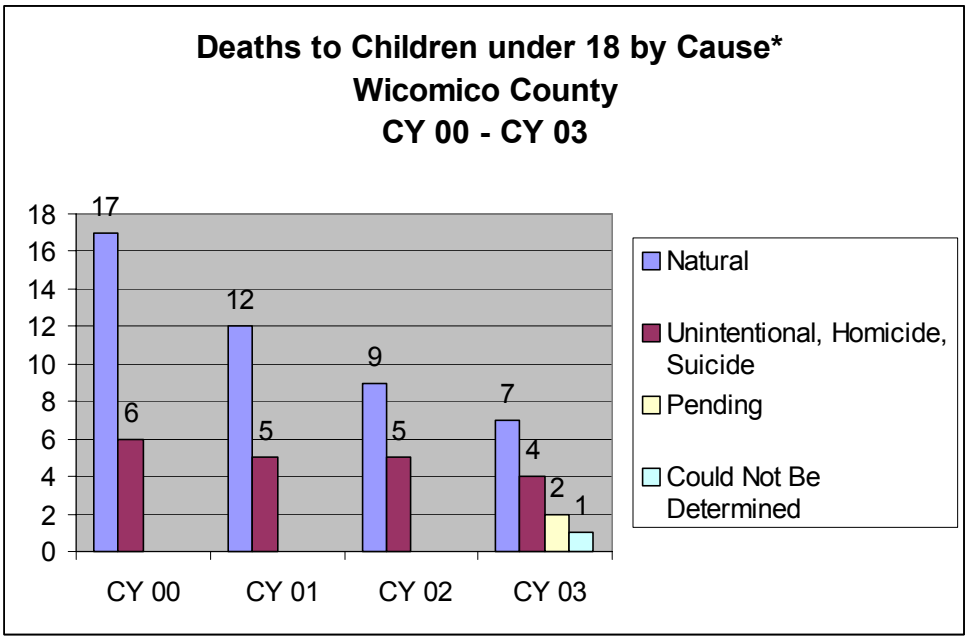
Actions taken in or by your jurisdiction:

1. A letter has been drafted to request law enforcement agencies to notify the Child Advocacy Center of child deaths.
2. CFR staff discussed recommendation #2 with 911 Director. The director felt that this change would require more time for 911 staff and that is not always necessary for law enforcement to respond to each call. It is also not considered a standard practice for other 911 centers. This information was shared with the team at the subsequent meeting**.** It was subsequently recommended to follow-up with the local medical examiner to determine if emergency (ER) staff would be the more appropriate person(s) to contact law enforcement. A request has been made to require the ER staff to initiate notification of law enforcement. This is currently under review.
3. State and local resources have been contacted to identify any training and education opportunities for health care providers on the classic warning signs of child abuse.
4. As a result of two MVAs where drowsy driving was suspected, an injury prevention specialist was invited to join the team to contact and coordinate prevention activities for this county as well as to work cooperatively with Worcester County for any joint efforts. As more cases are reviewed and trends identified, injury prevention programs may be proposed to educate and increase public awareness.
5. A member of the CFR team has participated in the case review of two residents whose deaths occurred in Worcester County.
6. In one case where the team felt abuse was a contributory factor, local law enforcement agreed to locate another child (now an adult) to determine if this adult had been abused as a child as well. The Department of Social Services also agreed to contact another adult who is receiving their services to report any abuse as a child.

Issues referred by Local Team to State Team for statewide consideration:

1. The team requested training and education of health care providers on the classic warning signs of child abuse be offered locally or regionally.
2. The team requested consideration for a standard protocol in how child deaths are reported to law enforcement and investigated by law enforcement.

According to the **2002 Annual Report for Child Deaths in Maryland,** the county death rate for children ages 1- 17 in Wicomico County is significantly higher than the Maryland average based on aggregate data for six years (1996 – 2000). The child death rate increased 26.5% from 32.4 (1991 – 1995) to 41.0 (1996-2000). The actual number of deaths increased by 10 for the respective time periods (30 to 40). A review of death certificates from 2000 – 2003 indicates the number of deaths has remained relatively stable by number and cause of death. See table below.



**Source: Vital Statistics, death certificates, 2000 – 2003*

In CY 2003, according to death certificates, there were a total of 14 deaths to children under age 18. Of those deaths, nine were to children under age 1 one year or infant deaths. The remaining deaths (5) were to children ages 1-17.

The most prevalent cause of death for infants is prematurity (5). The remaining causes of death are for viral syndrome (1), sudden unexplained death syndrome (1), and pending (2). Six of the deaths are to African American (AA) infants and of those, five are male and one female. The remaining deaths (3) are one White Hispanic female, one White non-Hispanic male and one White non-Hispanic female.

The most prevalent cause of death for children ages 1 – 17 is motor vehicle accident (2). Other causes of death are drowning (1), homicide (1) and cancer (1). Of the five deaths, three are AA and two are White. Two Deaths (homicide and MVA) are to AA females, one death (MVA) to AA male, one death (cancer) to White female and one death (drowning) to White male.

CFR Team Membership – Wicomico County

First	Last	Agency/Title
Michelle	**Bailey**	WiCHD -Mental Health
Lt. J.	**Bennett**	Salisbury EMS
Dr. Charlene	**Cooper-Boston c/o Carol Freed**	Wicomico Bd of Ed
Maryrose	**Custer**	PRMC / NICU unit
Kimberly	**Dumpson**	Life Crisis Center
Becky	**Griffin**	WiCHD - Maternal Child Health
Lt. Bill	**Harden**	Maryland State Police
Linda	**Hardman**	Wicomico Partnership
Donna	**Hoch**	Board of Education
Liz	**Ireland**	State's Atty's Office
Chief Paul	**Jackson**	Fruitland Police Dept
Rose	**Johnson**	WICHD, Maternal Child Health - Pgm Mgr
Major Jeffrey	**Livingston**	Salisbury Police Dept.
Sgt. Stephen	**Matthews**	WCSO/CAO
Sherriff Hunter	**Nelms**	Wicomico Cty Sheriff
Sgt. David	**Owens**	Maryland State Police
Marva	**Purnell-Greene**	WCDJJ
Joe	**Rando**	DSS, Assistant Director for Services
Lisa	**Renegar**	WiCHD - CSA
Suzanne	**Ruark**	Childcare Admin
Davis	**Ruark**	State's Atty's Office
Chief Hal	**Saylor**	Delmar Police Dept
Judith	**Sensenbrenner, MD**	WICHD- Health Officer

David	**See**	(Dept. Chief)-Salisbury EMS
Vicki	**Todd**	WiCHD - Maternal Child Health
Pam	**Thompson**	
Capt. Mark	**Tyler**	Salisbury Police Dept.
Chief Allan	**Webster**	Salisbury Police Dept.
Tracy	**Whitman**	WiCHD - Health Promotions
Deborah	**Winder**	Parole & Probation
Debra	**Davis**	Child Advocacy Ctr

Worcester County
Child Fatality Review
2003 Revised Report of Local Team Activities

Highlights and successes of local CFR Team for 2003: Worcester County was successful in identifying a family practice physician to participate in our team. We continue to be very successful in gaining participation from law enforcement agencies who investigate deaths to participate in individual reviews. This year for training purposes, the Worcester County CFR Team reviewed excerpts from a DVD entitled: ICAN Training: Child Death Review Team Overview, Part I Child Death Review: A National Perspective.

Social or Health Impact of CFR in your county since its inception: Worcester County Child Fatality Review Team was initiated in September 1999. Over the four year period that we have been completing reviews, the most predominate cause of child deaths was of smoke inhalation or fire. This prompted an enhanced Smoke Detector Distribution program. Many agencies were involved in this effort.

Goals for the future of the CFR Team: Review Child Fatalities and Near Fatalities that occur in Worcester County to develop strategies to prevent future child deaths**.**

Membership and leadership of Team:
The current membership is attached. Debbie Goeller, Health Officer is the Chairman of the Worcester County Child Fatality Review Team. Rebecca Shockley, Director of Nursing for Worcester County Health Department serves as Facilitator for the team meetings.

Meetings in 2003:
Four meetings were held in 2003.

Case Reviews:
Seven cases were reviewed that included Fatalities (6) and Near Fatalities (1) by the Worcester County Child Fatality Team in 2003. The cause of death for the six fatalities included: 3 automobile accidents, 1 SIDS, 1 drowning, and 1 fall. Of the seven reviews conducted, only 3 (fatalities) were Worcester County Residents. An additional four deaths were reviewed (3 fatalities and 1 near fatality) that occurred in Worcester County but the victims were not residents. Two of the four deaths were Wicomico children and a representative from the Wicomico County Child Fatality Team participated in our review meeting. The other death was an Anne Arundel resident with the incident occurring in Worcester County. We contacted Anne Arundel County and obtained permission to complete the review. There was an additional death that occurred in Worcester County that was presented to the team but a review was not completed because the death certificate indicated that it was a Natural Death.

There were no cases in which child abuse or neglect was substantiated (homicide) or cases in which the team felt abuse and/or neglect were contributory.

Recommendations by your CFR Team for local action:
In the course of the review process the following actions were discussed:
1- New or renovated housing for a dwelling that house 2 families must have sprinklers system.
2- Consider having an accident review completed by a reconstruction team for an accident of a single vehicle if the operator appears at fault.
3- Police vehicles need to be equipped with basic water rescue equipment and support development of Dive Team for Water Rescue in Ocean City.
4- Explore other state and local ordnances regarding warning signs on Balconies and use of netting on balconies for renters with young children.
In January 2004, the team will formulate local recommendations based on the 2003 reviews.

Actions taken in or by your jurisdiction:
SIDS death prompted the health department to distribute "Back to Sleep" literature in Department of Social Services and the Worcester Addictions treatment site in West Ocean City in an effort to enhance our education strategies to include males.
Programs are presented in the spring at the high schools regarding safe driving and avoiding alcohol.
SAMS Box with water rescue equipment (life ring and float rope) was installed at Northside Park in Ocean City.
Public Schools implemented an Ice Safety Awareness Program.

Issues referred by Local Team to State Team for statewide consideration:
In January 2004, the team will formulate any issues for statewide consideration based on the 2003 reviews.

Worcester County Child Fatality Review Team
Members List - 2003

Member	Agency			
Debbie Goeller **Health Officer**	**Worcester County Health Dept.**	**P.O. Box 249** **Snow Hill, MD 21863**	**Phone:** **Fax:**	**410-632-1100** **410-632-0906**
Doris Moxley **Addictions Director**	**Worcester County Health Dept.**			
Lynne Boyd **Mental Health Director**	**Worcester County Health Dept.**			
Becky Shockley **Nursing 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				
Dr. Glenn Arzadon **Physician**	**Atlantic General Health Services**			

Appendix D

State CFR Training
March 6, 2003

8:30 AM	Registration and Coffee
9:00 AM	**Welcome & Why Child Fatality Review in Maryland ?** Sally B. Dolch, M.S.W, Chairperson, State Child Fatality Review Team
	What have we learned so far? Maureen Edwards, M.D., M.P.H.
9:30 AM	**Forensic Investigations** David Fowler, M.D., Chief Medical Examiner Lt. Douglas Wehland, Maryland State Police
10:30 AM	Break
10:40 AM	**Ask the Medical Examiner and Law Enforcement** David Fowler, M.D., Chief Medical Examiner Lt. Douglas Wehland, Maryland State Police
11:15 AM	**Panel Discussion: Challenges for Local Child Fatality Review** Barbara Bonnin, Montgomery County Rose Johnson, R.N., Wicomico County Bill Icenhower, M.D., St. Mary's County Dawn Zulauf, R.N. Baltimore County
12:15 PM	Lunch Provided
1:00 PM	**Panel Discussion: Infant Safety** Scott Krugman, M.D. Beverly Byron, R.N. Carolyn Fowler, Ph.D.
2:00	**Call to Action!**
2:30	Adjourn The State Child Fatality Review Team invites you to join us for our quarterly meeting at 2:45PM.

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 me at hannona@dhmh.state.md.us and I'll send it to you as an attachment. That way you should be able to just click on the site to visit and search.

Appendix F
Recommendations to State CFR from Local CFR Teams
2003 Local CFR Issues for Statewide Consideration

Allegany

None

Anne Arundel

None

Baltimore City

1. Guidance for determination of abuse/neglect in a CFR case review.

2. State recommendations for tackling co-sleeping and asphyxia issues.

3. OCME should have investigators gain more information from families on the circumstances surrounding asthma deaths.

4. Cases from across the state should be examined to determine the degree to which coming from a " chaotic family" influences the risk of a child dying.

5. Interventions should be developed to target young, 11 – 12 year old children who are referred to DJS.

Baltimore County

1. Development of the State CFR database at the Office of the Chief Medical Examiner (OCME). We thank the OCME for support of review activities.

2. Visitors from HRSA MCHB encouraged the Team to promote and contribute to training and support for local CFR Teams, focusing on issues of team management and moving to action, rather than just the review process.

3. We thank Fran Pellerin for her careful screening and referral of cases to the team. Ms. Pellerin is an invaluable resource to CFR.

Calvert

For the State Team to expedite acquisition of autopsy reports and investigative files for local jurisdictions.

Caroline

The changing direction of the Fetal and Infant Mortality Review (FIMR) places emphasis on Community Action initiatives, not case review. This, along with a regional approach, makes it difficult to extrapolate any meaningful data.

Carroll

None

Cecil

Cecil County has requested the State Team facilitate a process for obtaining medical records when a death occurs in a state other than Maryland.

Charles

1. The Team finds that with many of the reviews, only the school has contact with the families, so information is very limited.

2. It is frustrating to conduct reviews without having the final autopsy.

3. It is likely that that some Charles County child fatalities do not get reviewed because the children are flown to hospitals in Prince George's County or Washington D.C. Deaths that are investigated by the police and Child Protective Services are not included in this population of children.

Dorchester County

No report filed

Frederick County

CFR requested a better system of reporting child fatalities to CFR from the Maryland Office of the Medical Examiner.

Garrett

None

Harford

1. The issue of elevator safety compliance in Maryland was a carryover from 2002, as a civil case was settled in 2003 which included safety equipment changes.

2. Encourage trauma centers to cooperate with requests from local CFRs.

Howard

1. There should be a mandatory waiting period for the purchase of ALL guns.

2. Pass a law restricting minors from riding in a vehicle driven by a minor.

Kent

None

Montgomery

In its efforts to focus on preventability, the CDC has replaced the "accident" category for deaths with "unintentional injures". This has become standard public health terminology and should be used in classifying deaths and in performing child fatality reviews.

Prince George's County

1. On-going training for CFR members.

2. Funding for local team activities.

3. Improved accountability of cases referred to local teams, as well as cases reviewed by local teams.

4. Dissemination of information from the State team to the local teams in a timely manner.

5. Revision of fatality review forms to ensure accuracy and timely completion of information.

Queen Anne's County

None

St. Mary's County

None

Somerset County

None

Talbot

The use and abuse of ATV's.

Washington County

Public awareness regarding:

- Gun Safety
- Suicide Hotline
- Grief Counseling
- Genetic Counseling

Wicomico

1. The team requested local or regional training and education of health care providers on the classic warnings signs of child abuse.

2. The team requested development of a standard protocol for the reporting of child deaths to law enforcement and for the investigation of child deaths by law enforcement.

Worcester

In 2004 the team will formulate any issues for statewide consideration based on the 2003 reviews.

TALLY OF LOCAL CFR RECOMMENDATIONS

Autopsy Reports and Investigations (3)

State Team should expedite the acquisition of autopsy reports and investigative files to assist the local CFR

Data Issues/History Gathering (4)

Develop the State CFR database at the OCME.

With the FIMR's changing focus to community action instead of case review, it makes it difficult to extrapolate any meaningful data.

Revise the fatality review forms to ensure accurate and timely completion.

Often the only agency having contact with the family is the school, so information is very limited.

Encourage Collaboration (4)

State Team should help facilitate a process for obtaining medical records when a death occurs in another state.

Determine how to follow up on kids who are flown to hospitals in other counties.

Encourage trauma centers to cooperate with local CFR's.

Timely dissemination of information from the State Team to the local teams.

Public Education (2)

Make recommendations for tackling the co-sleeping and asphyxia issues.

Raise public awareness regarding
- Gun Safety
- Suicide Hotline
- Grief Counseling
- Genetic Counseling

Training of CFR Teams and Other Professionals (4)

Guidance for determination of abuse or neglect in a CFR review.

On-going training for CFR members.

Train health care providers on classic signs of child abuse and neglect.

Improve the accountability of cases referred to and reviewed by local teams.

Other/Interventions/Further study (7)

Interventions should be developed to target young 11-12 year old children who are referred to DJS.

Pass a law restricting minors from riding in vehicles driven by a minor.

Examine the issue of elevator safety compliance.

Develop a standard protocol for reporting child deaths to law enforcement and for the investigation of child deaths by law enforcement.

Review all cases statewide to determine the degree to which coming from a chaotic family influences the risk of a child dying.

Fund local team activities.

Examine the use and misuse of ATVs.

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