

Maryland State Child Fatality Review Guidelines for Local Case Review

Updated September 2017



Acknowledgments

We wish to thank all of the local team members for their contributions to the child fatality review process in Maryland. Time after time, their expertise, ingenuity, and zeal for systemic change continue to encourage identification and implementation of state and local prevention strategies that keep Maryland’s children alive and safe.

Thank You to Local Coordinators

We truly appreciate the time and energy you are investing to help prevent unexpected deaths of children in the state. As a local coordinator, you play a crucial part in leading systematic, collaborative efforts to keep Maryland’s children healthy, safe and protected. This task is not always easy, so we sincerely appreciate your commitment. Without you, the success of the CFR process would not be possible!

Local Child Fatality Review Teams

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Thank You to the State Child Fatality Review Team

The State Child Fatality Review Team is made up of members who volunteer their time and expertise to review data and make recommendations to prevent child deaths. Without their dedication to this cause, the program would not be possible.

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Vision

We envision a Maryland where preventable child deaths are eliminated.

Mission

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

Guiding principles

1. We work cooperatively with other state and local review systems.
2. We base our recommendations on findings and consensus analysis from child death reviews.
3. Our understanding of child deaths must be based on both quantitative and qualitative information from child death reviews and observations.
4. Child fatality review must represent and consider the entire community.
5. Child fatality review must be both multidisciplinary and multi-agency.
6. Support of and advocacy for local child death review is a priority function of the State Child Death Review Team.
7. The State Child Fatality Review Team will build on the work of the local teams.
8. Reviews are conducted with respect for the child and family.
9. Confidentiality must be adhered to in all reviews.

Introduction

The Maryland Child Fatality Review (CFR) Guidelines for Local Case Review are designed to assist jurisdictions in the formation and operation of local CFR teams. Child fatality review is mandated by law, but communities may approach the operation of CFR with varied methods, expectations, and resources.

The guidelines are organized to clarify legal and/or other requirements that local CFR teams must observe, and serve as a reference and source of information for local child fatality review teams.

The Maryland Department of Health may make changes at any time to this document for clarification or correction.

Background

Health General Article, §5-701- §5-709 established the Maryland State Child Fatality Review Program in 1999. The Maryland CFR Program is comprised of 24 local child fatality review teams and a State Child Fatality Review Team. Local CFR teams review all unexpected deaths of children under the age of 18 in their jurisdictions, referred by the Office of the Chief Medical Examiner (OCME), and make community-level recommendations for the prevention of child deaths. The state CFR Team reviews statewide child fatality review data to make state agency-level recommendations for the prevention of child deaths.

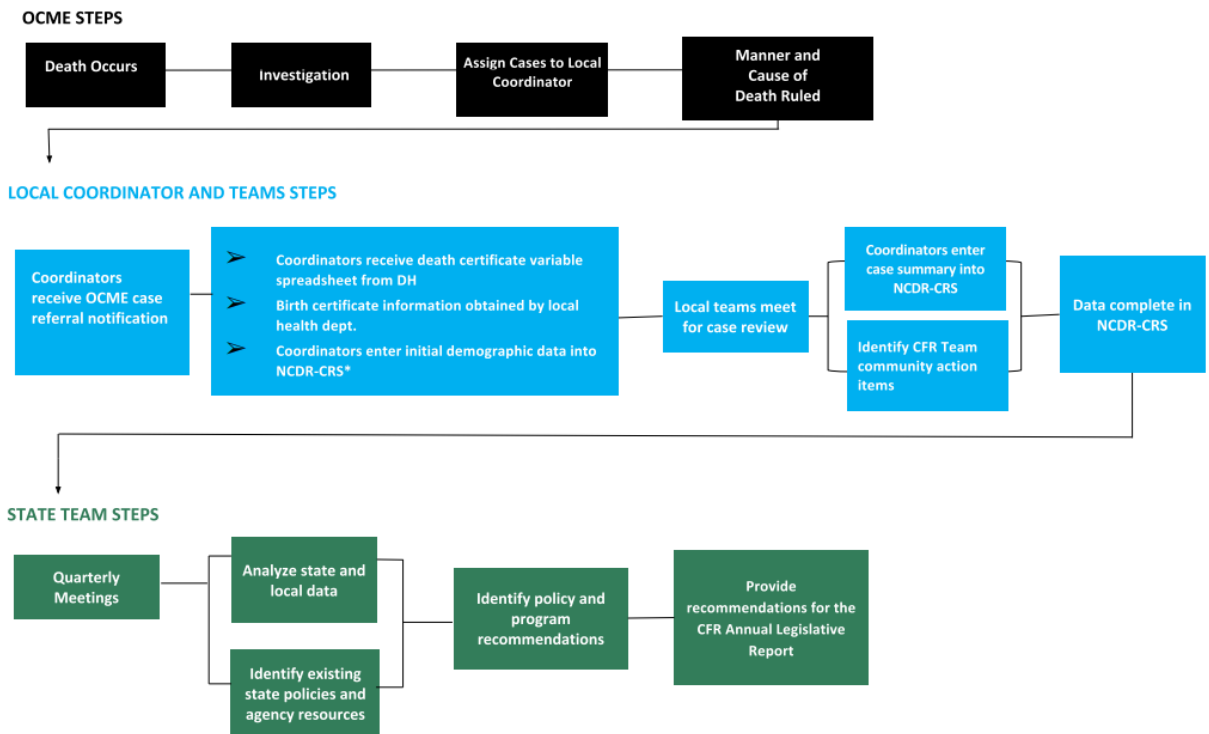
The purpose of the Maryland CFR Program is to prevent child deaths by:

- 1) Understanding the causes and incidence of child deaths;
- 2) Developing local and state recommendations to prevent child deaths; and
- 3) Implementing changes within local and state systems and agencies to prevent child deaths.

The program is administered by the Maternal and Child Health Bureau of the Maryland Department of Health (MDH). The State CFR Coordinator provides technical assistance and support to local CFR teams and staffs the state CFR Team. More information can be found on the Maryland CFR website at <http://phpa.dhmh.maryland.gov/Pages/crf-home.aspx>.

The National Center for Fatality Review and Prevention (National CFRP) <https://www.ncfrp.org> is a resource for state and local CFR teams that promotes, supports and enhances death review methodology and activities at the state, community and national levels.

Local CFR Timeline



*National Child Death Review Case Reporting System

Local Reviews: Operating Principle

The death of a child is a sentinel event indicating a systems problem. The circumstances surrounding a child's death are multidimensional, and deserve systematic, multi-agency review. The review should focus on prevention and should lead to effective recommendations and actions to prevent deaths and to keep children healthy, safe and protected.

Goals:

Child Fatality Review (CFR)¹ is an action-oriented means for communities to:

- Better understand the causes and incidence of child deaths;
- Develop and implement evidence-based policies, practices, and programs;
- Improve child health, safety and protection; and
- Prevent future child deaths.

Objectives:

- Conduct a multi-agency, multi-disciplinary review of every unexpected child death in Maryland
- Collect and enter case data into the National Child Death Review Case Reporting System (NCDR-CRS)
- Report to DHMH quarterly on suggested evidence-based policies, practices, and programs
- Implement prevention policies, practices, and programs

Local CFR Teams: Structure and Membership

Maryland Health-Gen Code § 5-705 mandates the establishment of local multi-agency and multi-disciplinary local CFR teams. Maryland has 23 county-based review teams and one city team (Baltimore).

¹ Also called Child Death Review or CDR in many states.

Frequency of Meetings

Maryland Health-Gen Code § 5-706 requires local CFR teams to meet at least **quarterly**.

Suggestion: Many fatality review teams find it difficult to have time to develop recommendations, implement them, or report on their findings during normally scheduled case review meetings. Local teams should look at the full range of their responsibilities in Maryland Health-Gen Code § 5-706 when deciding on a meeting schedule.

Local CFR Team Coordinator

The local CFR team is coordinated by a staff member of the local health department. The local CFR team coordinator plays a vital role in recruiting members, maintaining partnerships with members, developing case summaries, and entering case data into NCDR-CRS.

Common Coordinator Duties:

- Recruit team members
- Coordinate and facilitate local review team meetings
- Distribute and collect signed confidentiality agreements from all team members including ad hoc members and guests
- Compile case summaries to be reviewed and distribute to local review team members at the beginning of each meeting
- Ensure that all cases are entered into NCDR-CRS
- Compile and submit quarterly reports to state CFR team coordinator
- Oversee and maintain yearly budget
- Promote team success by following through with recommendations and prevention initiatives and activities
- Maintain contact with State CFR Coordinator

Local CFR Team Chair

The law requires each local team to elect a chairperson by majority vote. The chairperson may be any one of the team members. The chairperson serves at the discretion of the team; term length should be established by the team.

Suggested Chairperson Duties:

- Schedule and chair team meetings
- Ensure team meeting notices are received by all team members
- Ensure that team operates according to protocols adopted by the team and those

- required by law and by the State CFR Team
- Provide any additional support to team coordinator

Core Team Membership

Maryland Health-Gen Article § 5-705(b), stipulates that local team membership shall be drawn from the individuals, organizations, agencies, and areas of expertise listed below, when possible. Those listed may designate representatives from their departments or offices to represent them on the team.

- The county health officer;
- The director of the local Department of Social Services;
- The State's Attorney;
- The superintendent of schools;
- A representative from Child Protective Services (CPS);
- A State, county, or municipal law enforcement officer;
- The director of the county substance abuse treatment program;
- The chief attorney who represents the local Department of Social Services in child welfare proceedings;
- A representative of the local Early Childhood Advisory Council;
- The director of the county mental health agency or core service agency;
- A pediatrician with experience in diagnosing and treating injuries and child abuse and neglect, appointed by the county health officer;
- A psychiatrist or psychologist with experience in child abuse and neglect or child injury, appointed by the director of the county mental health agency, core service agency, or local behavioral health authority; and
- A member of the general public with interest or expertise in the prevention and treatment of child abuse and neglect, appointed by the county health officer.

Additional Members

The law does not specify the size of the team. *Maryland Health-Gen Article § 5-705 (b) (13)* provides for additional members recommended by the team and appointed by the county health officer.

Other potential members to consider include:

- Neonatologist;
- Clergy;
- Funeral home representative;
- Other healthcare professional (e.g., pediatric nurse, pathologist, emergency medicine physician)

- Emergency medical services representative; and
- Experts in Sudden Infant Death Syndrome (SIDS) and child injury prevention.

Ad Hoc Members and Guests

Additional persons may be invited to participate as consultants or ad hoc members when reviewing particular cases, rather than being permanent team members. Due to the sensitive nature of the case review, ad hoc members and guests are **required** to receive approval in advance by the Chair and **must** sign a confidentiality agreement.

Roles of Local Team Members

The role of local CFR team members can be flexible to meet the needs of particular communities. Each member should provide the team with information from their records, serve as a liaison to their professional counterparts, provide definitions of their profession's terminology, interpret procedures and policies of their agency, and explain the legal responsibilities or limitations of their profession.

All team members must have a clear understanding of their own and other professionals' and agencies' roles and responsibilities in response to child fatalities. Members should also be aware of and respect the expertise and resources offered by each profession and agency. The cooperation and collaboration of each team member is the key to a well-coordinated child fatality response system.

Public Health Members

Local team members from public health agencies contribute to the prevention perspective and goal of local child fatality reviews. Public health agencies facilitate and coordinate preventive health services and community health education programs. Representatives from public health agencies can provide vital records and epidemiological risk profiles of families for early detection and prevention of child fatalities, as well as information about local public health services. Public health representatives ultimately help build bridges between their institutions and other agencies and serve as liaisons between the local team and the community's other health care providers.

Mental Health Professionals

The mental health representative on a local review team can provide information and insight regarding the psychological issues related to events that caused a child death. Mental health representatives may suggest when counseling or other mental health service referrals for family members may be appropriate.

Local Law Enforcement

Law enforcement is often the first to respond to a scene of a child death. A team member from the local law enforcement agency can provide the team with information on the case status and investigation of the death scene as well as the criminal histories of family members and suspects. Importantly, a law enforcement team member can provide insight into how the team can improve coordination with law enforcement agencies to improve the child fatality review process and develop strategies to prevent future child death.

Child Protective Services (CPS)

CPS, within the local Department of Social Services, is responsible for investigating allegations of child abuse or neglect and for recommending or providing services to children and families when abuse or neglect is alleged or confirmed. A CPS representative is the liaison to the broader child welfare agency and many community resources. CPS representatives are especially helpful in that they can educate the team regarding child protection issues and how the local CPS system works. Additionally, CPS representatives can leverage specialized knowledge to suggest better intervention and prevention strategies and identify ways to integrate these strategies into the system.

School Districts

Educators, school nurses, and counselors can provide local teams with perspective on child health, growth and development. School representatives can also describe the policies and procedures guiding the services and supports they provide for children and their families. Their presence at child fatality reviews enhances the delivery of support services and interventions. Representatives from school districts are also able to provide leadership in implementing local CFR team prevention recommendations.

Emergency Medical Services (EMS)

EMS personnel are frequently first on the scene when a child dies or is seriously injured. EMS usually prepare run records of their response that they can share at reviews. EMS personnel usually obtain critical information regarding the scene and circumstances, including the behavior of witnesses. EMS also has well-established relationships with local hospitals and may be able to provide a perspective from these institutions.

Review Options for Smaller Jurisdictions

Maryland law requires that **all** local CFR teams meet quarterly to review fatalities. However, several jurisdictions receive few referrals, which can make meeting quarterly challenging. The

following are some ways in which local CFR teams with few cases may work more efficiently.

Regionalized Team Structure: Two or more jurisdictions may choose to collaborate to establish a single regional review team. Should a regional team be desired, a regional team shall execute a memorandum of understanding on membership, staffing, and operation. The State CFR Coordinator should be informed when teams are considering regionalizing.

Multidisciplinary Learning Opportunities: Local CFR teams might meet to study and discuss a local issue or an issue of interest related to child fatality if no cases have been referred during that quarter.

The following are some examples of learning opportunities smaller jurisdictions have facilitated in the past:

- A review of the State Team annual legislative report
- A review of local trends
- Presentations by guest speakers on topics that impact child safety such as CPS referral and investigation processes, all-terrain vehicle (ATV) safety, and emergency room (ER) visits related to influenza
- Discussion of high risk topics in the community such as an increase in substance exposed newborns
- Planning a community prevention activity based on case review findings, such as writing a letter to the local paper, developing a PSA campaign, writing an “alert” to be sent to community groups or health providers, etc.
- Examining other social determinants of health that may be contributing to child fatality. Example of possible social determinants can be found on the Healthy People 2020 website at <https://www.healthypeople.gov/2020/about/foundation-health-measures/Determinants-of-Health>.

Reviewing Near Fatalities: The State CFR Team and State CFR Coordinator can provide guidance on how local CFR teams might review cases of near fatalities or serious injuries in addition to referred cases.

Additional Responsibilities of Local CFR Teams

Reports and Recommendations

Quarterly Report

Local teams are required to submit quarterly reports. The following information should be included in the report:

- Number of cases referred by the OCME
- Number of cases reviewed
- Summary of meetings and activities
- Sign-in sheet from each meeting
- Actions taken to implement systems changes recommended by the local team within member agencies
- Recommendations on needed changes to State and local law, policy, and practice to prevent child deaths

Annual Report

On June 30th local teams will be asked to submit an annual report of the meetings and activities of the previous calendar year.

Making Recommendations and Implementing Prevention Strategies

There are a number of tools that can be utilized to help guide prevention efforts. One useful tool is that of the *Spectrum of Prevention* model. Developed by Larry Cohen, MSW in 1983, this model provides a comprehensive framework that describes seven levels at which prevention activities can and should take place. Further detail on this model is available at <http://cchealth.org/prevention/spectrum/>.

Importantly, this model helps remind us that while public health problems are often complex, all prevention efforts do not necessarily require extensive funding or intense planning.

Please refer to the “Determining Best Practices for Prevention” section for further information on formulating policy and program recommendations.

Case Identification and Assignment

Maryland Health-Gen Article § 5-309 (f) requires the OCME to notify the coordinator of a local child fatality review team of unexpected child death cases for the jurisdiction in which the child resided. **Local CFR teams are required to review all cases referred by the OCME. Once notification is received, local CFR coordinators should enter demographic information into the NCDR-CRS database.**

To facilitate this process, each month the OCME sends each team an electronic notification of

deaths in the team's jurisdiction from the previous month, including autopsy results when available. The following preliminary information is included by the OCME, when available.

- Child's name;
- Child's ethnicity and gender;
- Child's age (under the age of 18);
- Child's residence;
- Mother's name and address (both maiden and current names are usually required for background checks and prior CPS involvement);
 - If mother's name is unavailable, use father's or legal guardian's name and address; and
- Brief description of other circumstances surrounding death, if available.

Cause and manner of death are also listed on the case referral form and are the official decision of the OCME and will be entered on the death certificate.

Cause of death: The specific reason the child died, e.g., blunt force head injury, gunshot, pneumonia (*note that this may be pending when a referral is first sent*).

Manner of death (*note that this is separate from cause of death and can only be one of the five manners listed*):

- Homicide
- Suicide
- Accidental
- Undetermined
- Natural

Autopsy reports on children may require more than a month and often considerably longer to complete. OCME staff may in some cases share preliminary information with a local team. Local CFR teams should review cases in a timely manner, but often the autopsy results are critical to an informed review. Delayed autopsy reports **should not** prevent entry of available case data into NCDR-CRS.

Local CFR coordinators may contact the medical examiner on the case directly or they may contact the state CFR Coordinator for assistance in obtaining information on a pending case or autopsy report. A medical examiner may be available to participate in a review meeting via speakerphone.

Reviewable Deaths

All unexpected deaths of children under the age of 18 are referred by the OCME. Case assignment is determined by the deceased child's jurisdiction of residence, regardless of the jurisdiction in which the death occurred.

Cross-Jurisdictional Deaths

If a child dies outside of his/her jurisdiction of residence, the law requires the OCME to refer the death to the local team of the child's **residence**. However, to facilitate an effective CFR process, upon notification, the local coordinator from the child's jurisdiction of residence needs to contact the local coordinator where the child's death occurred to obtain records and information pertinent to the CFR process. In addition, the local coordinator needs to notify the state CFR coordinator of any and all cases outside of their jurisdiction.

Example: If a child who lives in Howard County dies in a motor vehicle accident in Baltimore City, the Howard County CFR team needs to coordinate with the Baltimore City coordinator to obtain details and records surrounding the death, such as the EMS and police reports.

Out-of-State Deaths

Deaths of Maryland residents occurring out-of-state present a difficult challenge, as there is no process of notification, and Maryland law granting CFR team's access to records does not apply elsewhere.

Other Reviewable Cases

Local CFR teams are permitted, but not required, to review cases of child deaths not referred by the OCME, including those due to acute or chronic illnesses. If the CFR team decides to review a non-OCME referred case the team would probably need to submit a specific data request to Vital Statistics Administration (VSA) in order to identify such cases in the jurisdiction. Examining causes of or contributing factors to fatal childhood illnesses or other conditions, including socioeconomic and environmental factors, may be productive and add to the overall knowledge base. However, the goal of the CFR process is to prevent unexpected child deaths and improve systems, **thus local CFR teams must prioritize OCME referred cases.**

Near Fatalities

There are no requirements for identifying cases of "near fatality" and no official method available for notifying CFR team leaders of near fatalities. Methods of finding cases will depend on the of cases to be reviewed.

Example: If there are several near drownings in one jurisdiction. Local CFR teams can try to establish a method to identify and obtain those records from local agencies.

“Near fatality” cases can be identified systematically from hospital databases, or from newspaper reports or from the input of local team members.

The State team defines “near fatality” as: “a child requiring professional health care for a life threatening event or for serious or critical condition as a result of a potentially preventable injury or illness.”

Information Sharing

Child death review teams are not a mechanism for criticizing or second-guessing an agency’s, institution’s or individual’s decisions. They are a forum for the sharing of information essential to improve a community’s response to child fatalities. The team may find that needed services in a case were not rendered or were inadequate. Such a finding is an opportunity for systems improvement in the future.

Organizations should have their own internal training, quality assurance, and management process to deal with specific problems. Background and current information from local CFR review team members’ records and other sources is necessary to assess circumstances of death. Team members are encouraged to use the knowledge obtained during confidential reviews to assist their individual agency in gathering additional information in a pending investigation of a specific case.

Members of a local team are not permitted to reveal outside of the meeting confidential information disclosed during the meeting. The one exception to this requirement, is that team members may bring back to their agency information about the case that will be used to further the agency’s work with that specific case (e.g., for investigation, to support survivors, to protect other children, or to improve services). The review meeting itself may not be cited as a source of information in agency records.

Records Needed for Review

Below is a list of common documents pertinent to a case of a child’s death across types of death.

- Scene investigation reports and photos
- Autopsy reports/Office of Chief Medical Examiner reports
- Law enforcement reports
- EMS trip reports

- Medical records/Emergency Department records
- Prior and most recent Child Protective Services (CPS) history on child or caregivers
- Media articles related to incident
- School records (per Family Educational Rights and Privacy Act regulations)

Requesting Records

Local CFR teams have statutory authority to request and receive records regarding a deceased child as needed to carry out their duties. *Maryland Health-Gen Article § 5-707* stipulates that, upon request of the chair of a local CFR team, the local team **shall be immediately** provided access to information and records maintained by health care providers (including dental and mental health records), law enforcement and court systems, and local and State agencies (including birth certificates, medical examiner investigative information, and records of social services agencies that provided services to the child or family, such as CPS). Requests for records are particularly useful for acquiring information from agencies that are not represented on the team (e.g., medical information from hospitals or providers, law enforcement investigative information, and records of a social services organization that provided services to the child). Examples of request for records forms are available in the [National Center for Fatality Review and Prevention \(National CFRP\) Program Manual](#).

In the event a child from one jurisdiction dies in another Maryland jurisdiction, local CFR coordinators need to collaborate with the corresponding local team coordinator in that jurisdiction to obtain records and any additional information pertaining to the child's death. Currently there is no formal process for reviewing the death of a child that happens outside a local team's jurisdiction; however, local teams are expected to collaborate to assure that the case is appropriately reviewed.

Team Operating Procedures

Seven Steps to Facilitating an Effective Child Fatality Review

1. State the goals and intended outcomes of the meeting

Start the meeting by stating the goals and intended outcomes of the meeting. Clarify any expectations of team members and standards for group etiquette. This can be done at each meeting or annually as preferred.

Suggestion: *Child death is a sensitive topic and discussion of these cases as a group can be challenging. Reading a statement of purpose at the start of each meeting can help keep*

team members aware of the purpose and set the tone for a collaborative meeting. The following is an example shared by the Frederick County CFR team:

“CFR needs to be a nonjudgmental, unbiased environment where members can express their questions and thoughts. This must be done with respect to other committee members and to the members of the victim’s family. The CFR Team’s role is not to place blame or disrespect the family’s beliefs or family’s practices. Our mission is to review child deaths to understand the circumstances around those deaths and to recommend strategies to prevent future child deaths.”

2. Share, question, and clarify all case information

Develop a consistent agenda for the sharing of case information. Invite each member of the team to contribute any information pertaining to the child, regardless of whether or not it seems relevant at the outset. Foster an environment that is welcoming of questions and robust discussion.

3. Summarize and discuss the investigation

Once case information has been shared, begin to summarize the findings for the group so that members can begin considering recommendations.

Suggestion: *It can be very helpful for the team coordinator to summarize the records, listed by agency or team member, in a document prior to the meeting. This document can act as the agenda for the meeting. Please review “Sample CFR Case Summary Form” in Appendix II of this guide. We thank the Baltimore City CFR team for sharing this example with us.*

4. Discuss the delivery of services

Questions to consider:

- What services was the family receiving and what systems were involved?
- Were there gaps in these services that this case has highlighted?
- Is there a need for any follow-up services to the family or community such as bereavement or other outreach?

5. Identify risk factors

Questions to consider:

- What common risk factors were present in the case?
- What protective factors could have been promoted by the systems involved with the family?

6. Recommend systems improvements

Encourage the group to make recommendations for systems improvements for each case.

7. Identify implementable prevention recommendations

Identify how the local team or its member agencies and organizations can implement the recommendations for systems improvements in each case.

Confidentiality and Immunity

Data obtained through NCDR-CRS is confidential. **Any misuse or inappropriate disclosure of the data is subject to penalties under applicable laws and cause for revocation of access to NCDR-CRS.** If you are uncertain about use of NCDR-CRS data, please contact the State CFR Coordinator for clarification.

Confidentiality

At a review team meeting, all data and information regarding the death of an identified child is confidential. Confidentiality agreements are **required** to be signed by every person who attends a case review meeting. A suggested CFR confidentiality form provided by the National CFRP Program Manual is available in the Attachments section of this guide. Jurisdictions using their own forms should submit a copy to the State CFR Coordinator for approval. Local CFR teams are encouraged to discuss and sign confidentiality forms at every meeting, to reinforce the importance of confidentiality of information.

Team members come to each meeting with their own records and leave with their own records. No transfer of written materials on specific cases should occur at review meetings. Any summary documents created by the local CFR coordinator should be returned to the Coordinator at the end of the meeting. **These summary documents may be stored by the local CFR coordinator in a secured, locked location (e.g. file cabinet) with limited access for up to 5 years.*** The guiding principle is that the review team meeting itself is the place given privilege in the law to discuss confidential information. The state CFR team applies this principle by requiring that only information that is a matter of public record (such as that on a death certificate) be distributed to the team before or after the meeting. (* As outlined in Maryland's Department of General Services Records Management - Records Retention and Disposal Schedule)

Team members may make notes only for the use of their agency, or for local coordinators to transfer information to the data system following the case review, according to agency confidentiality guidelines. The official record of the case discussion is limited to the electronic Case Report Form. Other deliberations of the team that are not case specific may of course be recorded and handled according to the judgment of the group.

Public Meetings

The meetings are closed to the public and not subject to Title 10, Subtitle 5 of the State Government Article when the team is discussing individual cases of child deaths. When the team is not discussing individual cases of child deaths, the meetings of local CFR teams shall be open to the public and are subject to Title 10, Subtitle 5 of the State Government Article. However, at a public meeting, no information identifying a deceased child, a family member, guardian or caretaker of a deceased child, or an alleged or suspected perpetrator of abuse or neglect, may be disclosed. Neither may information regarding the involvement of any agency with the deceased child or family be disclosed during a public meeting (See *Maryland Health-General Article §5-708* in Appendix III).

Immunity

Maryland Health-Gen Article §5-709(f)(1) grants local CFR team members exemption from disclosure, subpoena, discovery, or introduction into evidence in a civil or criminal proceeding (See *Maryland Health-General Article §5-7089* in Appendix III).

Case Entry and Completion

The importance of prompt entry of case data into NCDR-CRS cannot be overstated. At the state level, NCDR-CRS is one of the most important data sources used in maternal and child health programs and decision-making. The state relies on accurate and prompt data entry into this system.

Ensuring Data Quality

Whenever possible, teams should enter all available case information directly into NCDR-CRS as it is received. This helps ensure efficiency of the data entry process and helps coordinators catch potential entry errors as case reports are completed. Further, prompt entry of case data into the system helps identify a case that may have been assigned to the wrong jurisdiction and allows for timely transfer of the case to the correct jurisdiction for review.

Coordinators are encouraged to enter as much information as possible into the system before the review. At a minimum, coordinators should enter basic demographic information upon receiving notifications from the OCME, even if the official, un-pended cause and manner of death have not been determined. If you find that certain case information is missing or pending (e.g., official cause of death), complete as much of the abstraction as possible to ensure timely case entry.

Below are a several tips to help ensure the quality of case data:

- **Missing versus Unknown Variables:** A response of ‘unknown’ indicates that the team discussed the variable and that the information was not known or available. A missing or blank variable indicates that the question was skipped or not mentioned or discussed during the review.
- **Omission/Commission:** Completion of this section is important because it provides information about any human behaviors that may be involved in a child’s death. For further information on how to complete this section, please refer to *Section I. Acts of Omission or Commission including Poor Supervision, Child Abuse & Neglect, Assaults and Suicide* of the NCRPCD’s CDR Case Reporting System Data Dictionary available at https://www.ncfrp.org/tools_and_resources/tools-for-teams/.
 - Acts of Commission** are deliberate and intentional and include overt actions that cause the child’s death.
Examples: Someone shooting a child with a gun and the bullet wound causing the death; a caregiver shaking an infant so hard as to cause severe head trauma and death
 - Acts of Omission** are the failure to act which directly and/or substantially contributes to the death of the child.
Examples: An unsupervised toddler falling into an open residential pool and drowning; a caregiver failing to get necessary medical attention for an ill child who died of the untreated illness
- **Identifiers:** Do not include identifiers (such as names, birthdates, and addresses) in NCDR-CRS to help protect the identities of deceased children and their families.

Data Analysis

Local CFR teams will be able to access their own data through NCDR-CRS. This system allows teams to generate specific, standardized data about each case they review. The most important information about a child death from a local case review is the team’s findings in the case. This may include risk factors, judgments about prevention, or systems improvement opportunities, and team observations. When aggregated statewide, case data are very useful in understanding trends in child fatalities across the state and allowing jurisdictions to compare their information with others.

NCDR-CRS data generated by local CFR teams ultimately afford the State CFR team the opportunity to compile and analyze quantitative state statistical information and local information, looking for state level advocacy needs, systems improvements and prevention opportunities.

Technical Assistance and Training

The State CFR Team may develop formal training materials or programs that will be required for local team members. The State CFR Coordinator has material for training and orienting team members and materials can also be found on the National CFRP website at <https://www.ncfrp.org/>.

The State CFR Team holds an annual meeting each November to provide an opportunity for local CFR coordinators and team members to network, share best practices, and learn about injury and violence-related issues. In addition, the state CFR Team and/or the National CFRP may provide webinars and other learning opportunities throughout the year.

The National Center for Fatality Review and Prevention offers several webinars on topics related to child death review. Archived webinars are very helpful and can be found at https://www.ncfrp.org/tools_and_resources/archived-webinars-presentations/.

Determining Best Practices for Prevention



A Spectrum Model of Prevention

There are a number of tools that can be utilized to help guide prevention efforts. One useful tool is the *Spectrum of Prevention* model. Developed by Larry Cohen, MSW in 1983, this model provides a comprehensive framework that describes seven levels at which prevention activities can and should take place. Further details of this model are available at <http://cchealth.org/prevention/spectrum/>. Importantly, this model helps remind us that while public health problems are often complex, all prevention efforts do not necessarily require extensive funding or intense planning.

The Spectrum of Prevention Model in Action

- **Policy & Legislation:** Local CFR teams can influence policy and legislation by contacting legislators and elected officials.
- **Organizational Practices:** Local CFR teams should adopt regulations, modify standard operating procedures and shape norms to help improve the health and safety of

children.

- **Coalitions & Networks:** Local CFR teams should foster network building of individuals and groups to achieve broader goals and make an impact.
- **Training Providers:** Local CFR teams should educate medical professionals, courts, teachers, coaches, school administrators, and anyone else who has contact with children and their families.
- **Community Education:** Local CFR teams should engage their local communities with information and resources to promote health and safety and to prevent child injury or death.
- **Individual Knowledge & Skills:** Local CFR teams should work to educate at-risk families and equip these families with the tools needed for prevention.

Teams should keep in mind that the Spectrum of Prevention model is flexible and should not hesitate to adapt the model based on past experiences, successes, and challenges.

Taking Action to Prevent Child Deaths

The purpose of child fatality review is for both local CFR teams and the state CFR team to take action to prevent child deaths. Examples of local level community actions include the following:

- Working with partner agencies to change or develop new policies
- Public education and media campaigns
- Improving communication between local agencies and organizations
- Examining and improving existing procedures for screening and referral
- Education for providers

Examples of actions taken after local CFR reviews across Maryland

- Created a community action plan to host a family health and safety fair
- Conducted trainings for child care providers
- Distributed educational materials on safe sleep practices
- Provided information and marketing materials to obstetric and pediatric offices regarding the “Look Before You Lock” campaign
- Recruited new team members with specialized knowledge on certain child welfare issues
- Collaborated with Fetal and Infant Mortality Review on a variety of activities implemented to raise awareness about infant sleep-related deaths
- Visited local food establishments to provide information and education on recalls for controlled dangerous substances that were affecting children
- Expanded family access to cribs and age-appropriate car seats through the Cribs for Kids and Car Seat Assistance programs

There are many preventive action steps that local CFR teams can implement to prevent child deaths in local jurisdictions. Implementation can be challenging, especially with limited resources, but with the right partnerships and collaborations it is possible to improve local systems to prevent child deaths. The Maryland State Child Fatality Review Team and the National Center for Fatality Review and Prevention are resources for guidance and support; local teams should feel free to use these resources for additional assistance with child fatality review.

Frequently Asked Questions

Is my team required to meet even when there are no cases to review?

Yes, *Maryland Health-Gen Code § 5-706* requires local CFR teams to meet at least **quarterly**. However, several jurisdictions receive few referrals, which can make meeting quarterly challenging. The following are some ways in which local teams with few cases may work more efficiently.

Regionalized Team Structure: Two or more jurisdictions may choose to collaborate to establish a single a regional review team. Should a regional team be desired, a regional team shall execute a memorandum of understanding on membership, staffing, and operation. The State CFR Coordinator should be informed when teams are considering regionalizing.

Multidisciplinary Learning Opportunities: Local CFR teams might meet to study and discuss a local issue or an issue of interest related to child fatality if no cases have been referred during that quarter.

The following are some examples of learning opportunities smaller jurisdictions have facilitated in the past:

- A review of the State Team annual legislative report
- A review of local trends
- Presentations by guest speakers on topics that impact child safety such as CPS referral and investigation processes, all-terrain vehicle (ATV) safety, and emergency room (ER) visits related to influenza
- Discussion of high risk topics in the community such as an increase in substance exposed newborns
- Writing a letter to the local Planning and Zoning Commission to obtain better fencing around waterways in residential areas

Reviewing Near Fatalities: The State CFR Team and State CFR Coordinator can provide guidance on how local CFR teams might review cases of near fatalities or serious injuries in addition to any referred.

Is my team required to review every child death that happens in my jurisdiction?

Local CFR teams are **required** to review every death referred by the OCME. Occasionally, the team may learn of a child death in their county that was not referred. This may be due to several factors, such as a natural cause of death, or a change in the child's residence. Teams may elect to review these cases in addition to those referred by the OCME. However, the team is not required

to review cases that have not been referred by the OCME.

What happens if a child from my jurisdiction dies in another jurisdiction/out-of-state?

If a child resides in one Maryland jurisdiction but dies in another Maryland jurisdiction, the death will be referred to the jurisdiction of the child’s residence. However, if the child dies out-of-state, no referral will be made.

If a child from your jurisdiction dies in another jurisdiction, you need to coordinate with the local CFR coordinator in the county where the child died in order to obtain information surrounding the death.

*Example: If a child that lives in Howard County dies in a motor vehicle accident in Baltimore City, the Howard County CFR team **must** coordinate with the Baltimore City coordinator to obtain details and records surrounding the death such as the EMS and police reports.*

What do I do if the cause/manner of death for a case is still pending?

The case reporting system contains a field for “cause and manner of death from death certificate.” In Maryland, cases are referred electronically by the OCME to the local child fatality review coordinator and so the official cause and manner from the referral should be used. It can take time for the OCME to complete the investigation and autopsy. It is appropriate to wait until the cause and manner have been un-pended to review the case. However, if it takes longer than 6 weeks to un-pend the cause of death for a case, please reach out to the State CFR Coordinator for assistance.

How do I obtain the birth and death certificates for a case in review?

Birth certificates can be requested from the Vital Statistics Administration. Please contact the State CFR Coordinator for information on contacting VSA.

Death certificates are sent by the State’s database specialist to local coordinators. Please contact Debbie Walpole at debbie.walpole@maryland.gov for more information on obtaining death certificates.

If the local review team disagrees with the official manner and cause of death, where can I document this information?

In the National CFRP database, you can document this information in question L7. This question is multiple choice, you can select more than one response. In addition to entering in question L7, please include in narrative.

How long can I retain case information and case records?

No transfer of written materials on specific cases should occur at review meetings. Any summary documents (see Appendix II) created by the local CFR coordinator should be returned to the Coordinator at the end of the meeting. **These summary documents may be stored by the local CFR coordinator in a secured, locked location with limited access for up to 5 years.*** The guiding principle is that the review team meeting itself is the place given privilege in the law to discuss confidential information.

Where can I get technical assistance?

The State CFR Coordinator is able to provide technical assistance for local teams around issues such as effective case reviews, improving collaborations, and case entry into the case reporting system. The State CFR Coordinator is also able to bring issues to the State CFR Team when appropriate. The State CFR Coordinator should be your primary contact for technical assistance. There is also a wealth of information on the National Center for Fatality Review and Prevention website at <https://www.ncfrp.org/>.

Please reach out with any additional questions to:

Jennifer Herrera
State CFR Coordinator
Jennifer.herrera@maryland.gov

Appendix I. Sample CFR Team Confidentiality Agreement

The purpose of a Child Fatality Review Team is to conduct a multiagency, systematic examination of each child death in _____ County/City by the _____ County/City CFR team.

In order to assure a coordinated response that fully addresses all systemic concerns surrounding child fatalities, all relevant data, including historical information concerning the deceased child and his or her family, must be shared at team reviews. Much of this information is protected from disclosure by law, especially medical and child abuse/neglect information. Therefore, team reviews are closed to the public, and confidential information cannot be lawfully discussed unless the public is excluded. In no case should any team member or designee disclose any information regarding team decisions outside the team, other than pursuant to team confidentiality guidelines. Failure to observe this procedure may violate various confidentiality

statutes that contain penalties. Any agency team member may make a public statement about the general purpose or nature of the child death review process, as long as it is not identified with a specific case.

The undersigned agree to abide by the terms of this confidentiality agreement.

Name

Agency

Appendix II. Sample Case Summary Form

CFR Case Summary Form – (Date)	
Case:	
Name:	
Next of Kin:	
DOB:	
Age:	
Sex:	
Race/Ethnicity:	
Manner of Death:	
Cause of Death:	
Date of Death:	
Time of incident:	
Hospital:	

Prenatal Care:	
Pediatric Care:	
Cause and Circumstances of Unnatural Death:	
Sleep Environment Factors:	
Sleeping inside a crib/bassinet	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Sleeping outside a crib/bassinet	<input type="checkbox"/> Crib in home but not being used <input type="checkbox"/> No crib in home <input type="checkbox"/> Unknown whether crib in home
Bed-sharing	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Not sleeping on back	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Unsafe bedding/toys	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Prenatal smoke exposure	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Primary supervisor at time of death	<input type="checkbox"/> Mother <input type="checkbox"/> Father/Partner <input type="checkbox"/> Other _____
OCME:	
Fire Department:	
Police Department:	
Hospital:	
Department of Juvenile Service:	
State Attorney's Office:	
Public School System:	
Insurance:	
Home visiting:	

Preventability Summary	
Could this death have been prevented?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Could not be determined
Did an act of commission or omission lead to this death?	<input type="checkbox"/> Directly caused it <input type="checkbox"/> Contributed to it <input type="checkbox"/> Neither
What was the act?	
Was the death related to child maltreatment (abuse or neglect)?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Could not be determined
What was the maltreatment?	

Appendix III. Statute

Health-General Article, §5-705-709, Annotated Code of Maryland

§ 5-705 - Local child fatality review teams - Established

(a) (1) Except as provided in paragraph (2) of this subsection, there shall be a multidisciplinary and multiagency child fatality review team in each county.

(2) Instead of a local team in each county, two or more counties may agree to establish a single multicounty local team.

(3) A multicounty local team shall execute a memorandum of understanding on membership, staffing, and operation.

(b) The local team membership shall be drawn from the following individuals, organizations, agencies, and areas of expertise, when available:

- (1) The county health officer;
- (2) The director of the local department of social services;
- (3) The State's Attorney;

- (4) The superintendent of schools;
 - (5) A State, county, or municipal law enforcement officer;
 - (6) The director of the county substance abuse treatment program;
 - (7) The chief attorney who represents the local department of social services in child welfare proceedings;
 - (8) The Early Childhood Development Division in the State Department of Education;
 - (9) The director of the county mental health agency or core service agency;
 - (10) A pediatrician with experience in diagnosing and treating injuries and child abuse and neglect, appointed by the county health officer;
 - (11) A psychiatrist or psychologist with experience in child abuse and neglect or child injury, appointed by the director of the county mental health agency or core service agency;
 - (12) A member of the general public with interest or expertise in the prevention and treatment of child abuse and neglect, appointed by the county health officer; and
 - (13) Any other individual necessary to the work of the local team, recommended by the local team and appointed by the county health officer.
- (c) The members described under subsection (b)(1) through (9) of this section may designate representatives from their departments or offices to represent them on the local team.
- (d) From among its members, each local team shall elect a chairperson by majority vote.

§ 5-706 - Local child fatality review teams - Purpose; duties

- (a) The purpose of the local team is to prevent child deaths by:
- (1) Promoting cooperation and coordination among agencies involved in investigations of child deaths or in providing services to surviving family members;
 - (2) Developing an understanding of the causes and incidence of child deaths in the county;

- (3) Developing plans for and recommending changes within the agencies the members represent to prevent child deaths; and
 - (4) Advising the State Team on changes to law, policy, or practice to prevent child deaths.
- (b) To achieve its purpose, the local team shall:
- (1) In consultation with the State Team, establish and implement a protocol for the local team;
 - (2) Set as its goal the investigation of child deaths in accordance with national standards;
 - (3) Meet at least quarterly to review the status of child fatality cases, recommend actions to improve coordination of services and investigations among member agencies, and recommend actions within the member agencies to prevent child deaths;
 - (4) Collect and maintain data as required by the State Team;
 - (5) Provide requested reports to the State Team, including discussion of individual cases, steps taken to improve coordination of services and investigations, steps taken to implement changes recommended by the local team within member agencies, and recommendations on needed changes to State and local law, policy, and practice to prevent child deaths; and
 - (6) In consultation with the State Team:
 - (i) Define “near fatality”; and
 - (ii) Develop procedures and protocols that local teams and the State Team may use to review cases of near fatality.
 - (c) In addition to the duties specified in subsection (b) of this section, a local team may investigate the information and records of a child convicted of a crime or adjudicated as having committed a delinquent act that caused a death or near fatality described in § 5-707 of this subtitle.

§ 5-707 – Local child fatality review teams – Investigations

Upon request of the chair of the local team and as necessary to carry out the local team's

purpose and duties, the local team shall be immediately provided:

- (1) By a provider of medical care, including dental and mental health care, with access to information and records regarding a child whose death is being reviewed by the local team, including information on prenatal care; and
- (2) Access to all information and records maintained by any State or local government agency, including birth certificates, law enforcement investigative information, medical examiner investigative information, parole and probation information and records, and information and records of a social services agency that provided services to the child or family.

§ 5-708 - Meetings

(a) Meetings of the State Team and of local teams shall be closed to the public and not subject to Title 10, Subtitle 5 of the State Government Article when the State Team or local teams are discussing individual cases of child deaths.

(b) Except as provided in subsection (c) of this section, meetings of the State Team and of local teams shall be open to the public and subject to Title 10, Subtitle 5 of the State Government Article when the State Team or local team is not discussing individual cases of child deaths.

(c) (1) Information identifying a deceased child, a family member, a guardian or caretaker of a deceased child, or an alleged or suspected perpetrator of abuse or neglect upon a child, may not be disclosed during a public meeting.

(2) Information regarding the involvement of any agency with the deceased child or family may not be disclosed during a public meeting.

(d) This section does not prohibit the State Team or a local team from requesting the attendance at a team meeting of a person who has information relevant to the team's exercise of its purpose and duties.

(e) Violation of this section is a misdemeanor and is punishable by a fine not exceeding \$500 or imprisonment not exceeding 90 days or both.

§ 5-709 – Disclosure of records and information

(a) All information and records acquired by the State Team or by a local team, in the exercise of its purpose and duties under this subtitle, are confidential, exempt from disclosure under Title 10, Subtitle 6 of the State Government Article, and may only be disclosed as necessary to carry out the team's duties and purposes.

- (b) Statistical compilations of data that do not contain any information that would permit the identification of any person to be ascertained are public records.
- (c) Reports of the State Team and of a local team that do not contain any information that would permit the identification of any person to be ascertained are public information.
- (d) Except as necessary to carry out a team's purpose and duties, members of a team and persons attending a team meeting may not disclose what transpired at a meeting that is not public under § 5-708 of this subtitle or any information the disclosure of which is prohibited by this section.
- (e) Members of a team, persons attending a team meeting, and persons who present information to a team may not be questioned in any civil or criminal proceeding regarding information presented in or opinions formed as a result of a meeting. This subsection does not prohibit a person from testifying to information obtained independently of the team or that is public information.
- (f) (1) Except as provided in paragraph (2) of this subsection, information, documents, and records of the State Team or of a local team are not subject to subpoena, discovery, or introduction into evidence in any civil or criminal proceeding.
- (2) Information, documents, and records otherwise available from other sources are not immune from subpoena, discovery, or introduction into evidence through those sources solely because they were presented during proceedings of the team or are maintained by a team.
- (g) Violation of this section is a misdemeanor and is punishable by a fine not exceeding \$500 or imprisonment not exceeding 90 days or both.