Maryland
DEPARTMENT OF HEALTH

Public Health Services Administration

Maryland State Child Fatality Review Guidelines for Local Case Review

Revised Date: January 2025

Maryland Department of Health · Public Health Services Administration · Maternal and Child Health Bureau
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Acknowledgments

We wish to thank all 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.

Cooperative Data Agreement Acknowledgment

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Introduction

The Maryland State Child Fatality Review Guidelines for Local Case Review are designed to assist jurisdictions in the formation and operation of local Child Fatality Review (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 CFR teams.

The Maryland Department of Health (MDH) may make changes at any time to this document for clarification or correction. Please visit the MDH CFR webpage for the most up-to-date information.

Background

Health General Article, §5-701- §5-709 (see Appendix V) established the Maryland State Child Fatality Review Program in 1999. CFR is a systematic, multi-agency, and multi-disciplinary review of unexpected child deaths. The Maryland CFR Program is composed of 24 local and one State CFR 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 CFR 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.

State Child Fatality Review Team

The State Child Fatality Review Team is made up of 25 multi-disciplinary members who work on preventing child deaths by developing an understanding of the causes and incidence of child deaths; developing plans for and implementing changes within the agencies represented on the State CFR Team to prevent child deaths, and to advise the Governor, General Assembly, and the public on changes to law, policy, and practice to prevent child death. Maryland law also requires the establishment of local teams composed of multi-agency and multi-disciplinary team members to convene regular meetings to review unexpected child deaths. Without their dedication to this cause, Maryland's CFR program would not be possible. Below are the current or incumbent members of the State CFR Team and their position.

Current State Child Fatality Review Team Members

Position	Current/Incumbent
Attorney General	• Karen Anderson-Scott, designee
Chief Medical Examiner	• Pamela Ferreria, MD, MPH, designee
Secretary of Human Services	• Richard Lichenstein, MD, FAAP, designee
Secretary of Health	• Shelly Choo, MD, MPH, designee
State Superintendent of Schools	• Alicia L. Mezu, MSN/Ed, BSN, BS, RN, designee
Secretary of Juvenile Services	• Jennifer Maehr, MD, FAAP, designee
Special Secretary for Children, Youth and Families	• Permanent vacancy due to the sunset of the Office for Children, Youth, and Families in 200
Secretary of State Police	• Amanda Voggenreiter, designee
President of the State's Attorneys' Association	• Christine Dulla Rickard, designee
Chief of the Division of Vital Records	• Monique Wilson, DrPH, designee

Position	Current/Incumbent
Representative of the Center for Infant and Child Loss	• LaToya Bates, LCSW-C
Director of the Behavioral Health Administration	• Laura Torres, LCSW-C, designee
Pediatricians with experience in diagnosing and treating injuries and child abuse and neglect, Governor appointed from a list submitted by the State Chapter of the American Academy of Pediatrics	• Adrian Jamon Holloway, MD • Brian R. E. Schultz, MD
Members of the general public with interest or expertise in child safety and welfare, Governor appointed, including child advocates, CASA volunteers, health and mental health professionals, and attorneys who represent children	• Anntinette Williams, LICSW • Cynthia Wright Johnson • Ivone Kim, MD • Jennifer A. Thomas • Joyce P. Williams, DNP • Laurel Moody, RN, MS • Mary C. Gentile, LCSW-C • Richelle J. Cricks, CNM, MSN • Shantell Roberts • Sharyn King

Local Child Fatality Review Teams

In Maryland there is a local CFR team for each county and Baltimore City, totaling 24 local CFR teams. Local coordinators play a crucial part in leading systematic, collaborative efforts to keep Maryland's children healthy, safe, and protected. Local coordinators are encouraged to reach out to other coordinators via the SQI listserv: dlmchbsqicoordinators_mdh@maryland.gov. You may also contact the State CFR Coordinator to connect with others individually via email.

Vision

We envision a Maryland where preventable child deaths are eliminated.

Mission

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

Guiding Principles

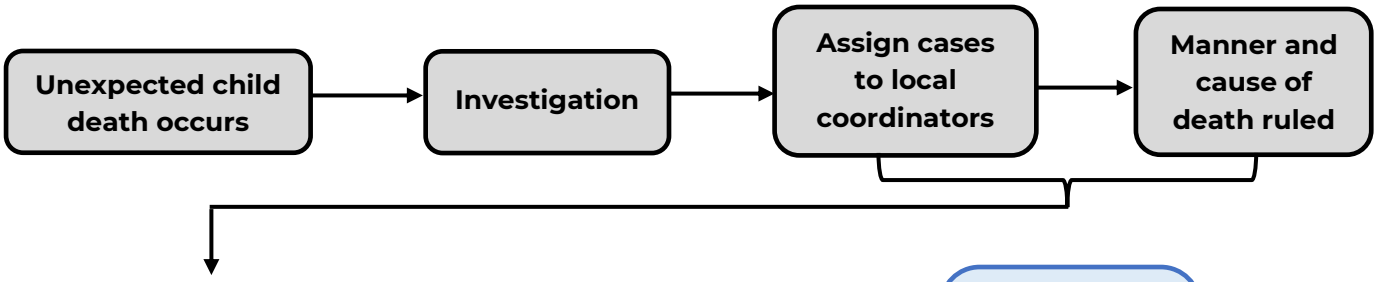
- We work cooperatively with other state and local review systems.
- We base our recommendations on findings and consensus analysis from child death reviews.
- Our understanding of child deaths must be based on both quantitative and qualitative information from child death reviews and observations.
-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

The CFR program is administered by MDH's Maternal and Child Health Bureau (MCHB). The State CFR coordinator provides technical assistance and support to local CFR teams and staffs the State CFR Team. Find more information at health.maryland.gov/phpa/mch/Pages/cfr-home.aspx. The National Center for Fatality Review and Prevention (NCFRP), 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.

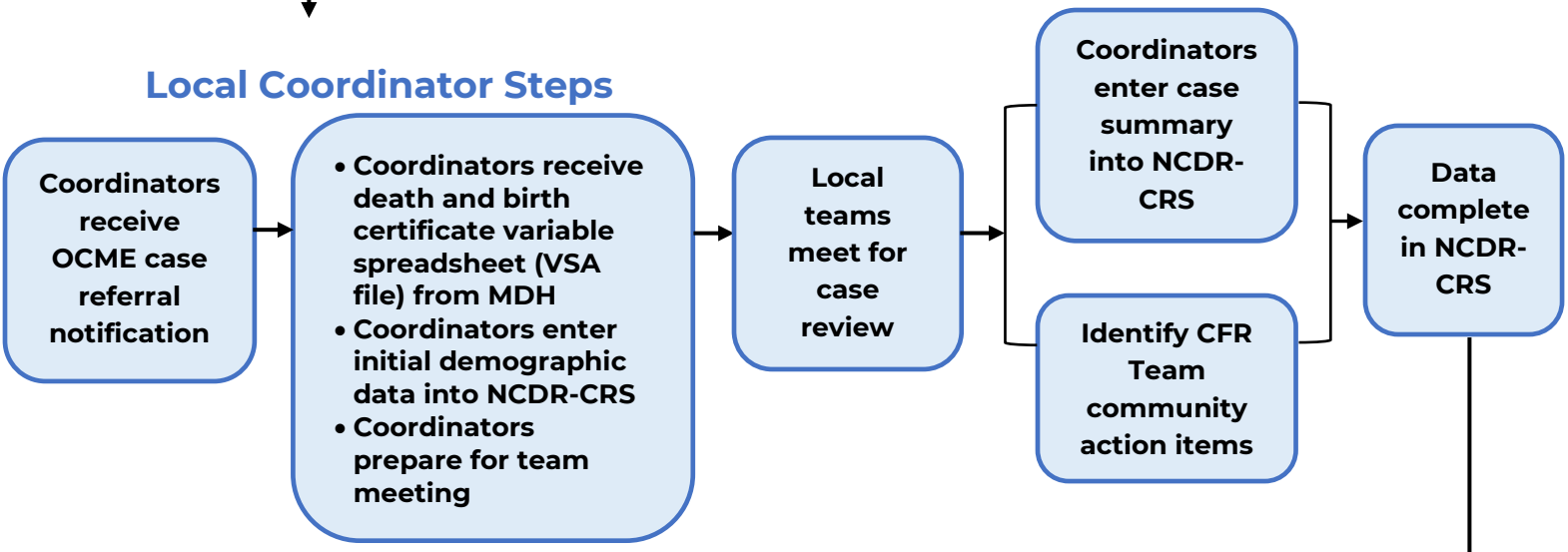
Maryland Child Fatality Review Steps

The specific steps that span OCME, local coordinators and the State CFR Team are outlined below.

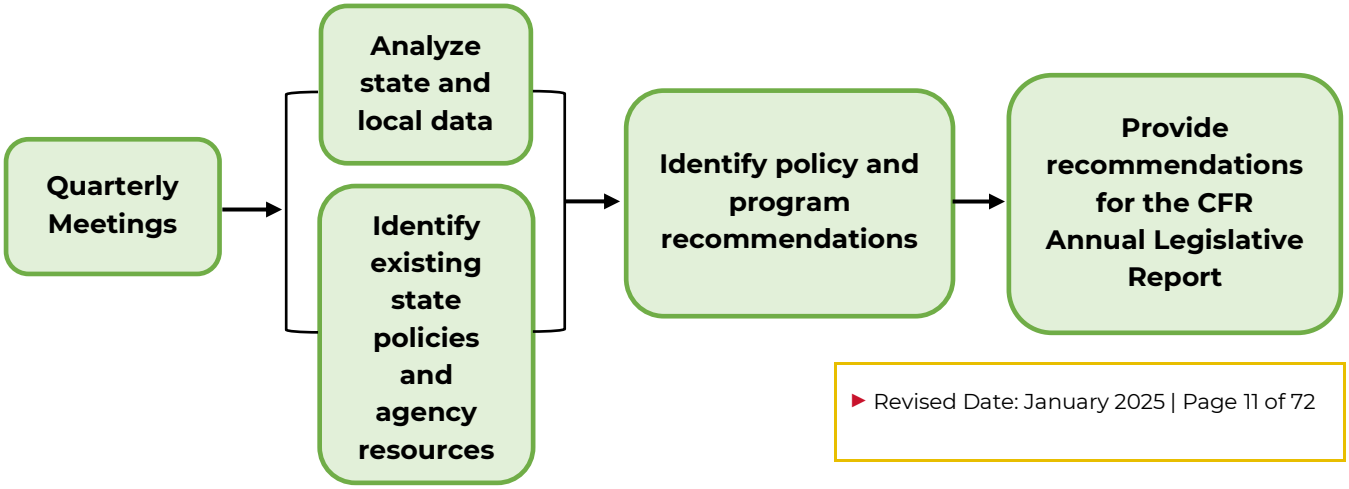
OCME Steps to Case Identification



Local Coordinator Steps



State Team Steps



Local Reviews: Operating Principles

The death of a child is a sentinel event indicating a system-level 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 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 Fatality Review Case Reporting System (NFR-CRS)
- Report to MDH 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 City). All teams receive funding from the Maryland Department of Health to support their fatality review processes.

Frequency of Meetings

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

quarterly. Many fatality review teams find it challenging to have time to develop recommendations, implement them, and 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 the NFR-CRS.

Common Local Coordinator Duties:

- Recruit and train 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
- Encourage sharing information for effective case reviews
- Compile case summaries to be reviewed and distributed to local review team members at the beginning of each meeting
- Ensure that all cases are entered into NFR-CRS
- Compile and submit quarterly reports to State CFR Coordinator
- Oversee and maintain yearly budget
- Track findings from reviews to impact prevention recommendations
- Promote team success by following through with recommendations and prevention initiatives and activities
- Maintain contact with State CFR Coordinator
- Ensure that team members have opportunities to debrief and address vicarious trauma from discussions

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 to ensure effective and productive case review meetings

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.

Per state legislation, other potential members to consider include:

- Neonatologist;
- Clergy;
- Funeral home representative;
- Other healthcare professionals (e.g., pediatric nurse, pathologist, emergency medicine physician)
- Emergency medical services representative; and
- Experts in Sudden Infant Death Syndrome (SIDS) and child injury prevention.

Additionally, the NCFRP recommends the following list of potential CFR team members that may also add to a robust and effective case review:

- Attorney for Child Protective Services
- Child Care Licensing Investigator or authority
- Domestic Violence Expert
- Fire Department
- Juvenile Justice
- Local Hospital
- Mental Health Provider

- Maternal and Child Health representative
- Child Abuse Prevention Organization
- Non-Profit Community Groups
- Housing Authority
- Home Visiting/ Outreach Programs
- Disabilities Protection and Advocacy Agency
- Safe Sleep and/or Sudden Unexpected Infant Death Program
- Substance Abuse Treatment or Prevention Program
- Vital Statistics representative
- Prevention Partners
- Other members as needed based on case

Ad Hoc Members and Guests

Additional persons may be invited to participate as consultants or ad hoc members when reviewing specific 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 (Appendix I).

Confidentiality agreements may be signed using a wet or digital signature.

Roles of Local Team Members

The role of local CFR team members can be flexible to meet the needs of 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.

Most CFR teams will have at least a representative from the following agencies or professions:

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.

Pediatrician or Family Health Provider

Pediatricians provide a clinical perspective in child death cases. They can provide insight into the clinical context, community needs, and possible intervention in the health care setting. Participation in the American Academy of Pediatrics (AAP) allows them to collaborate with other professionals on issues related directly to child death review in the AAP Section on Child Death Review and Prevention.

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.

Prosecutor/District Attorney

District Attorneys can provide valuable insight into the legal process and procedures. This knowledge is often very useful to review teams. Because of state regulations, some states, including Maryland, are only allowed to review cases that are not in civil or criminal litigation. Other states review current cases, and their findings may help the district attorney determine their approach to a death. Some state teams have subpoena power, and this may have an impact on the types of cases that they review.

Medical Examiner

Medical Examiners are uniquely involved in the death investigation and autopsy processes and determine the cause and manner of death. In Maryland, they set investigation protocols for use by local investigators. They are an integral part of the child fatality review process.

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 the first on the scene when a child dies or is seriously injured. EMS personnel usually prepare run records of their response that they can share at reviews. They oftentimes 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.

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's death. Mental health representatives may suggest when counseling or other mental health service referrals for family members may be appropriate.

Review Options for Smaller Jurisdictions

Maryland law requires that all local CFR teams meet at least quarterly (at least 4 times a year) to review fatalities. However, several jurisdictions receive few referrals, which can make meeting quarterly challenging. The following are a few 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 a few examples of learning opportunities smaller jurisdictions have facilitated in the past:

- A review of the State Team annual legislative report
- A review of local child health and fatality 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 to 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. Examples of possible social determinants of health can be found on the Healthy People 2030 website.

If your jurisdiction receives a lower number of cases and you have questions about quarterly meeting topics, contact the State CFR Coordinator.

Additional Responsibilities of Local CFR Teams

Quarterly Report

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

- Number of OCME referred deaths received during the last quarter
- Number of OCME referred deaths reviewed
- Number of cases referred from other sources
- Number of cases reviewed from other sources
- Number of cases with completed entry in the National Death Review Database (NCCDR) within 30 days of review
- Number of cases reviewed using CDC Case SUID registry algorithm
- Number of days from receipt of OCME investigation report to case review of ALL SUID deaths
- Number of days from date of review to completed data entry in NFR-CRS for SUID cases
- Number of letters sent to hospitals of birth for infant sleep-related deaths

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.

Making Recommendations and Implementing Prevention Strategies

Preparing Recommendations after CFR Review

Recommendations from CFR provide critical context and guidance to help design relevant prevention programs, policies, and interventions. The review team does not have to be the group that sees the prevention action through from start to finish. Instead, they can play the important role of being the catalyst for change.

To develop effective, actionable recommendations, local teams must review findings. Though some teams may do so more frequently, the NCFRP recommends that review teams should review all their data and findings

every 12-18 months, identifying the prominent, leading risk factors across their causes of death. By doing this on a regular basis, CFR teams will maximize their impact, addressing risk factors that drive fatalities from multiple causes.

Recommendations should be formulated using the SMARTIE method to ensure they are actionable. Recommendations should be:

- **S**trategic
- **M**easurable
- **A**mbitious
- **R**ealistic
- **T**ime-bound
- **I**nclusive
- **E**quitable

Local coordinators should ensure that local review teams are familiar with this method of formulating recommendations and connecting members to training, if needed. If the local coordinator is unfamiliar with the SMARTIE method, they may use the resources linked in this section or reach out to the State CFR Coordinator for technical assistance.

Implementing Prevention Strategies

There are several 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 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 cchealth.org/services-and-programs/prevention/the-spectrum-of-prevention.

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 on page 45 of this Guidelines 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 NFR-CRS database.

To facilitate this process, the OCME sends each team an electronic notification of deaths in the team's jurisdiction, 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 underlying medical condition, disease or injury that begins a lethal chain of events resulting in death, e.g., blunt force head injury, gunshot, pneumonia (*note that this may be pending when a referral is first sent*).

Manner of Death

The way in which a death occurs (*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 NFR-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.

Reviewable Deaths

Pursuant to Statute §5-309, OCME provides case criteria for deaths to be reported to the Office of the Chief Medical Examiner. All unexpected deaths of children under the age of 18 are referred to jurisdictions 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 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 access to records does not apply elsewhere. We recommend you contact the State CFR Coordinator if you are aware of or notified of a death that occurs out of state.

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 the Vital Statistics Administration (VSA) 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 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 fatality 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 non-identifiable 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.

- Death scene investigation reports including scene reports, interviews and photos
- Autopsy reports/Office of Chief Medical Examiner reports
- Law enforcement reports
- EMS trip reports
- Medical records/Emergency records concerning the child, including birth records and health histories
- Information on the social services provided to the family or child, including prior and most recent CPS history, Women, Infants and Children (WIC) and family planning
- Media articles related to the incident
- Relevant information on the child's education experience and school records (per Family Educational Right and Privacy Act regulations)
- Information on court proceedings or other legal matters resulting from the death
- Information on the person(s) supervising the child at the time of death
- Relevant family information, including siblings, biological and stepparents, extended family, living conditions, neighborhood, prior child deaths, etc.

Depending on how the child died, additional information and sources may need to be identified. Teams should take a broad, whole-child approach when considering what relevant records may shed light on the case.

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 in 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

Individual case discussions should be done in an organized, systematic format. This will ensure that the team has allowed all important information to be shared among agencies and can focus on identifying key risk factors and findings that will help to decide on prevention actions and system improvement changes.

It is imperative to remember that child fatality review should not be viewed as an opportunity for different agencies or community groups to gather and discuss blame related to an individual death or shame each other regarding their actions related to a death. It is not meant to be a peer review or second

guessing of family members, individual staff performance, or agency actions. Although agency actions may be discussed during a review, it is critically important that team members use their understanding of the circumstances leading to a child's death to focus on the future: **what can be done differently and better in the future to protect children and keep them safe and healthy**.

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. 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 it seems relevant at the outset. Foster an environment that is welcoming of questions and robust discussion.

- **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. 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.

- **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?

- **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?

3. Discuss systems improvements

Once all the facts of the case have been shared, clarified, and discussed, there may be issues involving agency response that need to be addressed. The team member representing the agency in question will explain their protocols to the team. This way, team members learn more about what the parameters of others' responsibilities are, including legal purviews of the organizations that each member represents. The team may identify gaps in policy and procedure in response to the death. Encourage the group to make recommendations for systems improvements for each case.

4. Summarize Findings

Once a case has been fully discussed, it is important for the team leader to summarize all the findings. Findings are objective observations of risk and protective factors in the case. These can include needed systems or practice improvements, and strengths exhibited by participating agencies, the family, or community. These findings are necessary to craft actionable, effective prevention recommendations.

5. 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. See the section on "Making Recommendations and Implementing Prevention Strategies" for more detail on how to formulate actionable recommendations.

The NCFRP's guidance on facilitation methods and strategies for fatality review can be found at: ncfrp.org/wp-content/uploads/NCRPCD-Docs/Fatality_Review_Facilitation_Guide.pdf.

Secondary Case Review

In Maryland, a local CFR team may request that a child fatality case that is reviewed at the local level, also be reviewed by the State CFR Team. After a primary review is conducted at the local level, the State CFR Team will conduct a subsequent review. Primary and secondary child fatality case reviews are *not punitive*.

The following parties may participate in the secondary review process:

- State CFR Team members
- State CFR Team Chair and Vice-Chair
- Local CFR Coordinator from referring jurisdiction
- State CFR Coordinator
- Other individuals that would be beneficial to the secondary review process (ex. Subject matter experts, representatives from relevant agencies, etc.)

The following are types of cases that should be referred by a local CFR team for Secondary Review:

- Cases where there are multiple jurisdictions involved;
- Cases that are high-profile or where there is a significant community impact;
- Cases involving multiple agencies;
- There is substantial conflict within the local team on cause of death or opportunities for prevention; or
- Cases that are made more complicated by other factors not listed here.

Local CFR coordinators may reach out to the State CFR Coordinator and Chairs to discuss if a specific case is a good fit for Secondary Review. If a case is not deemed a good fit, other support may be offered to the local CFR team as appropriate. This could include connecting with a subject matter expert or a representative from a specific state agency to participate in the primary review process.

A local coordinator can request that a case be considered for secondary review by contacting the State CFR Coordinator. A meeting will be scheduled to discuss the case and the reason(s) for requesting a secondary review. The case will be shared with the CFR State Team Chair and Vice-Chair, and a determination will be made of whether the case is a good fit for secondary review. If it is determined that it is a good fit, the process outlined below will proceed. If it is determined that the case is not a good fit for secondary review, other technical assistance and resources will be provided as appropriate.

The local CFR coordinator will be asked to draft a case summary, including information provided by the OCME. This information will include:

- 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;
- Brief description of other circumstances surrounding death, if available; and
- Cause and manner of death

The local CFR coordinator will work with the State CFR Coordinator to inventory all records that were procured during the local review process. An assessment of gaps in records will be made. The State CFR Coordinator will share the case summary with CFR State Team members via an encrypted email. The inventory of records obtained will also be shared. Requests to obtain additional records will be made to relevant CFR State Team members. Individual team members may be contacted for additional information if relevant. The State CFR Coordinator will work in conjunction with the local CFR coordinator to establish a timeline of relevant events to outline the case. This will be presented at the secondary review meeting.

The secondary case review will be scheduled as an agenda item of an upcoming Quarterly State CFR Team meeting. The local CFR coordinator will be invited to present the case to the State CFR Team.

Following a secondary review, the State CFR Coordinator will share the findings and recommendations with the referring local CFR coordinator. The State CFR Coordinator and local CFR coordinator will collaborate to ensure that the recommendations are pursued, and action items are identified.

Considerations for Remote Fatality Review

Some CFR teams may consider having virtual child fatality review meetings versus in-person meetings to increase team members' participation. Some may find that hybrid meetings, using both virtual and in-person meetings, allow their team flexibility to hold review meetings as needed.

Considerations for local review teams before moving to virtual meetings:

- Does your agency allow virtual meetings that discuss sensitive and confidential information?
- Does your virtual platform contain end-to-end encryption or is HIPAA compliant?
- Does your virtual meeting platform have the capability to remove participants from the virtual platform if participants are unable to comply with privacy requirements and your agency's policy and procedure?
- Do all team members have access to reliable internet?
- Do all team members have access to a private space to participate in virtual team discussions?
- Are team members able to store records in compliance with any state and federal laws?
- Can team members use a teleconferencing/web conferencing platform?
- Do team members have enough capacity to focus on fatality review? Many agencies and individuals may concurrently have many competing priorities.
- Can team members sign and return confidentiality agreements? This could be accomplished via email.

If local teams determine that virtual meetings are possible, best practices for facilitating meetings include:

- Require that all team members join the virtual platform from a private and secure space. Participation from public or shared areas is not permitted, as confidentiality and discretion are non-negotiable requirements.
- Before the meeting, consider:
    - having access control such as meeting passwords or authentication to join, waiting rooms/lobbies to screen team members before admitting them, and send invites through secure channels,
    - verifying participants, and

    - remind team members of confidentiality.
- Utilize video conferencing to allow team members to see each other and stay engaged.
- Practice launching your meeting through the virtual platform to ensure team members can join you and that you are able to share screens.
- Sharing screens via a webinar platform can eliminate the need to read sensitive documents aloud and address concerns around record storage.
- Assign one team member the job of monitoring the chat box.
- Make sure your facilitator is prepared with discussion questions, a process for conducting the review, and a process for voting.
- Come to team consensus about sending case information.
- If your team shares case information ahead of time, make sure to give team members extra time to gather documents since regular work processes may be disrupted.
- Identify a method for voting virtually.

Please follow your agency's policies regarding virtual platforms for sensitive and confidential information. In addition, local teams should consult with their IT division to ensure compliance with data security protocols. Before using any notetaking software or AI tools during closed meetings, teams must consult with their agency's legal counsel. (These tools may create separate government records, which could be subject to the Maryland Public Information Act (MPIA), even in redacted form, or subject to subpoena.) For more detailed guidance on facilitating remote review meetings, local teams may reference the NCFRP guide: ncfrp.org/wp-content/uploads/NCRPCD-Docs/Planning-For-Remote-Fatality-Reviews.pdf.

Confidentiality, Immunity, and Public Meetings

Confidentiality is crucial to the CFR process and does not have to be a barrier or roadblock to conducting child fatality reviews. All data obtained through NFR-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 NFR- CRS. If you are uncertain about use of NFR-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 Appendix I 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.

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).

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 per the Maryland Open Meetings Act 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).

Case Entry and Completion

The importance of prompt entry of case data into NFR-CRS cannot be overstated. At the state level, NFR-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. According to the NCFRP, persistent data problem areas are:

- Missing data
- Inconsistent data
- Overuse of “other” specify field

- Entering identifying information into text fields
- Timeliness of data entry

Ensuring Data Quality

Whenever possible, teams should enter all available case information directly into NFR-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 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 several tips to help ensure the quality of case data:

- Missing versus Unknown Variables:
    - A missing or blank variable indicates that the question was skipped or not mentioned or discussed during the review.
    - An 'unknown' indicates that the team discussed the variable, and that the information was not known or available.
- Life Stressors Section: This document supports the work of teams in determining where to find data for Section I7.
- Complete additional training on Data Quality: There are several resources and training the NCFRP has available to help improve data quality.

Additional Suggestions

- Utilize the Data Dictionary when unclear.

- Ensure all "NFR-CRS CDR Data Quality Priority Variables" are entered.

Maryland will receive a Data Quality Summary report from the NCFRP which will include the number and percent of missing and unknown responses for all priority variables for national data and Maryland. The data account for skip patterns in the NFR-CRS. The data are updated annually and sent to the State CFR Coordinator. The reports can be used as a training tool and to monitor data quality so if you're interested in learning more, please reach out to your State CFR Coordinator.

Data Analysis

Local CFR teams will be able to access their own data through the NFR-CRS. This system allows teams to generate specific, standardized data about each case they review. The most important information about a child's 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.

NFR-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 child fatality-related issues. In addition, the State CFR Team and/or the NCFRP may provide webinars and other learning opportunities throughout the year.

The NCFRP offers various resources related to child fatality review such as webinars, written products, and training modules, which are very helpful and can be found at https://ncfrp.org/center-resources/.

Addressing Racial Disparities and Equity in Fatality Review

Racial Disparities in Child Deaths

If a health outcome occurs more often or less often for a given group than the general population, the difference between those groups is called a disparity[2]. Racial disparities in mortality exist throughout Maryland and the United States and are complex. Infant and child mortality is influenced by a range of intergenerational social, economic, clinical, and environmental determinants. Racial disparities across non-clinical factors – such as income, opportunities for stable employment, affordable housing, and access to preventive health care sites and family planning services – can exacerbate differences in infant and child mortality by race[3,4].

For example, across the United States, Black infants are at higher risk for Sudden Unexpected Infant Death (SUID), the leading cause of sleep-related infant death. Some families may find it especially difficult to follow safe sleep recommendations due to several social and economic reasons, such as non-traditional work schedules, exhaustion, inability to afford a crib or Pack 'n Play, cultural misconceptions about safe sleep practices, or home safety concerns that lead caregivers to believe bed-sharing is the safest option[4].

Additionally, low socioeconomic status is correlated with injury-related child fatalities. Families living in low-income communities, which are characterized by a lack of resources and effective infrastructure, may be at higher risk for

unsafe conditions. Examples include:

- Families with lower incomes and limited resources may need to prioritize basic needs such as housing, food, and transportation over safety equipment. Items such as child passenger safety seats and bicycle helmets can be expensive. Many communities do not have consistent access to organizations that may provide these safety items for free or at reduced cost.
- Older vehicles are equipped with fewer safety features than newer ones.
- Economically disadvantaged neighborhoods may not have municipal swimming pools or access to free or low-cost water safety and swimming lessons.
- Dilapidated buildings, open drainage canals, limited hazard mitigation, high rates of violent crime, poorly lit or poorly designed roadways, and limited enforcement of road safety rules put children at risk.
- Limited access to affordable, quality childcare may result in infants and children being cared for by people who do not have adequate safety training.
- Limited access to quality trauma care can result in worse injury outcomes.

Addressing structural and socioeconomic inequities, such as the ones listed above, at a community and institutional level will help reduce health disparities, as well as overall infant and child fatalities. Further, efforts to reduce inequities must address structural racism, which is a key driver of disparities in income, education, neighborhood safety, and access to quality care.

Integrating a Health Equity Strategy in Fatality Review

Health equity is the ethical and human rights principle that motivates us to eliminate health disparities; health disparities are how we measure progress toward health equity[1]. Health equity can be achieved when every person has the opportunity to attain his or her full health potential and no one is

disadvantaged from achieving this potential because of social position or other socially determined circumstances. Health inequities are reflected in differences in length of life; quality of life; rates of disease, disability, and death; severity of disease, and access to treatment[1].

Infant and child mortality are two of the most critical indicators of the overall health of a population, and although Maryland has made significant strides to improve infant and child health, there is still work to be done. While the infant mortality rate in Maryland has declined, it is still above the national average of 5.6 per 1,000 live births, and the Healthy People 2030 goal of 5.0 infant deaths per 1,000 live births, and significant disparities persist.

In Maryland, infant mortality rates among Black non-Hispanic births are consistently more than double the rates among White non-Hispanic births. While the infant mortality rate in Maryland was 6.2 per 1,000 live births in 2022, the Black non-Hispanic infant mortality rate was 10.3 per 1,000 live births (a 5% increase since 2021), compared to 3.1 per 1,000 live births in the non-Hispanic white population (a 16% decrease since 2021).[5,6]

It is critical that CFR teams help to achieve equity by seeking out root causes for behavior and outcomes. Instead of focusing on the individual level risk factors of personal behavior, the team should focus on systems-level factors that individuals may respond to in unhealthy ways. Systems-level factors impact the most people, are frequently oppressive, and their improvement promises to increase health and wellbeing broadly. Specific ways a health equity approach can be incorporated into fatality review include:

- Invite persons to serve on the team that represent the child populations being reviewed.
- Clarify values and assumptions that team members may have to foster shared principles.
- Challenge assumptions during reviews.
- Provide training on equity.
- Provide a context for data.

Local jurisdictions in Maryland are charged with addressing health equity in their programs. Some strategies for how teams can address health are listed below:

- Workforce development
- Analyzing program data by racial/ethnic groups to inform program design and to measure progress
- Pursuing program or community policy change
- Making data available to your target community
- Engaging community in program development and evaluation
- Developing recommendations addressing racial disparities in child deaths

For more information, a Health Equity Toolkit, Facilitator's Manual Health Equity: Diversity, Equity, and Inclusion Assessment Guide for Multidisciplinary Teams, and a Using Health Equity in Fatality Review training video are available for CFR teams from the NCFRP. In addition, the Injury Equity Framework: Establishing a Unified Approach for Addressing Inequities provides "theoretical basis to guide systematic data collection and analysis related to the complex, multilevel structural factors at the root of these inequities [injury-related inequities] and the design of innovative interventions needed to address them. Complex problems require complex solutions, and the medical, public health, policy, and injury-prevention communities will need to unite in a multidisciplinary effort to drive change."

Guidance on Addressing Vicarious Trauma and Self-Care for Fatality Review Teams

It is important to acknowledge that the work involved in the CFR process is both challenging and stressful. The information shared in case review involves many difficult situations that over time can result in "vicarious trauma". This is defined as experiencing or feeling something by hearing the details of someone else's trauma, as opposed to experiencing it firsthand. Vicarious trauma (VT) occurs because of elevated levels of exhaustion from the cumulative, repeated, pervasive, long-term stress of exposure to others' traumatic experiences. Thus, VT is a type of empathetic engagement that can

be an occupational concern of serving on a CFR team. All partners engaged in the CFR process, either individually or on a team, can be adversely affected by the repeated exposure to traumatic information.

Signs and symptoms of vicarious trauma may manifest in various physical and psychological manners. Recognizing these signs and manifestations is critical to ensuring the individual is supported and helped. The following are just a few examples of how VT may manifest in individuals or teams:

- Fatigue
- Inability to sleep
- Dependency on drugs, alcohol, food etc.
- Psychosomatic complaints
- Reduced productivity
- Unable to hear “sad stories”
- Depression, anxiety, “burnout”
- Irritable, intolerant, impulsive
- Loss of idealism in work, apathy

There are many actions that CFR teams, local coordinators, individuals, and agencies can take to mitigate the impact of VT. Some of these include:

- Increase knowledge about VT.
- Accept and acknowledge that all team members face stress from review of child deaths.
- Talk with team members, share resources and strategies, and look to them for support; ensure the review discussion acknowledges the struggles, allows sharing, and allows others to learn from the sharing.
- Leave time at the end of each meeting to check in with the members about what they are feeling.
- Maintain contact with local CFR teams, staff, and coordinators.
- Check in regularly with CFR staff and teams to see how they’re doing.
- Identify triggers that cause VT for you and know your level of tolerance.
- Set clear work-life boundaries.
- Work with a therapist.

Some best practices local review teams can utilize for VT awareness and mitigation include:

- Develop a pre-review routine, such as exercise or positive affirmation.
- Use a moment of silence at the start and end of case review to hold space for any difficult feelings one may experience and to honor the lives being discussed during review.
- Use strategies to disrupt visual experiences such as photos.
- Plan "off task" time following the meeting. Return to the office, or home, to work on something that brings a sense of fulfillment and happiness.

For more information on understanding addressing vicarious trauma see here for the NCFRP's guidance. Additional resources and guidance can be found in the publication Trauma Stewardship: An Everyday Guide to Caring for Self While Caring for Others or at https://traumastewardship.com/.

Determining Best Practices for Prevention

A Spectrum Model of Prevention

There are several tools that can be utilized to help guide prevention efforts. One useful tool is the *Spectrum of Prevention* model. Developed by Larry Cohen 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 cchealth.org/services-and-programs/prevention/the-spectrum-of-prevention. 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, and providing recommendations to the State CFR Team, whose role is "to advise the Governor, General Assembly, and the public on changes to law, policy, and practice to prevent child death."
- 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 childcare 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 (FIMR) 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 utilize these resources for additional assistance with child fatality review.

Frequently Asked Questions

What is the purpose of the Child Fatality Review (CFR)?

The Maryland Department of Health, Maternal and Child Health Bureau coordinates the Child Fatality Review Program. Per *Maryland Health-Gen Code § 5-706*, reviews are mandatory for all unexpected deaths of children under 18 years of age. Local panels meet to review child deaths, identify risk factors, and provide recommendations to help reduce the occurrence of child mortality in the future. Review panels are made up of multidisciplinary groups of professionals. These groups are also called case review teams. The State Review team meets to review data and identify policy and program recommendations.

What is the difference between the State and the local CFR programs?

Local CFR teams review all unexpected deaths of children under the age of 18 in their jurisdictions, referred by the OCME, and make community-level recommendations for the prevention of child deaths. The State CFR Team does not regularly review cases, but rather reviews statewide child fatality review data to make state agency-level recommendations for the prevention of child deaths.

What types of deaths are reviewed?

Deaths of children between 0 and 17 years of age who die unexpectedly in Maryland are eligible for case review, regardless of resident status. Commonly reviewed cases include deaths attributable to unintended injuries, homicide (including those due to child abuse and neglect), suicide, SUID, and unknown causes. Refer to Appendix IV: The Mortality Surveillance Algorithm for a better understanding of which deaths are included in CFR and FIMR.

Does anyone review other types of deaths?

There are two other mortality review systems currently used by MDH. These are the Maryland Maternal Mortality Review Team (MMRT) and FIMR. Cases in which mothers die during or within one year of pregnancy are reviewed

through MMRT. Cases involving infant deaths that do not meet CFR criteria may be reviewed through the FIMR system. These cases include infants who died of medical causes between birth and their first birthday.

Are local CFR teams 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 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 a few 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 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. However, OCME has set a goal to close a case within 90 days or sooner. It is appropriate to wait until the cause and manner have been un-pended to review the case. If it takes longer than six weeks to un-pend the cause of death for a case, please reach out to the

State CFR Coordinator for assistance.

How are deaths identified by local teams?

The OCME refers cases directly to local coordinators by email notification via the OCME portal. Local CFR coordinators use these data to identify deaths in their respective counties. Please reach out to your State CFR Coordinator if you did not receive notification or wish to learn more about receiving notification.

What happens after a death is identified?

Local CFR coordinators obtain case information from medical records, autopsies, death scene investigations, and first responder reports. This information is entered into a secure database and used for surveillance at the state level and to create case summaries which are presented for review at local CFR meetings. The review process uses data to create recommendations to prevent similar deaths in the future.

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

On a monthly basis, local CFR coordinators receive VSA files from the MCHB Epidemiologist that contain birth and death certificate information. Information includes birth and death certificate numbers for CFR cases whose manner of death is accident, homicide, suicide, or undetermined. For CFR cases whose manner of death is natural, please contact the State CFR Coordinator for information on contacting VSA. Please note that VSA files for fetal records will only contain death certificate information.

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 M7. This question is multiple choice; you can select more than one response. In addition to entering question M7, please include it in the narrative.

How are recommendations from the CFR meetings used?

Recommendations from the CFR meetings are reviewed at the State CFR Team meetings which are composed of multidisciplinary stakeholders who develop action plans based on the recommendations generated from the local meetings.

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. 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.

Where can I get technical assistance?

The State CFR Coordinator can 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. Please reach out to the State CFR Coordinator via REDCap form, which is confidential and HIPAA compliant at: redcap-phpa.health.maryland.gov/surveys/?s=9F8H8PT7C33E9C3T

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 fatality 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/bass inet	☐ Yes ☐ No ☐ Unknown
Sleeping outside a crib/bassinet	☐ Crib in home but not being used ☐ No crib in home ☐ Unknown whether crib in home
Bed-sharing	☐ Yes ☐ No ☐ Unknown
Not sleeping on back	☐ Yes ☐ No ☐ Unknown
Unsafe bedding/toys	☐ Yes ☐ No ☐ Unknown

Prenatal smoke exposure	☐ Yes ☐ No ☐ Unknown
Primary supervisor at time of death	☐ Mother ☐ Father/Partner ☐ 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?	☐ Yes ☐ No ☐ Could not be determined
Did an act of commission or omission lead to this death?	☐ Directly caused it ☐ Contributed to it ☐ Neither
What was the act?	
Was the death related to child maltreatment (abuse or neglect)?	☐ Yes ☐ No ☐ Could not be determined
What was the maltreatment?	

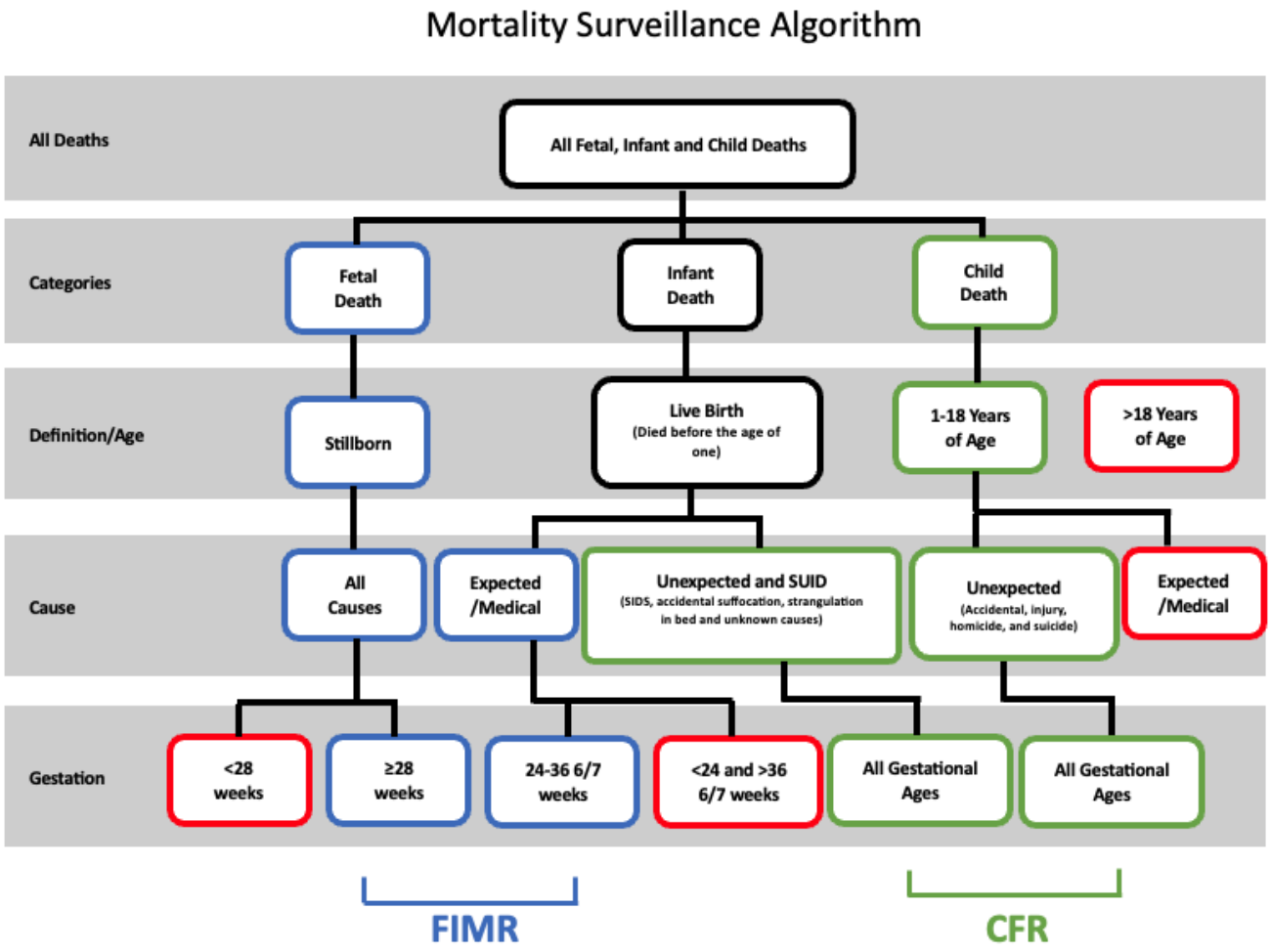
Appendix III. Acronyms and Key Terms

Acronym	Expansion
CDC	Center for Disease Control and Prevention
CDR	Child Death Review
CFR	Child Fatality Review
COD	Cause of Death
FIMR	Fetal Infant Mortality Review
HRSA	Health Resources and Services Administration
MCH	Maternal and Child Health
MDH	Maryland Department of Health
MVC	Motor Vehicle Crash
NCFRP	National Center for Fatality Review and Prevention
NFR-CRS	National Fatality Review Case Reporting System
OCME	Office of the Chief Medical Examiner
SIDS	Sudden Infant Death Syndrome (ICD 10 code R95)
SUID	Sudden Unexpected Infant Death (ICD 10 codes W75, R95, and R99)

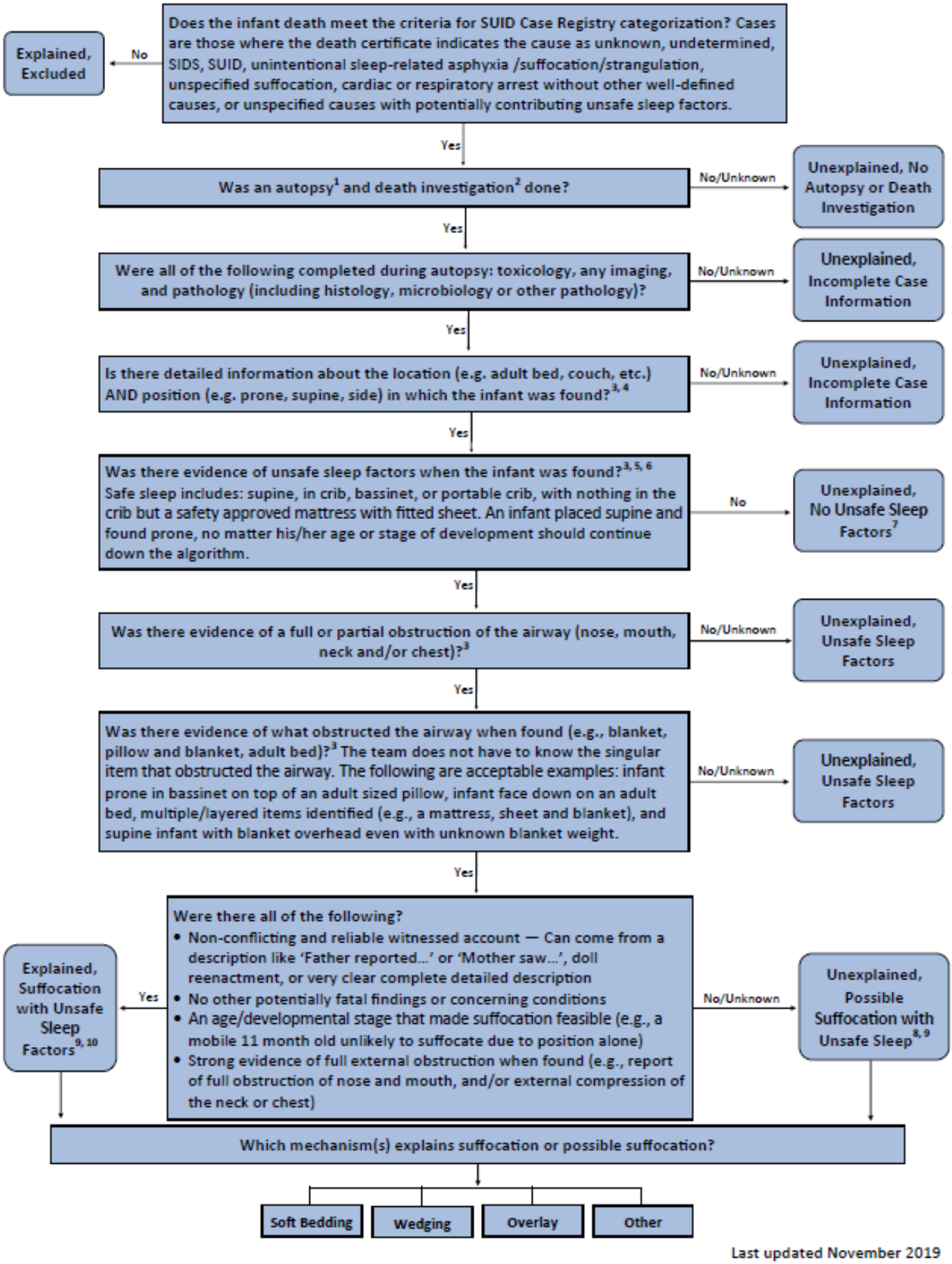
Key Term	Definition
Fetal Death	Stillborn with gestation greater than 20 weeks or birth weight greater than 350 grams
Infant Death	Deaths of infants under 1 year of age
Vicarious Trauma	Experiencing or feeling something by hearing the details of someone else's trauma, as opposed to experiencing it firsthand

Appendix IV. Mortality Surveillance Algorithm

The algorithm below outlines the determination process for which fatality cases are reviewed under CFR and FIMR.



Appendix V. SUID Categorization Guide



Last updated November 2019

Footnotes for the SUID Categorization Guide

1. Autopsy must include an internal exam.
2. Death investigation = Any agency obtaining information about the circumstances of the death; this does not need to include a visit to the scene or have complete information.
3. When there is conflict:
   - Use the expertise of your multi-disciplinary team and ALL of the evidence to figure out what really happened.
   - If there is enough evidence for the team to resolve the conflict, then document the team's decision in the narrative and continue down the algorithm.
   - If the evidence does not reveal a clear resolution, then document the sustaining conflict and treat it as an unknown.
   - Refrain from making assumptions, err on the side of unknown.
4. Consideration of lividity may be useful in verifying position, but lack of information on lividity does not make the case incomplete. Lividity that indicates supine positioning could be from flipping the infant after death and should be considered cautiously.
5. Answer no, if the infant was not sleeping.
6. Infant put in car seat…
   - To sleep, should continue down the algorithm
   - To travel, not sleep, with soft objects or loose bedding, should continue down the algorithm
   - To travel, not sleep, with no soft objects or loose bedding, should be categorized as Unexplained, No Unsafe Sleep Factors
7. Includes infants who were witnessed going unresponsive.
8. Includes infants whose airways were obstructed by a Consumer Product Safety Commission approved mattress used as recommended in a crib, portable crib, or bassinet.
9. Needs to be assigned at least one mechanism using the following definitions (the following are examples, not a comprehensive list):
   - **Soft bedding:** when an infant's airway is obstructed by a blanket, sheet, pillow, couch or recliner cushions, or other soft objects of loose bedding that are part of the immediate sleep environment.
     ⇒ Nose and/or mouth obstructed at the intersection of soft bedding (e.g., where a pillow and mattress meet, where the back and seat of a couch meet)
   - **Wedging:** when an infant's airway is obstructed as a result of being stuck or trapped between inanimate objects.

⇒ Wedged with face clear (e.g., in gap, face above mattress), chest/neck obstruction only

- **Overlay:** when a person rolls on top of or against an infant obstructing the infant's airway.
  - ⇒ Overlay with face clear (obstructed chest/neck only)
  - ⇒ Face into person with or without chest/neck obstruction
  - ⇒ Infant pinned between person and couch, facing person
  - ⇒ *Note: Surface sharing only is not enough evidence for overlay. An overlay needs to be witnessed (e.g., someone waking up on top of an infant, or someone seeing someone else on top of an infant).*
- **Other:** when an infant's airway is obstructed by something in the sleep environment other than soft bedding, overlay or wedging like a plastic bag.
  - ⇒ *Note: Other should not be selected for unsafe sleep factors like prone positioning or impaired caregivers.*
- **Multiple mechanisms:**
  - ⇒ **Wedging and Soft Bedding**
    - Wedged with face into soft bedding (mattress, pillow, blankets), nose and mouth obstructed
    - Wrapped/entangled in blankets and wedged
  - ⇒ **Overlay and Soft Bedding**
    - Overlay with nose/mouth obstructed by soft bedding (mattress, pillow, blankets)
    - Infant pinned between person and couch, facing couch

10. Examples include:

- A 1-month-old infant found face down in a pillow with her nose and mouth fully obstructed.
- A 2-month-old infant found with her head and face wedged between the cushions at the back of the sofa.
- A 4-month-old infant found lifeless in a twin bed with his head and body underneath his mother.

Reference: Shapiro-Mendoza CK, Camperlengo L, Ludvigsen R, et al. Classification system for the Sudden Unexpected Infant Death Case Registry and its application. *Pediatrics*. 2014;134:e210-e219.

Appendix VI. CFR Statute

[Health-General Article, §5-701-709, Annotated Code of Maryland]

§ 5-701. Definitions

(a) In general. -- In this subtitle the following words have the meanings indicated.

(b) Child. -- "Child" means an individual under the age of 18 years.

(c) Child death review case reporting system. -- "Child death review case reporting system" means a national, standardized, web-based reporting system for the confidential collection, analysis, aggregation, and reporting of child death data that is maintained and operated by a national center for child death review.

(d) Data use agreement. -- "Data use agreement" means a contract between the Department and a national center for child death review that establishes the terms and conditions for the State and local child fatality review teams' participation in a child death review case reporting system.

(e) Health care provider. -- "Health care provider" means:

(1) An individual licensed or certified under the Health Occupations Article to provide health care; or

(2) A facility that provides health care to individuals.

(f) Local team. -- "Local team" means the multidisciplinary and multiagency child fatality review team established for a county.

(g) Meeting. -- "Meeting" includes meetings through telephone conferencing.

(h) National center for child death review. -- "National center for child death review" means a public, private, nonprofit, or governmental organization or entity that is funded or otherwise recognized by the United States Department of Health and Human Services and is responsible for:

(1) Developing a child death review case reporting system;

(2) Training and serving as a liaison to State agencies

participating in the system; and

(3) Disseminating national child death review data generated by the system.

(i) State Team. -- "State Team" means the State Child Fatality Review Team.

(j) Unexpected child death. -- "Unexpected child death" means a death of a child investigated by the office of the Chief Medical Examiner as required by § 5-309 of this title.

§ 5-702. Established

(a) In general. -- There is a State Child Fatality Review Team.

(b) Affiliates. -- The State Team is part of the Department for budgetary and administrative purposes.

§ 5-703. Membership

(a) Multidisciplinary and multiagency. -- The State Team shall be a multidisciplinary and multiagency review team, composed of at least 25 members, including:

(1) The Attorney General;

(2) The Chief Medical Examiner;

(3) The Secretary of Human Resources;

(4) The Secretary of Health and Mental Hygiene;

(5) The State Superintendent of Schools;

(6) The Secretary of Juvenile Services;

(7) The Special Secretary for Children, Youth, and Families;

(8) The Secretary of State Police;

(9) The president of the State's Attorneys' Association;

(10) The chief of the Division of Vital Records of the Department;

(11) A representative of the State SIDS Information and Counseling Program;

(12) The Director of the Behavioral Health Administration of the Department;

(13) Two pediatricians with experience in diagnosing and treating injuries and child abuse and neglect, appointed by the Governor

from a list submitted by the State Chapter of the American Academy of Pediatrics; and

(14) Eleven members of the general public with interest or expertise in child safety and welfare, appointed by the Governor, including child advocates, CASA volunteers, health and mental health professionals, and attorneys who represent children.

(b) Designation of representatives. -- The members described under subsection (a)(1) through (12) of this section may designate representatives from their departments or offices to represent them on the State Team.

(c) Staffing. -- The State Team may employ a staff in accordance with the State budget. Each member of the Team under subsection (a)(1) through (12) of this section shall provide sufficient staff support to complete the State Team's responsibilities.

(d) Expenses. -- Members of the State Team shall serve without compensation, but may be reimbursed for reasonable expenses incurred in the performance of their duties in accordance with the Standard State Travel Regulations and as provided in the State budget.

(e) Chairperson. -- The State Team shall select a chairperson from among its members.

(f) Meetings. -- The State Team shall meet not less than once every 3 months.

§ 5-704. Legislative purpose

(a) Prevention of child deaths. -- The purpose of the State Team 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; and

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

(b) Duties. -- To achieve its purpose, the State Team shall:

(1) Undertake annual statistical studies of the incidence and causes of child fatalities in the
State, including an analysis of community and public and private agency involvement with
the decedents and their families before and after the deaths;
(2) Review reports from local teams;
(3) Provide training and written materials to the local teams established under § 5-705 of this subtitle to assist them in carrying out their duties, including model protocols for the operation of local teams;
(4) In cooperation with local teams, develop a protocol for child fatality investigations, including procedures for local health departments, law enforcement agencies, local medical examiners, and local departments of social services, using best practices from other states and jurisdictions;
(5) Develop a protocol for the collection of data regarding child deaths and provide training to local teams and county health departments on the use of the protocol;
(6) Undertake a study of the operations of local teams, including the State and local laws, regulations, and policies of the agencies represented on the local teams, recommend appropriate changes to any regulation or policy needed to prevent child deaths, and include proposals for changes to State or local laws in the annual report required by paragraph (12) of this subsection;
(7) Consider local and statewide training needs, including cross-agency training and service gaps, and make recommendations to member agencies to develop and deliver these training needs;
(8) Examine confidentiality and access to information laws, regulations, and policies for agencies with responsibilities for children, including health, public welfare, education, social services, mental health, and law enforcement agencies, recommend appropriate changes to any regulations and policies that impede the exchange of information necessary to protect children from preventable deaths, and include proposals for

changes to statutes in the annual report required by paragraph (12) of this subsection;

(9) Examine the policies and procedures of State and local agencies and specific cases that the State Team considers necessary to perform its duties under this section, in order to evaluate the extent to which State and local agencies are effectively discharging their child protection responsibilities in accordance with:

(i) The State plan under 42 U.S.C. § 5106a(b);

(ii) The child protection standards set forth in 42 U.S.C. § 5106a(b); and

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

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

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

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

(13) In consultation with local teams:

(i) Define "near fatality"; and

(ii) Develop procedures and protocols that local teams and the State Team may use to review cases of near fatality.

(c) Coordinated activities. -- The State Team shall coordinate its activities under this section with the State Citizens Review Board for Children, local citizens review panels, and the State Council on Child Abuse and Neglect in order to avoid unnecessary duplication of effort.

(d) Prohibitions; disclosure of information. --

(1) Except as provided in paragraph (2) of this subsection, members and staff of the State Team:

(i) May not disclose to any person or government official

any identifying information about any specific child protection case about which the State Team is provided information; and

(ii) May make public other information unless prohibited by law.

(2) (i) In carrying out the responsibilities under this section and subject to subparagraph (ii) of this paragraph, the members and staff of the State Team may provide identifying information to a national center for child death review in accordance with a data use agreement that:

1. Authorizes access to identifiable information only to the members and staff of the State Team;
2. Authorizes the national center for child death review to access only de-identified information; and
3. Requires the national center for child death review to act as a fiduciary agent of the State and local teams.

(ii) Information provided to a national center for child death review in accordance with this subsection is confidential and subject to the same confidentiality and discovery protections that apply to the State and local teams as set forth in § 5-709 of this subtitle.

(e) Penalties. -- In addition to any other penalties provided by law, the Secretary may impose on any person who violates subsection (d) of this section a civil penalty not exceeding $ 500 for each violation.

§ 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.

Appendix VII. References

1. National Center for Fatality Review and Prevention (NCFRP): A Program Manual for Child Death Review.
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7. Maryland State Child Fatality Review. Annual Legislative Report 2021. Accessed: https://health.maryland.gov/phpa/mch/Documents/CFR/Annual/HG%20%c2%a75-704%28b%29%2812%29%20and%20SB%20464%20%28Chapter%20355%20of%20the%20Acts%20of%201999%29%20-%202021%20Annual%20State%20Child%20Fatality%20Review%20Team%20Report.pdf