Maryland State Child Fatality Review

Guidelines for Local Case Review

This document is the work of the Maryland State Child Fatality Review Team. It is a working document, revised as the CFR program in Maryland develops, and is superceded by any versions with a later date. The document is maintained by the Maryland Department of Health and Mental Hygiene, Family Health Administration, Center for Maternal and Child Health: 410-767-6713.

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Maryland Child Fatality Review

Vision

We envision a Maryland where preventable child deaths are eliminated.

Mission

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

Guiding principles

1. We work cooperatively with other state and local review systems.

2. We base our recommendations on findings from child death reviews.

3. Our understanding of child deaths must be based on both quantitative and qualitative information from child death reviews and observations.

4. Child death review must represent and consider the entire community.

5. Child death review must be both multi-disciplinary and multi-agency.

6. Support of and advocacy for local child death review is a priority function of the State Child Death Review Team.

7. The State Child Death Review Team will build on the work of the local teams.

8. Reviews are conducted with respect for the child and family, and for those who served them.

9. To facilitate the sharing of information openly and honestly, confidentiality is adhered to in all reviews.

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About these Guidelines

The Maryland CFR Guidelines for Local Review are designed to assist counties in the formation and operation of local Child Fatality Review teams. CFR is a community level activity. Communities will approach the operation of CFR with varied methods, expectations, and resources. In Maryland, CFR also has a state level of activity. Both state and local CFR teams are guided by law. They are also guided by a common purpose, in implementing Child Fatality Review in a way that will best serve the children of the state.

The guidelines are organized to make clear the legal or other requirements that local teams must observe, and then to offer suggestions in the areas that counties are free to develop as they see fit. The State CFR Team and supporting staff wish to be a resource to localities for technical assistance, training, and consultation. We encourage you to contact us with any questions or difficulties in interpreting or implementing the material presented here. While care for accuracy has been taken in producing this document, the State Team may make changes at any time to correct errors or reflect further development of the process.

The Law

Child Fatality Review is established in Maryland by Senate Bill 464 of 1999. The portion of that law relevant to Child Fatality Review is contained in Maryland Code in Article Health - General, Subtitle 7. Child Fatality Review Teams, Sections 5-701 through 5-709. Additions relevant to CFR were made to sections 4-306 and 5-309. All of these sections are reproduced in the appendix.

These guidelines discuss or summarize portions of the law in the text. These statements are not a substitute for the law itself. ***Local teams must read and implement Maryland Code as cited above*** *and contained in the attached appendix, as well as any other law or regulation that is applicable. In any case of discrepancy between this document and the law, interpretation of the law will prevail.*

Procedures

Where there is no reference to legislation in these guidelines, the policy stated is from the State CFR Team or other agency.

Suggestions

Information marked as suggestion is not mandated or required, but will be helpful to the operation of local teams.

Acknowledgment
The Maryland State CFR Team is grateful for the generosity of other state CFR programs for allowing free use and adaptation of their materials, particularly the programs in Arizona, Michigan, and Pennsylvania.

I. Introduction and Background

A. The Purpose of Child Fatality Review

The death of a child is a community problem. The circumstances involved in most child deaths are too multidimensional for responsibility to rest in any one place. Child Fatality Review (CFR)[1] is an action-oriented means for communities to improve understanding of how and why children die; to demonstrate the need for and to influence policies and programs to improve child health, safety and protection; and to prevent future child deaths. This is accomplished through multi-disciplinary, multi-agency review of individual cases of child deaths. The case review team makes recommendations for improvements to systems and for public and professional education; and advocates for their implementation.

Child deaths are sentinel events, health outcomes that are the least acceptable. Carefully examining these events offers us a window into risk factors, service system functioning, and community norms or behaviors. Called Child *Fatality* Review, CFR is nonetheless interested in preventing morbidity as well as mortality. System improvements to prevent or better treat serious injuries or illnesses will benefit many children and their families.

B. History of Child Fatality Review in Maryland

In 1985, the state Child Protective Services Advisory Committee was concerned that little was known about child deaths, and that in many cases Child Protective Services was inaccurately perceived by the community as solely responsible for prevention of most unexpected child deaths. A multi-agency planning group developed some proposals, but no official steps were taken to implement the plan. In about 1990, a number of professionals decided that CFR was needed, and explored ways of conducting CFR, at least informally, without funding or mandate. The Office of the Chief Medical Examiner (OCME) hosted the process, and reviews began at the state level. By 1993 data forms were developed and revised, and since then, every child death seen by the OCME has been reviewed at the state level with data collected.

This effort yielded some useful information, but was limited by lack of good local case information and lack of a functioning computerized database to analyze the data. Further, without any executive or legislative standing, the state CFR had no basis to speak out or act. Several individuals gave many hours to the effort, and the state Department of Human Resources supported a part time position to assist the team with gathering data. The Office of Child Health at DHMH also provided funds through the Center For Infant and Child Loss, producing a report in January 1999 entitled An Assessment of Child Fatality Review in Maryland. At the time, several Maryland counties were operating or developing local CFR, and in every other county the Health Officers expressed willingness to explore development of a team.

Beginning in 1993, Fetal and Infant Mortality Review (FIMR) was developed in several Maryland Counties. FIMR is also a community-based mortality review process, focused on the health of mothers and babies. By 1999, a FIMR program was operating in every

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

jurisdiction in the state, and permanently funded by the Office of Maternal Health and Family Planing at DHMH. In the process of working with local FIMRs, some limited technical assistance was given about CFR, enabling a few counties to begin local teams. In the 1999 state legislative session, a bill was passed enacting required, state and local CFR in Maryland. The legislation is described below. The CFR program is housed at DHMH, under the Center for Maternal and Child Health. In the Fall of 1999 the appointed State CFR Team began to meet.

C. State Legislation Establishing Child Fatality Review

Child Fatality Review is mandated in Maryland by Senate Bill 464 of 1999. The portion of SB464 relevant to Child Fatality Review is contained in Maryland Code in Article Health - General, Subtitle 7, Child Fatality Review Teams, Sections 5-701 through 5-709. Additions relevant to CFR were made to sections 4-306 and 5-309.

The law contains three major provisions: establishing the State Council on Child Abuse and Neglect (SCCAN); the Citizens Review Board for Children (CRBC) and local Citizen's Review Panels (CRP); and Child Fatality Review at the state and local level. The law was introduced by child advocates in response to the federal Child Abuse Prevention and Treatment Act (CAPTA). CAPTA requires that for states to receive certain federal funds, they must have several citizen review processes examining aspects of child protection. The CFR law makes reference to some CAPTA requirements and mandates certain reporting on child protection. Child Fatality Review in Maryland is, not, however, concerned with child maltreatment to any different extent than unintentional injury, illness, and other causes of death. The section of the bill mandating CFR is placed under Health - General, with the Department of Health and Mental Hygiene as the lead agency, because CFR is a public health activity. (The other two sections are under Family Law, and the Department of Human Resources.)

D. The Concept of Prevention

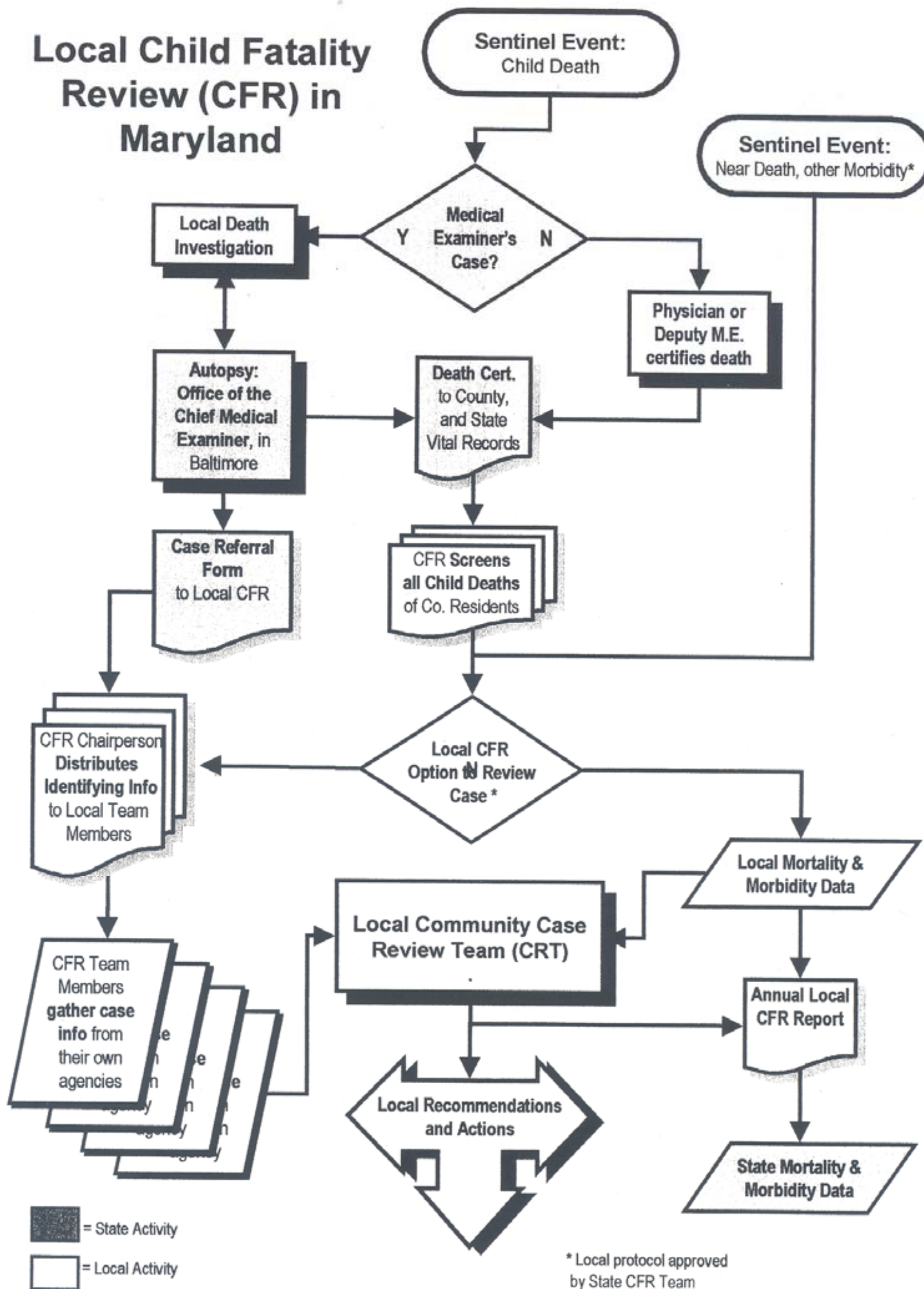
The Maryland CFR law, in section 5-701, Definitions, does not define 'prevention'. The State CFR Team takes the position that CFR in Maryland is a broad activity to improve services and educate the public about child safety. Accordingly, 'prevention' is used in these guidelines to mean reducing risk or improving service, rather than a judgement about whether a particular case could have had a different outcome. Speculation about *preventability* in a local case review is not encouraged. It is important, however, to explore whether a case illustrates opportunities for *future* prevention of morbidity or mortality, or suggests service improvements.

E. The Child Fatality Review Team Process in Maryland

Child Fatality Review in Maryland is similar to that in many states. However, several state-specific factors determine some of the structure of the state and local review process here:

- Maryland has a statewide Medical Examiner system, with trained forensic pathologists performing all autopsies, centrally in Baltimore.
- There is a mandatory autopsy law for Medical Examiner cases.
- The 1999 state CFR law requires local CFR teams in every county or region.
- The law also requires coordination with other child protection review processes.
- Fetal and Infant Mortality Review is operating in all jurisdictions in Maryland, along with a statewide Maternal Mortality Review.

Figure: Investigation and Review of Child Deaths
The following figure illustrates the events following a child death relevant to CFR in Maryland. Responsibility for investigating a death and determining cause and manner of death is illustrated. This process is independent of CFR, but shows the connection between CFR and existing systems, and indicates some sources of information for case reviews.



II. Responsibilities of the State Child Fatality Review Team

The legislated purpose of the State CFR Team is to prevent child deaths by developing an understanding of the deaths that occur, planning and implementing prevention strategies, and reporting to the government and the public. In studying and preventing child deaths, the goal is also to improve the safety of Maryland children, reducing injuries and improving services. The Team has adopted the Vision, Mission, and Guiding Principles set forth on the first page of this document. The State CFR Team has various responsibilities, summarized here emphasizing it's relationship to local teams.

A. Responsibilities Established in the Law

The members of the State CFR team are appointed according to section 5-703.

The State CFR Team is charged with specific responsibilities in 5-704. Summarized by type of activity, these are:

Report to the Governor, the Legislature, and the Public

- Provide statistical reports on the incidence and causes of child deaths
- Analyze agency involvement with the decedents and their families before and after death
- Recommend changes to state or local laws, regulations or policies:
  -for prevention
  -to improve interagency exchange of information to protect children
  -to facilitate the CFR process
- Evaluate the extent to which state and local agencies are effectively protecting children, including accordance with the state child protection plan and federal standards
- Educate the public about prevention

Support and Oversee Local Teams

- Provide training and written materials to local teams, including model protocols
- In consultation with local teams, establish a protocol for operation of local CFR teams
- Develop a protocol for data collection and train local teams to use it
- Study the operation of local CFR teams, including the effect of laws, regulations and policies
- With local teams, define 'near fatality' and develop protocols to review such cases
- Review reports from local teams

Advocate

- Develop, in cooperation with local teams, local child death investigation protocols
- Evaluate training needs of local and statewide agencies, including cross-agency training and service gaps, with recommendations to agencies on meeting these needs.

Coordinate Citizen Reviews

- Coordinate with the other two entities in SB 464: the Council on Child Abuse and Neglect, and the State and Local Citizens Review panels

B. Other Responsibilities and Tasks

The State CFR Team will undertake such activities as it deems necessary to its purpose, in addition to those mandated by law.

C. Documentation and Standard Data Collection

It is the duty of the State Team to establish a system to collect and analyze data from each jurisdiction. As of December 2000, the system consists of the Case Report Forms completed for every case reviewed locally, or centrally at the OCME for jurisdictions which do not yet have local case reviews. An electronic database is being developed, including means to analyze information from the Case Report Forms filed in previous years.

There are three types of information generated by local CFR teams and collected by the State.

Case Information

Local CFRs generate specific, standardized data about each case. This case information is very useful when aggregated statewide to understand the distribution of variables across the state, to allow jurisdictions to compare their information with others, and to make observations from a larger sample than is possible in most jurisdictions due to the relatively rare nature of these events. This data is primarily quantitative.

The Findings of the Case Review Team about each case reviewed

The most important information about a child death from a local case review is the team's findings in the case. This may include risk factors, judgements about prevention, or system improvement opportunities. The observations of the individuals and agencies actually engaged with the events are a unique resource, not available from analysis of statistical information. This data is qualitative.

Annual Analysis, Recommendations, and Actions

CFR is community based. It recognizes that opportunities for prevention and system improvement are often unique to the local situation. Geography, customs, resources, and politics are some of the variables that influence the nature of risk factors, the possibility of change, and the priorities for doing so. The recommendations from a well functioning local CFR reflect all of these variables, and are more likely to lead to actual system improvement and effective prevention efforts than statistical information from the state or federal level. This data is largely qualitative. The State Team will compile the local information, looking for state level systems improvements and prevention opportunities, for local needs that may need advocacy, and for information to aggregate for statewide reporting.

The State CFR Team will collect and analyze the above information. Procedures regarding the collection and transmission of data are described in the following sections.

III. Responsibilities of the Local Child Fatality Review Team

A. Responsibilities Established in the Law

Section 5-706 (A) of the law states the purpose of local CFR:

- Prevent child deaths
- Promote cooperation and coordination among agencies investigating child deaths or serving surviving families
- Understand causes and incidence of child deaths in the county
- Recommend changes within agencies to prevent child deaths, and a work plan to implement them.
- Advise the state team on changes to law, policy, and practice to prevent child deaths.

The responsibilities of the local jurisdiction, summarized from section 5-706 (B):

- Recruit the team
- Elect a chair by majority vote
- With the state team: establish and implement a protocol for the local team
- Work for investigation of child deaths in accordance with national standards
- With the state team: Define ‘near fatality’ and develop procedures and protocols to review such cases
- If a regional CFR: develop a memorandum of understanding on membership, staffing, and operation between the jurisdictions
- Meet at least quarterly
- Review cases of child death
- Recommend actions to improve coordination of services and investigations among agencies
- Recommend actions within agencies to prevent child deaths
- Collect and maintain data as required by the state team
- Provide requested reports to the state team
- Open meetings to the public when not reviewing specific cases
- Obtain needed case information, and assure confidentiality safeguards

B. Local CFR Team Operating Procedures

1 Local Child Fatality Review Team Membership

a. Team Composition

The law stipulates that local team membership shall be drawn from the individuals, organizations, agencies, and areas of expertise listed below, when available. 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 States Attorney
- The Superintendent of Schools
- 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

- The regional representative of the Child Care Administration
- 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 county mental health agency or core service agency
- 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

The above are considered important to CFR and while not required in the law, a local team should include them unless not present in the jurisdiction or otherwise not available. Note that two are appointed by the Health Officer, and the other positions listed in the law are filled by invitation or assigned by agencies.

- Any other individual necessary to the work of the local team, recommended by the team and appointed by the County Health Officer

Suggestion: Other potential members to consider include a neonatologist, clergy, funeral home representative, hospital staff, hospice staff, emergency medical services representative, fire department personnel, and experts in SIDS and child injury prevention. Alternatively, such persons may be invited to participate as consultants or ad hoc members when reviewing particular cases, rather than being permanent team members.

Suggestion: The local Deputy Medical Examiner may be a useful addition to the team. Many Deputy M.E.s will be able to provide death scene investigation information. They will not generally have information about the autopsy, which is performed in Baltimore. Since Maryland has a statewide medical examiner system, and all Medical Examiners are in Baltimore, the M.E. who ruled on the case will not generally be available at local review meetings. The Office of the Chief Medical Examiner, through its representative on the state team, will work with local CFRs to make information available, including the possibility of telephone contact at the review meeting.

b. Number of Members

The law does not specify the size of the team; each county or multi-county unit may assemble a team which best represents the above disciplines and best meets the needs of the region. Section 5-705 (B) (13) provides for additional members recommended by the team and appointed by the county Health Officer. Also essential is the inclusion of a recording secretary to keep track of documents and to record the conclusions and recommendations of the team.

c. Guests or Individuals Associated with a Specific Case

Teams should involve in the review meeting various experts or those front-line personnel who worked with a specific case. Section 5-708 (D) expressly permits such individuals to attend. Core team members notified of the case should identify and invite the appropriate staff members from their agency. The investigating officer, the DSS worker, or a public health nurse who worked with the family will be invaluable. Where a regional team is implemented, a representative of the key agency(s) involved with the death investigation of a specific case (at the least, law enforcement and health department) from the county of residence of the deceased child will need to be present when that case is reviewed, even if they are not regular team members. The principle is that the team will only hear information from agencies represented at the meeting and given notice to bring records. Each case will require different sources of information. A local CFR team which only meets with it's core members will not be able to function effectively.

Suggestion: Due to the sensitive nature of the case review, teams are urged to have a definite policy about how invitations for ad hoc members are made, e.g., approval in advance by the Chair, signing the confidentiality agreement, and so on. The policy should also cover guests, such as observers wishing to learn about the CFR process.

d. Regional CFR Teams

While local CFR is required in every county, the law permits two or more counties to cooperate in a regional review team. A regional team must develop a memorandum of understanding on membership, staffing, and operation. Regional review teams present opportunity for jurisdictions with small numbers of fatalities to review a more consistent set of cases, and to pool resources. There are, however, also complications involved. These include the size of the team, commitment from all agencies involved, leadership, and so on. At this time no regional teams have been established in Maryland, and no guidelines have been developed.

e. Training Requirements for Local Team Members

The State 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 local teams are urged to make use of this resource.

f. Member Designees and Meeting Attendance

Teams may decide on membership policy. E.g., members may designate another representative of their agency to replace them at meetings they are unable to attend. Members are urged to recognize the importance of regular attendance to build trust in the team, and to share the expertise and knowledge for which they were recruited. Team members who consistently miss meetings should be replaced. Although agencies may wish to appoint their own replacement representatives, team members may be able to suggest individuals they believe would have the needed interest and commitment.

Suggestion: The team may wish to adopt a policy for notifying absent members, and criteria for dismissal. Other operating procedures may be devised in order to reduce misunderstandings and facilitate the work of the team.

2 Chairperson

The law directs that a chairperson is selected by the team. The chair may be any one of the team members, and serves at the discretion of the team. The length of term is decided by the team.

Suggestion: A specific process should be agreed upon by the team for choosing a chair. For instance, entertaining nominations at the organizational meeting, and voting at a subsequent meeting. Informally choosing a chair seldom results in committed leadership.

Suggestion: Chairperson duties:

- Call for and chair team meetings.
- See to it that meeting notices are sent to team members.
- Officially invite ad hoc members, and visitors.
- Obtain names and compile the summary sheet of child deaths to be reviewed for distribution to team members two weeks prior to each meeting, or designate this function.
- Submit data reports to the State Child Fatality Review Team no later than one month after each completed review.
- Ensure that the team operates according to protocols as adopted by the team.
- Ensure that all new team members and *ad hoc* members sign a confidentiality agreement.

3 Auspices

Local Child Fatality Review Teams in Maryland are established by law. They operate upon their own authority, not that of any particular agency, regardless of which agency may host the meetings, provide secretarial support, or be represented by the chair. The reports, public statements, or actions of the team do not require approval of any agency. This status is intended to ensure that the group represents the community, and that the team is not disproportionately influenced by any one agency or organization. The local CFR team should speak with a voice committed to the welfare of children rather than allegiance to the status quo. Team members represent the expertise of their agency, and must abide by their agency protocols regarding confidentiality or making public statements on it's behalf. Agencies may specify how their employees represent agency policy on any matter. But team members are also citizens, and serve in that capacity. CFR is a type of citizens review panel. Agencies may not require members to divulge team deliberations or dictate their personal position on matters before the team.

The law mentions local health departments in regards to obtaining records, and the Health Officer is given authority in the law to appoint certain team members. A local health department will in most cases have a major role with local teams, as CFR is a

public health function. However, the law does not place the local team under the health department, nor is that department required to host or logistically support the team.

4 Frequency of Meetings

Local CFR teams are required by law to meet at least quarterly. The law does not waive this requirement when no deaths have occurred in the jurisdiction during that time. As a practical matter, many fatality review teams find that they do not have time to develop recommendations, implement them, or report on their findings during normally scheduled case review meetings. Local teams should look at the full range of their responsibilities in 5-706 when deciding on a meeting schedule.

Suggestion: Schedule a CFR team meeting for the same day each month so that members have it on their calendar. If the team has completed all it's outstanding business, it may decide to cancel the next meeting if no new cases occur and no other business arises. It is easier to cancel a meeting than to call for one.

5 Protocol for Local CFR

The Local and State CFR teams are required to work with each other to establish a protocol for local CFR. This document, Guidelines for Local Case Review, has been developed in cooperation with local team representatives, and may be amended at any time by action of the State CFR Team to reflect needs of local jurisdictions. Although no national standards for CFR exist at this time, these guidelines are based on the best models of existing state CFR programs and material from the American Bar Association national project for CFR support. The Maryland CFR law and the policies adopted by the State Team form the basis for local CFR protocols. Local teams will make decisions about other aspects of their team operation. There is no requirement at this time for local teams to develop written local protocols (except in the specific areas called for in these guidelines), unless a team wishes to adopt policies differing from these guidelines. The State Team will work with the local team in such a circumstance to arrive at a local protocol.

6 Finding Cases

See section IV, Criteria for Reviewing Cases, for a discussion of the types of cases to be reviewed.

Death certificates are available from the county health department. The State Team will also establish a method for local CFRs to receive periodic information from the Office of Vital Records at DHMH.

In Medical Examiner cases, the OCME sends a referral form to the designated county CFR contact. The top portion of the form should not be considered official or completely accurate information. The following preliminary information, when available, is included on the Case Referral Form from the OCME.

- Child's name.
- Child's ethnicity, age, and gender.
- Child's date of birth and date of death.

- Mother's name and address (both maiden and current names are usually required for background checks and prior Child Protective Service 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 information is available.

Cause and Manner of Death, if listed on the case referral form, are the official decision of the OCME and will be entered on the death certificate.

- Cause of death (may be pending when the referral is initially sent). Cause of death is the specific reason the child died, *e.g.*, blunt force head injury, gunshot, pneumonia.
- Manner of death. Note that this is separate from cause of death. The possibilities are only five: natural, homicide, suicide, accidental or undetermined.

Suggestion: Many local teams fax or otherwise forward the Case Referral form from the OCME to their team members (it is designed for this purpose).

Upon request, the OCME will forward a copy of a deceased child's autopsy report to the local team when it is complete. Local teams have requested an automatic mechanism to receive reports on cases that have been referred to them. At present there is no such protocol. Although autopsy reports require more than a month and usually considerably longer, to complete, OCME staff may in some cases share preliminary information with a local team, should it wish to begin review prior to receipt of the final autopsy report. A medical examiner may be available to participate in a review via speaker phone. Contact the state CFR Coordinator for information on a pending case or autopsy report.

There are presently no requirements for identifying cases of 'near fatality'. Methods of case finding will depend on the types of cases to be reviewed. The State Team will provide technical assistance about methods of identification when discussing with the local team it's proposed definition of near fatality cases to be reviewed.

7 Notifying Team Members of Cases for Review

The county chairperson or designee compiles and sends to all review team members a referral sheet of basic identifying information for each death to be reviewed. Each team member should specify a means of transmission that safeguards confidentiality. This information is usually obtained from the death certificate or the referral form from the Office of the Chief Medical Examiner. Team members should examine the list and search their own agency records for information pertaining to each death.

The purpose of the referral information is to help members look up cases in their agency records, (the key information needed to retrieve a record varies by agency), and to give the official cause and manner of death, if available.

Suggestion: Ask local team members what minimum information is sufficient for this purpose, and how to transmit it.

8 Obtaining Case Information for Team Reviews

Teams may request information and records regarding a deceased child as needed to carry out their duties. Background and current information from team members' records and other sources is necessary to assess circumstances of death. Such requests should usually be addressed to the "custodian of the records" or agency director and should include the review team authorizing statute (Health General Article, §5-701 *et. seq.* Annotated Code of Maryland and particularly Health General Article, §5-707 which provides that such records "shall be immediately provided" to the local team), and information regarding the team's operation and purpose. These requests are particularly useful for acquiring information from agencies that are not represented on the team, e.g., medical information from numerous hospitals or providers.

Some specific policies about gathering case information:

- Local Teams must designate an individual to receive referrals from the state Office of the Chief Medical Examiner.
- Local teams will wish to work closely with the health department to obtain the names of all other children who have died in the county. Contact the State CFR Coordinator for information available from the state Vital Records office at DHMH.
- In reviewing deaths of child residents of other counties, team members should contact their corresponding agencies in those counties and request information.
- The State Fatality Review Team will submit copies of out-of-county deaths to local team chairpersons as they become available. This can take up to six months after a death and over a year for out of state deaths.
- Local Chairpersons who have the names of children who died in their counties but lived elsewhere in Maryland (non-resident occurrences) should send those names to the county review team chairperson where the children lived and reach an agreement as to which county should review the case.

Suggestion: Arrange for a standing inter-agency agreement with those institutions you frequently request records from.

9 Reviewing Cases

Team members should bring to the meeting any information their agency has on the case. This usually means bringing actual case folders or printouts, and possibly the staff member who dealt with the family. There is usually no need for preparing a written summary, since no written materials are permitted to leave the meeting.

Facilitating case review meetings is an important factor in CFR team success. Techniques for doing so are outside the scope of this document. There are no requirements at this time for conducting team meetings, but local teams are referred to materials from state training on this subject.

10 Relationship to Other Review Processes

The relationship of CFR to other reviews or multi-disciplinary functions will vary by county. The law requires that there be a group in each county that convenes for the purpose of Child Fatality Review. That designated group or team is responsible for seeing that the required cases are reviewed. If a group other than the CFR team reviews a

required case, the CFR must obtain from them a state CFR case report form and submit it to the state. In several Maryland counties or regions, a group performs several functions such as Fetal and Infant Mortality Review or Child Protection Team in addition to Child Fatality Review, although there are usually some membership differences for the various functions. In other counties, some individuals may be members on more than one committee, but the committees are organized as separate entities.

Suggestion: Where there are separate teams but overlap in membership, the teams can be scheduled sequentially on the same day for convenience.

However teams are structured, the local CFR should coordinate with the local Fetal and Infant Mortality Review (FIMR) committee, Citizens Review Panel (CRP) etc. to prevent duplication of reviews and the burden on agencies required to give information. Some counties have chosen to review a case in more than one process, and found this useful. This is permitted, although confidentiality and other issues differ between the types of review. Each jurisdiction is required to develop procedures, to be approved by the State CFR Team, for sharing information between it's local review programs. The various types of reviews operate under different sections of Maryland law, and under different expectations of confidentiality. For example, the FIMR includes a maternal interview in which a specific confidentiality agreement is signed which prohibits any identified information from being revealed. Health care providers are also promised anonymity. Therefore the mother's comments from FIMR cannot be revealed in a CFR or a Citizens Review Panel in which the identity of the deceased child is known.

The State CFR, FIMR, and Citizens Review Board programs are committed to working cooperatively, and will help local teams coordinate case reviews so that there is not a burden of duplication or confusion over jurisdiction.

11 Confidentiality and Immunity

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. There is a suggested state CFR confidentiality forms. Jurisdictions using their own forms should submit a copy to the State Team.

Suggestion: Sign confidentiality forms at every meeting, to reinforce the importance of careful use 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. The guiding principal is that the review team meeting itself is the place given privilege in the law to discuss confidential information. The state 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 before or after the meeting. This means that no written summary, minutes, or other printed case information is to be taken from a review team meeting. Team members may make notes only for the use of their agency, according to agency confidentiality guidelines. The official record of the case discussion is limited to the state CFR case information forms. Other deliberations of the team that

are not case specific may of course be recorded and handled according to the judgement of the group.

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. Members of a local team are not permitted to reveal outside of the meeting confidential information which was disclosed during the meeting. The one exception to this requirement is that team members may bring back to their agency information about the case that will be used to further the agency's work with that specific case. E.g., for investigation, to support survivors, to protect other children.

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

Statistical information that would not permit the identification of any person is public information. However, confidentiality must be maintained in team recommendations and reports. Certain facts or statements may be easy to relate to characteristics of well known local cases. Since the death is a matter of public record, it is not necessary to disguise every reference to a case completely. The requirement is that aspects of the case not in the public record be protected. (For example, the community is well aware of an accidental firearm death: The team may engage in public education about firearm safety, obviously in response to that case. But it cannot report that a parent was recently enrolled in a substance abuse program.) The state team wishes to be a resource to local CFR teams in this regard, and will give opinions or review drafts upon request.

Section 5-709 of the CFR law grants CFR teams exemption from disclosure under title 10, subtitle 6 of the State Government Article, subpoena, discovery, or introduction into evidence in a civil or criminal proceeding. Team members can be assured that it is safe to discuss sensitive topics in the CFR meeting.

12 Use of Information from a CFR Meeting

Child death review teams are not a mechanism for criticizing or second-guessing any agency decisions; they are a forum for the sharing of information essential to the improvement of 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, not blame for the past. Agencies should have their own internal training, quality assurance, and management process to deal with specific problems. (If not, that lack of internal controls is a systems issue, rather than the behavior of one person in a case).

Information from a review has occasionally contributed significantly to the outcome of a pending death investigation (though most case reviews in Maryland take place more than

a month after the death, in order to have complete information). Team members may use the knowledge obtained during confidential reviews to assist their agency in gathering additional information in a pending investigation. The review meeting itself may not be cited as a source of information in agency records, due to the confidentiality requirements for team meetings.

Suggestion: The team may make an agreement about deciding when and to whom information or recommendations may be disclosed. E.g., upon vote of the group, or approval of the chair. It is helpful to have a policy about media requests for information. Without a clear policy, strongly felt views can easily lead to misunderstandings and disagreements about who 'owns' the findings and the voice of the team.

13 Record Keeping

As described above under confidentiality, case specific information is recorded only on the state case report form, along with any local additions to that form. A standard report form shall be completed on all deaths reviewed. These reports are sent to the State Child Fatality Review Team and entered as aggregate data. A copy is also retained by the local team. Local teams are free to keep whatever additional information they wish about the case, as long as it is clearly identified as part of the local CFR team case record.

Suggestion: Someone may be appointed to fill out the state CFR report form during the meeting. It is then possible at the end of case discussion to read out missing items and ask if anyone has the information. It is time consuming to try to fill in the form after the meeting is over, and many data elements will be missing. Someone may also be designated to begin filling out report forms prior to review meetings to save time during the meeting. The pre-filled data should still be validated during the case discussion, in case other team members have different information.

In addition to case specific information, the team will have recommendations, actions steps for advocacy, housekeeping business, and so on. Recommendations and action steps are actually the *most important products of the team*. The local team uses it's collective expertise, special knowledge of the community and the situation to analyze cases. The results of this analysis are not available in any other way. Individuals who may later aggregate case data may make other valuable contributions, but will never be able to extract from it any of the specific local solutions to problems or ways to improve local systems. The chairperson should be sure that a record is maintained of these items. They are not subject to the confidentiality restrictions for case information, but may still be sensitive or even controversial. See the above discussion in Use of Information from a CFR Meeting.

Suggestion: Many local review teams have lost valuable findings and recommendations because they focus on gathering information on the case rather than recording their own analysis of it. If the chair or facilitator is giving adequate attention to group process, keeping the group on track, etc., he or she will not be able to also record the discussion. It is useful for the group leader to write on a board or chart, and achieve consensus about what the team decided. However, writing it down in an orderly way

for future use is still necessary. Experience has shown that rotating the responsibility of recorder is also ineffective. If no one in the group is willing or skilled at this, consider recruiting someone for the purpose.

It is helpful to record minority opinions. The team is recruited to represent various viewpoints. From time to time those will result in different perceptions or opinions, which may be a valuable finding in and of itself. The opposing views may represent similar views in the community or between agencies. Recording only majority opinions prevents this diversity or disagreement from being known.

14 Investigation of Child Deaths According to National Standards

This provision of the legislation is difficult to apply, as it is a clause from law in another state: 'Set as it's goal the investigation of child deaths in accordance with national standards.' In some states CFR teams have responsibility to investigate deaths. However, that is not the case in Maryland. Therefore the meaning for Maryland local CFR teams would be that they should evaluate local death scene investigations against national standards, and advocate for improvement where needed. There are no specific guidelines for this activity. The State Team welcomes discussion with local teams about their evaluation of death scene investigation.

C. Reports and Recommendations

Child Fatality Review is only useful when the insights gained from reviewing cases are put into recommendations and then implemented in some way. Guidelines for forming valid and achievable recommendations will be developed by the State CFR team and training offered in the future.

1 Annual Report

The State CFR Team adopted a report for the first year of the CFR program under the state law. For the year 2001, local teams will be required to report their findings to the state team. The calendar year will be the reporting period, to match vital records and other data. The data system under development will define many of the elements to be reported.

Specific requirements for annual reports are formulated by the State CFR Team, and will change over time. However, the general reporting categories required in the law are:

- Number of meetings, and the agency agencies or organizations represented at each meeting.
- Description of the causes and incidence of all child deaths in the county, including those not reviewed by the multi-disciplinary team, and comparison with state data.
- State and local recommendations for improving services, coordination of services, and investigations.
- State and local recommendations for preventing morbidity and mortality.
- Recommended changes to local or state law, policy, and practice.
- Evaluation of the extent to which state and local agencies are effectively discharging their child protection responsibilities in accordance with the state plan under 42 U.S.C. 5106A(B), and the standards it sets forth.

- Any actions taken by the team, e.g., implementation of the recommendations or advocacy for them

2 Implementing Recommendations: Community Action

At this time, there are no specific policies for implementing recommendations. The law requires local teams to recommend actions to agencies that will improve coordination of services and investigations, and prevent deaths.

Local teams should consider having action committees or subcommittees to make and follow-up on recommendations and provide community education. It is difficult for a local CFR team to find the resources to work on systems improvement. The most successful local CFR teams make partnerships with other organizations in the community with which they accomplish change. For example, in some counties the Local Management Board has taken up recommendations from the CFR.

IV. Criteria for Reviewing Cases

The Maryland CFR law requires local jurisdictions to review child deaths, and to annually report on them. The law does not define which cases need full multi-disciplinary review versus some other form of review. The State CFR Team has interpreted the law as follows.

Local Teams should perform:

- Vital Records review of all resident child deaths
- Full multi-disciplinary review by the local CFR team of child deaths to county residents which are Medical Examiner cases
- Discretionary review of records or local multi-disciplinary team review of other resident or non-resident child deaths and non-fatal sentinel events, as the team defines them.

A. Age

Section 5-701-(B) requires review of deaths in children up to age 18. (I.e., through the 17th year.) Local teams may elect to review deaths up to age 21 years, for example in the case of a developmentally delayed person. Deaths occurring in the first year of life which are a Medical Examiner's case should be reviewed for purposes of CFR, even if also reviewed for purposes of the Fetal and Infant Mortality Review (FIMR) committee, as different aspects of the death are examined by each group. In some jurisdictions, some members may sit on both committees. Insights of one committee may be shared with the other, to the extent that this can be accomplished without breach of confidentiality. See section above on Relationship to Other Review Processes, including the requirement to submit to the state team a procedure for sharing information between review processes.

B. Residence

Cases are determined by the deceased child's county of residence, regardless of the county or out-of-state location in which the death occurred (as are vital records). It is often advisable, though not required, for the county in which a death occurs or in which an incident occurs which results in a death elsewhere, to review the death. The circumstances in which a non-resident death occurs may represent hazards to the resident community, such as a dangerous

intersection, poorly fenced swimming pool, or unique natural feature such as shoreline or mountain. If a team reviews a non-resident death, they should consult with the county of residence, and send a copy of the case report form to that team. The team in the county of residence is responsible for filing a report (which may include information submitted by the county of occurrence) with the state. It is also necessary to differentiate resident from non resident deaths in reports.

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

Suggestion: Working with a neighboring state's Office of Maternal and Child Health or CFR may facilitate interstate exchange of data. See current information from the State CFR Team on contacts and policies in neighboring states and the District of Columbia.

In the absence of autopsy reports and other data, reviews should be performed using whatever information is available from local data sources, including newspapers. Because out-of-state deaths are not evaluated by the Maryland OCME, it is likely that some of these will be unknown to the local team and will thus not be reviewed.

C. Review of All Child Deaths Using Vital Records

The local CFR team is responsible for annually reporting on all deaths to children in the county. See the section above on Reporting, and the current reporting requirements from the State CFR Team. Reviewing vital records may be done in a number of ways by staff or a subcommittee of the local CFR team. The results of the record review should, however, be discussed by the full review team before being reported. The purpose of the record review is to describe the universe of fatalities and the context for the fully reviewed deaths. Emphasis should be on prevention and systems improvement, just as with fully reviewed cases.

D. Medical Examiner Cases

The state Office of the Chief Medical Examiner (OCME) will refer identifying information about all cases, ages 0 through 17, to the designated local contact person in the jurisdiction of residence in the month following the death. See sections above. All ME cases are to be reviewed by the full multi-disciplinary team.

E. Other Reviewable Cases

Local teams are encouraged to review child deaths not referred by the OCME, including those due to acute or chronic illness. The goal of the child fatality review process is to prevent child deaths and improve systems. Examining causes of or contributing factors to fatal childhood illnesses or other conditions, including socioeconomic and environmental factors, may be productive.

Suggestion: Teams may wish to adopt a policy that permits any team member to suggest non-OCME cases or near fatalities for full review. This practice is similar to the way most multi-disciplinary child protection teams operate, to ensure that potential cases in the community are being screened from all angles and professional judgments.

Jurisdictions with a small number of child deaths are particularly encouraged to review 'near fatalities'. Health-General Article 5-706 (6) provides that the State Team, in consultation with local teams, is to 'define 'near fatality' and develop procedures and protocols that local teams and the State Team may use to review cases of near fatality'. It is anticipated that the definition of 'near fatality' will vary from one jurisdiction to another. For example, a team may discover an issue from a fatality review, and wish to explore it by examining cases of non-fatal injury or illness due to the same circumstances. There may be risk factors inherent to certain jurisdiction but absent from others. At this time, each jurisdiction or local team should decide, in consultation with the State Team, what cases would constitute a 'near fatality'. This determination should be based on the purpose, as stated in the statute, that the goal of the local teams is to 'prevent child deaths'. As the State Team has opportunity to consult with and review the reports of the local teams, further definition for this term may be adopted for purposes of state level data collection. Data from reviews of non-fatalities will be kept separate from fatalities.

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