

**MARYLAND**  
**STATE CHILD FATALITY REVIEW TEAM**  
**Baltimore, Maryland 21201**

September 1, 2016

The Honorable Larry Hogan  
Governor  
State of Maryland  
Annapolis, MD 21401-1991

The Honorable Thomas V. Mike Miller, Jr.  
President of the Senate  
State House, H-107  
Annapolis, MD 21401-1991

The Honorable Michael E. Busch  
Speaker of the House  
State House, H-101  
Annapolis, MD 21401-1991

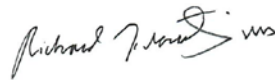
RE: Health-General Article, § 5-704(b)(12) and Senate Bill 464 (Chapter 355 of the Acts of 1999) –  
2016 Legislative Report of the State Child Fatality Review Team

Dear Governor Hogan, President Miller, and Speaker Busch:

Pursuant to Health-General Article, § 5-704(b)(12) and Senate Bill 464, Chapter 355 of the Acts of 1999, the Maryland State Child Fatality Review Team submits this 2016 report on its progress and accomplishments in calendar year 2015. The report sets forth data relating to unexpected child deaths in Maryland occurring in calendar year 2015, reported by the Office of the Chief Medical Examiner, and reviewed by the local Child Fatality Review team in each jurisdiction.

If you have questions or need further information about this report, please contact me at (410) 328-2079 or [rlichenstein@peds.umaryland.edu](mailto:rlichenstein@peds.umaryland.edu).

Sincerely,



Richard Lichenstein, MD  
Chairperson

Enclosure

cc: Allison Taylor, M.P.P., J.D., Director, Office of Governmental Affairs  
Howard Haft, M.D., Deputy Secretary, Public Health Services  
Michelle Spencer, M.S., Director, Prevention and Health Promotion Administration  
Ilise Marrazzo, R.N., B.S.N., M.P.H., Director, Maternal and Child Health Bureau  
Sarah Albert, MSAR #7575

# **MARYLAND STATE CHILD FATALITY REVIEW TEAM**

## **2016 Annual Legislative Report**

Health-General Article, § 5-704(b)(12)

Larry Hogan  
Governor

Boyd K. Rutherford  
Lt. Governor

Van T. Mitchell  
Secretary, Department of  
Health and Mental Hygiene

<http://phpa.dhmh.maryland.gov/mch/Pages/cfr-home.aspx>

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## **Overview of Maryland Child Fatality Review**

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

The purpose of the Maryland State Child Fatality Review (CFR) Team is to prevent child deaths by: (1) understanding the causes and incidence of child deaths; (2) implementing changes within the agencies represented on the State CFR Team to prevent child deaths; and (3) advising the Governor, the General Assembly, and the public on changes to law, policy, and practice to prevent child deaths. The State CFR Team envisions the elimination of preventable child fatalities by successfully using the CFR process to understand the circumstances around incidents of child fatality and to recommend strategies for prevention of future fatalities.

The Maryland CFR Program, established in statute in 1999, is housed within the Department of Health and Mental Hygiene (DHMH) for budgetary and administrative purposes. The 25 member State CFR Team is comprised of representatives from multiple State agencies and professional organizations, as well as two pediatricians and 11 members of the general public with interest and expertise in child safety and welfare who are appointed by the Governor (see Appendix A). The State CFR Team meets at least four times a year to address 13 statutorily-mandated duties (see Appendix B). One of these meetings is in conjunction with an all-day training for local CFR team members on select topics related to child fatality issues (see Appendix C).

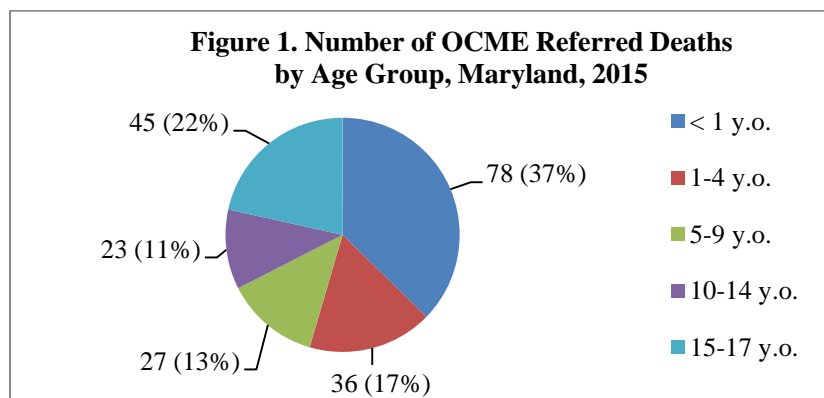
The State CFR Team provides support to local CFR teams that operate in each jurisdiction. Each month the local CFR teams receive notice from the Office of the Chief Medical Examiner (OCME) of unexpected resident child deaths (under age 18). The local CFR teams are required to review each of these deaths. Local teams meet at least quarterly to review cases and make recommendations for local level systems changes to statute, policy, or practice to prevent future child deaths, and work to implement these recommendations. This report covers data for calendar year 2015 OCME referred deaths.

Other teams in Maryland have similar charges to prevent child injury and death. The State Council on Child Abuse and Neglect (SCCAN) and the Citizen Review Board for Children (CRBC) examine policies and practices for protecting children. The State CFR Team is encouraged to work collaboratively with SCCAN and CRBC to coordinate prevention efforts. Also, the DHMH Morbidity, Mortality, and Quality Review Committee (MMQRC), established by legislation in 2008, is charged with reviewing morbidity and mortality associated with pregnancy, childbirth, infancy, and early childhood. The MMQRC provides another opportunity for review and dissemination of information and recommendations developed through the CFR process. The local CFR teams also work collaboratively with local Fetal and Infant Mortality Review (FIMR) teams in each jurisdiction.

## Unexpected Child Deaths - Maryland, 2015

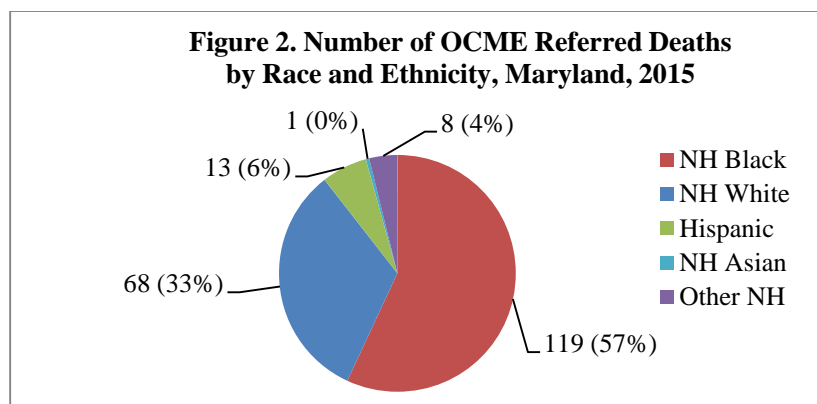
Childhood deaths are a major public health concern, as many of these deaths are preventable. Surveillance of childhood deaths is important because it helps to measure the magnitude of the problem, and to assess the causes and populations affected. These data are crucial in identifying trends and targeting interventions to prevent childhood deaths. The CFR process reviews unexpected child deaths referred by the OCME. This subset of child deaths includes cases of Sudden Unexplained Infant Death (SUID), unintentional injury, homicide, suicide, and some deaths due to natural causes. The Office of Maternal and Child Health Epidemiology within the DHMH Maternal and Child Health Bureau has reviewed OCME referred child deaths for summary in this report. This report examines data related to 2015 child deaths available as of June 2, 2016.

In 2015, the OCME referred 209 child deaths to the local CFR teams for review. Figure 1 shows the distribution of these deaths by age. Seventy-eight deaths (37 percent) occurred among infants (under one year of age). Of the 209 child deaths, 124 deaths (59 percent) occurred among male children and 85 deaths (41 percent) among female children.



Source: OCME Referral Tracker (i); referrals made as of 6/2/2016  
 (i) OCME database of cases referred for local CFR team review. y.o.: years old.

Figure 2 shows the distribution of 2015 OCME referred deaths by race and ethnicity. Deaths among non-Hispanic Black children were 1.8 times more frequent than deaths among non-Hispanic White children, and nine times more frequent than deaths among Hispanic children.



Source: OCME Referral Tracker; referrals made as of 6/2/2016. NH: Non-Hispanic

In Table 1, the number and percentage of OCME referred deaths occurring in 2015 are shown by cause of death category. Among the 209 referred deaths, the three leading causes of death were injury, SUID, and homicide. Together these three causes accounted for 76 percent of all OCME referred deaths. For three cases from 2015, the final cause of death is still pending.

The OCME defines SUID as “...the sudden death of an infant less than one year of age that cannot be explained after a thorough investigation is conducted, including a complete autopsy, examination of the death scene, and a review of the clinical history. All potentially non-natural causes of death cannot reasonably be excluded by the investigation and/or there is an issue of concern; for example an unsafe sleeping environment or other environmental concerns, previous SIDS in the immediate family, healed unexplained injuries, parental substance abuse etc.” Sudden Infant Death Syndrome (SIDS) is included in this category.

<b>Table 1. OCME Referred Deaths by Cause of Death Category, Maryland, 2015</b>		
	<b>#</b>	<b>%</b>
Injury	63	30.1
SUID*	59	28.2
Homicide	36	17.2
Suicide	16	7.7
Medical Conditions	14	6.7
Infectious Disease	11	5.3
SUDIC**	5	2.4
Pending	3	1.4
Birth Related	2	1.0
<b>Total</b>	<b>209</b>	<b>100</b>

Source: OCME Referral Tracker; referrals as of 6/2/2016

\* Sudden unexplained infant death (<1 y.o.)

\*\* Sudden unexplained death in childhood (SUDIC) (1-17 y.o.)

Injury was the leading cause of 2015 OCME referred deaths. Table 2 further breaks down the injury deaths by subcategory. Motor vehicle accidents (MVAs) were the leading cause of injury death (38 percent), followed by fire and burns (18 percent), and asphyxia (which includes suffocation, strangulation, choking, confinement in a tight space, etc.) (16 percent). These three types of injuries accounted for 72 percent of all injury deaths.

Local CFR teams reported 5 deaths (2.4 percent) resulting from “confirmed” abuse or neglect among the 209 deaths occurring in 2015. This means there was a finding of “indicated” abuse or neglect by Child Protective Services or police investigation.

<b>Table 2. OCME Referred Injury Deaths by Subcategory, Maryland, 2015</b>		
	<b>#</b>	<b>%</b>
MVA	24	38.1
Fires/Burns	11	17.5
Asphyxia	10	15.9
Poisoning	8	12.7
Drug Related	5	7.9
Drowning	1	1.6
Electrocution	1	1.6
Falling Object	1	1.6
Head Trauma	1	1.6
Hyperthermia	1	1.6
<b>Total</b>	<b>63</b>	<b>100</b>

Source: OCME Referral Tracker; referrals as of 6/2/2016

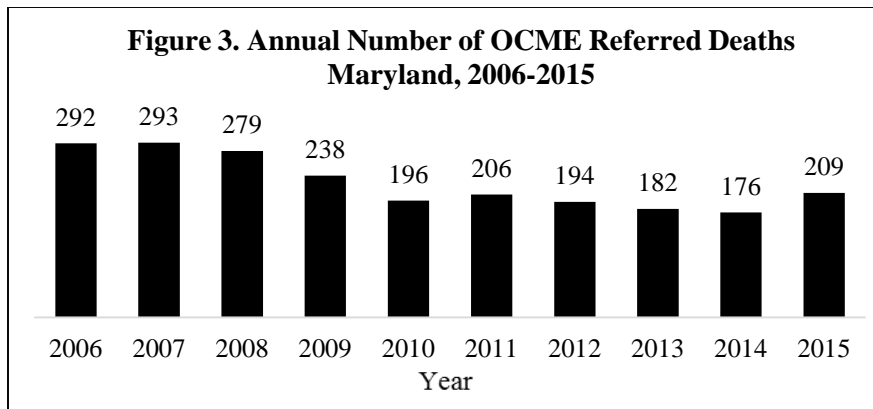
In Table 3, the number and percentage of deaths in 2015 are shown by jurisdiction of residence of the child at the time of death. Six jurisdictions (Baltimore City; Baltimore, Anne Arundel, Prince George's, Montgomery, and Washington Counties) accounted for 67 percent of all referred child deaths. Almost one quarter of all OCME referred deaths occurred among Baltimore City resident children.

<b>Table 3. OCME Referred Deaths by Jurisdiction of Residence, Maryland, 2015</b>		
	<b>#</b>	<b>%</b>
Baltimore City	49	23.4
Baltimore County	25	12.0
Anne Arundel	19	9.1
Prince George's	18	8.6
Montgomery	17	8.1
Washington	12	5.7
Charles	8	3.8
Somerset	8	3.8
Wicomico	7	3.4
Cecil	6	2.9
Carroll	5	2.4
Harford	5	2.4
Howard	5	2.4
St. Mary's	5	2.4
Allegany	4	1.9
Queen Anne's	4	1.9
Frederick	3	1.4
Calvert	2	1.0
Caroline	2	1.0
Garrett	2	1.0
Dorchester	1	0.5
Talbot	1	0.5
Worcester	1	0.5
Kent	0	0.0
<b>Total</b>	<b>209</b>	<b>100</b>

Source: OCME Referral Tracker; referrals as of 6/2/2016

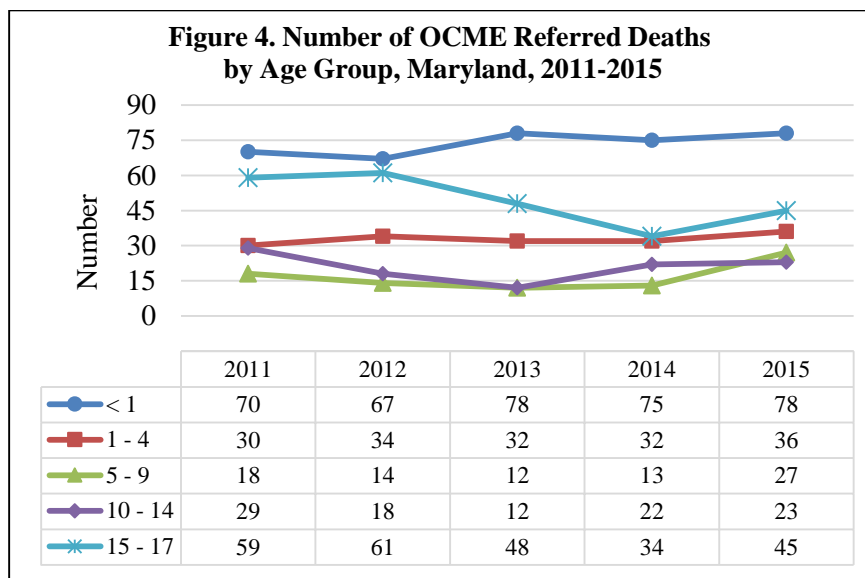
## Trends in Maryland Unexpected Child Deaths

Figure 3 shows the annual number of unexpected child deaths referred by the OCME for the past ten years (2006 to 2015). Discrepancies between the numbers of annual OCME referred deaths reported in the 2015 and 2016 reports can be attributed to the removal of fetal deaths from the counts. On occasion, fetal deaths are included in OCME referrals; however, these cases are not reviewed by the CFR teams. The figures in the 2016 report represent updated values with the removal of fetal deaths from the count of OCME referred deaths. The annual number of referred deaths changed very little from the beginning of the CFR program in 2000 through 2008. From 2008 to 2014 the number of referred deaths decreased by 37 percent. This represented an actual decrease in the number of unexpected child deaths in the State since there was no change in the case selection or reporting process during that period. Unfortunately, this trend did not continue in 2015 with a 17 percent increase in the number of referred deaths over 2014.



Source: OCME Referral Tracker; referrals made as of 6/2/2016

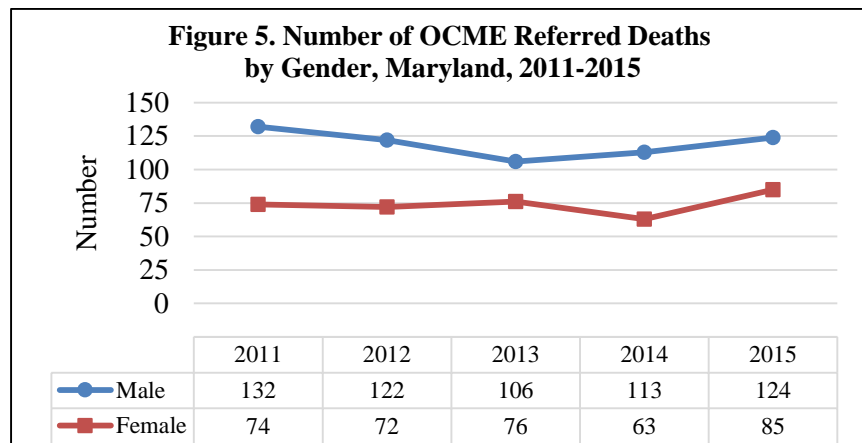
Figure 4 shows the number of OCME referred deaths by age group over the five year period from 2011 to 2015. Between 2014 and 2015, the number of deaths increased in all age groups, but the largest increases were among children age five to nine and among teens age 15 to 17.



Source: OCME Referral Tracker; 2015 referrals made as of 6/2/2016

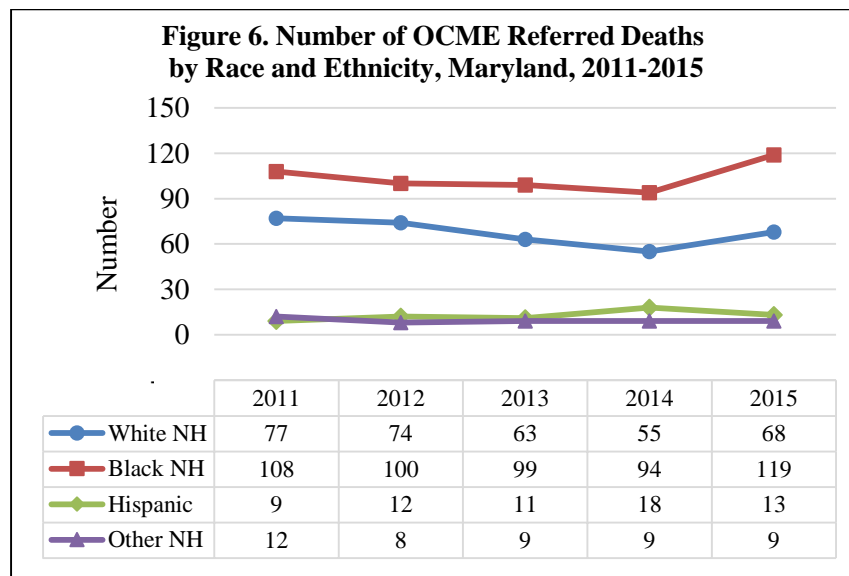


During the same period (2011 to 2015), the number of referred deaths was consistently higher among male children than among female children (Figure 5). In 2015, unexpected deaths were 1.5 times more likely among male children than among female children.



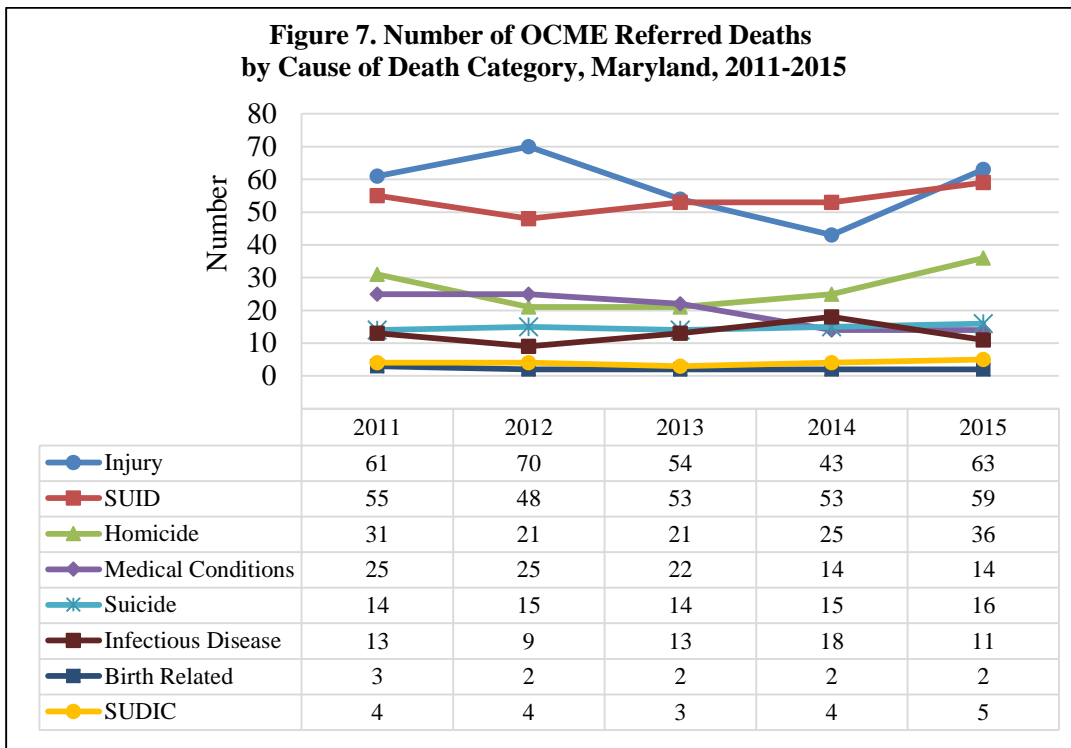
Source: OCME Referral Tracker; 2015 referrals made as of 6/2/2016

Similarly, Figure 6 shows the continued disparities among racial and ethnic groups. Deaths among non-Hispanic Black children were 1.4 to 1.8 times more frequent than deaths among non-Hispanic White children, and 5.2 to 12.0 times more frequent than deaths among Hispanic children. Between 2014 and 2015, OCME referred deaths among non-Hispanic Black children increased by 27 percent, while those among non-Hispanic White children increased by 24 percent. Referred deaths among Hispanic children remained much lower, with a 28 percent decrease in 2015.



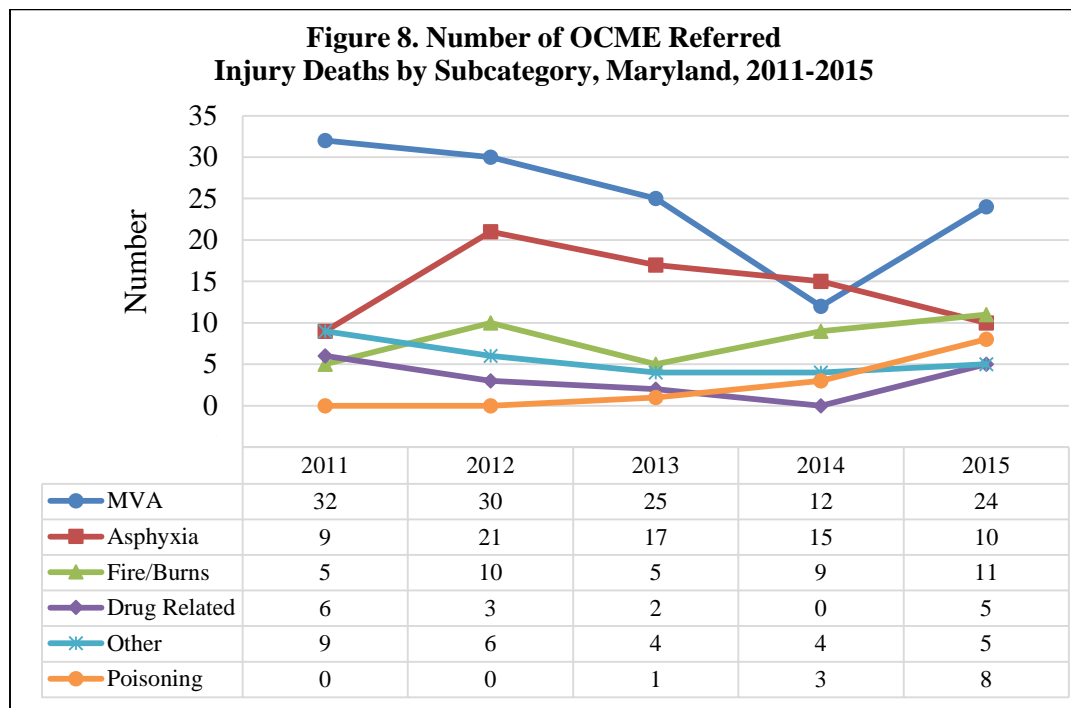
Source: OCME Referral Tracker; 2015 referrals made as of 6/2/2016

Figure 7 shows the number of OCME referred deaths by cause of death for the past five years. Injury was the leading cause and SUID the second leading cause of death for each year except 2014 when SUID became the leading cause. Between 2014 and 2015, injury deaths increased 47 percent, SUID deaths increased by 11 percent, and deaths due to homicide increased 44 percent.



Source: OCME Referral Tracker; 2015 referrals made as of 6/2/2016. Excludes 'pending' cases (2 in 2014; 3 in 2015)

Figure 8 shows the subcategories of injury deaths over the past five years. The increase in injury deaths in 2015 was largely due to a doubling of the number of deaths from motor vehicle accidents. Deaths in all subcategories of injury deaths increased except deaths from asphyxia.



Source: OCME Referral Tracker; referrals made as of 6/2/2016

Table 4 shows the number of OCME referred deaths by jurisdiction of residence of the child at the time of death. During the five-year period from 2011 to 2015, the number of resident child deaths decreased in Prince George's County by 42 percent. In Washington County, there has been a steady increase in the number of resident child deaths over this period.

<b>Table 4. Number of OCME Referred Deaths by Jurisdiction of Residence, Maryland, 2011-2015</b>						
	<b>2011</b>	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>Total</b>
Baltimore City	53	48	40	45	49	235
Baltimore County	22	23	19	21	25	110
Prince George's	31	20	26	14	18	109
Montgomery	10	19	15	31	17	92
Anne Arundel	20	19	11	11	19	80
Harford	8	12	13	9	5	47
Washington	5	6	7	9	12	39
Charles	7	5	9	3	8	32
Frederick	9	1	11	6	3	30
Howard	7	9	6	2	5	29
Cecil	10	5	3	3	6	27
Carroll	5	5	3	3	5	21
Wicomico	2	5	3	2	7	19
Allegany	2	3	3	5	4	17
St. Mary's	3	1	1	5	5	15
Caroline	1	5	2	2	2	12
Calvert	3	4	1	1	2	11
Somerset	0	0	0	2	8	10
Queen Anne's	2	1	0	0	4	7
Talbot	3	2	1	0	1	7
Worcester	2	1	2	0	1	6
Dorchester	0	0	3	1	1	5
Garrett	0	0	2	1	2	5
Kent	1	0	1	0	0	2
<b>Total</b>	<b>206</b>	<b>194</b>	<b>182</b>	<b>176</b>	<b>209</b>	<b>967</b>

Source: OCME Referral Tracker; 2015 referrals made as of 6/2/2016

## **Sudden Unexplained Infant Deaths in Maryland**

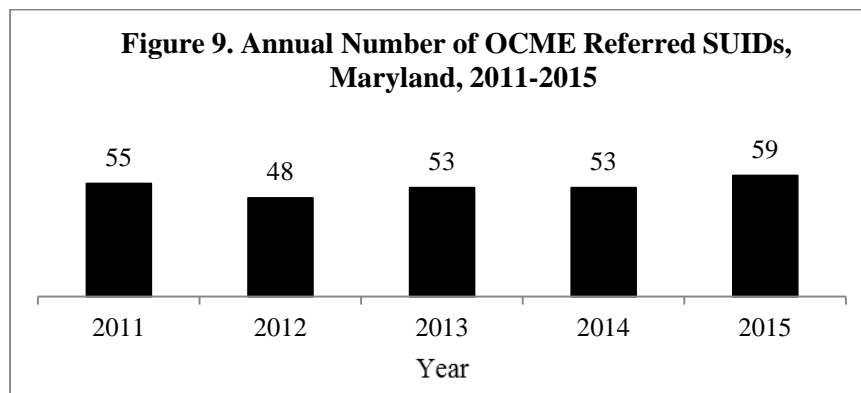
SUID is the sudden death of an infant less than one year of age that cannot be fully explained after a thorough review of the medical history, a complete autopsy, and examination of the death scene. Approximately 3,500 infants die suddenly and unexpectedly each year in the United States. The majority of these deaths occur while the infant is sleeping in an unsafe sleep environment. The majority of these deaths could have been prevented if safe sleep practices were always followed. Key components of a safe sleep environment are placing infants to sleep alone, on their backs, on a firm sleep surface with no soft objects, and in a smoke-free environment.

While unsafe sleep factors are present in a majority of cases, an exact cause of death cannot always be determined. These deaths are often not witnessed, the death scene may be disturbed before it can be examined, key facts may be forgotten or go unreported, and there may be no autopsy finding or medical test to prove the exact cause of death (e.g. suffocation). The mechanisms that lead to many sleep-related deaths include:

- Accidental suffocation by a soft sleep surface (e.g. an adult bed, waterbed mattress, pillows, soft couch or chair cushions) or other soft materials placed in the infant's sleep environment (e.g. stuffed toys, blankets, crib bumpers).
- Overlay when the infant is bed-sharing with another person who rolls on top of or against the infant.
- Wedging or entrapment of the infant between two objects (e.g. a mattress and wall or bed frame, or between furniture cushions).
- Strangulation when the infant's head and neck become caught between crib railings, or the infant's neck becomes entangled in a cord or other material within the sleep environment.

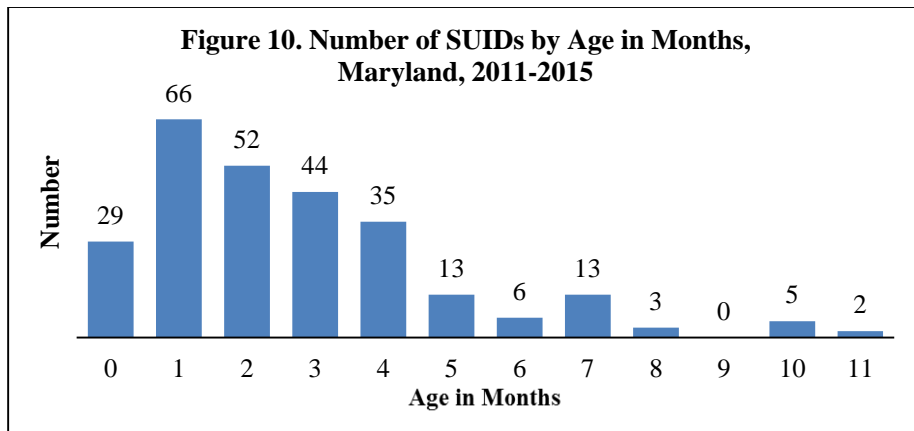
Even after a thorough investigation, there are some SUID cases in which there is no evidence of non-natural cause of death or issues of concern within a reasonable degree of certainty. These cases fall under the subcategory of Sudden Infant Death Syndrome or SIDS. SIDS is a diagnosis of exclusion, assigned only when all known and possible causes of death have been ruled out.

In Maryland, there is an average of 54 SUID cases referred by the OCME for review each year. A total of 268 SUID cases occurred between 2011 and 2015 (Figure 9).

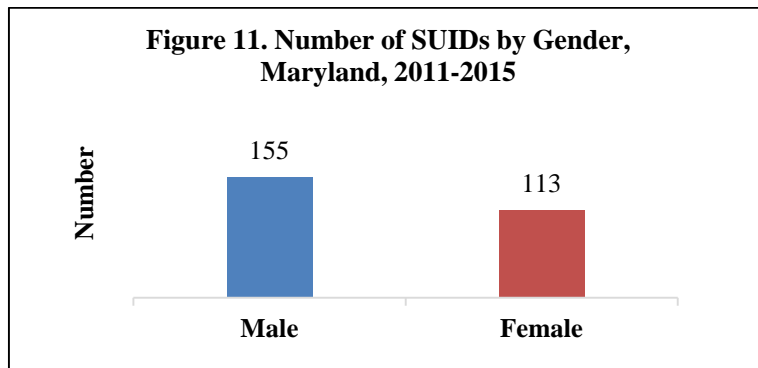


Source: OCME Referral Tracker; 2015 referrals made as of 6/2/2016

Of the 268 SUIDs during this period, 226 (84 percent) occurred in the first four months of life (Figure 10). Fifty-eight percent of these deaths occurred among male infants, and 42 percent occurred among female infants (Figure 11).

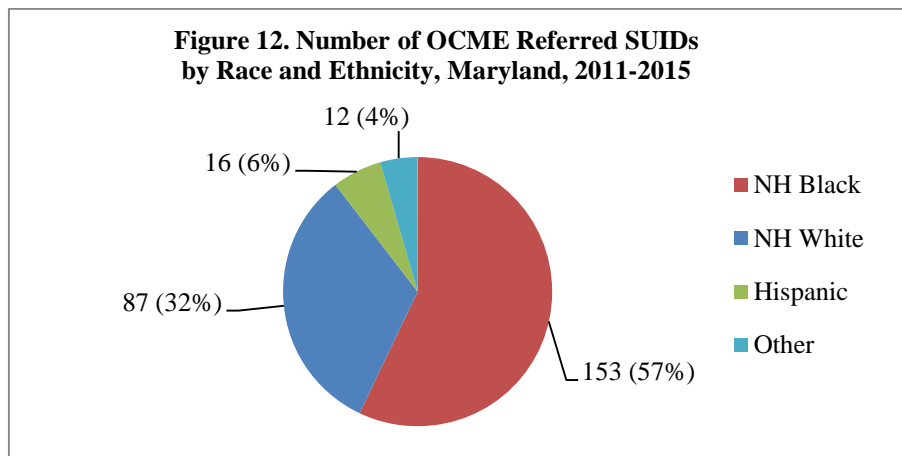


Source: OCME Referral Tracker; 2015 referrals made as of 6/2/2016



Source: OCME Referral Tracker; 2015 referrals made as of 6/2/2016

Of the SUID cases occurring from 2011 to 2015, 153 deaths (57 percent) occurred among non-Hispanic Black infants. This is 1.8 times the number of cases among non-Hispanic White infants, and almost 10 times the number among Hispanic infants (Figure 12).



Source: OCME Referral Tracker; 2015 referrals made as of 6/2/2016

Table 5 shows the number of SUIDs by jurisdiction of residence of the infant at the time of death for each of the last five years (2011 to 2015). The largest number of SUIDs each year occurred among residents of Baltimore City, which accounted for 28 percent of all SUIDs during this period. The number of SUID cases is small in most other jurisdictions, which makes it difficult to identify trends.

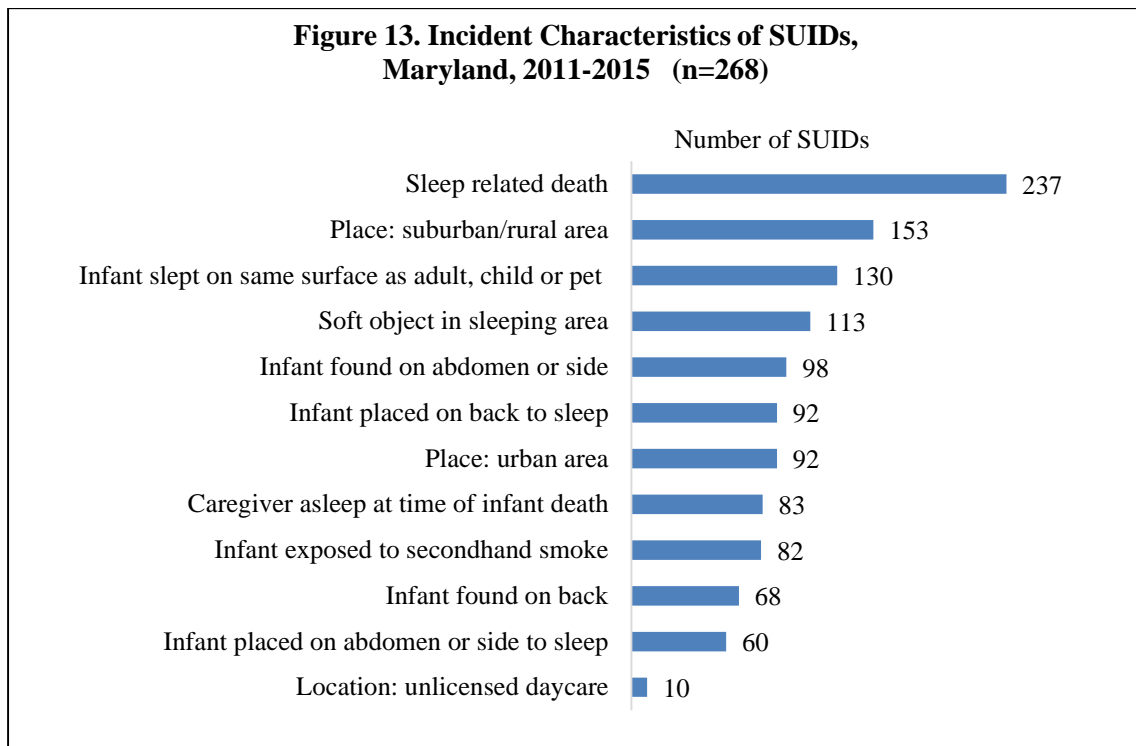
<b>Table 5. Number of OCME Referred SUIDs by Jurisdiction of Residence, Maryland, 2011-2015</b>						
	<b>2011</b>	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>Total</b>
Baltimore City	15	13	19	14	13	74
Baltimore County	3	6	5	11	8	33
Prince George's	8	6	5	5	7	31
Anne Arundel	6	6	7	3	1	23
Montgomery	1	6	4	4	5	20
Harford	1	2	3	5	1	12
Washington	2	0	1	3	6	12
Cecil	4	2	1	1	2	10
Howard	2	2	2	0	4	10
Allegany	2	0	1	2	3	8
St. Mary's	2	0	1	1	2	6
Charles	0	1	2	1	1	5
Worcester	2	1	1	0	1	5
Carroll	2	1	0	0	1	4
Talbot	1	1	1	0	1	4
Frederick	2	0	0	1	0	3
Calvert	0	0	0	1	1	2
Caroline	0	1	0	0	0	1
Dorchester	0	0	0	0	1	1
Garrett	0	0	0	0	1	1
Kent	1	0	0	0	0	1
Somerset	0	0	0	1	0	1
Wicomico	1	0	0	0	0	1
Queen Anne's	0	0	0	0	0	0
<b>Total</b>	<b>55</b>	<b>48</b>	<b>53</b>	<b>53</b>	<b>59</b>	<b>268</b>

Source: OCME Referral Tracker; 2015 referrals made as of 6/2/2016

All OCME referred deaths, including SUIDs, are reviewed by the local CFR team in the jurisdiction of residence. Data from these case reviews are entered into a national database, the Child Death Review Case Reporting System (CDRCRS), which is maintained by the National Center for the Review and Prevention of Child Death. Maryland data have been entered into the CDRCRS since January 2010. This database provides more detailed information on SUIDs. The OCME referred cases were linked to their case reviews in the CDRCRS based on a match of the case number and, if missing, the child's name and date of death. Ninety-six percent of Maryland's 268 SUID referrals were found in the CDRCRS, and 87% had a completed case review. Eleven of the 35 incomplete reviews were 2015 SUID cases which may still be under review.

The SUID case reviews entered into the CDRCRS database were further analyzed to determine more detailed information surrounding these deaths. Information on every item was not available for every case. The specific information may not have been known or reported. Therefore, the numbers of cases shown in Figure 13 and Figure 14 represent a minimum number of cases with a given characteristic.

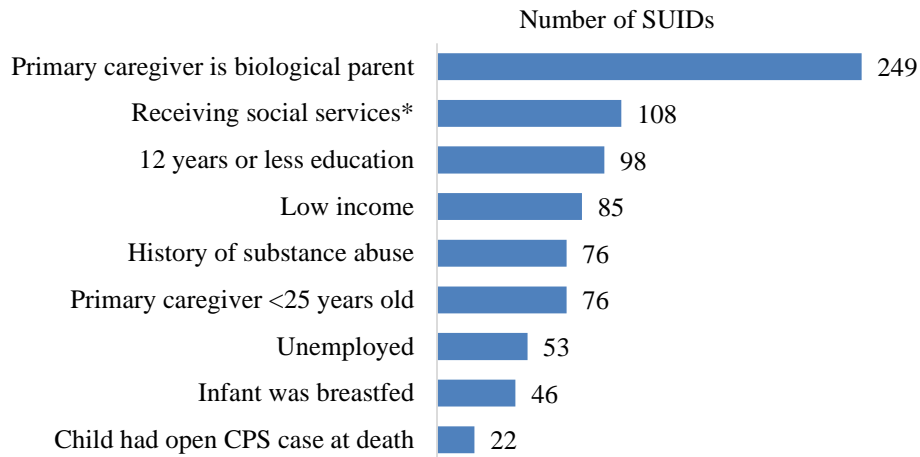
Figure 13 shows incident characteristics of SUIDs in Maryland. The death was determined to be sleep-related in 237 (88 percent) of the 268 SUID cases. Fifty-seven percent of cases occurred in suburban or rural areas. In 130 cases (49 percent), the infant was sleeping on the same surface as an adult, child or pet (bed-sharing). Thirty-seven percent of the infants were found on their abdomen or side. Thirty-one percent of the infants were exposed to secondhand smoke. Ten deaths occurred at an unlicensed daycare setting.



Source: OCME Referral Tracker and CDRCRS Database as of 6/2/2016

Characteristics of the primary caregiver for the infants who died of SUID are shown in Figure 14. A biological parent was the primary caregiver in 249 (93 percent) of the cases. Forty percent of caregivers were receiving social services. Twenty-eight percent of caregivers were under 25 years old, 37 percent had a high school education or less, 32 percent were low income, and 20 percent were unemployed. Twenty-eight percent of caregivers had a history of substance abuse. Forty-six percent of the infants were enrolled in Medical Assistance.

**Figure 14. Caregiver Characteristics Associated with SUIDs, Maryland, 2011-2015 (n=268)**



\*Social services include: Medical Assistance, TANF (ii), WIC (iii), food stamps

Source: OCME Referral Tracker and CDRCRS Database as of 6/2/2016

(ii) Temporary Assistance for Needy Families (TANF)

(iii) Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)

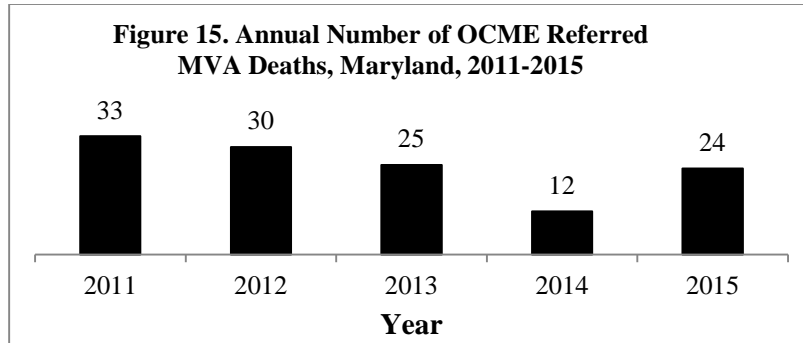
Based on these data, it appears that the number of SUIDs referred by the OCME is increasing. It is unclear if this is due to an increase in recognition and reporting of these cases, or a true increase in the number of deaths. The vast majority of these deaths are sleep-related and therefore potentially preventable if adherence to safe infant sleep practices is improved.

There is a distinct racial and ethnic disparity in SUIDs, with a disproportionate number of these deaths occurring among non-Hispanic Black infants. Additionally, many of these families were receiving social services at the time of the infant's death. Health care providers and social service agencies should use every contact with the parent or caregiver of an infant to reinforce safe sleep practices.



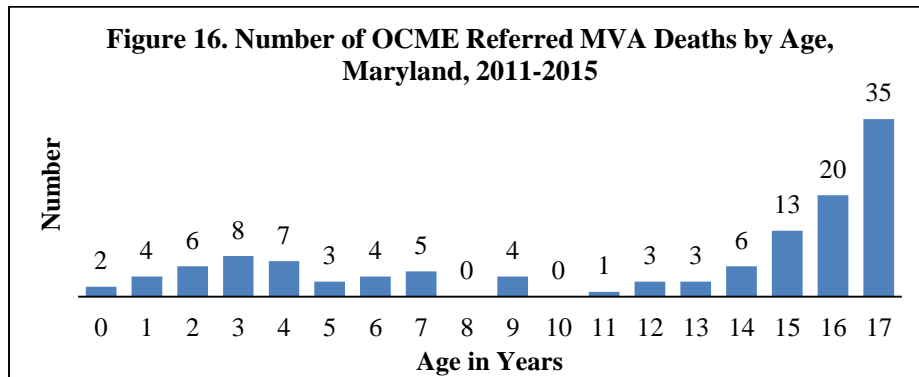
## Motor Vehicle Accident Deaths in Maryland

Injury was the leading cause of 2015 OCME referred deaths, with motor vehicle accidents (MVAs) accounting for almost 40 percent of injury deaths. The number of MVA child deaths had dropped by 64 percent from 2011 to 2014, but has doubled from 2014 to 2015 (Figure 15). Because of this sharp increase, MVA deaths were reviewed in greater detail.

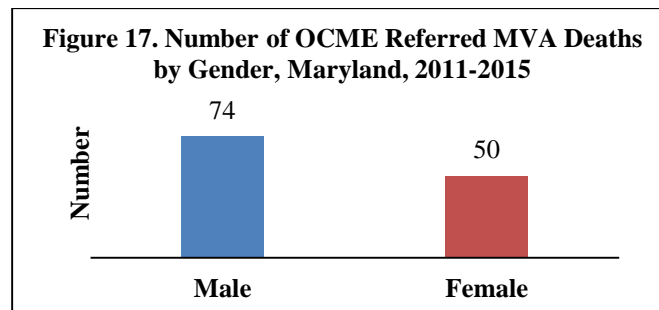


Source: OCME Referral Tracker; 2015 referrals made as of 6/2/2016

Of the 124 MVA deaths occurring in the five year period from 2011 to 2015, 62 percent were among teens age 13-17 (Figure 16). Thirty-two percent of deaths were among children under the age of eight. Sixty percent of MVA deaths occurred among male children and 40 percent among females (Figure 17).

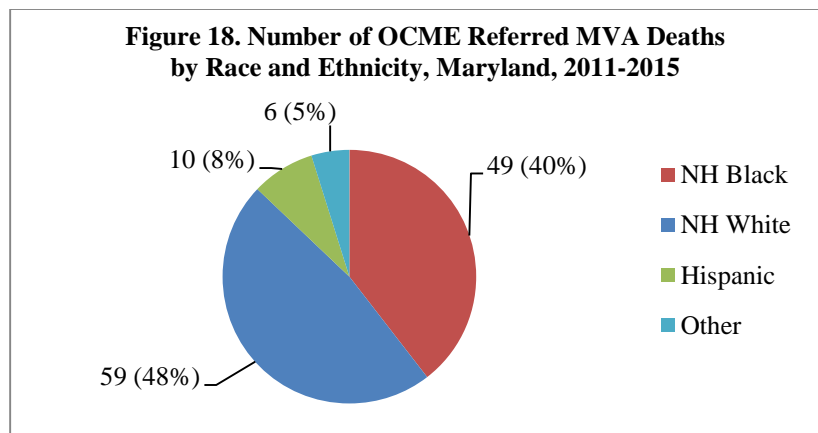


Source: OCME Referral Tracker; 2015 referrals made as of 6/2/2016



Source: OCME Referral Tracker; 2015 referrals made as of 6/2/2016

Forty-eight percent of the MVA deaths occurred among non-Hispanic White children, 40 percent among non-Hispanic Black children, and eight percent among Hispanic children (Figure 18). MVA deaths by jurisdiction of residence are shown in Table 6.



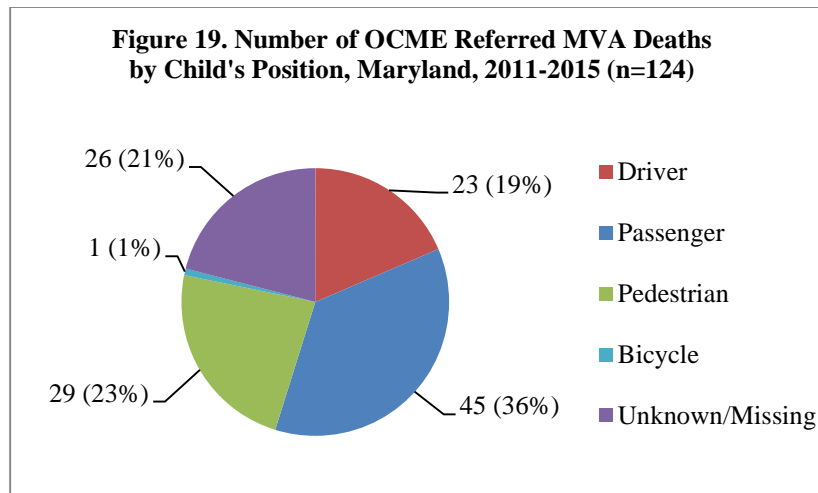
Source: OCME Referral Tracker; 2015 referrals made as of 6/2/2016

	2011	2012	2013	2014	2015	Total
Prince George's	8	1	5	1	5	20
Baltimore City	8	4	2	2	3	19
Baltimore County	3	6	2	0	4	15
Montgomery	1	3	3	3	2	12
Charles	2	3	3	1	0	9
Harford	2	1	3	2	0	8
Washington	1	3	0	1	1	6
Anne Arundel	1	3	1	0	0	5
Carroll	0	2	1	0	1	4
Frederick	2	0	1	0	1	4
Caroline	0	0	0	1	2	3
Cecil	1	1	0	0	1	3
Queen Anne's	1	0	0	0	2	3
Wicomico	0	1	1	0	1	3
Howard	1	0	0	1	0	2
St. Mary's	1	1	0	0	0	2
Allegany	0	1	0	0	0	1
Calvert	0	0	1	0	0	1
Dorchester	0	0	1	0	0	1
Somerset	0	0	0	0	1	1
Talbot	1	0	0	0	0	1
Worcester	0	0	1	0	0	1
Garrett	0	0	0	0	0	0
Kent	0	0	0	0	0	0
<b>Total</b>	<b>33</b>	<b>30</b>	<b>25</b>	<b>12</b>	<b>24</b>	<b>124</b>

Source: OCME Referral Tracker; 2015 referrals made as of 6/2/2016

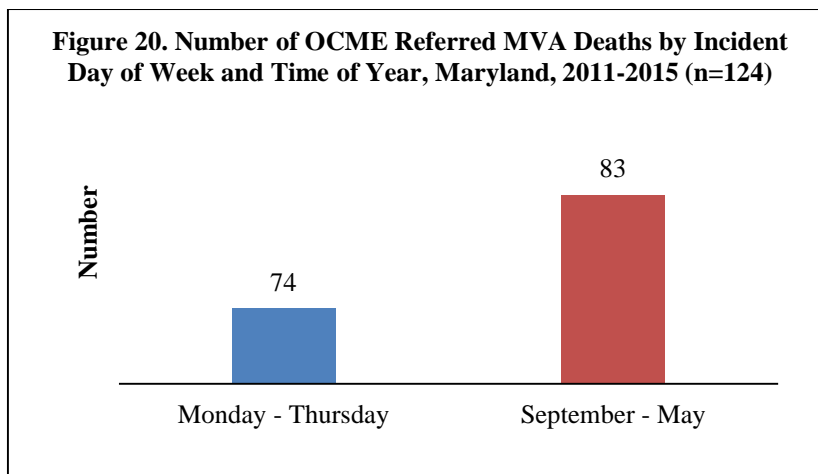
More detailed information on MVA deaths is available in the CDRCRS database. Information on every item was not available for every case. The specific information may not have been known or reported. Therefore, the numbers of cases shown in the following figures represent a minimum number of cases with a given characteristic.

Figure 19 shows the position of the child in the MVA. In 36 percent of cases, the child was a passenger, in 23 percent a pedestrian, and in 19 percent the driver.

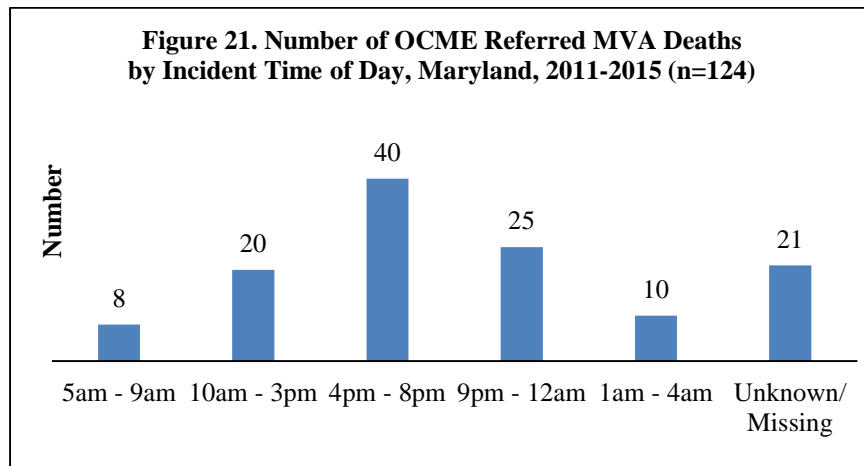


Source: OCME Referral Tracker and CDRCRS Database as of 6/2/2016

Sixty percent of MVA deaths occurred between Monday and Thursday and 67 percent occurred between September and May, months when school is in session (Figure 20). Sixty-nine percent of MVA deaths occurred between 10:00 am and midnight, with the peak occurrence (32 percent) between 4:00 pm and 8:00 pm (Figure 21).

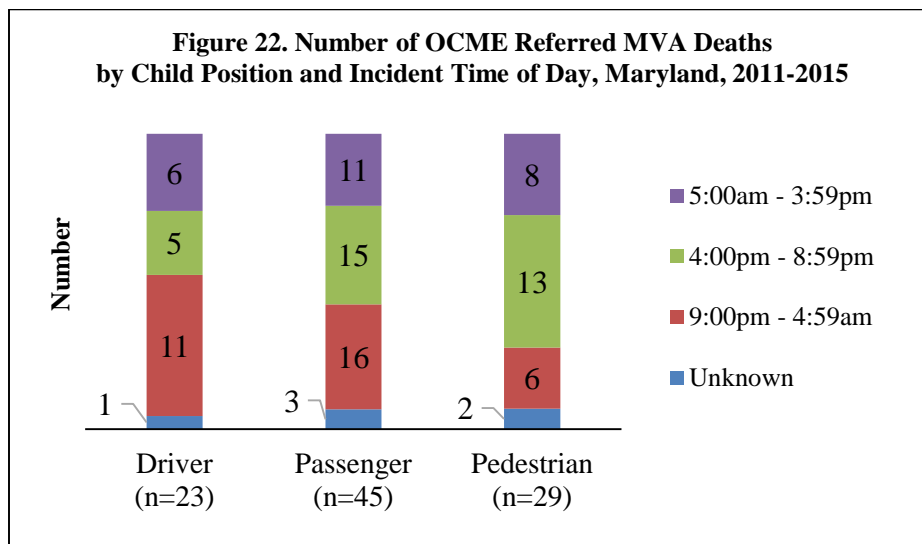


Source: OCME Referral Tracker and CDRCRS Database as of 6/2/2016



Source: OCME Referral Tracker and CDRCRS Database as of 6/2/2016

Almost half of MVA deaths in which the victim was the driver occurred at night, between 9:00 pm to 4:00 am (48 percent). Forty-five percent of deaths where the child was a pedestrian occurred in the evening, between 4:00 pm to 8:00 pm (Figure 22).



Source: OCME Referral Tracker and CDRCRS Database as of 6/2/2016

Among MVA deaths, a male victim was more than twice as likely to be the driver while a female victim was nearly twice as likely to be a passenger. MVA deaths involving the driver were more frequent among non-Hispanic White children than among non-Hispanic Black children. MVA deaths involving a pedestrian, however, were more common among non-Hispanic Black children. In at least 25 percent of MVA deaths, speeding, racing or reckless driving was a factor. At least seven percent of MVA deaths involved drugs or alcohol, and at least three percent involved cell phone use.

## **Summary and Recommendations**

In 2015, the OCME referred 209 unexpected child deaths for review by the Child Fatality Review Team. The number of unexpected child deaths in Maryland decreased from 2010 to 2014, but increased 17 percent from 2014 to 2015. The number of OCME referred deaths increased among children age five to nine and teens age 15 to 17, and among both non-Hispanic Black and non-Hispanic White children. Deaths due to injury, SUID and homicide increased from 2014 to 2015. Injury and SUID continue to be the leading causes of OCME referred deaths in 2015. Among injury deaths, the number of MVA deaths doubled. Infants under one year of age continue to account for the largest proportion of unexpected deaths. The majority of OCME referred infant deaths are due to SUID and involve unsafe infant sleep practices. Racial and ethnic disparities persist, with a disproportionate number of these deaths occurring among non-Hispanic Black children.

In response to the 2015 review of OCME referred child deaths in Maryland, the State CFR Team puts forth the following recommendation and proposed action:

The State CFR Team depends on complete data entered by the local CFR teams into the national Child Death Review Case Reporting System (CDRCRS) in order to make evidence-based recommendations for the prevention of child fatalities. Data entry by local CFR teams in 2015 was not consistent. The State CFR Team recommends the implementation of a plan to ensure that local CFR teams enter data into the CDRCRS in a complete and timely manner. The plan includes updated review protocols and guidelines for local CFR team coordinators to include the importance of entering data, the expected time frame for data entry, priority variables, and available training for coordinators from the National Center for the Review and Prevention of Child Deaths. The plan also includes a mechanism for quarterly review of the data system to establish a quality improvement procedure with LHDs. The State CFR Coordinator and the State CFR Team will be responsible for coordinating and implementing this plan in early Fiscal Year 2017. The State CFR Coordinator is engaged in a needs assessment process with the local CFR teams and information from this process will be used to ensure that the plan is appropriately addressing barriers to data entry. Moving forward, this will allow the State CFR Team to make recommendations for specific activities to address the leading causes of death.

## **Appendix A: 2015 State Child Fatality Review Team Members**

Health-General Article §5-703(a), Annotated Code of Maryland provides that the State Team shall be a multidisciplinary and multiagency review team, composed of at least 25 members, including:

- (1) Attorney General – Christle Sheppard Southall, Esq, designee
- (2) Chief Medical Examiner – Ling Li, MD, designee
- (3) Secretary of Human Resources – Vernice McKee, LGSW, designee
- (4) Secretary of Health and Mental Hygiene – Lawrence Reid, PhD, MPH, designee
- (5) State Superintendent of Schools – Lynne Muller, PhD, designee
- (6) Secretary of Juvenile Services – Jenny Maehr, MD, designee
- (7) Special Secretary for Children, Youth and Families – permanent vacancy due to the sunset of the Office for Children, Youth, and Families in 2005.
- (8) Secretary of State Police – Det. Sgt. Stephen Hall, designee
- (9) President of the State’s Attorneys’ Association – Ernest Reitz, JD, designee
- (10) Chief of the Division of Vital Records – Lee Hurt, DrPH, MS, designee
- (11) A Representative of the State SIDS Information and Counseling Program – LaToya Bates, LCSW-C, Director, Center for Infant and Child Loss
- (12) Director of the Behavioral Health Administration – Al Zachik, MD, designee
- (13) Two pediatricians with experience in diagnosing and treating injuries and child abuse and neglect, appointed by the Governor from a list submitted by the state chapter of the American Academy of Pediatrics –  
Richard Lichenstein, MD, FAAP  
Wendy Lane, MD, MPH, FAAP
- (14) Eleven members of the general public with interest or expertise in child safety or welfare, appointed by the Governor, including child advocates, CASA volunteers, health and mental health professionals, and attorneys who represent children –  
Tim C. Allen  
Mary C. Gentile, LCSW-C  
Judith Kandel, CRNP  
Roger Lerner, JD  
Laurel Moody, RN, MS  
John Rusinko, MSW  
Martha R. Tuthill  
Keith Whalen  
Anntinette Williams, LICSW  
Cynthia Wright Johnson  
One general public vacancy

## **Appendix B: Duties of the State Child Fatality Review Team**

Health-General Article, §5-704 (b), sets forth the State CFR Team's 13 duties. To achieve its purpose the State CFR 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 the local teams, develop a protocol for child fatality investigations, including procedures for local health departments, law enforcement agencies, local medical examiners, and local departments of social services, using best practices from other states and jurisdictions.
- 5) Develop a protocol for the collection of data regarding child deaths and provide training to local teams and county health departments on the use of the protocol.
- 6) Undertake a study of the operations of local teams, including the State and local laws, regulations, and policies of the agencies represented on the local teams, recommend appropriate changes to any regulation or policy needed to prevent child deaths, and include proposals for changes to State and local laws in the annual report required by paragraph (12) of this subsection.
- 7) Consider local and statewide training needs, including cross-agency training and service gaps, and make recommendations to member agencies to develop and deliver these training needs.
- 8) Examine confidentiality and access to information laws, regulations, and policies for agencies with responsibility for children, including health, public welfare, education, social services, mental health, and law enforcement agencies, recommend appropriate changes to any regulations and policies that impede the exchange of information necessary to protect children from preventable deaths, and include proposals for changes to statutes in the annual report required by paragraph (12) of this subsection.
- 9) Examine the policies and procedures of the State and local agencies and specific cases that the State Team considers necessary to perform its duties under this section, in order to evaluate the extent to which State and local agencies are effectively discharging their child protection responsibilities in accordance with:
  - i) The State plan under 42 U.S.C. §5106a (b);
  - ii) The child protection standards set forth in 42 U.S.C. §5106a (b); and
  - iii) Any other criteria that the State Team considers important to ensure the protection of children.
- 10) Educate the public regarding the incidence and causes of child deaths, the public role in preventing child deaths, and specific steps the public can undertake to prevent child deaths.
- 11) Recommend to the Secretary any regulations necessary for its own operation and the operation of the local teams.
- 12) Provide the Governor, the public, and subject to §2-1246 of the State Government Article, the General Assembly with annual written reports, which shall include the State Team's findings and recommendations.
- 13) In consultation with local teams:
  - i) Define "near fatality;" and
  - ii) Develop procedures and protocols that local teams and the State Team may use to review cases of near fatality.

**Appendix C: Maryland State Child Fatality Review Team**  
**Annual Meeting Agenda**

**AGENDA**

**Maryland State Child Fatality Review Team Annual Meeting**  
**Tuesday, November 17, 2015**

Location: Howard County Department of Fire and Rescue  
James N. Robey Public Safety Training Center  
2200 Scott Wheeler Drive, Marriottsville, MD, 21104  
410-313-1361

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- 8:45**      **Registration**
- 9:30**      **Welcome and Introduction of State Team Members**  
Richard Lichenstein, MD  
Chair, The Maryland State Child Fatality Review Team
- 9:45**      **Short Topic Review**  
-Review of State CFR Annual Report, Data & Database: Lawrence Reid, PhD, MPH  
-Evidence Based Practices for Teen Crashes and Safe Sleep: Wendy Lane, MD MPH  
-LCFRT Brainstorming: What LCFRTs Can Do.  
-Prescription Drug Monitoring Program (PDMP): Brief Update for LCFRTs  
-SCFRT Funding Sub-committee: Brief Update
- 10:45**     **Local CFR Leaders Sharing/Quick Presentations: 5 Minutes per County**  
The Three Questions
- 12:00**     **Lunch**
- 12:45**     **Recruitment and Retention of Team Members: Sheilah O'Connor**  
Montgomery County CFR Coordinator
- 1:00**      **“Stalking a Serial Killer: Heroin/Prescription/Synthetic/Drug Use in Teens”**  
Charles “Buck” Hedrick, Drug Enforcement Agency
- 2:00**      **Local CFR Leaders Sharing/Quick Presentations**
- 2:45**      **Mock Case Review: Anne Arundel County CFR Team**
- 3:25**      **Wrap-up**  
Richard Lichenstein, MD, Chair