

MARYLAND STATE CHILD FATALITY REVIEW TEAM

2015 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/SitePages/cfr-home.asp>

TABLE OF CONTENTS

Overview of Maryland Child Fatality Review.....	2
Unexpected Child Deaths – Maryland, 2014.....	3
Trends in Maryland’s Unexpected Child Deaths.....	6
Sudden Unexplained Infant Deaths in Maryland.....	10
Summary and Recommendations.....	15
Appendix A: 2014 State Child Fatality Review Team Members.....	16
Appendix B: Duties of the State Child Fatality Review Team.....	17
Appendix C: Maryland State Child Fatality Review Team Annual Meeting Agenda.....	18

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 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).

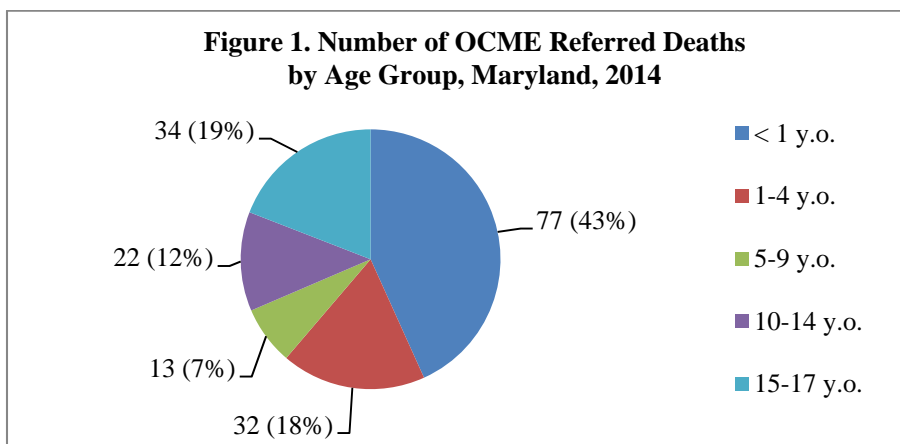
The State CFR Team oversees the efforts of local CFR teams that operate in each jurisdiction. Each month the local CFR teams receive notice from the Office of the Chief Medical Examiner (OCME) of unexpected resident child deaths (under age 18). The local CFR teams are required to review each of these 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 2014 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, 2014

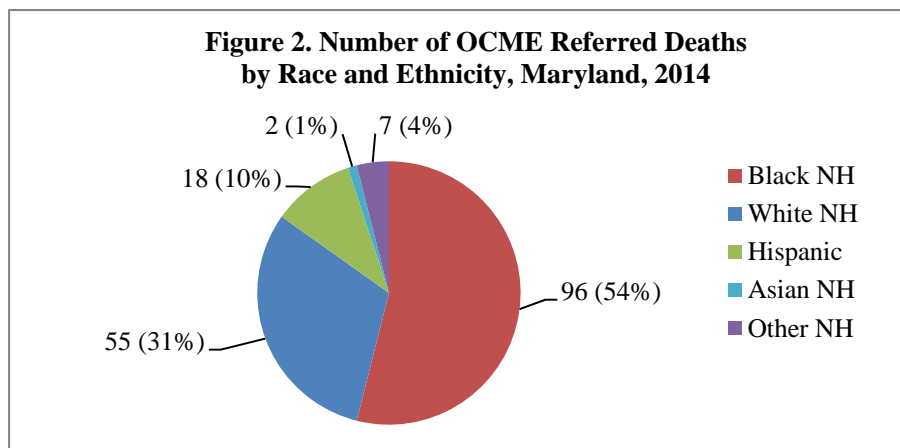
Childhood deaths are a major public health concern, as many of these deaths are preventable. Surveillance of childhood deaths is important because it helps to measure the magnitude of the problem, and helps to assess the causes and populations affected. These data are crucial in identifying trends and 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.

In 2014, the OCME referred 178 child deaths to the local CFR teams for review. Figure 1 shows the distribution of these deaths by age. Seventy-seven deaths (43 percent) occurred among infants (under one year of age). Of the 178 child deaths, 114 deaths (64 percent) occurred among male children and 64 deaths (36 percent) among female children (see Figure 5).



Source: OCME Referral Tracker (i); referrals made as of 4/27/2015
(i) OCME database of cases referred for local CFR team review

Figure 2 shows the distribution of 2014 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 five times more frequent than deaths among Hispanic children.



Source: OCME Referral Tracker; referrals made as of 4/27/2015. NH: Non-Hispanic

In Table 1, the number and percentage of OCME referred deaths occurring in 2014 are shown by cause of death category. Among the 178 referred deaths, the three leading causes of death were SUID, injury, and homicide. Together these three causes accounted for 67 percent of all OCME referred deaths. For five cases from 2014, 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.

The leading cause of unexpected child death in 2014 was SUID. Maryland SUID cases will be reviewed in greater detail later in this report.

Table 1. OCME Referred Deaths by Cause of Death Category, Maryland, 2014		
	#	%
SUID*	50	28.1
Injury	47	26.4
Homicide	22	12.4
Infectious Disease	18	10.1
Suicide	15	8.4
Other Medical Condition	14	7.9
Pending	5	2.8
SUDIC**	4	2.3
Birth Related	3	1.7
Total	178	100

Source: OCME Referral Tracker; referrals made as of 4/27/2015

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

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

Injury was the second leading cause of 2014 OCME referred deaths. Table 2 further breaks down the injury deaths by subcategory. Asphyxia (which includes suffocation, strangulation, choking, confinement in a tight space, etc.) was the most frequent subcategory of injury death (38 percent), followed by motor vehicle accidents (MVAs) (28 percent), and fire and burns (19 percent). These three types of injuries accounted for 85 percent of all injury deaths.

Local CFR teams reported seven deaths (four percent) resulting from "confirmed" abuse or neglect among the 178 deaths occurring in 2014. This means there was a finding of "indicated" abuse or neglect by Child Protective Services or police investigation.

Table 2. OCME Referred Injury Deaths by Subcategory, Maryland, 2014		
	#	%
Asphyxia	18	38.3
MVA	13	27.7
Fire/Burns	9	19.1
Poisoning	3	6.4
Hyperthermia	2	4.3
Building Collapse	1	2.1
Stabbing/Cutting	1	2.1
Total	47	100

Source: OCME Referral Tracker; referrals made as of 4/27/2015

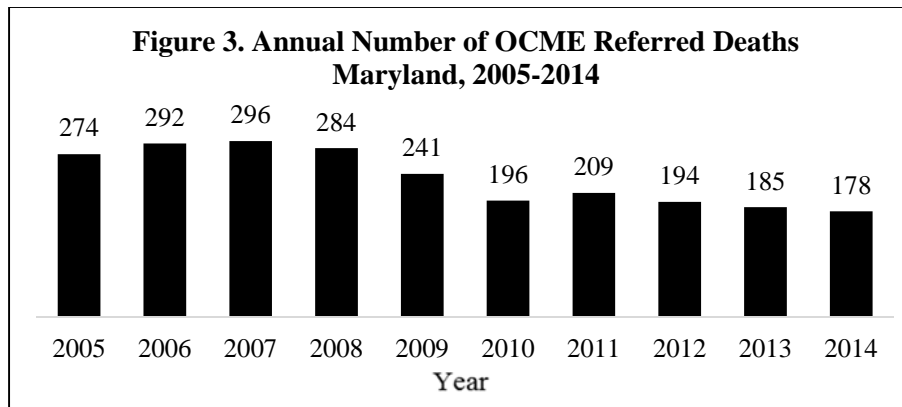
In Table 3, the number and percentage of deaths in 2014 are shown by jurisdiction of residence of the child at the time of death. Five jurisdictions (Baltimore City; Montgomery, Baltimore, Prince George's, and Anne Arundel Counties) accounted for 69 percent of all referred child deaths. Approximately one quarter of all OCME referred deaths occurred among Baltimore City resident children.

Table 3. OCME Referred Deaths by Jurisdiction of Residence, Maryland, 2014		
	#	%
Baltimore City	46	25.8
Montgomery	31	17.4
Baltimore County	21	11.8
Prince George's	14	7.9
Anne Arundel	11	6.2
Harford	9	5.1
Washington	9	5.1
Frederick	7	3.9
Allegany	5	2.8
St. Mary's	5	2.8
Carroll	3	1.7
Cecil	3	1.7
Charles	3	1.7
Caroline	2	1.1
Howard	2	1.1
Somerset	2	1.1
Wicomico	2	1.1
Calvert	1	0.6
Dorchester	1	0.6
Garrett	1	0.6
Kent	0	0
Queen Anne's	0	0
Talbot	0	0
Worcester	0	0
Total	178	100

Source: OCME Referral Tracker; referrals made as of 4/27/2015

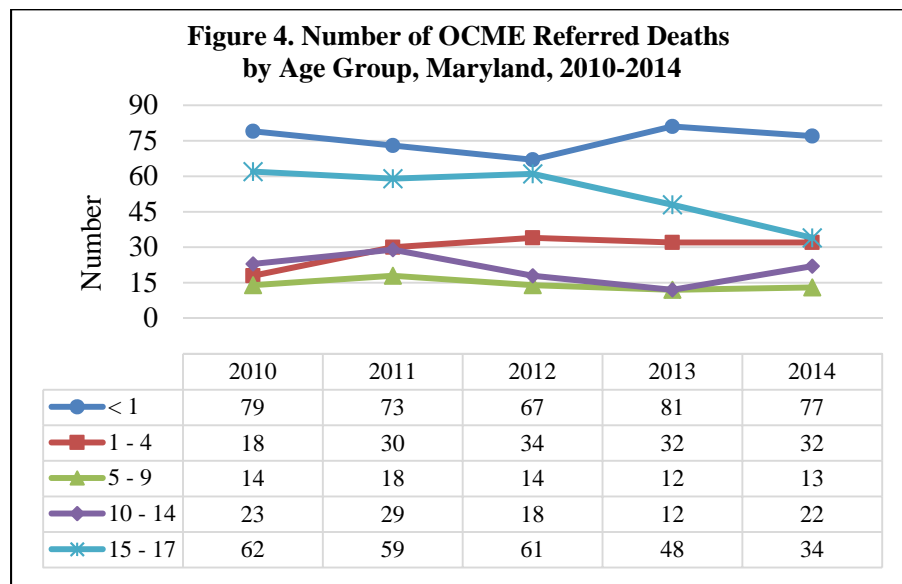
Trends in Maryland's Unexpected Child Deaths

Figure 3 shows the annual number of unexpected child deaths referred by the OCME for the past ten years (2005 to 2014). The annual number of referred deaths changed very little from the beginning of the CFR program in 2000 through 2008; however, from 2008 to 2014 the number of referred deaths has decreased by 37 percent. This represents an actual decrease in the number of unexpected child deaths in the State since there has been no change in the case selection or reporting process during that period.



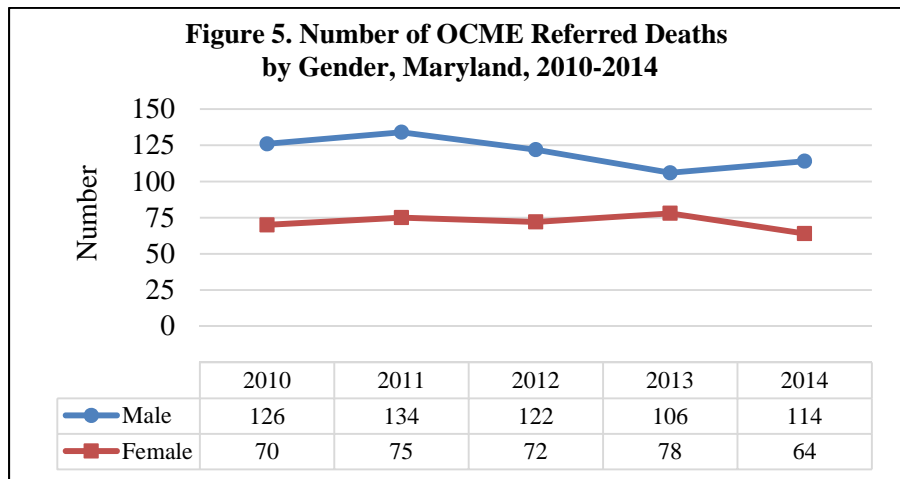
Source: OCME Referral Tracker; 2014 referrals made as of 4/27/2015

During the period from 2010 to 2014, the largest decline in OCME referred deaths by age group was among teens age 15 to 17 (Figure 4). In this age group, deaths decreased by 45 percent. Referred deaths among other age groups showed little if any change during this period.



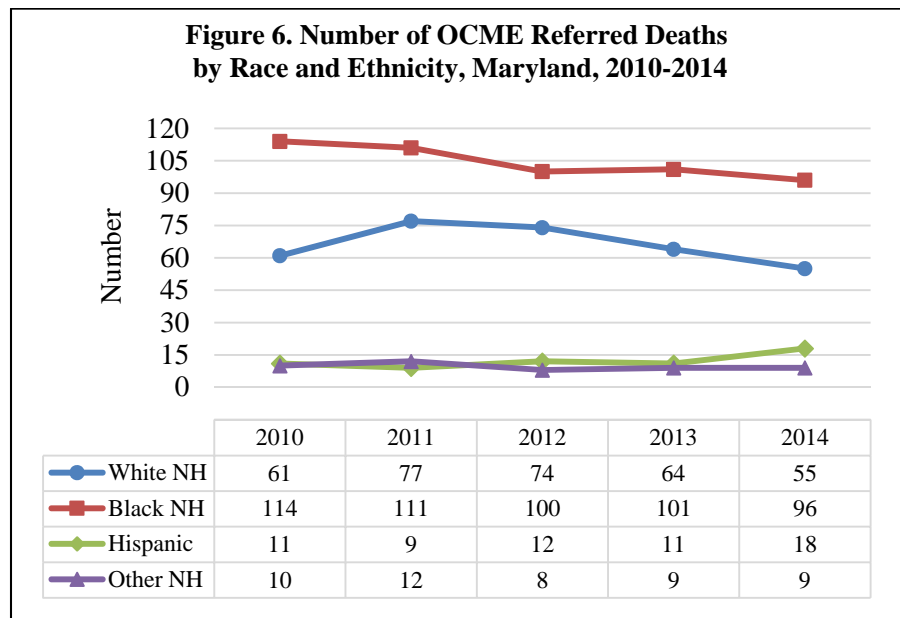
Source: OCME Referral Tracker; 2014 referrals made as of 4/27/2015

During the same period (2010 to 2014), deaths among male children decreased by 10 percent while those among female children decreased by nine percent (Figure 5). The disparity in deaths by gender persisted with unexpected deaths 1.8 times more likely among male children than among female children in 2014.



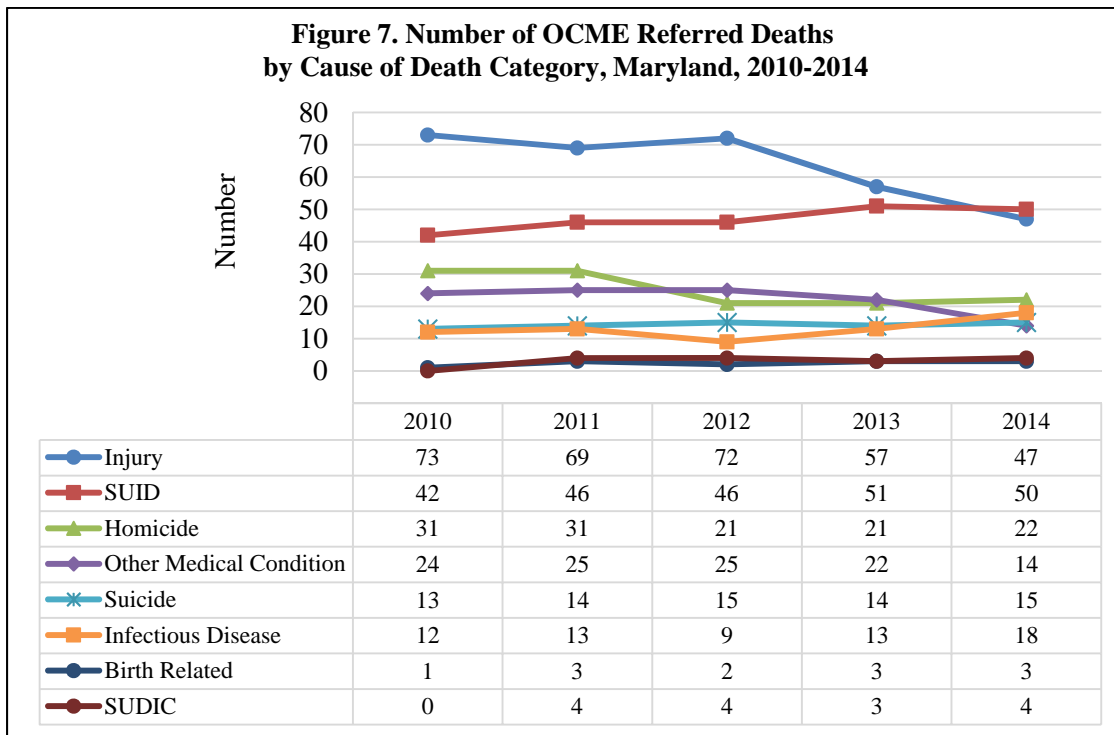
Source: OCME Referral Tracker; referrals made as of 4/27/2015

Similarly, Figure 6 shows the continued disparities among racial and ethnic groups. Deaths among non-Hispanic Black children were 1.4 to 1.9 times more frequent than deaths among non-Hispanic White children, and 5.3 to 12.3 times more frequent than deaths among Hispanic children. Between 2010 and 2014, OCME referred deaths among non-Hispanic Black children decreased by 16 percent, while those among non-Hispanic White children decreased by 10 percent. Referred deaths among Hispanic children remained much lower, but increased by six percent in 2014.



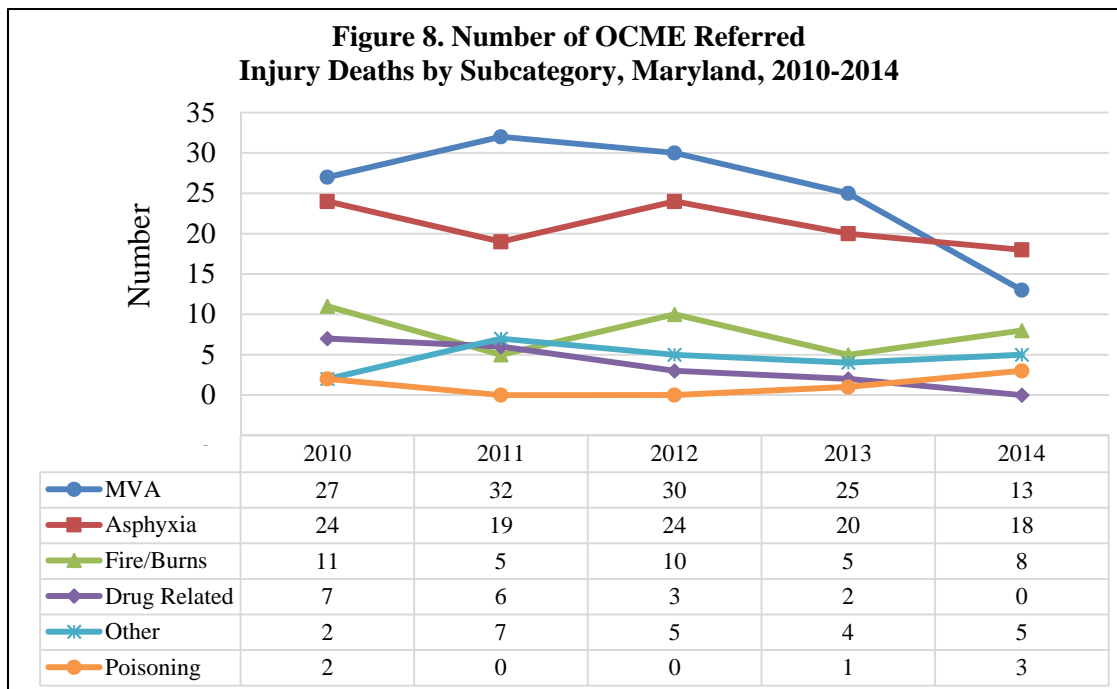
Source: OCME Referral Tracker; 2014 referrals made as of 4/27/2015. NH: Non-Hispanic

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. Since 2010, injury deaths have decreased by 36 percent while SUID deaths have increased by 19 percent. Deaths due to homicide decreased by 29 percent from 2010 to 2014; deaths due to suicide were essentially unchanged during this period.



Source: OCME Referral Tracker; 2014 referrals made as of 4/27/2015

Figure 8 shows the subcategories of injury deaths over the past five years. The decrease in injury deaths since 2010 was due primarily to a decrease in deaths from motor vehicle accidents and asphyxia. Motor vehicle involved deaths decreased by 52 percent, and deaths from asphyxia decreased by 25 percent. Although the numbers are small, drug related deaths also decreased steadily during this period, from seven deaths in 2010 to zero in 2014.



Source: OCME Referral Tracker; referrals made as of 4/27/2015

Table 4 shows the number of OCME referred deaths by jurisdiction of residence of the child at the time of death. During the period from 2010 to 2014, the number of resident child deaths decreased in Prince George's county by 63 percent, and in Baltimore City by 18 percent. In Montgomery County, the number of referred deaths has almost tripled since 2010, with the greatest increase in the OCME referred deaths occurring between 2013 and 2014.

Table 4. Number of OCME Referred Deaths by Jurisdiction of Residence, Maryland, 2010-2014						
	2010	2011	2012	2013	2014	Total
Baltimore City	56	55	48	40	46	245
Prince George's	38	31	20	27	14	130
Baltimore County	19	22	23	19	21	104
Montgomery	11	10	19	15	31	86
Anne Arundel	9	20	19	12	11	71
Harford	13	8	12	13	9	55
Washington	6	5	6	7	9	33
Frederick	4	9	1	11	7	32
Cecil	8	10	5	3	3	29
Charles	4	7	5	9	3	28
Howard	4	7	9	6	2	28
Carroll	3	5	5	3	3	19
Allegany	4	2	3	3	5	17
Wicomico	3	3	5	3	2	16
Caroline	4	1	5	2	2	14
St. Mary's	4	3	1	1	5	14
Calvert	2	3	4	1	1	11
Talbot	1	3	2	1	0	7
Worcester	1	2	1	3	0	7
Queen Anne's	2	2	1	0	0	5
Dorchester	0	0	0	3	1	4
Garrett	0	0	0	2	1	3
Kent	0	1	0	1	0	2
Somerset	0	0	0	0	2	2
Total	196	209	194	185	178	962

Source: OCME Referral Tracker; 2014 referrals made as of 4/27/2015

Sudden Unexplained Infant Deaths in Maryland

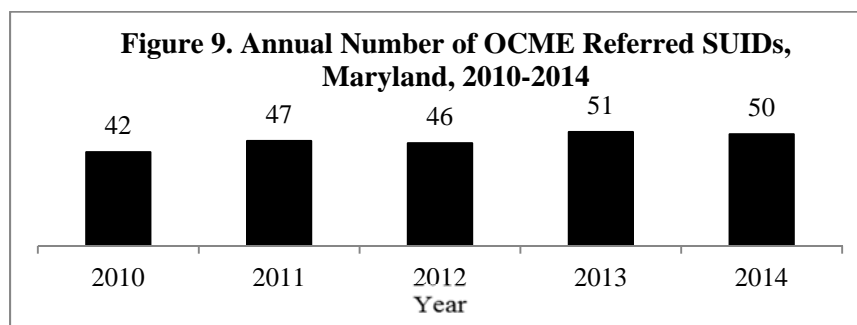
Among the OCME referred deaths occurring in Maryland in 2014, Sudden Unexplained Infant Death (also called Sudden Unexpected Infant Death) or SUID was the leading cause of death for the first time. SUID is the sudden death of an infant less than one year of age that cannot be fully explained after a 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. pillows, waterbed mattress, 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 co-sleeping 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.

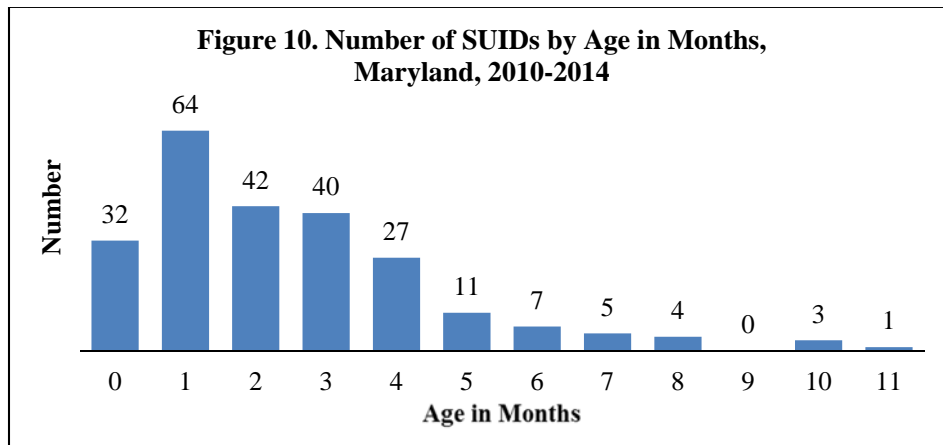
Even after a thorough investigation, there are some SUID cases in which there is no evidence of non-natural cause of death or issues of concern within a reasonable degree of certainty. These cases fall under the subcategory of Sudden Infant Death Syndrome or SIDS. SIDS is a diagnosis of exclusion, assigned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

In Maryland, the annual number of SUID cases referred by the OCME has increased by 19 percent over the past five years. A total of 236 SUID cases occurred between 2010 and 2014 (Figure 9).

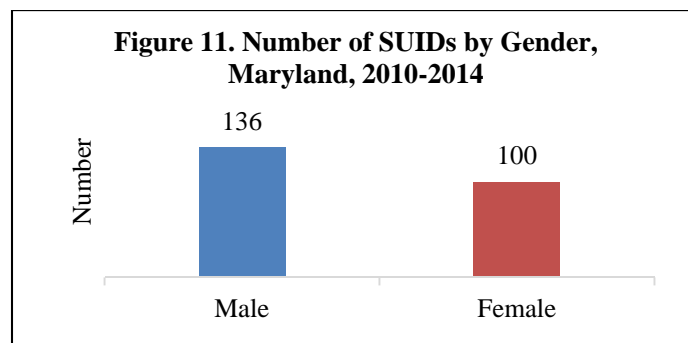


Source: OCME Referral Tracker; 2014 referrals as of 4/27/15

Of the 236 SUIDs in Maryland during this period, 216 (92 percent) occurred in the first five months of life (Figure 10). Fifty eight percent of these deaths occurred among male infants, and 42 percent occurred among female infants (Figure 11).

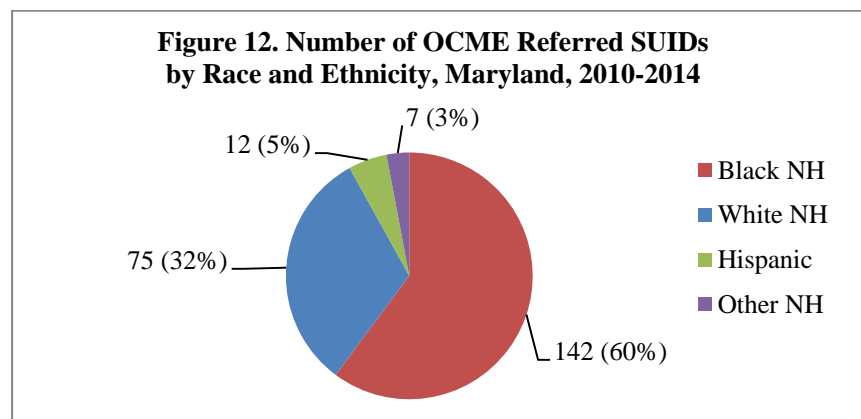


Source: OCME Referral Tracker; 2014 referrals as of 4/27/15



Source: OCME Referral Tracker; 2014 referrals as of 4/27/15

Of the SUID cases occurring from 2010 to 2014, 142 deaths (60 percent) occurred among non-Hispanic Black infants. This is almost twice the number of cases among non-Hispanic White infants, and almost twelve times the number among Hispanic infants (Figure 12).



Source: OCME Referral Tracker; 2014 referrals as of 4/27/15. NH: Non-Hispanic

Table 5 shows the number of SUIDs by jurisdiction of residence of the infant at the time of death for the last five years (2010 to 2014). The largest number of SUIDs each year occurred among residents of Baltimore City, which accounted for 31 percent of all SUIDs during this period. The number of cases in Baltimore City has changed very little over the past five years. The number of cases of SUID is small in most other jurisdictions in the State, which makes it difficult to identify trends. However, Prince George’s County has had a decline in the number of SUIDs, while Baltimore and Harford Counties have seen an increase during the past five years.

Table 5. Number of OCME Referred SUIDs by Jurisdiction of Residence, Maryland, 2010-2014						
	2010	2011	2012	2013	2014	Total
Baltimore City	15	15	13	17	14	74
Prince George's	9	7	6	6	5	33
Baltimore County	4	3	6	5	9	27
Anne Arundel	2	6	5	6	2	21
Montgomery	3	1	5	4	3	16
Harford	0	1	2	3	5	11
Washington	1	2	0	1	3	7
Allegany	1	2	0	1	2	6
Cecil	1	1	2	1	1	6
Charles	2	0	1	2	1	6
Howard	1	0	2	2	0	5
St. Mary's	1	2	0	1	1	5
Frederick	0	2	0	0	2	4
Worcester	0	2	1	1	0	4
Carroll	1	1	1	0	0	3
Talbot	0	0	1	1	0	2
Calvert	0	0	0	0	1	1
Caroline	0	0	1	0	0	1
Kent	0	1	0	0	0	1
Queen Anne's	1	0	0	0	0	1
Somerset	0	0	0	0	1	1
Wicomico	0	1	0	0	0	1
Total	42	47	46	51	50	236

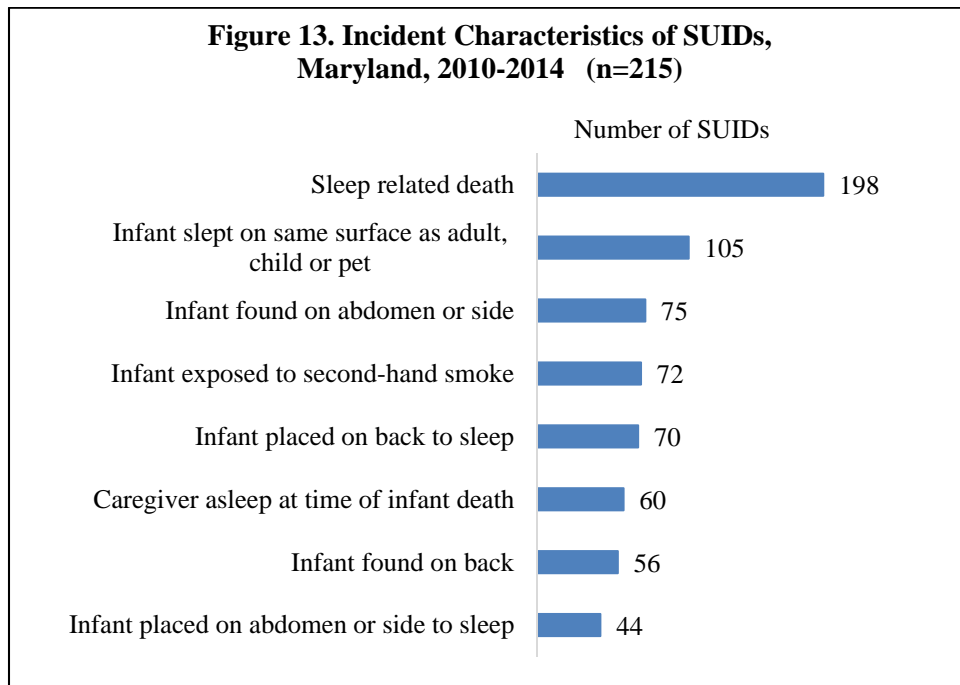
Source: OCME Referral Tracker; 2014 referrals as of 4/27/15

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 child’s name and date of death. Twenty-one (nine percent) of the 236 SUIDs from 2010 to 2014 were not found in the national database based on these criteria. Eleven of these were 2014 SUID cases which may still be under review or awaiting final data entry. The remaining 10 cases were from 2010 and 2011.

The 215 SUID cases entered into the CDRCRS database were further analyzed to determine more detailed information surrounding the 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.

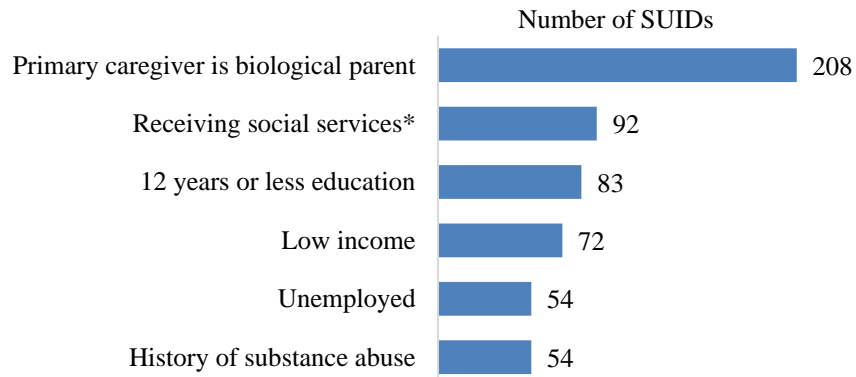
Figure 13 shows incident characteristics of SUIDs in Maryland. The death was determined to be sleep-related in 198 (92 percent) of the 215 SUID cases entered into the CDRCRS database. In 105 cases (49 percent), the infant was sleeping on the same surface as an adult, child or pet (co-sleeping). Thirty-five percent of the infants were found on their abdomen or side. Thirty-four percent of the infants were exposed to second-hand smoke. In 28 percent of cases, the caregiver was asleep at the time of the infant’s death.



Source: OCME Referral Tracker as of 4/27/15 and CDRCRS Database as of 5/20/15.

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 208 (97 percent) of the cases. Forty-three percent of caregivers were receiving social services, 39 percent had a high school education or less, 34 percent were low income, and 25 percent were unemployed. Twenty-five percent of caregivers also had a history of substance abuse. In addition to the caregiver receiving social services, 50 percent of the infants were enrolled in Medical Assistance.

Figure 14. Caregiver Characteristics Associated with SUIDs, Maryland, 2010-2014 (n=215)



*Social services include: Medicaid, TANF (ii), WIC (iii), food stamps

Source: OCME Referral Tracker as of 4/27/15 and CDCRS Database as of 5/20/15.

(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 increased.

There is a distinct racial and ethnic disparity in SUIDs, with a disproportionate number of these deaths occurring among 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 a parent or caregiver to reinforce safe infant sleep practices.

Summary and Recommendations

In 2014, the OCME referred 178 unexpected child deaths for review by the Child Fatality Review Program. The number of unexpected child deaths in Maryland has decreased over the past five years. This decrease appears to be due to a drop in deaths among teens age 15 to 17, and deaths due to injury, especially MVAs. Infants under one year of age continue to account for the largest proportion of unexpected deaths. Racial and ethnic disparities persist, with a disproportionate number of these deaths occurring among non-Hispanic Black children, although the number of deaths in this group has decreased by 16 percent since 2010. With the decrease in injury deaths, Sudden Unexplained Infant Death or SUID became the leading cause of deaths referred by the OCME in the State in 2014. The vast majority of these deaths was sleep-related and involved an unsafe infant sleep environment.

In response to the 2014 review of OCME referred child deaths in Maryland, the State CFR Team puts forth the following recommendations and proposed actions:

- The State CFR Team recommends strengthening and expanding efforts to teach new parents and all caregivers about safe infant sleep practices. Specifically, the Center for Infant and Child Loss proposes working with birthing hospitals, DHMH, and other expert groups to develop model policies and best practices to teach new parents about safe sleep; providing all birthing hospitals with teaching resources; and seeking their commitment to provide comprehensive teaching for all new parents on safe sleep.

To support this effort, DHMH is directing all local CFR teams to send a letter to the hospital of birth whenever an infant sleep-related death is reviewed. This letter to hospital leadership will reinforce the need to educate new parents on safe sleep practices.

- Although teen deaths and deaths from MVAs have decreased in Maryland, MVAs continue to be a cause of child deaths, even with implementation of the graduated licensing system for new drivers. New Jersey implemented a graduated driver's license decal provision in 2010. This additional initiative resulted in a sustained decline in MVA rates among drivers under age 21 during the first two years of the program.¹ The State CFR Team recommends implementing a similar provision that would require all drivers holding a provisional license to display a reflective decal on both front and back license plates of the vehicle they are operating to decrease teen motor vehicle accidents. The American Academy of Pediatrics Maryland Chapter will lead this effort.

¹ Allison Curry et al., "Long-term changes in crash rates after introduction of a graduated driver licensing decal provision," *Am J Prev Med*, 48 (2015):121.

Appendix A: 2014 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 – Betty Stemley, JD, 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 – Ilise Marrazzo, RN, BSN, 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 – Lt. Joseph Gamble, designee
- (9) President of the State’s Attorneys’ Association – Ernest Reitz, JD, designee
- (10) Chief of the Division of Vital Records – Hal Sommers, MA, 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 – David Putsche, designee
- (13) Two pediatricians with experience in diagnosing and treating injuries and child abuse and neglect, appointed by the Governor from a list submitted by the state chapter of the 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 and 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
Danee’ Moran, MA
John Rusinko, MSW
Martha R. Tuthill
Anntinette Williams, LICSW

Two general public vacancies

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 Team shall:

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

Maryland State Child Fatality Review Team Annual Meeting
Wednesday, November 19, 2014

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

- | | |
|--------------|--|
| 9:00 | Registration Begins |
| 10:00 | Welcome
Introduction of State CFR Team Members
Richard Lichenstein, MD
Chair, Maryland State Child Fatality Review Team |
| 10:10 | KISS – Kids in Safety Seats
What’s New in the World of Child Safety?
Tracey Whitman, DHMH |
| 11:00 | Local CFR Leaders Sharing/Quick Presentations |
| 12:00 | Lunch & Luncheon Speaker
- NCRPCD Data Collection & Entry
- State CFR Leadership
Richard Lichenstein |
| 12:40 | New Safe Sleep Video Presentation
Latoya Bates, Center for Infant and Child Loss |
| 1:00 | Local CFR Leaders Sharing/Quick Presentations |
| 2:30 | Suicide and Social Media
Timothy Jansen
Director, Community Crisis Services |
| 3:25 | Wrap-up
Richard Lichenstein |