

**MARYLAND STATE CHILD FATALITY REVIEW TEAM**

2007 Annual Legislative Report

Martin O'Malley  
Governor

Anthony G. Brown  
Lt. Governor

John M. Colmers  
Secretary  
Department of Health  
and Mental Hygiene

## **Overview of the Maryland State Child Fatality Review Team**

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 child fatality review process to understand the circumstances around those fatalities and to recommend strategies for prevention.

Child Fatality Review was established in Maryland statute in 1999. The 25 member Maryland State CFR Team is comprised of the Secretaries (or their designees) and representatives of 12 State agencies or offices, 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 for 2007 State CFR Team membership.) The State CFR Team meets at least four times a year to address 13 statutorily-prescribed duties (see Appendix B for State CFR Team duties). One of the quarterly meetings is designed as an all-day training on select topics.

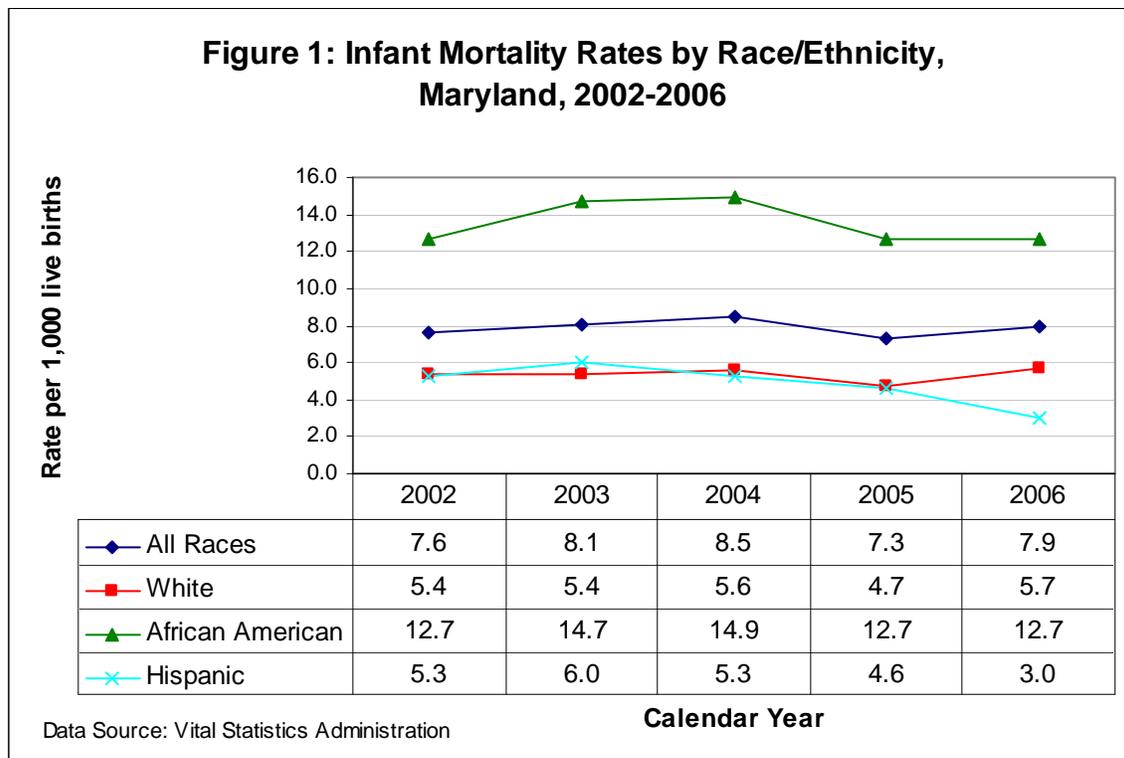
In Maryland, besides the State CFR Team, each local jurisdiction has a CFR Team. These local CFR teams convene regular meetings to review unexpected deaths of child residents living within their geographic borders. The teams concentrate on issues specific to each area, reviewing deaths that may be impacted by changes in systems, policies, or practices at the local level. Administrative support for the State CFR Team and the local child fatality review teams is provided by the Center for Maternal and Child Health within the Department of Health and Mental Hygiene (DHMH).

Detecting and preventing child abuse and neglect remain an important focus of CFR, the DHMH and the Department of Human Resources (DHR). Whatever the cause and manner of death, the majority of childhood deaths raise questions about the general child health system and warrant thorough systematic investigation. The overarching benefit of CFR is an examination of the system of service delivery and an evaluation of the adequacy of services provided in order to prevent child deaths.

## Summary of the Maryland Child Death Report 2007 Reflecting Deaths Occurring 2002-2006

Childhood deaths are a major public health problem and 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 the population groups most affected. The data is crucial for identifying trends and targeting interventions to reduce childhood mortality.

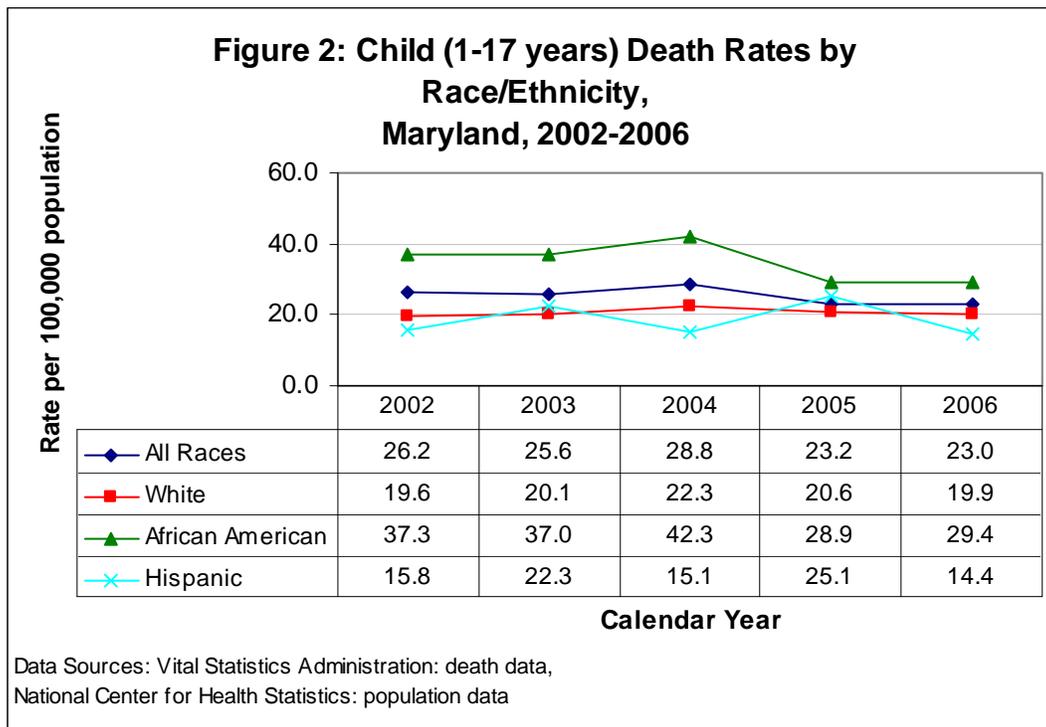
The Child Death Report focuses on deaths in children below the age of 18. In 2006, there were 615 infant deaths and 296 deaths to children between the ages of 1 and 17. Deaths to infants (< 1 year of age) are usually analyzed separately from deaths to children between 1 to 17 years of age. The three leading causes of death in infants for 2006 were disorders related to preterm birth or low birth weight (20.0%), congenital abnormalities (17.9%), and sudden infant death syndrome (10.9%). The infant mortality rate increased in 2006, to 7.9 per 1,000 live births (Figure 1).



There were substantial racial disparities in infant mortality rates in 2006. The infant mortality rate for Whites was 5.7 per 1,000 live births compared to 12.7 per 1,000 live births for African Americans.

In 2006, the child death rate (1-17 years of age) decreased slightly, to 23.0 per 100,000 population (Figure 2). In 2006, the child death rate for Whites was 19.9 per 100,000

population compared to 29.4 per 100,000 population for African Americans. The child death rate for Hispanics in 2006 was 14.4 per 100,000 population. Among children aged 1-17, the three leading causes of death were unintentional injuries, homicide, and malignant neoplasms in 2004 through 2006 (Note: data are aggregated over a three year period to provide more stability). Table 1 shows the leading causes of death by age group. For the injury related deaths, 39.7% were due to motor vehicle collisions (Tables 2, 3). 61.4 % of motor vehicle deaths occurred in males. The greatest proportion of motor vehicle related injury deaths occurred in children aged 15 to 17 (56.0%). The rates for motor vehicle related deaths by race and ethnicity were 5.4 for Whites, 5.6 for African Americans, and 3.3 for Hispanics, per 100,000 population.



Children’s death by homicide continues to be a significant public health problem in Maryland. In the period 2004 through 2006 there were 20 homicides of infants and 133 homicides among children aged 1-17 years. The rate of homicides among children aged 0-17 is substantially higher among African Americans, at 7.6 per 100,000 population, compared to 1.8 per 100,000 population for Whites. Fifty-four percent of the homicides of children aged 0-17 involved firearms. The age group with the highest homicide rate was that of children between 15 to 17 (12.7 per 100,000 population). The group with the next highest rate was that of infants (9.0 per 100,000). Males aged 0-17 were victims of homicide at a much higher rate than females, 5.4 versus 2.0 per 100,000 population, respectively.

There were 44 suicides among children over the period from 2004 to 2006. The rate of suicide was greatest among those aged 15 to 17 (4.0 per 100,000 population). Suicides occurred less frequently among younger children aged 10 to 14 (1.3 per 100,000 population). Among children aged 10 to 17, males committed suicide more frequently than females (3.6 compared to 1.0 per 100,000 population, respectively). The suicide rates were similar among African American (2.1 per 100,000 population) and White children (2.2 per 100,000 population). There were no suicides reported among Hispanic children during this time period.

**Table 1. Leading Causes of Death by Age Group in MD, 2004-2006**

Rank	Age Group				
		1-4 years	5-9 years	10-14 years	15-17 years
1	<b>Cause of Death</b>	Unintentional Injury	Unintentional Injury	Unintentional Injury	Unintentional Injury
	<b># of Deaths</b>	57	54	63	144
	<b>% of Deaths in Age Group</b>	24.1%	37.0%	29.7%	38.3%
2	<b>Cause of Death</b>	Congenital Malformations	Malignant Neoplasms	Malignant Neoplasms	Homicide
	<b># of Deaths</b>	31	33	27	93
	<b>% of Deaths in Age Group</b>	13.1%	22.6%	12.7%	24.7%
3	<b>Cause of Death</b>	Malignant Neoplasms	Congenital Malformations	Diseases of the Circulatory System	Suicide
	<b># of Deaths</b>	26	10	17	29
	<b>% of Deaths in Age Group</b>	11.0%	6.9%	8.0%	7.7%
4	<b>Cause of Death</b>	Homicide	Diseases of the Nervous System	Diseases of the Nervous System	Malignant Neoplasms
	<b># of Deaths</b>	20	9	17	23
	<b>% of Deaths in Age Group</b>	8.4%	6.2%	8.0%	6.1%
5	<b>Cause of Death</b>	Diseases of the Circulatory System	Diseases of the Respiratory System	Homicide	Diseases of the Circulatory System
	<b># of Deaths</b>	18	7	15	15
	<b>% of Deaths in Age Group</b>	7.6%	4.8%	7.1%	4.0%

\* Data Source: Analysis of Data from Vital Statistics Administration, DHMH

**Table 2. Child (1-17 years) Injury-Related Deaths by Type of Injury and Gender in MD  
2004-2006**

Type of Injury	Male	Female	Total Deaths	% of Total Injury Deaths
<b>Motor Vehicle Collision</b>	127	80	207	39.7%
<b>Other Transport Injury</b>	8	6	14	2.7%
<b>Falls</b>	3	3	6	1.2%
<b>Drowning</b>	26	10	36	6.9%
<b>Fire</b>	25	5	30	5.8%
<b>Poisoning</b>	1	2	3	0.6%
<b>Other Non-Transport Injury</b>	15	7	22	4.2%
<b>Homicide by Firearm</b>	71	11	82	15.7%
<b>Homicide by Other Means</b>	32	19	51	9.8%
<b>Suicide by Firearm</b>	15	1	16	3.1%
<b>Suicide by Other Means</b>	20	8	28	5.4%
<b>Undetermined Intent</b>	18	7	25	4.8%
<b>Legal Intervention</b>	1	0	1	0.2%

\* Data Source: Analysis of Data from Vital Statistics Administration, DHMH

**Table 3. Child (1-17 years) Injury-Related Deaths by Type of Injury and Race in MD  
2004-2006**

Type of Injury	White	African American	Other	Total Deaths	% of Total Injury Deaths
<b>Motor Vehicle Collision</b>	125	76	6	207	39.7%
<b>Other Transport Injury</b>	9	5	0	14	2.7%
<b>Falls</b>	3	2	1	6	1.2%
<b>Drowning</b>	22	13	1	36	6.9%
<b>Fire</b>	12	18	0	30	5.8%
<b>Poisoning</b>	1	2	0	3	0.6%
<b>Other Non-Transport Injury</b>	11	11	0	22	4.2%
<b>Homicide by Firearm</b>	13	69	0	82	15.7%
<b>Homicide by Other Means</b>	20	31	0	51	9.8%
<b>Suicide by Firearm</b>	11	3	2	16	3.1%
<b>Suicide by Other Means</b>	15	11	2	28	5.4%
<b>Undetermined Intent</b>	18	6	1	25	4.8%
<b>Legal Intervention</b>	0	1	0	1	0.2%

\* Data Source: Analysis of Data from Vital Statistics Administration, DHMH

## 2007 State CFR Team Activities

### Training and Education

One of the statutory duties of the State CFR Team is to conduct educational and training events in response to the needs of local CFR teams. Each year, the State CFR Team collects reports from the local CFR teams. (see Appendix C for Summary of Local CFR Team Case Reviews). In these reports the teams describe their activities of the previous year, their training needs, and their recommendations for State CFR Team action. (see Appendix D for local CFR team recommendations). State CFR Team members review these local reports and respond by providing technical assistance, training, and education directed at the needs described.

Topics of special interest are covered in depth at the State CFR Team quarterly meetings and at an annual training meeting held at the end of each year. Presentations are made by expert State CFR Team members or invited guests.

In 2007, special presentations made at the quarterly State CFR meetings included:

<b>Pedestrian Safety</b>	Margo Stanton Montgomery County Traffic Safety Program Director
<b>House Bill 1071</b> (CFR Review of Homicide Perpetrators)	Joshua Sharfstein, MD Health Officer for Baltimore City Baltimore City Health Department
<b>The New Partnership for a Safer Maryland</b>	Becky Roosevelt, MA, Injury Prevention Coordinator Maryland Department of Health and Mental Hygiene

The State CFR Team annual meeting typically focuses on educational training pertaining to several specific health or risk areas. For the 2007 annual meeting, the focus was adolescent issues. The two areas of teen risk highlighted were motor vehicle accidents and violence. The agenda for the 2007 annual meeting is in Appendix E.

At all annual training events, CFR team leaders are encouraged to interact with the team leaders of other jurisdictions with similar characteristics. Examples include those with a predominantly rural or urban population, or a high death rate due to a particular cause, such as automobile deaths or suicides. Because similar regions often share risk profiles, they can benefit from joint communication, effort, and public education campaigns.

## Newsletter

In 2007, another source for communication, networking, and education was the quarterly State CFR Team newsletter, which is edited by State CFR Team members. The newsletter provides a regular update for local team members regarding relevant legislation, training opportunities, State CFR Team membership changes, helpful Web sites, and other valuable information.

The newsletter often focuses on special, timely topics. In 2007, information was provided on child pedestrian fatalities, water safety, the Safe Haven law for new mothers, House Bill 1071 (allows CFR teams to review the records of the teen perpetrator as well as the victim in homicides), an upcoming suicide prevention conference, and State CFR Team priorities for the upcoming year, which were based on local CFR Team recommendations.

Copies of the newsletter can be viewed at <http://www.fha.state.md.us/mch/cfr/>.

## Electronic Data System

2007 saw the State CFR Team make progress towards establishing a Statewide electronic data system for collecting child fatality review data. The National Child Death Review Center (NCDRC), operating out of Michigan and funded by the Health Resources Services Administration (HRSA), offers a system for local CFR teams to complete uniform case reports electronically during their case review meetings. The data is then sent to the NCDRC central office where individual state data, as well as national data is collected and made available to the participating states. The system is free to states and the NCDRC offers training to state and child fatality review teams. The State CFR Team worked throughout 2007 to address administrative and operational issues with the goal that the new data system be implemented by 2009.

## Defining Near Fatality

Currently, case reviews are done only on child fatalities, not near fatalities. In 2007, the State CFR Team developed the following definition of near fatality:

**“A child requiring professional health care for a life-threatening event or a serious or critical condition as a result of a potentially preventable injury or illness.”**

Development of a definition of near fatality was the first step towards enabling local CFR teams to do formal case reviews of near fatalities. The next step will be to work out a system for local CFR teams to be notified about the near fatalities that occur to child residents of their jurisdiction.

As the system works now, the Office of the Chief Medical Examiner (OCME) sends information on recent child fatalities to each local jurisdiction every month. These are the cases local child fatality review teams are supposed to review, and receipt of the fatality information from the OCME initiates the review process. However, because the OCME does not have information on near fatalities, another system of notification will need to be developed before the State CFR Team can formally help and encourage local CFR teams to review near fatalities. Near fatality notification will most likely be accomplished through an arrangement with local hospitals or the Emergency Medical System, but the exact process is, as of yet, undetermined.

### **Collaboration Efforts**

In 2007 the State CFR Team increased collaboration efforts with the State Council on Child Abuse and Neglect (SCCAN) and the Citizens' Review Board for Children (CRBC). Health-General Article §5-704(c) requires these three groups to coordinate activities. The statute provides that "The State Team shall coordinate its activities under this section with the State Citizens' Review Board for Children, local citizen review panels, and the State Council on Child Abuse and Neglect in order to avoid unnecessary duplication of effort." The leaders of all three groups met several times in 2007 with the goal of determining the best way to join forces to create a safer Maryland for children.

### **State CFR Team Future Activities**

The State CFR Team will continue to work in partnership with local CFR teams toward the prevention of child deaths. A primary focus of the State CFR Team will be the implementation of the data system described above in collaboration with the National Child Death Review Center. The system will streamline efforts of local child fatality review teams and significantly improve the ability to analyze child deaths in Maryland, as well as nationally.

Training and education efforts will continue, as will work to find more resources for CFR in general. There are no funds currently allocated for CFR. A comprehensive, Statewide or regional approach is necessary if the State and local CFR teams are to have the ability to make significant change over the long term. Any child's death is a tragedy and the state and local CFR teams will continue to work to understand why unexpected child deaths occur and how their number can be reduced.

## **Appendix A: 2007 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) THE ATTORNEY GENERAL – Eileen McInerney, J.D., designee
- (2) THE CHIEF MEDICAL EXAMINER – Tasha Greenberg, M.D., designee
- (3) THE SECRETARY OF HUMAN RESOURCES – Rosalind McDaniel, designee
- (4) THE SECRETARY OF HEALTH AND MENTAL HYGIENE – George Thorpe, M.D., designee
- (5) THE STATE SUPERINTENDENT OF SCHOOLS – vacancy
- (6) THE SECRETARY OF JUVENILE SERVICES – Jenny Maehr, M.D., designee
- (7) THE SPECIAL SECRETARY FOR CHILDREN, YOUTH, AND FAMILIES –  
\* Permanent Vacancy due to the sunset of the Office for Children, Youth, and Families in 2005.
- (8) THE SECRETARY OF THE STATE POLICE – Tina Becker, designee
- (9) THE PRESIDENT OF THE STATE’S ATTORNEYS’ ASSOCIATION –  
Jonathan G. Newell, J.D., designee
- (10) THE CHIEF OF THE DIVISION OF VITAL RECORDS – Hal Sommers, M.A., designee
- (11) A REPRESENTATIVE OF THE STATE SIDS INFORMATION AND COUNSELING PROGRAM, Donna Becker, R.N., M.S.N., Director, Center for Infant and Child Loss
- (12) THE DIRECTOR OF THE ALCOHOL AND DRUG ABUSE 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 –  
Nerita Estampador-Ulep, M.D., FAAP  
Richard Lichenstein, M.D., 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 –  
Sally Dolch, MDiv, MSW, Chairperson  
Carolyn Fowler, Ph.D, M.P.H., Vice-Chair, Citizen Advocate for Children  
Mary C. Gentile, LCSW-C, Citizen Advocate for Children  
Dorothy Marge, Ph.D., Citizen Advocate for Children  
Albert Rolle, M.D., FACS, Citizen Advocate for Children  
John Rusinko, LCSW-C, Citizen Advocate for Children  
Anntinette Williams, LICSW, Citizen Advocate for Children  
\* Four Current Vacancies from General Public Membership

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

Health-General Article, §5-704 (b), sets forth the State CFR Team's 13 duties as follows:

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: Summary of Local CFR Team Case Reviews

2007 Summary of Local Case Review Meetings and Findings Maryland Jurisdictions*	
*Three counties had either no cases, no case reviews, or no report NF=Near Fatality	
	Total
1. Total Number of CFR meetings held in 2007.	89 Includes 2 NF
2. In how many jurisdictions were all Medical Examiner cases reviewed by the team?	Yes 16 No 5 N/A 3
3. Total number of cases reviewed at local CFR team meetings in 2007, regardless of year of death.	323
4. Of all the cases reviewed by all teams in 2007, in how many was abuse or neglect <u>confirmed</u> ; e.g., there was a finding of “indicated abuse” or “indicated neglect” by Child Protective Services (CPS) or a positive police investigation?	40
5. Not including those children counted in number 4 above; what is the total number of cases that teams <i>subjectively</i> felt abuse or neglect may have <u>contributed</u> to the death?	21 Includes 1 NF
6. Of the total cases reviewed in 2007, in how many was there a <u>previous</u> history of child abuse, as determined by CPS?	12
7. How many had a <u>previous</u> history of child neglect, as determined by CPS?	15
8. How many had a history of involvement with the Department of Juvenile Services (formerly Dept. of Juvenile Justice)?	32

## **Appendix D**

### **2007 Local CFR Team Recommendations for State CFR Team by Topic Area**

#### **Administrative (5 local teams made suggestions)**

- Include a hospice representative on the State CFR Team. (Caroline)
- Finalize the Guidelines manual. (Cecil)
- Provide a list of statewide resources. (Frederick)
- Provide resource referrals for the local teams for community programs. (Prince George's)
- Increase communication between the State team and local teams. (Prince George's)
- Consider adopting the CDC recommended tools for Statewide use in the investigation of sudden infant/child deaths. (Wicomico)

#### **Advocacy/Publicity (4)**

- Have fire and rescue teams check for carbon dioxide levels in homes where a fire has occurred. (Montgomery)
- Have a Statewide bi-lingual campaign on the dangers of co-sleeping, utilizing ads, commercials and literature. (Montgomery)
- Increase public awareness by promoting safe sleep practices. (Wicomico)
- Provide training on how to arrange publicity on certain issues that come up in meetings. (Garrett)
- State CFR should consider supporting Connor's Law – the Pool Lifeguard legislation to increase the number of lifeguards. (Anne Arundel). (Also below under "Drowning").

#### **Autopsy/Forensics (1)**

- More training for local forensics investigators on the need for autopsy. (Allegany)
- Training on what the forensic process should be in an ideal setting. (Allegany)

#### **Data Systems (3)**

- Need training on local data collection and reporting. (Caroline)
- Training in the area of data analysis. (Prince George's)
- Move forward with the implementation of the child death database. (Prince George's)
- Revision of the data collection tool (likely part of state database). We anticipate a state computerized data tool and will need training to implement. (Worcester)

#### **Drowning/Pool/Lifeguards (1)**

- State CFR should consider supporting Connor's Law –the Pool Lifeguard legislation to increase the number of lifeguards. (Anne Arundel)

#### **Feedback (1)**

- Would like more feedback from the State Team regarding recommendations made by locals. (Anne Arundel)

**Funding (2)**

- Would like funding to implement local CFR recommendations or provision of resources for parents, families and friends (e.g., books such as The Death of a Child, Reflections for Grieving Parents by Elaine Stillwell). (Caroline)
- Training in the area of grant writing. (Prince George's)

**MVA/Teen Driving (1)**

- More training on how to service families of teens getting ready to drive. (Charles)

**Near fatality (2)**

- Overview and discussion of near fatality was obtained in February 2008. Continue support. (Washington)
- Define near fatality and reporting guidelines. (Worcester).

**State CFR Newsletter (1)**

- Continue the State CFR Newsletter (Anne Arundel)

**Suicide/School Violence (1)**

- A State CFR training on recognizing the signs of adolescent suicidal behavior and any information on the correlation between alcohol ingestion and school violence. (Montgomery)

**Appendix E: Agenda**  
**State Child Fatality Review Team Annual Meeting**  
**December 4, 2007**

**9:00 – 9:15 am      Welcome & Introduction**

Richard Lichenstein, M.D.  
Chairman, Maryland State Child Fatality Review Team  
Associate Professor of Pediatrics  
Director, Pediatric Emergency Medicine Research, University of Maryland  
School of Medicine

**9:15 – 9:45 am      Adolescent Deaths in Maryland**

Tasha Greenberg, M.D.  
Vice-Chair, Maryland State Child Fatality Review Team  
Assistant Medical Examiner, Office of the Chief Medical Examiner,  
State of Maryland

9:45 – 10:00 am      Break

**10:00 – 11:00 am      Youth Violence and Strategies for Saving Our Children**

Carnell Cooper, M.D., FACS  
Founder of Baltimore's Violence Intervention Program  
Associate Professor of Surgery, University of MD School of Medicine  
Attending, RA Cowley Shock Trauma Center  
Chief, Trauma Services, Prince George's Hospital Center

**11:00 – 12:00 pm      School-Based Response to Child Death: Traumatic Loss Team  
Intervention**

Lynne E. Muller, Ph.D., NCC, LCPC  
Laurel Moody, R.N., M.S.  
Traumatic Loss Team for Baltimore County Public Schools

Lunch Break

**1:30 – 2:15 pm      The Novice Young Driver Problem: Causes and Solutions**

Bruce Simons-Morton, EdD, MPH  
Chief, Prevention Research Branch, DESPR, NICHD, NIH

**Adjourn**