MARYLAND STATE CHILD FATALITY REVIEW TEAM

2009 Annual Legislative Report

Martin O'Malley Governor	Anthony G. Brown Lt. Governor	John M. Colmers Secretary, Department of Health and Mental Hygiene

http://fha.maryland.gov/mch/cfr_home.cfm

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 2009 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, to enhance knowledge on child fatality issues.

In Maryland, besides the State CFR Team, each jurisdiction has a local 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 in order to determine beneficial changes in systems, policies, or practices at the local level. The State CFR Team is part of the Department of Health and Mental Hygiene (DHMH) for budgetary and administrative purposes.

Detecting and preventing child abuse and neglect remain an important focus of CFR, DHMH, and the Department of Human Resources (DHR). 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.

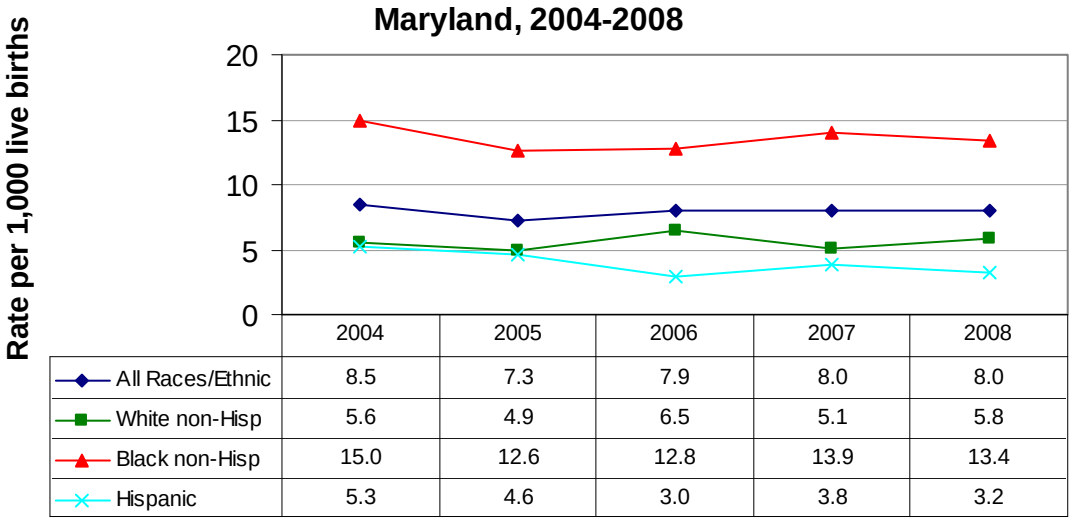
Summary of the Maryland Child Death Report 2009

Reflecting Deaths Occurring 2004-2008

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 2008, there were 617 infant (< 1 year of age) deaths and 307 deaths to children between the ages of 1 and 17. Deaths to infants are usually analyzed separately from deaths to children between 1 to 17 years of age. The three leading causes of death in infants for 2008 were: (1) disorders related to preterm birth or low birth weight (26.1%); (2) congenital abnormalities (15.6%); and (3) sudden infant death syndrome (12.0%). The infant mortality rate remained at 8.0 per 1,000 live births in 2008 (Figure 1).

Figure 1. Infant Mortality Rates by Race/Ethnicity, Maryland, 2004-2008



	2004	2005	2006	2007	2008
All Races/Ethnic	8.5	7.3	7.9	8.0	8.0
White non-Hisp	5.6	4.9	6.5	5.1	5.8
Black non-Hisp	15.0	12.6	12.8	13.9	13.4
Hispanic	5.3	4.6	3.0	3.8	3.2

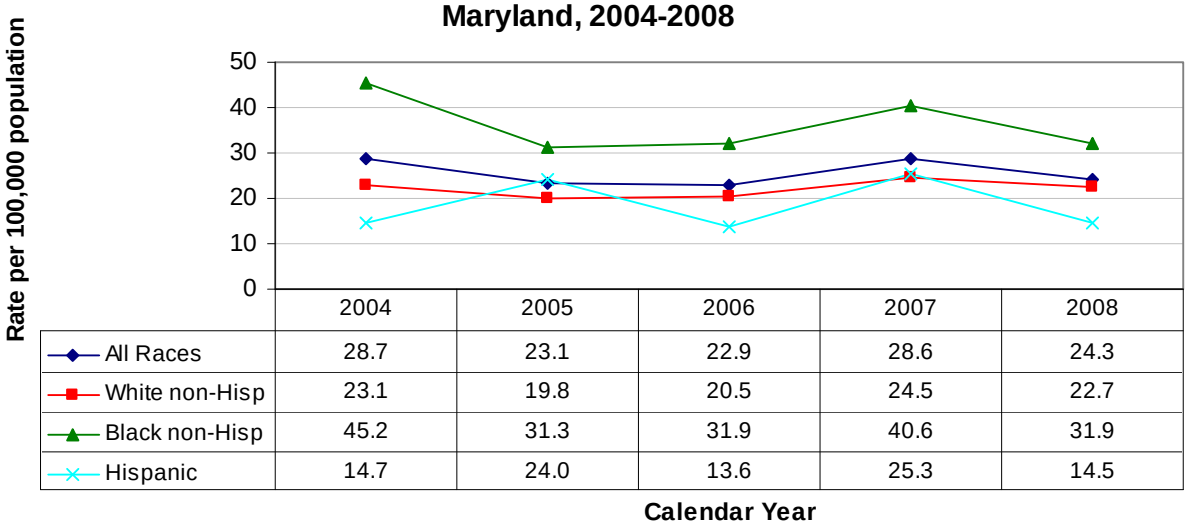
Data Source: MD DHMH, Vital Statistics Administration

There were substantial racial disparities in infant mortality rates in 2008. The infant mortality rate for Black non-Hispanics (13.4 per 1,000 live births) was over twice as high as the rate for White non-Hispanics (5.8 per 1,000 live births), and four times as high as the rate for Hispanics (3.2 per 1,000 live births).

In 2008, the child death rate (1-17 years of age) decreased to 24.3 per 100,000 population (Figure 2). In 2008, the child death rate for White non-Hispanics was 22.7 per 100,000 population compared to 31.9 per 100,000 population for Black non-Hispanics. The child death rate for Hispanics in 2008 was 14.5 per 100,000 population. Among children aged 1-17, the three leading causes of death were: (1) unintentional injuries; (2) homicide; and (3) malignant neoplasms during the years 2006 through 2008 (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, 35.8% were due to motor vehicle collisions (Tables 2, 3). Sixty percent of motor vehicle deaths occurred in males. The greatest proportion of motor vehicle-related injury deaths occurred in children aged 15 to 17 (55.4%). The rates for motor vehicle-related deaths by race and ethnicity were 5.0 for White non-Hispanics, 5.3 for Black non-Hispanics, and 3.6 for Hispanics, per 100,000 population.

Figure 2: Child (1-17 years) Death Rates by Race/Ethnicity, Maryland, 2004-2008



	2004	2005	2006	2007	2008
All Races	28.7	23.1	22.9	28.6	24.3
White non-Hisp	23.1	19.8	20.5	24.5	22.7
Black non-Hisp	45.2	31.3	31.9	40.6	31.9
Hispanic	14.7	24.0	13.6	25.3	14.5

Data Sources: MD DHMH, Vital Statistics Administration: death data, Maryland Department of Planning: population data

Children's death by homicide continues to be a significant public health problem in Maryland. In the period 2006 through 2008 there were 18 homicides of infants and 149 homicides among children aged 1-17 years. The rate of homicides among children aged 0-17 is substantially higher among Black non-Hispanics, at 9.1 per 100,000 population, compared to 3.9 per 100,000 population for Hispanics, and 1.7 per 100,000 population for White non-Hispanics. Fifty-seven 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 years (12.4 per 100,000 population). The group with the next highest rate was that of infants (8.0 per 100,000). Seventy-seven percent of the child victims of homicide (aged 0-17 years) were male.

There were 38 suicides among children over the period from 2006 to 2008. The rate of suicide was greatest among those aged 15 to 17 years (3.8 per 100,000 population). Suicides occurred less frequently among younger children aged 10 to 14 years (0.9 per 100,000 population). Among children aged 10 to 17, 63.2% of suicides were committed by males. The suicide rates were slightly higher among White non-Hispanic children (2.5 per 100,000 population) compared to

Black non-Hispanic children (1.6 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, MD, 2006-2008					
Rank	**Age Group**				
		1-4 years	**5-9 years**	**10-14 years**	**15-17 years**
1	**Cause of Death**	Unintentional Injury	Unintentional Injury	Unintentional Injury	Unintentional Injury
	# of Deaths	63	44	57	127
	% of Deaths in Age Group	23.8%	31.9%	28.4%	34.8%
2	**Cause of Death**	Congenital Malformations	Malignant Neoplasms	Malignant Neoplasms	Homicide
	# of Deaths	37	15	23	91
	% of Deaths in Age Group	14.0%	10.9%	11.4%	24.9%
3	**Cause of Death**	Homicide	Diseases of the Nervous System	Homicide	Suicide
	# of Deaths	31	12	21	28
	% of Deaths in Age Group	11.7%	8.7%	10.5%	7.7%
4	**Cause of Death**	Diseases of the Respiratory System	Diseases of the Respiratory System	Diseases of the Nervous System	Diseases of the Circulatory System
	# of Deaths	19	10	16	20
	% of Deaths in Age Group	7.2%	7.3%	8.0%	5.5%
5	**Cause of Death**	Malignant Neoplasms	Congenital Malformations	Diseases of the Circulatory System	Undetermined Intent
	# of Deaths	18	10	16	20
	% of Deaths in Age Group	6.8%	7.3%	8.0%	5.5%

- Data Source: MD DHMH, Vital Statistics Administration

Table 2. Child (1-17 years) Injury-Related Deaths by Type of Injury and Gender, Maryland, 2006-2008

Type of Injury	Male	Female	Total Deaths	% of Total Injury Deaths
Motor Vehicle Collision	110	74	184	35.8%
Homicide by Firearm	82	11	93	18.1%
Homicide by other Means	35	21	56	10.9%
Drowning	30	7	37	7.2%
Undetermined Intent	29	5	34	6.6%
Fire	24	9	33	6.4%
Suicide by other Means	16	11	27	5.3%
Other Non-Transport Injury	12	7	19	3.7%
Suicide by Firearm	8	3	11	2.1%
Other Transport Injury	4	5	9	1.8%
Falls	4	4	8	1.6%
Legal Intervention	2	0	2	0.4%
Poisoning	1	0	1	0.2%

* Data Source: MD DHMH, Vital Statistics Administration

Table 3. Child (1-17 years) Injury-Related Deaths by Type of Injury and Race/Ethnicity, Maryland, 2006-2008

Type of Injury	White non-Hispanic	Black non-Hispanic	Hispanic	Other	Total Deaths
Motor Vehicle Collision	100	64	12	8	184
Homicide by Firearm	12	77	3	1	93
Homicide by other Means	15	31	10	0	56
Drowning	21	13	2	1	37
Undetermined Intent	23	9	2	0	34
Fire	9	22	2	0	33
Suicide by other Means	17	8	0	2	27
Other Non-Transport Injury	7	10	2	0	19
Suicide by Firearm	8	2	0	1	11
Other Transport Injury	5	4	0	0	9
Falls	3	2	1	2	8
Legal Intervention	0	1	0	1	2
Poisoning	1	0	0	0	1

* Data Source: MD DHMH, Vital Statistics Administration

2009 State CFR Team Activities

Training and Education

One of the statutory duties of the State CFR Team is to provide educational and training activities to assist local CFR teams in carrying out their duties. Each year, the State CFR Team collects reports from the local CFR teams (See Appendix C for a summary of local CFR team case review meetings and findings). In these reports the local 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 training needs and 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 the annual training meeting held at the end of each year. Presentations are made by expert State CFR Team members and invited guests.

In 2009, a number of topics were covered at quarterly State CFR meetings. These included a general legislative update as well as an update on the change to CFR law, allowing Maryland to participate in the Internet-based case reporting system offered to states by the National Center for Child Death Review (NCCDR). Also presented were a review of Shaken Baby Syndrome, a review of recommended safe-sleep practices, recommendations of local CFR teams to the State CFR Team, and the local team descriptions of their training needs. The fall quarterly meeting was devoted to an all-day training on the Internet-based child death review case reporting system presented by Teri Covington, Director of the NCCDR.

Specific health issues or risk areas are highlighted at each State CFR Team annual meeting. The 2009 annual meeting included a panel discussion of the relationship of domestic violence to child deaths, a presentation on preventing accidental falls from windows, a presentation of a motor vehicle safety program initiated by one county, and a discussion and update on the Internet-based child death review case reporting system. The full agenda for the 2009 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 demographics. Examples include those with a predominantly rural or urban population, or a high death rate due to a particular cause, such as homicides or automobile-related deaths. Because similar regions often share risk profiles, they can benefit from joint communication, effort, and public education campaigns. Some local teams have expressed an interest in increasing networking opportunities with other teams.

Newsletter

In 2009, as in previous years, an excellent source of communication, networking, and education has been the quarterly State CFR Team newsletter, which is edited by State CFR Team members

Laurel Moody, RN, MS and Donna Mazyck, RN, BSN. The newsletter provides a regular update for local team members regarding relevant legislation, training opportunities, meeting dates, State CFR Team membership changes, Web sites, and other valuable information.

Each newsletter focuses on special, timely topics and in 2009 a number of issues were highlighted. This included a review of H1N1 pediatric fatalities, the American Academy of Pediatrics statement on the role of the pediatrician in youth violence prevention, information on the establishment of a new Governor's Commission on Suicide Prevention, the dangers posed to children from overdoses of over-the-counter medications, and seasonal topics such as window falls prevention, back-to-school tips and the risks posed when children are left alone inside automobiles. The quarterly newsletter can be viewed at http://fha.maryland.gov/mch/cfr_home.cfm

Child Death Review Case Reporting System

The NCCDR is funded by the U.S. Department of Health and Human Services', Health Resources Services Administration (HRSA), Maternal and Child Health Bureau and provides an Internet-based standardized case reporting tool for use by states with child death review programs. The NCCDR Case Reporting System allows local and state users to enter case data, access and download their data and download standardized reports via the Internet. Users are able to complete data analysis and develop their own reports. With data use agreements between states, users may be able to compare their data with other states and with national compilations. The NCCDR also offers free training to State and local CFR teams to ensure proper initiation and use of the system.

As mentioned above, thanks to passage of House Bill 705/Senate Bill 862 (2009) (Child Fatality Review – Child Death Review Case Reporting System) Maryland became eligible to participate in the NCCDR Case Reporting System in 2009. The legislation amended the statute governing Child Fatality Review. The enactment of this legislation and the promulgation of related regulations under COMAR 10.11.05 (Child Death Review Case Reporting System) meant that comprehensive training and plans to fully implement the system could be finalized.

Subsequently, an all-day training was held in September, 2009. Teri Covington, MPH, Director of the National Center for Child Death Review, provided an in-depth presentation discussing all aspects of the new system. The event was well attended by local CFR team leaders. The official initiation of the Internet-based system occurred in January of 2010, and at this time CFR leaders became responsible for Internet-based data entry of their case review information. The data collected by the NCCDR is significantly more comprehensive than that on the previously used Maryland case report forms, requiring more in-depth information gathering during case review meetings.

Near Fatality

Official case reviews are still performed only on child fatalities, not near fatalities, in accordance with statute. 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**."

It is hoped that with this first step of the development of the definition of near fatality, eventually a system will be devised enabling local CFR teams to do formal case reviews of these cases. However, for all local CFR teams to be able to formally review near fatalities, a system of official notification about such cases would first need to be developed.

In the current notification system, the Office of the Chief Medical Examiner (OCME) sends information on recent child fatalities to each local jurisdiction CFR leader every month. Receipt of this notification from the OCME initiates the local CFR team's review process. However, because the OCME only has information on deaths and not on near fatalities, another system of notification will need to be developed before the local CFR teams can uniformly review near fatalities. Near fatality notification will most likely be accomplished through an arrangement with local hospitals, but the exact process is yet to be determined.

Collaboration Efforts

Collaborative efforts between the State CFR Team, the State Council on Child Abuse and Neglect, and the State Citizens' Review Board for Children continued in 2009, with team leaders communicating with one another. Health-General Article §5-704(c) promotes coordination between the three "sister" teams via the statute that states, "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." Members from each of the three teams plan to attend meetings of the other respective teams for the purpose of coordination of activities and to further strategies on partnerships for common goals on behalf of Maryland children.

State CFR Team Future Activities

A primary focus of the State CFR Team in 2010 will continue to be the implementation of the Internet-based reporting system described above, in collaboration with the NCCDR. Local teams will go through a transition as they work to amass more detailed information during case review meetings. The new Internet-based system will significantly improve each team's ability to analyze child deaths in their locale and it will help the State CFR Team more efficiently coordinate efforts based on analysis of the data and trends.

The State CFR Team will continue to direct a special focus on safe sleep, working with the Maryland Center for Infant and Child Loss to increase safe sleep training for professionals, and education and awareness for the general public. This effort also includes promoting the Center's grief and bereavement trainings, which are an essential component where fatalities are involved. In 2009 the State CFR Team also worked with the Anne Arundel County CFR team to begin a pilot program for suicide prevention through a program of analysis of psychiatric visit data in hospital emergency departments. This pilot was to form the basis for collaboration among local agencies and hospitals to better understand trends and risk factors, to aid the development of community-based interventions on suicide prevention.

Other State CFR Team goals for 2010 and beyond include establishing a media campaign (television, radio, print, Internet) to disseminate messages on child injury prevention, timed for when injuries are most prevalent among children. The State CFR Team shares the view that Injury prevention messages can be delivered efficiently to the population using media and may have a positive impact on reducing infant and child deaths.

Similarly, the State CFR Team would like to explore improving communications with the local teams via a listserv for internal use by the State CFR Team and local CFR teams. It is felt that this would improve dissemination of successful community efforts on child fatality prevention and create a medium for dialogue from which all teams may benefit.

Governor Martin O'Malley established a new Governor's Commission on Suicide Prevention, to convene in 2010. State CFR Team Coordinator, Joan Patterson, LCSW-C, was appointed by DHMH to serve on the Commission as designee for Frances B. Phillips, Deputy Secretary, Public Health Services. This will enable the State CFR Team to learn about and contribute to the work of the new Commission.

Beyond these plans, training and education on prevention and the process of child fatality review itself will continue, as will efforts to find more resources for Maryland CFR in general. There are currently no funds allocated for CFR. A comprehensive, Statewide or regional approach is necessary if the State CFR Team and local CFR teams are to have the ability to make meaningful, significant changes 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: 2009 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 – Amanda Scott, JD, designee
(2) THE CHIEF MEDICAL EXAMINER – Ling Li, MD, designee
(3) THE SECRETARY OF HUMAN RESOURCES – Vernice McKee, LGSW, designee
(4) THE SECRETARY OF HEALTH AND MENTAL HYGIENE – Marsha Smith, MD, MPH, designee
(5) THE STATE SUPERINTENDENT OF SCHOOLS – Donna Mazyck, RN, BSN, designee
(6) THE SECRETARY OF JUVENILE SERVICES – Jenny Maehr, MD, 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 – Michael Mann, JD, designee
(9) THE PRESIDENT OF THE STATE'S ATTORNEYS' ASSOCIATION – Julie Drake, JD, designee
(10) THE CHIEF OF THE DIVISION OF VITAL RECORDS – Hal Sommers, MA, designee
(11) A REPRESENTATIVE OF THE STATE SIDS INFORMATION AND COUNSELING PROGAM, LaToya Bates, LCSW-C, 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, MD, FAAP
Richard Lichenstein, MD, 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 –
Akin Akintola, MD, Citizen Advocate for Children
Mary C. Gentile, LCSW-C, Citizen Advocate for Children
Roger Lerner, JD, Citizen Advocate for Children
Laurel Moody, RN, MS, Citizen Advocate for Children
Albert Rolle, MD, FACS, Citizen Advocate for Children
Anntinette Williams, LICSW, Citizen Advocate for Children
(Five pending general public vacancies)

Appendix B: The 13 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

2009 Summary of Local Case Review Meetings and Findings Maryland Jurisdictions	
	Total
1. Total Number of CFR meetings held in 2009.	74
2. Were all Medical Examiner cases reviewed by the local CFR team in your jurisdiction?	Yes 12 No 11 N/A 1
3. Total number of cases reviewed at local CFR team meetings in 2009, regardless of year of death.	242
4. Of all the cases reviewed by all teams in 2009, in how many was abuse or neglect confirmed; e.g., there was a finding of "indicated abuse" or "indicated neglect" by Child Protective Services (CPS) or a positive police investigation?	32
5. Not including those children counted in number 4 above, what is the total number of cases that teams *subjectively* felt abuse or neglect may have contributed to the death?	36
6. Of the total cases reviewed in 2009, in how many was there a previous history of child abuse, as determined by CPS?	10
7. How many had a previous history of child neglect, as determined by CPS?	27
8. How many had a history of involvement with the Department of Juvenile Services?	17

Appendix D

2009 Local CFR Recommendations for State CFR Team by Topic Area

Administrative (2 Counties) *

1. Finalize the State CFR Policy and Procedure Manual. (Cecil)
2. Would appreciate assistance in identifying health care providers for children who have experienced a fatality in their family. (Montgomery)

Advocacy/Publicity (4 Counties)

1. Publicize required reporting of child abuse. (Carroll)
2. Local health departments require more support to provide home visiting to at-risk children. (Carroll)
3. Provide realtors, banks, mortgage companies, etc., resources for mental health assistance for families in financial crisis. (Frederick)
4. Better education for parents of teens regarding the use of cell phones by teens. (Washington)
5. Increased education about the need for smoke detectors. (Washington)
6. The team recommends a Statewide initiative to increase public awareness about safe-sleep practices. (Wicomico)

Autopsy/Forensics (2 Counties)

1. State should help facilitate timely distribution of Medical Examiner (ME) reports so that cases can be reviewed in a timelier manner. (Charles)
2. We appreciate getting ME reports in a timely fashion. (Garrett)

Communication/Feedback (3 Counties)

1. Provide more information on CFR activities around the State. (Anne Arundel)
2. Increase the level of communication between the State and local teams. (Prince George's)
3. Continue to share successful programs created by local CFR teams as the result of CFR recommendations. (Somerset)
4. Create opportunities for local teams to network, besides just the annual meeting. (Prince George's)

Data Systems Reporting and/or Training on Electronic System (2 Counties)

1. Remind local CFR teams that they can continue using a paper version of the new case report form during CFR meetings, and enter the data into the Web-based system after the meeting. (Prince George's)
2. Glad the new electronic system will replace the cumbersome forms! (Talbot)

Funding (3 Counties)

1. Funding for prevention activities would be helpful. (Allegany)
2. Funding to CFR teams for collaborative projects. (Dorchester)
3. Funding to support activities. (Worcester)

*** Represents the number of counties that made recommendations on each topic.**

MVA/Teen Driving (1 County)
1. The State Team may seek to promote public education and outreach re: adolescent motor vehicle trauma and mortality. (Howard)

Newsletter (2 Counties)
1. Continue the State CFR Team Newsletter. (Anne Arundel)
2. Recommend that two areas of concern be included in the State CFR Team newsletter: hyperthermia deaths and deaths occurring on railroad tracks. (Baltimore County)

Suicide (2 Counties)
1. Include suicide prevention curriculum in public middle schools. (Harford)
2. Raise awareness throughout programs of the state suicide prevention plan. (Caroline)

Training and/or Technical Assistance Requests (11 Counties)
1. Provide additional mock reviews with a focus on recommendation for different manner and causes of death. (Anne Arundel)
2. Provide written guidance regarding sharing of CFR and Fetal and Infant Mortality Review (FIMR) information within a jurisdiction. (Anne Arundel)
3. Provide feedback on local CFR recommendations that are sent to State CFR Team. (Anne Arundel)
4. Continue to assess the electronic data system. (Baltimore County)
5. Secondary trauma – CFR teams, investigators, etc. (Caroline)
6. Sources of funding to implement CFR recommendations. (Caroline)
7. Follow-up information regarding data entry. (Carroll)
8. Amtrak runs through several jurisdictions and there have been recent child fatalities in multiple jurisdictions, so perhaps an Amtrak safety summit could be considered. (Harford)
9. Trainings that address suicide among adolescents and the State's suicide prevention plan as it relates to school age children. (Howard)
10. Electronic data system. (Montgomery)
11. We need training for an alternate person who would assume the duties of data entry for the new electronic database starting in 2010. (Montgomery)
12. Training in the area of usage of the database. (Prince George's)
13. Grant writing and identification of funding sources. (Prince George's)
14. Any prevention-related trainings as they relate to preventable child deaths. (Somerset)
15. Would like it if people from the State CFR Team could attend a Talbot County CFR meeting every year or two. (Talbot)
16. Best practices model for conducting reviews. (Worcester)
17. Anticipate additional guidance will be needed on the electronic data system. (Worcester)

Appendix E

Agenda
Maryland State Child Fatality Review Team Annual Meeting
November 17, 2009
Location: Maryland Department of Transportation
7201 Corporate Center Drive, Hanover, Maryland
410-865-1142

8:30 – 9:30	**Registration**
9:30 – 9:45	**Welcome & Introductions** -Richard Lichenstein, MD Chair, The Maryland State Child Fatality Review Team -Introduction of Attendees
9:45 – 12:00	**Panel Discussion** **Child Deaths and Domestic Violence** -Laura Chase, Esq. Director, Family Violence Unit, Montgomery County -Julie Drake, Esq. State's Attorneys' Office and State CFR Team Member -Pia May, LCSW-C Children & Youth Services Manager, House of Ruth Maryland, Inc.
12:00 – 1:00	**Lunch**
1:00 – 1:30	**Pediatric Window Falls Prevention Program** -Beverly Byron, BSN, MA Co-Chair, Montgomery County CFR Team -Nerita Estampador-Ulep, MD State CFR Vice-Chair & Montgomery County CFR Member
1:30 – 2:00	**Howard County Motor Vehicle Safety Program** -Richard Lichenstein, MD Chair, State Child Fatality Review Team
2:00 – 3:00	**The New Web-based Reporting System** -Teri Covington, MPH Director, The National Center for Child Death Review (NCCDR)
3:00	**Wrap-up** -Joan Patterson, LCSW-C Coordinator, Maryland State Child Fatality Review