

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

December 20, 2021

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

The Honorable Bill Ferguson  
President of the Senate  
State House, H-107  
Annapolis, MD 21401-1991

The Honorable Adrienne A. Jones  
Speaker of the House  
State House, H-101  
Annapolis, MD 21401-1991

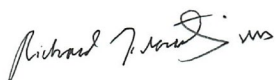
RE: Health – General Article, §5-704(b)(12) and Senate Bill 464 (Chapter 355 of the Acts of 1999) – 2020 Legislative Report of the State Child Fatality Review Team

Dear Governor Hogan, President Ferguson, and Speaker Jones:

Pursuant to Health-General Article, §5-704(b)(12) and Senate Bill 464 (Chapter 355 of the Acts of 1999), the Maryland State Child Fatality Review Team submits this 2020 report on its progress and accomplishments in calendar year 2020. The report includes data relating to unexpected child deaths in Maryland that occurred in calendar year 2019. These deaths were reported by the Office of the Chief Medical Examiner and reviewed by the local Child Fatality Review team in each jurisdiction.

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

Sincerely,



Richard Lichenstein, MD  
Chair

Cc: Heather Shek, JD, MS, Director, Office of Governmental Affairs  
Jinlene Chan, MD, MPH, FAAP, Deputy Secretary, Public Health Services  
Donna Gugel, MHS, Director, Prevention and Health Promotion Administration  
Shelly Choo, MD, MPH, Director, Maternal and Child Health Bureau  
Sarah Albert, MSAR #7575

# **MARYLAND STATE CHILD FATALITY REVIEW TEAM**

2020 Annual Legislative Report

Health-General Article, §5-704(b)(12)

Larry Hogan  
Governor

Boyd K. Rutherford  
Lt. Governor

Dennis R. Schrader  
Secretary of Health

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

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## **List of Abbreviations**

AAP	American Academy of Pediatrics
CDRCRS	National Child Death Review Case Reporting System
CFR	Child Fatality Review
CPS	Child Protective Services
CRBC	Citizen Review Board for Children
DSS	Department of Social Services
MDH	Maryland Department of Health
MMQRC	Morbidity, Mortality, and Quality Review Committee
NH	Non-Hispanic
OCME	Office of the Chief Medical Examiner
SIDS	Sudden Infant Death Syndrome
SUID	Sudden Unexpected Infant Death
ZCTA	ZIP Code Tabulation Area

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

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

The purpose of the Maryland State CFR Team (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 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 Team envisions the elimination of preventable child fatalities. To achieve this goal, the Team aims to successfully use the CFR process to understand the circumstances around incidents of child fatality and to recommend strategies to prevent future fatalities.

The Maryland CFR Program (Program) was established by statute in Health - General Article, §5-702 and Senate Bill 464 (Chapter 355 of the Acts of 1999). The Program is housed within the Maryland Department of Health (MDH) for budgetary and administrative purposes. The 25-member 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 Team meets at least four times a year to address 13 statutorily-mandated duties (see Appendix B). One of these meetings occurs in conjunction with an all-day training for local CFR team members on select topics related to child fatality issues (see Appendix C).

The Team provides support to local CFR teams that operate in each jurisdiction. The local CFR teams receive notice from the Office of the Chief Medical Examiner (the OCME) of unexpected resident deaths of children 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 2019 OCME-referred deaths.

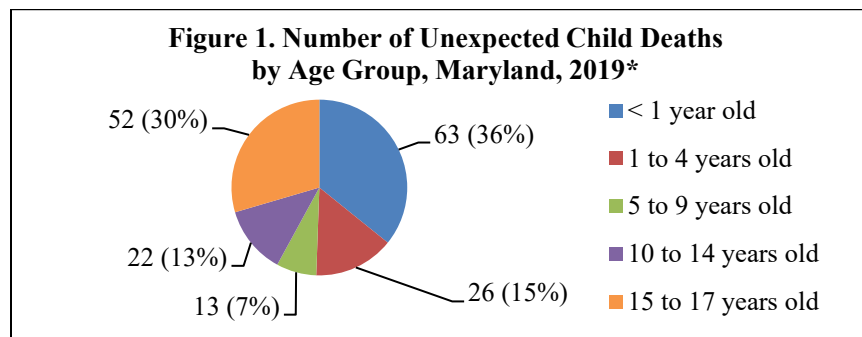
Other multidisciplinary groups in Maryland have similar charges to prevent child injury and death. The State Council on Child Abuse and Neglect and the Citizen Review Board for Children examine policies and practices for protecting children. Also, the MDH Morbidity, Mortality, and Quality Review Committee (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 teams in several jurisdictions as well as with other review teams such as pedestrian fatality and overdose fatality programs.

## Unexpected Child Deaths – Maryland, 2019

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 assess the causes and populations affected. These data are crucial in identifying trends and targeting interventions to prevent childhood deaths. The CFR process reviews all unexpected child deaths referred by the OCME. This subset of child deaths includes cases of Sudden Unexpected Infant Death (SUID), unintentional injury, homicide, suicide, and some deaths due to natural causes.<sup>1</sup> Epidemiologists within the MDH Maternal and Child Health Bureau analyzed OCME-referred child deaths for summary in this report. This report examines data related to 2019 child deaths available as of March 2, 2021.

An important aspect of Maryland’s CFR review process is the local team’s use of additional data sources – including medical records, school district data, police investigations, emergency medical service records, and investigations by the Department of Social Services (DSS) – to improve the overall quality of the case review data. In recent years, local CFR teams have received additional training to accurately and consistently classify child deaths. These data are then uploaded to the National Child Death Review Case Reporting System (CDRCRS), which was authorized in 2009 by House Bill 705 (Chapter 108 of the Acts of 2009 of the General Assembly of Maryland). Because of the improved capacity at the local level to report more accurate and complete data, fatality analysis in this report uses the data as reported to CDRCRS from local reviews, rather than the OCME data used in previous reports. Thus, the annual number of cases by different demographic characteristics may vary from previous annual reports. Due to the COVID-19 pandemic, many local CFR teams were unable to meet quarterly to review cases, leading to the increased number of cases that were not reviewed from 2019.

In 2019, the OCME referred 176 unexpected child deaths to the local CFR teams for review. Figure 1 shows the distribution of these deaths by age. Sixty-three deaths (36 percent) occurred among infants (children under one year of age), and fifty-two deaths (30 percent) occurred among children ages 15 to 17 years old. Of the 176 unexpected child deaths, 115 deaths (65 percent) occurred among male children and 61 deaths (35 percent) among female children.

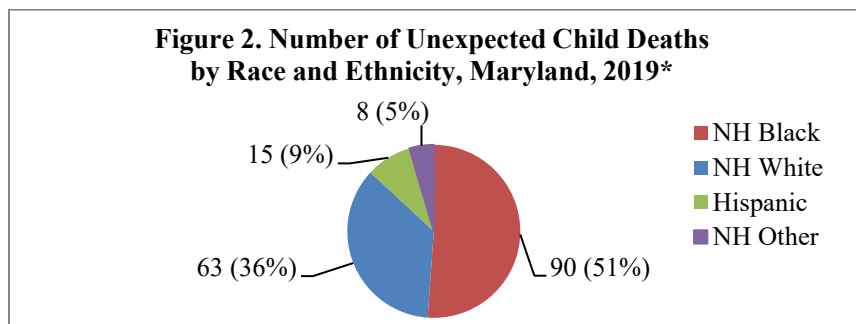


Source: CDRCRS, as of 3/2/2021.

\*Percentages will total more than 100 percent due to rounding.

<sup>1</sup>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.

Figure 2 shows the distribution of unexpected child deaths by race and ethnicity in 2019. Non-Hispanic (NH) Black children had the highest number of unexpected deaths, six times greater than unexpected deaths among Hispanic children and 1.4 times greater than the number of unexpected deaths among NH White children.



Source: CDCRCS, as of 3/2/2021.

\*Percentages will total more than 100 percent due to rounding.

The number and percentage of child fatality cases occurring in 2019 by manner and cause of death categories are shown in Table 1. Most cases reviewed by teams are referred to teams by the OCME. There were 15 deaths that were not reviewed by the CFR team due to no autopsy being indicated, the death not being referred through the OCME, the teams not receiving immediate notification of the death, or time or resource constraints. Consistent with guidance provided by the National Center for Fatality Review and Prevention in an effort to report accurate and specific results of the child fatality review process, this report reflects reviews conducted by local CFR teams. Previously, if local teams deemed the manner of death to be undetermined, attempts were made to assign cases to a specific category. This year's report leaves undetermined cases within the undetermined category.

Cases that are undetermined include cases where it was not possible for the team to classify the death as due to an injury or due to a medical cause. A case can also be classified as unknown if the team did not have information on the primary cause of death. Differentiating a cause of death from suicide, homicide, or accidents can be a difficult for teams. This lack of consensus among review teams can also result in the cause of death being listed as undetermined. The cause of death is marked as undetermined if it is not possible to classify the death as due to an injury or medical cause, and the cause of death is marked as unknown if the team does not have information on the primary cause of death.

The leading manner of child deaths in 2019 was undetermined, accounting for 26.7 percent of all child deaths. Accidents were the second leading manner of child deaths, accounting for 20.5 percent of all child deaths. Motor vehicle accidents were the leading cause of accidental deaths (11.9 percent of all deaths), followed by drowning (2.8 percent of all deaths). Natural causes were the third leading manner of child deaths in 2019, with other (non-pneumonia and non-influenza) infections contributing to 5.1 percent of all deaths, and cardiovascular conditions and pneumonia each accounting for 3.4 percent of all deaths. Homicide and suicide accounted for 15.3 percent and 9.7 percent of child deaths in 2019, respectively. Fifteen cases (8.5 percent) were not reviewed.



Local CFR teams reported 23 deaths (13.1 percent) resulting from confirmed abuse or neglect among the 176 deaths occurring in 2019, an increase from 16 deaths (8.6 percent) in 2018. Teams incorporated information from autopsy records, DSS findings, and police investigations. Findings were shared by members of the local CFR team that determined that child abuse or neglect was indicated in the incident that led to the child's death.

**Table 1. Unexpected Child Deaths by Manner and Cause of Death, Maryland, 2019** Source: CDRCRS, as of 3/2/2021. Rounding may cause variations in percentages.

	<u>Number</u>	<u>Percent</u>
<b>Undetermined</b>	<b>47</b>	<b>26.7</b>
Undetermined if medical or external cause	42	23.9
Unknown cause	3	1.7
External – Poison	1	0.6
External – Undetermined	1	0.6
<b>Accident</b>	<b>36</b>	<b>20.5</b>
External – Motor Vehicle Accident	21	11.9
External – Drowning	5	2.8
External – Asphyxia	3	1.7
External – Other	2	1.1
External – Missing	1	0.6
External – Fire, burn, or electrocution	1	0.6
External – Fall or crush	1	0.6
External - Poisoning	1	0.6
Unknown cause	1	0.6
<b>Natural</b>	<b>34</b>	<b>19.3</b>
Medical – Other infection	9	5.1
Medical – Cardiovascular	6	3.4
Medical – Pneumonia	6	3.4
Medical – Other medical cause	4	2.3
Medical – Asthma	2	1.1
Medical – Congenital Anomaly	2	1.1
Medical – Influenza	2	1.1
Medical – Asphyxia	1	0.6
Medical – Neurological, seizure	1	0.6
Unknown cause	1	0.6
<b>Homicide</b>	<b>27</b>	<b>15.3</b>
External – Weapon (including assault)	23	13.1
External – Fire, burn, or electrocution	1	0.6
External – Poison	1	0.6
External – Other	1	0.6
Undetermined if medical or external cause	1	0.6
<b>Suicide</b>	<b>17</b>	<b>9.7</b>
External – Weapon (including asphyxia)	12	6.8
External – Other	3	1.7
External – Poison	1	0.6
External – Fall or crush	1	0.6
<b>Not Reviewed</b>	<b>15</b>	<b>8.5</b>
<b>Total</b>	<b>176</b>	<b>100.0</b>

In Table 2, the number and percentage of deaths in 2019 are shown by jurisdiction of residence of the child at the time of death. More than 20 percent of all child fatality cases occurred among children residing in Baltimore City.

<b>Table 2. Unexpected Child Deaths by Jurisdiction of Residence, Maryland, 2019*</b>		
	<u>Number</u>	<u>Percent**</u>
Baltimore City	36	20.5
Baltimore	30	17.0
Anne Arundel	22	12.5
Prince George's	13	7.4
Montgomery	12	6.8
Cecil	7	4.0
Harford	7	4.0
Howard	7	4.0
Charles	6	3.4
Frederick	6	3.4
Washington	6	3.4
Allegany	5	2.8
Wicomico	4	2.3
Carroll	3	1.7
Calvert	2	1.1
St. Mary's	2	1.1
Worcester	2	1.1
Caroline	1	0.6
Dorchester	1	0.6
Garrett	1	0.6
Queen Anne's	1	0.6
Somerset	1	0.6
Talbot	1	0.6
<b>Total</b>	<b>176</b>	<b>100.0</b>

Source: CDRCRS, as of 3/2/2021.

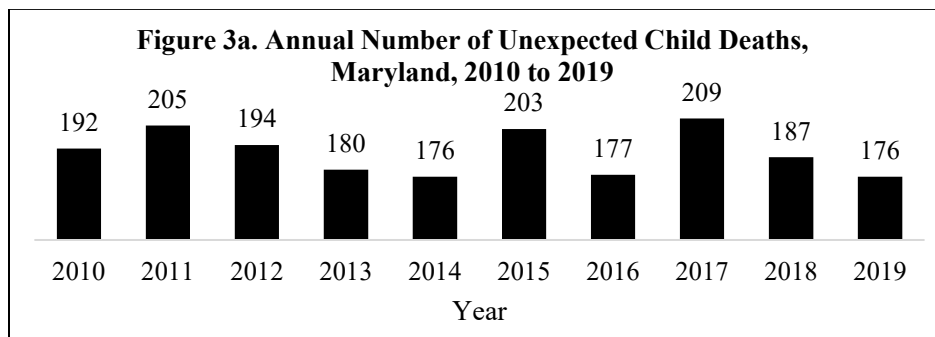
\*Kent County had no child deaths and is not listed.

\*\*Percentages will total more than 100 percent due to rounding.

## Trends in Maryland Unexpected Child Deaths

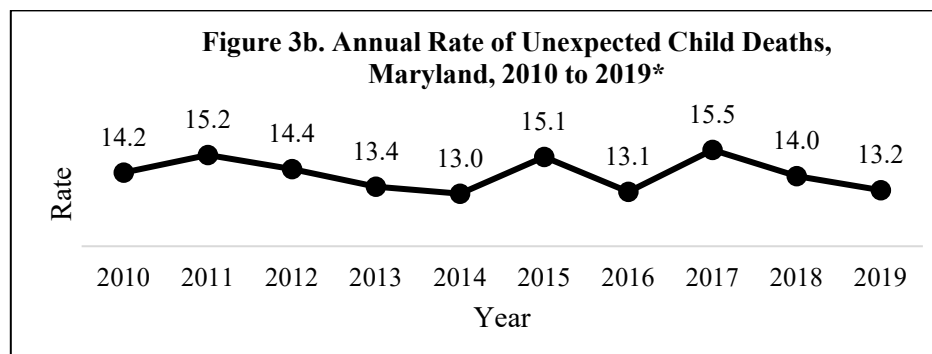
The data collection efforts of local CFR teams have undergone significant process improvements in recent years. Reports now rely on child demographic data input by CFR teams into a national database.<sup>2</sup> Prior to 2017, only case details provided by the OCME were used for reporting child demographic data. Thus, the annual number of cases by different demographic characteristics may vary from previous annual reports.

Figure 3a shows the annual number of unexpected child deaths referred by the OCME during the 10 year period from 2010 to 2019. Since 2014, the number of child fatality cases has fluctuated between 176 and 209. Since 2010, the number of referred unexpected child deaths has represented about 27 percent of all deaths of children under 18 years old.



Source: CDRCRS, as of 3/2/2021.

Figure 3b shows the annual rate of unexpected child deaths per 100,000 population for children ages 0 to 17 for the 10-year period from 2010 to 2019. The rate declined from 2010 to 2019.

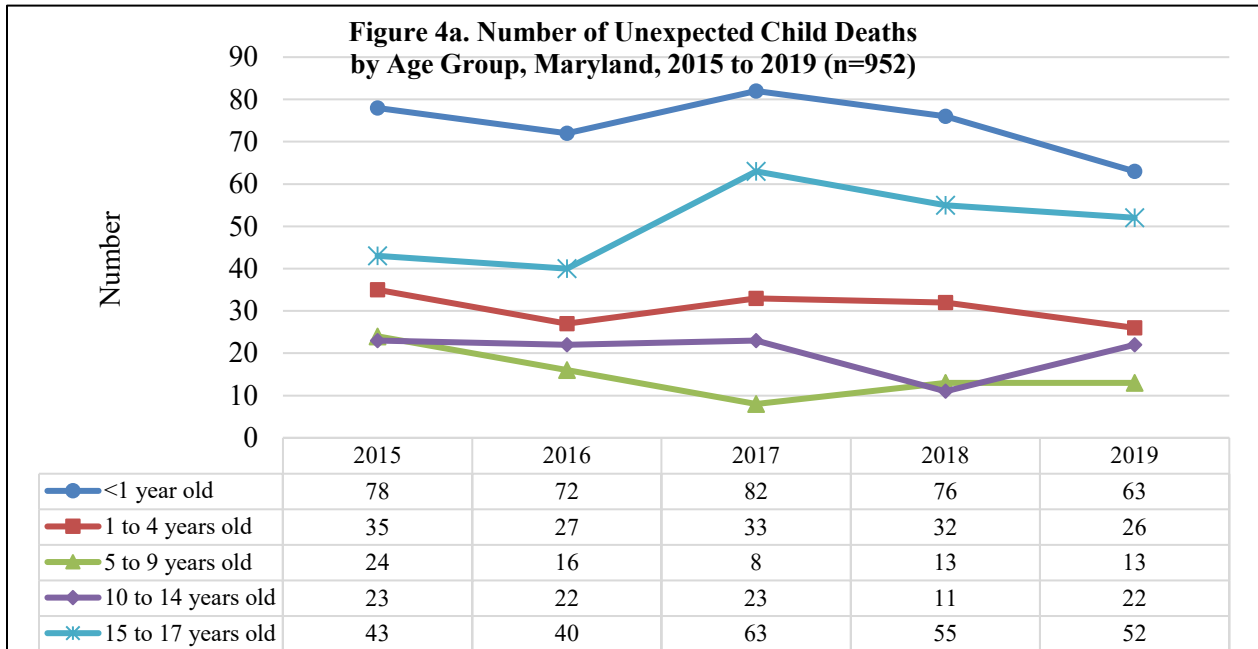


Source: CDRCRS, as of 3/2/2021.

\*Rates per 100,000 population based on National Vital Statistics System population estimates.

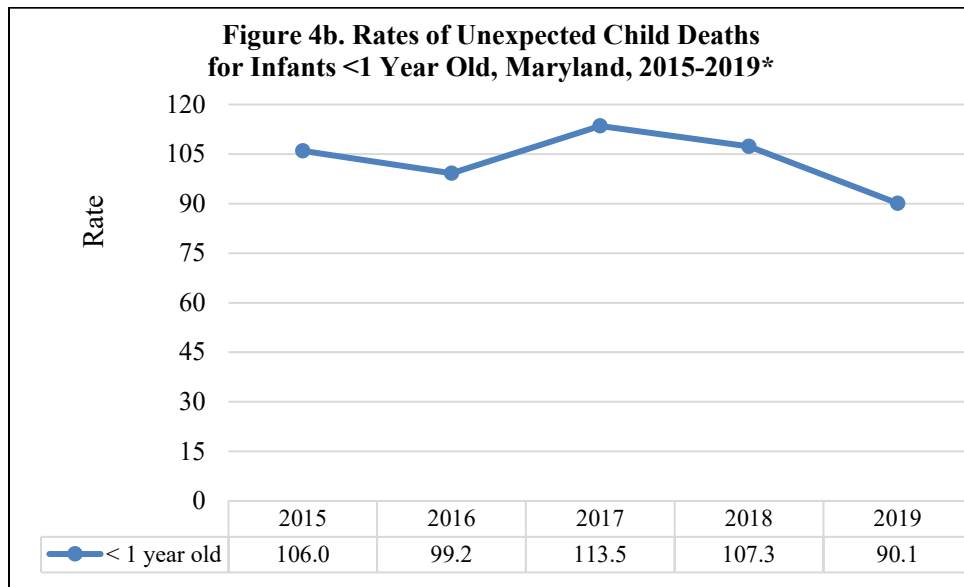
Figure 4a shows the number of child fatality cases by age group over the five-year period from 2015 to 2019. Between 2018 and 2019, the number of deaths remained the same or decreased among all age groups except deaths among children ages 10 to 14 years old. Among infant deaths, 74 percent occurred between the ages of 1 month to 6 months, accounting for 29 percent of all unexpected child deaths.

<sup>2</sup> National Child Death Review Case Reporting System. The National Center for Fatality Review and Prevention. Accessed 11 April, 2021. <https://www.ncfrp.org/data/nfr-crs/>



Source: CDRCRS, as of 3/2/2021.

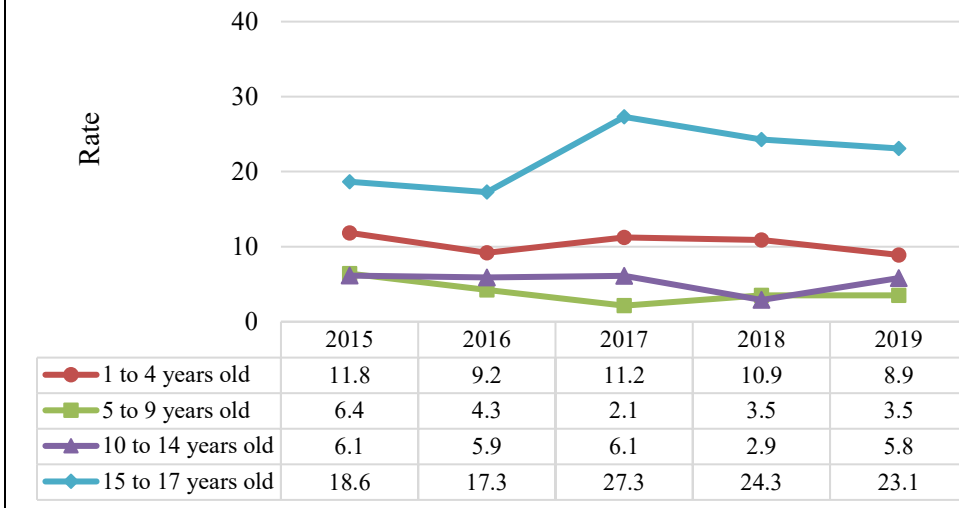
Figures 4b and 4c show a much higher rate of unexpected child deaths among infants (children less than one year of age) over the five-year period from 2015 to 2019 (rate ranging from 113.5 to 90.1 per 100,000 population), compared to all other age groups (rates ranging from 2.1 to 27.3 per 100,000 population). The overall rate of deaths among infants in Maryland was more than four times higher than the rate among children ages 15 to 17 years old during this period.



Source: CDRCRS, as of 3/2/2021.

\*Rates per 100,000 population based on National Vital Statistics System population estimates.

**Figure 4c. Rates of Unexpected Child Deaths for Children Ages 1 and Older by Age Group, Maryland, 2015-2019\***

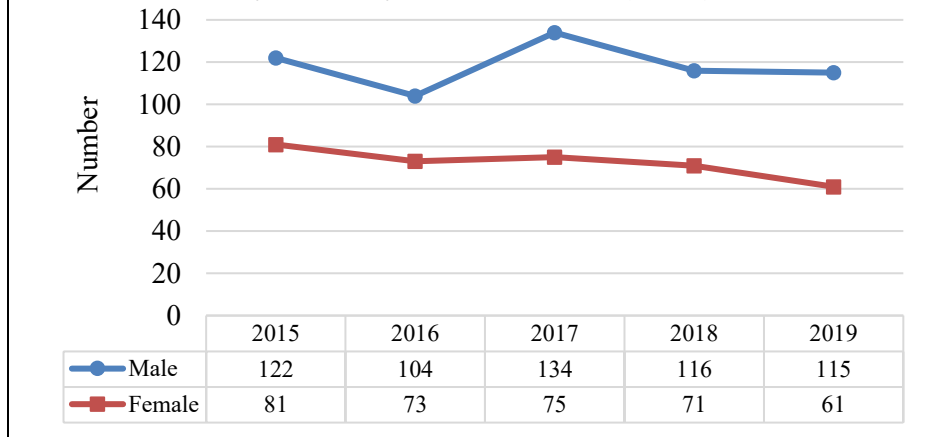


Source: CDRCRS, as of 3/2/2021.

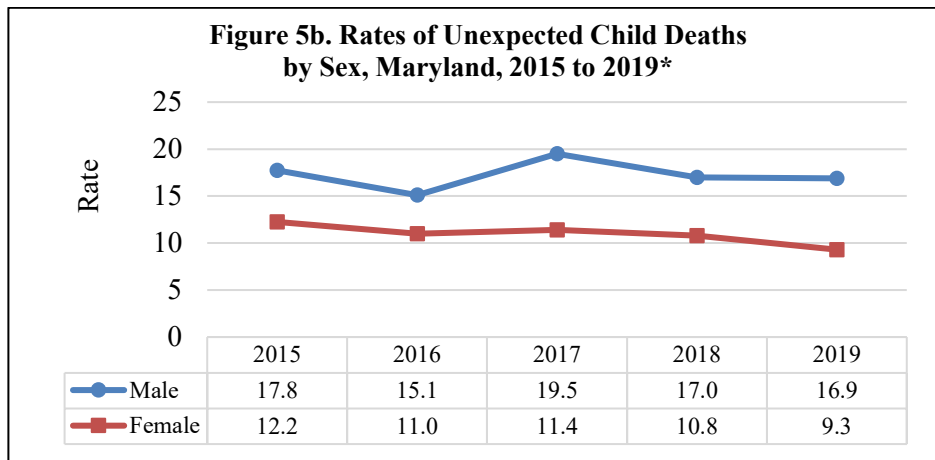
\*Rates per 100,000 population based on National Vital Statistics System population estimates.

During the same period (2015 to 2019), the number (Figure 5a) and rate (Figure 5b) of unexpected deaths was consistently higher among male children than among female children. In 2019, the number of unexpected deaths was 89 percent higher among male children than among female children.

**Figure 5a. Number of Unexpected Child Deaths by Sex, Maryland, 2015 to 2019 (n=952)**



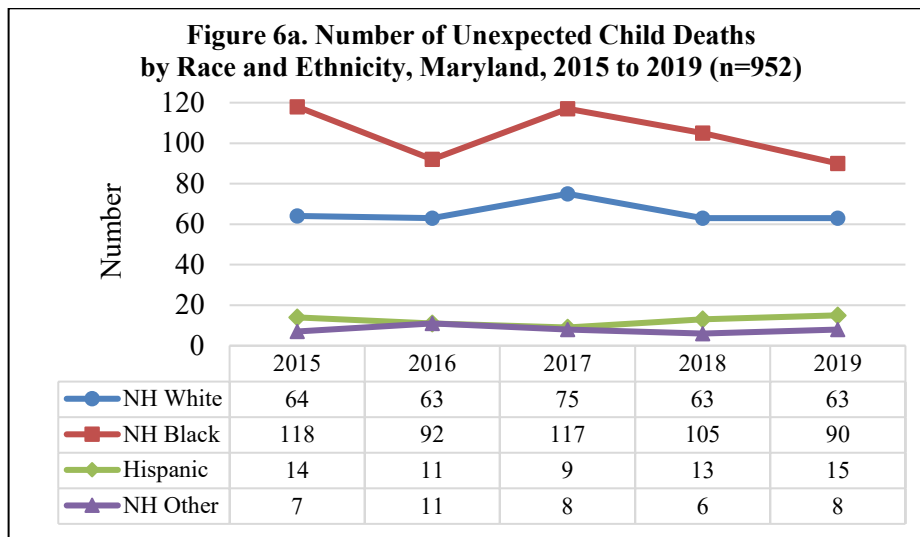
Source: CDRCRS, as of 3/2/2021.



Source: CDRCRS, as of 3/2/2021.

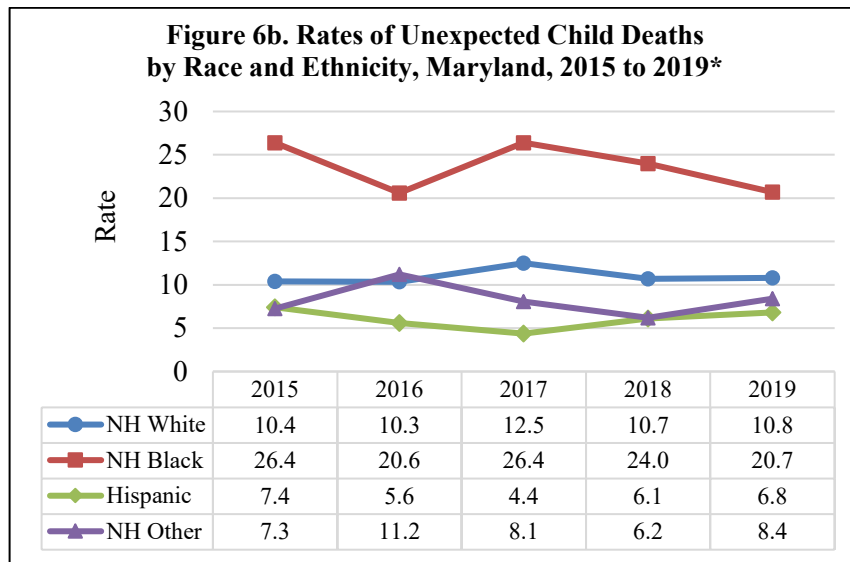
\*Rates per 100,000 population based on National Vital Statistics System population estimates.

Similarly, Figure 6a shows the continued disparities among racial and ethnic groups. In 2019 the number of unexpected child deaths among NH Black children was 30 percent higher than the number of deaths among NH White children.



Source: CDRCRS, as of 3/2/2021.

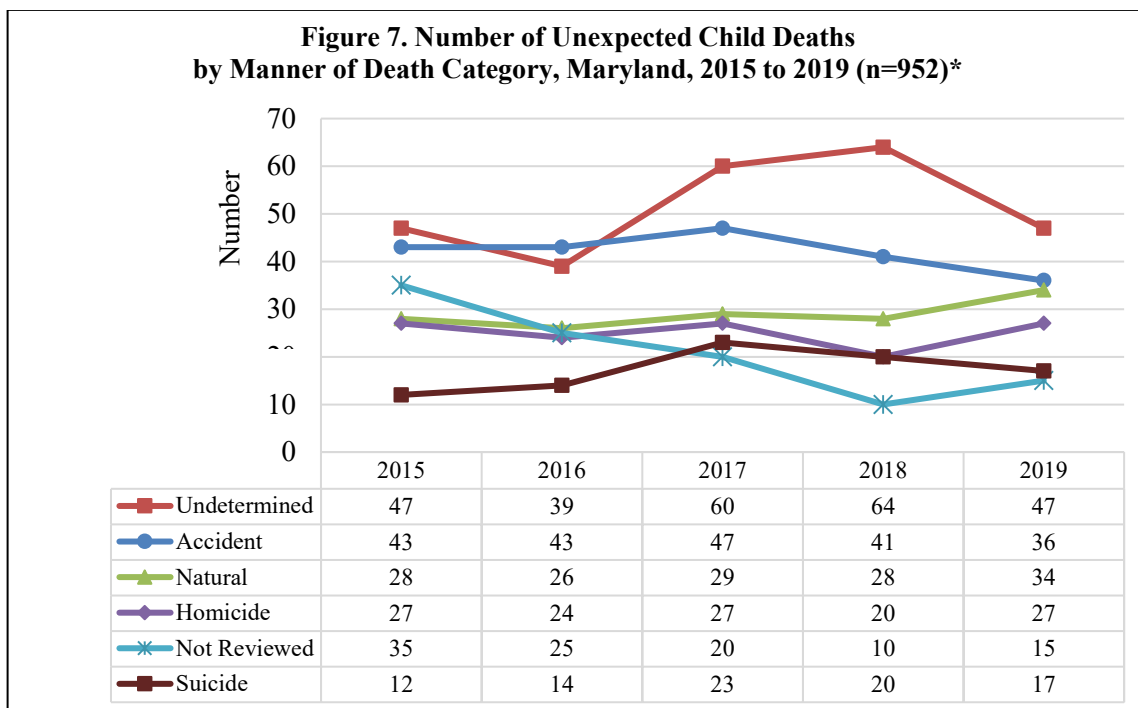
Overall, the rate of unexpected deaths from 2015 to 2019 among NH Black children was 2.2 times greater than the rate among NH White children, and 3.9 times greater than the rates among Hispanic children (Figure 6b). The rate of unexpected deaths increased the most (15 percent) among NH children of other races, from 7.3 per 100,000 population in 2015 to 8.4 in 2019. The rate of unexpected child death among NH Black children has decreased by 22 percent since 2015. In 2019, the rate of unexpected deaths among NH Black children was 1.9 times greater than the rate among NH White children.



Source: CDCRCS, as of 3/2/2021.

\*Rates per 100,000 population based on National Vital Statistics System population estimates.

Figure 7 shows the number of unexpected child deaths by manner of death for the period from 2015 to 2019. Undetermined was the leading manner of death for all years except 2016, when accidents became the leading manner of death. Eleven percent of the deaths during this period were not reviewed.



Source: CDCRCS, as of 3/2/2021.

\*Excludes cases where manner was unknown (16 cases), pending (5 cases) or missing a response (3 cases).

Table 3 shows the number of unexpected child deaths by jurisdiction of residence of the child at the time of death. Baltimore City has had the highest number of resident child deaths for each of

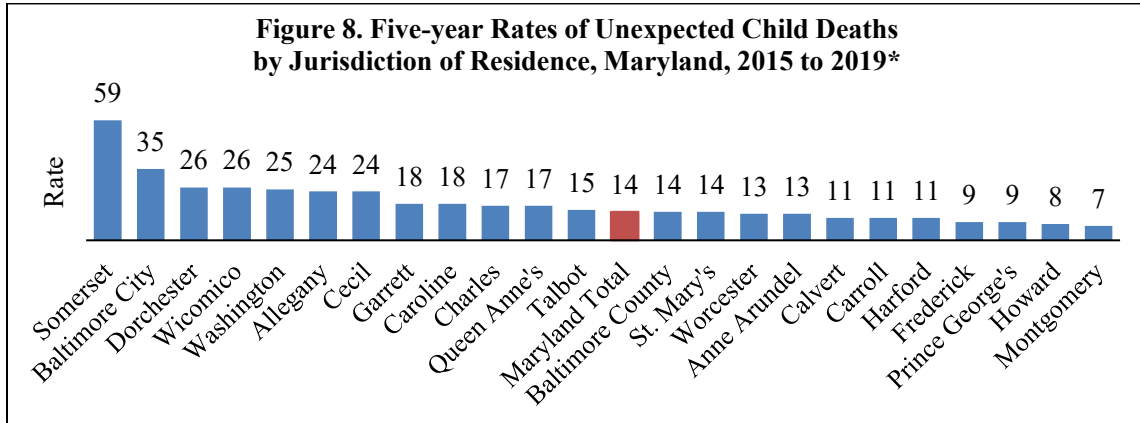


the past five years, but overall the number of resident child deaths has decreased by 27 percent from 2015 to 2019. Baltimore, Prince George’s, Montgomery, and Anne Arundel Counties have consistently been in the top five. During the five year period from 2015 to 2019, the number of resident child deaths decreased in Prince George’s County by 24 percent and in Montgomery County by 29 percent. During the same five year period, the number of resident child deaths increased in Baltimore by 25 percent, and in Anne Arundel County by 16 percent.

<b>Table 3. Number of Unexpected Child Deaths by Jurisdiction of Residence, Maryland, 2015 to 2019 (n=952)</b>						
	2015	2016	2017	2018	2019	Total
Baltimore City	49	39	49	49	36	222
Baltimore	24	14	35	24	30	127
Prince George’s	17	16	23	20	13	89
Montgomery	17	22	18	18	12	87
Anne Arundel	19	19	16	9	22	85
Washington	11	5	14	5	6	41
Charles	8	5	7	7	6	33
Howard	5	8	4	7	7	31
Harford	4	9	4	6	7	30
Wicomico	7	5	6	7	4	29
Cecil	6	6	5	4	7	28
Frederick	3	7	5	5	6	26
Carroll	5	3	4	5	3	20
St. Mary’s	5	2	4	6	2	19
Allegany	4	3	2	1	5	15
Somerset	8	2	2	0	1	13
Calvert	2	2	4	2	2	12
Dorchester	1	2	1	4	1	9
Queen Anne’s	3	1	1	3	1	9
Caroline	1	2	0	3	1	7
Worcester	1	2	1	0	2	6
Garrett	2	1	0	1	1	5
Talbot	1	0	2	1	1	5
Kent	0	2	2	0	0	4
<b>Total</b>	<b>203</b>	<b>177</b>	<b>209</b>	<b>187</b>	<b>176</b>	<b>952</b>

Source: CDRCRS, as of 3/2/2021.

The rates of unexpected child death were highest in Somerset County, Baltimore City, Dorchester County, and Wicomico County (Figure 8). From 2015 to 2019, there were 59 unexpected child deaths per 100,000 population in Somerset County, followed by 35 per 100,000 in Baltimore City, and 26 per 100,000 in Dorchester and Wicomico Counties. The lowest rate of unexpected child death was among children in Montgomery County (7 per 100,000 population).



Source: CDRCRS, as of 3/2/2021.

\*Rates per 100,000 population based on National Vital Statistics System population estimates. Minimum five reviewed deaths for inclusion.

## **Sudden Unexpected Infant Deaths in Maryland**

Approximately 3,500 infants die suddenly and unexpectedly each year in the United States. While an exact cause of death cannot always be determined, unsafe sleep factors are present in the majority of cases, indicating that the deaths could have potentially been prevented if safe sleep practices were always followed.<sup>3</sup>

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

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

The National Center for Fatality Review and Prevention defines SUID as deaths that occur suddenly and unexpectedly in previously healthy infants and have no obvious cause of death prior to investigation (unexplained). In cases of SUID there are two possible scenarios: 1) all potentially non-natural causes of death cannot reasonably be excluded by the investigation; or 2) there is an issue of concern. Issues of concern include an unsafe sleeping environment or other environmental concerns, previous Sudden Infant Death Syndrome (SIDS) in the immediate family, healed unexplained injuries, parental substance abuse, and other factors.

Even after a thorough investigation, there are some SUID cases in which there is no evidence of a non-natural cause of death or circumstances that cause concern for investigators. These cases fall under the subcategory of SIDS. SIDS is a diagnosis of exclusion, assigned only when all known and possible causes of death have been ruled out.

For the purposes of data analysis, a case is considered a SUID if the manner or cause of death meets the following criteria:

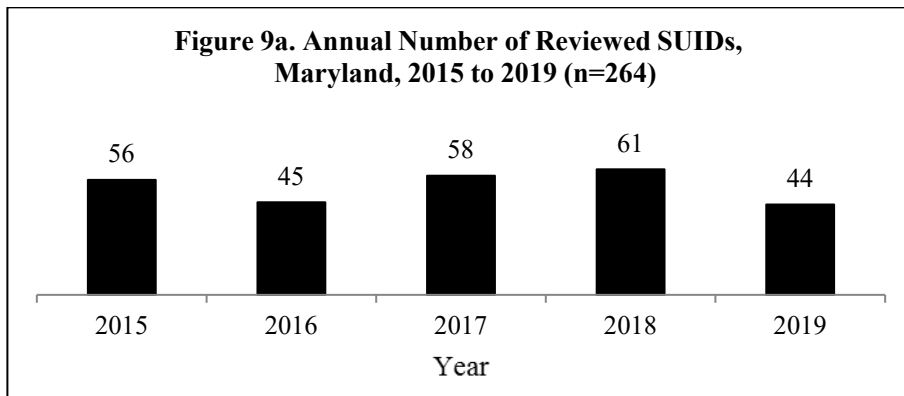
- The cause of death is undetermined or unknown;
- The cause of death was one of the following injury causes:
  - Asphyxia;
  - Undetermined causes; or

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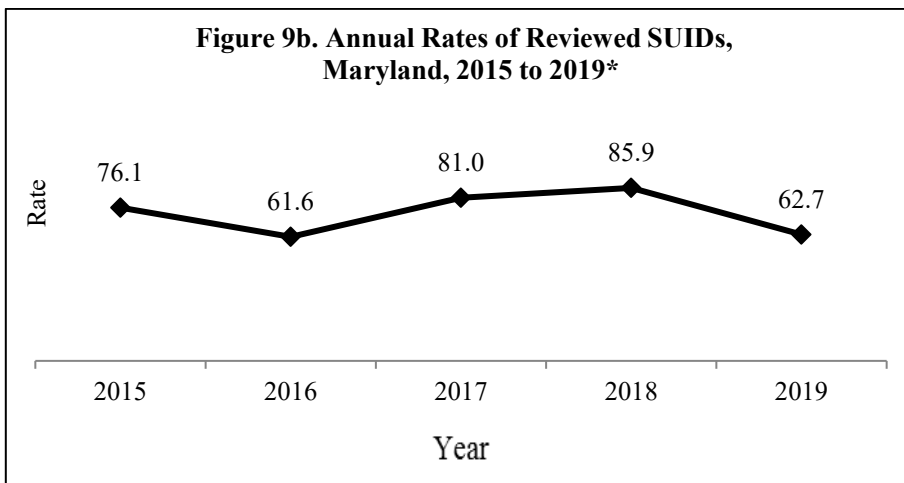
<sup>3</sup> Key components of a safe sleep environment are placing infants to sleep alone, on their backs, on a firm sleep surface with no soft objects, and in a smoke-free environment.

- Unknown causes; and
- The cause of death was one of the following medical causes:
  - SIDS;
  - Undetermined causes; or
  - Unknown causes.

Only cases that had a completed review by local teams were included in the analysis. In Maryland, there is an average of 53 SUID cases referred for review by the local CFR teams each year. A total of 264 reviewed SUID cases occurred between 2015 and 2019 (Figure 9a). Three (one percent) of these deaths were attributed to SIDS. From 2015 to 2019, the annual rate of Child Fatality Review SUID cases decreased by 18 percent (Figure 9b).



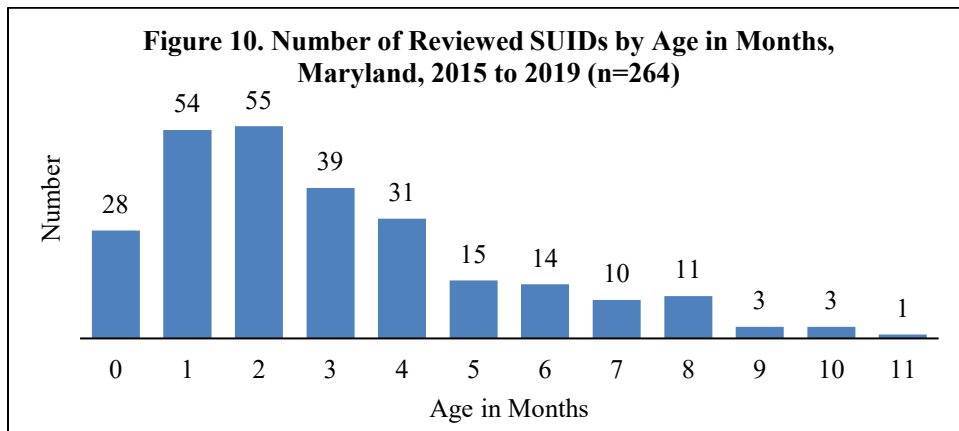
Source: CDRCRS, as of 3/2/2021.



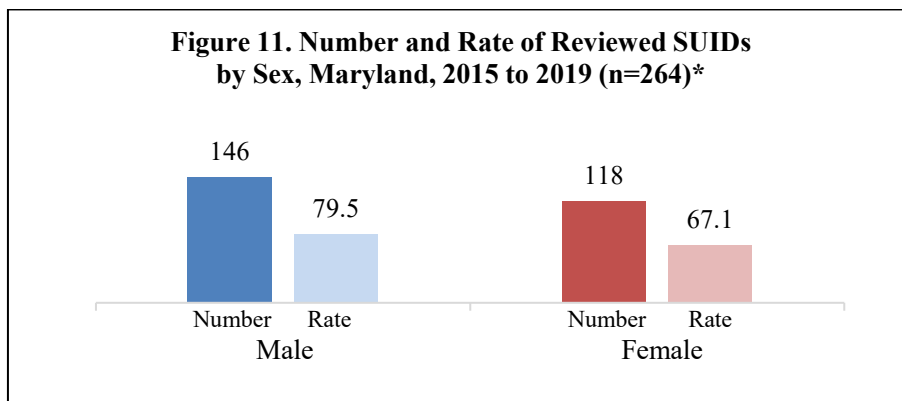
Source: CDRCRS, as of 3/2/2021.

\*Rates per 100,000 live births based on Maryland Vital Statistics Administration live birth data.

Of the 264 SUID cases during the period from 2015 to 2019, 207 (78 percent) occurred during the period from birth to 4 months of age (Figure 10). The majority of SUID deaths occurred at 2 months of age (21 percent). Fifty-five percent of these deaths occurred among male infants, and 45 percent occurred among female infants (Figure 11).



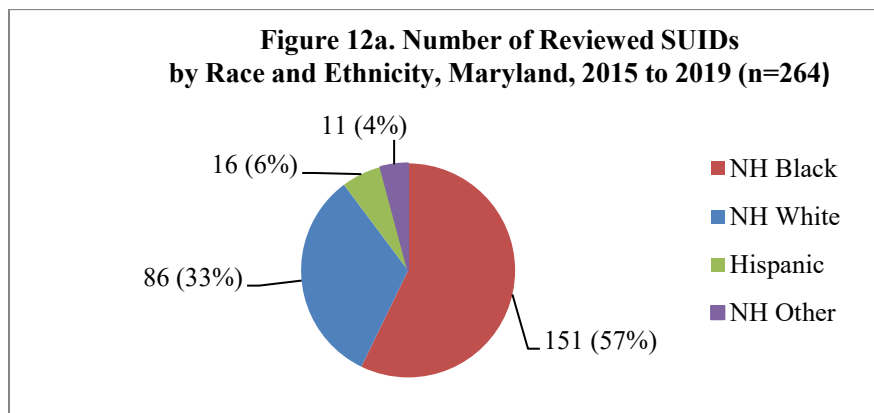
Source: CDRCRS, as of 3/2/2021.



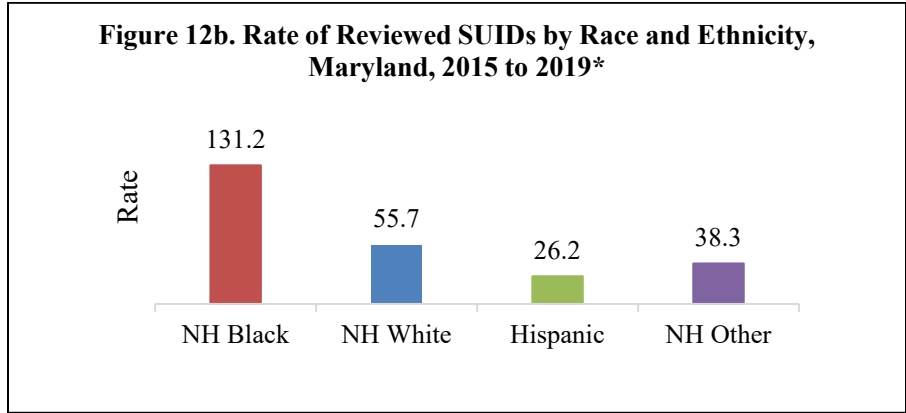
Source: CDRCRS, as of 3/2/2021.

\*Rates per 100,000 live births based on Maryland Vital Statistics Administration live birth data.

Of the reviewed SUID deaths occurring from 2015 to 2019, 151 deaths (57 percent) occurred among NH Black infants (Figure 12a). Considering the population of infants by race and ethnicity, the SUID rate among NH Black infants was over two times greater than the rate among NH White infants, and more than five times greater than the rate among Hispanic infants (Figure 12b).



Source: CDRCRS, as of 3/2/2021.



Source: CDRCRS, as of 3/2/2021.

\*Rates per 100,000 live births based on Maryland Vital Statistics Administration live birth data.

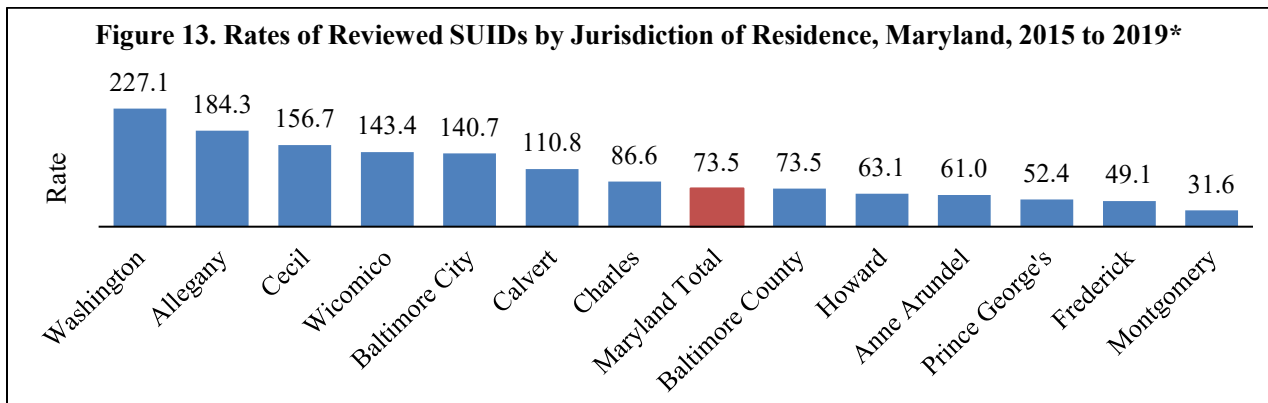
Table 4 shows the number of SUIDs by jurisdiction of residence of the infant at the time of death from 2015 to 2019. The largest number of SUIDs occurred among residents of Baltimore City, which accounted for 22 percent of all SUIDs during this period. The number of SUID cases is small, which makes it difficult to identify trends across jurisdictions. Several SUID cases were not reviewed in time for this report due to COVID-19, and therefore the number of SUID cases in some larger jurisdictions is artificially suppressed.

<b>Table 4. Number of Reviewed SUIDs by Jurisdiction of Residence, Maryland, 2015 to 2019 (n=264)*</b>						
	2015	2016	2017	2018	2019	Total
Baltimore City	12	4	14	15	12	57
Baltimore	7	4	11	9	5	36
Prince George's	7	6	4	12	3	32
Anne Arundel	2	8	5	4	2	21
Montgomery	5	4	4	5	2	20
Washington	6	2	7	1	3	19
Howard	4	3	0	1	3	11
Cecil	3	4	1	1	0	9
Wicomico	0	1	2	3	3	9
Charles	1	3	1	1	2	8
Frederick	0	1	3	1	2	7
Allegany	2	1	0	0	3	6
Calvert	1	0	2	2	0	5
Carroll	1	0	0	2	1	4
Dorchester	0	0	1	3	0	4
Harford	1	2	0	0	1	4
Queen Anne's	0	0	1	1	1	3
Garrett	1	0	0	0	1	2
Kent	0	1	1	0	0	2
St. Mary's	2	0	0	0	0	2
Somerset	0	0	1	0	0	1
Talbot	1	0	0	0	0	1
Worcester	0	1	0	0	0	1
<b>Total</b>	<b>56</b>	<b>45</b>	<b>58</b>	<b>61</b>	<b>44</b>	<b>264</b>

Source: CDRCRS, as of 3/2/2021.

\*Caroline County had no SUID deaths during the time period shown.

Similar to overall child death rates, the greatest number of SUID cases came from urban areas, but the rates were highest in Maryland's rural counties (Figure 13). Infants residing in Washington County had the highest rate of SUID cases at 227.1 per 100,000 live births during the period from 2015 to 2019, which was more than three times the statewide rate of 73.5 deaths per 100,000 live births during the same period. Montgomery County had the lowest rate of reportable SUID cases at 31.6 per 100,000 live births from 2015 to 2019, which was less than half of the Statewide rate of SUID cases.



Source: CDRCRS, as of 3/2/2021.

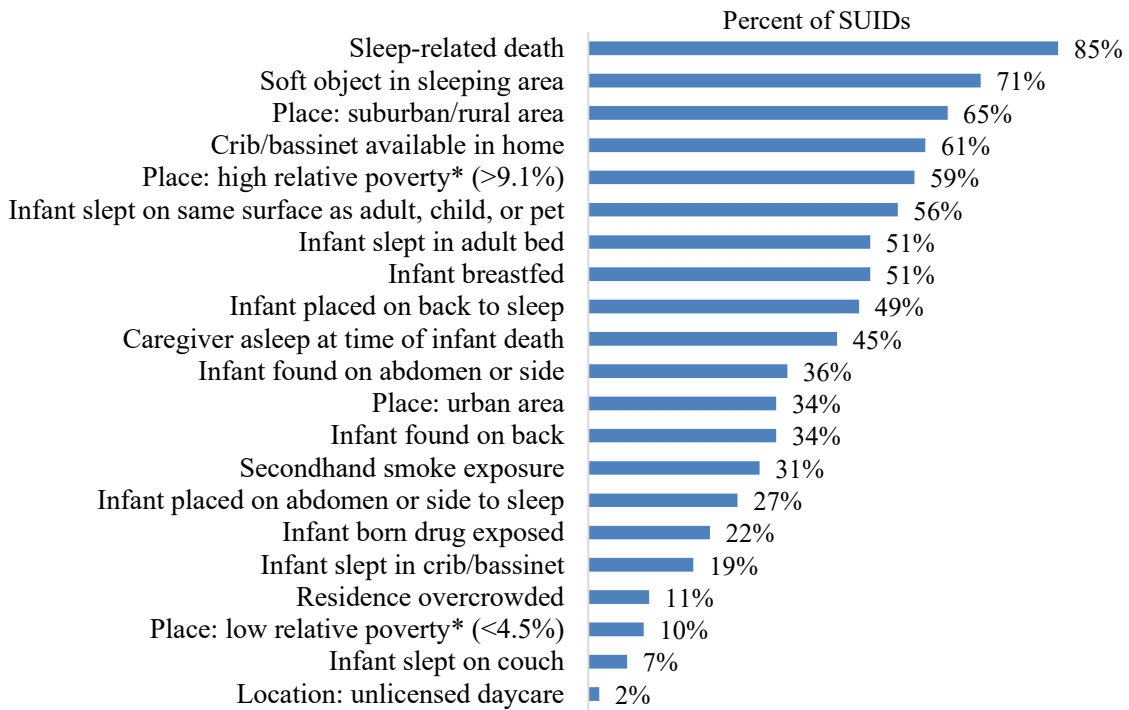
\*Rates per 100,000 live births based on Maryland Vital Statistics Administration live birth data. Minimum five SUID cases. Carroll, Dorchester, Garrett, Harford, Kent, Queen Anne's, St. Mary's, Somerset, Talbot, and Worcester Counties had fewer than five SUID cases and are not displayed. Caroline County had no SUID cases.

All OCME-referred deaths, including SUIDs, are reviewed by the local CFR team in the jurisdiction of residence. Due to the COVID-19 pandemic, team meetings were delayed. As a result, not all 2019 cases were able to be reviewed prior to the publication of this report. As previously stated, data from these case reviews are entered into 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. The SUID case reviews entered into the CDRCRS database were further analyzed to determine more detailed information surrounding these deaths. Information on each 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 14 and Tables 5 and 6 represent a minimum number of cases with a given characteristic.

Figure 14 shows incident characteristics of SUIDs in Maryland. The death was determined to be sleep-related in 85 percent of the 264 SUID cases. Sixty-five percent of cases occurred in suburban or rural areas. In 56 percent of cases, the infant was sleeping on the same surface as an adult, child, or pet, otherwise known as "bed-sharing." Fifty-nine percent of the infants lived in zip codes with high relative poverty. Thirty-six percent of the infants were found on their abdomen or side. Thirty-one percent of the infants were exposed to secondhand smoke. Two percent of SUID cases occurred at an unlicensed daycare setting.



**Figure 14. Incident Characteristics of Reviewed SUIDs, Maryland, 2015 to 2019 (n=264)**



Source: CDCRCS, as of 3/2/2021.

\*Poverty estimates are taken from US Census American Community Survey 2018 five-year ZIP code tabulation area (ZCTA) estimates; one percent of SUID deaths had missing ZCTA information. Poverty rates are defined by the percentage of residents reporting poverty status in the past 12 months on the survey. The low and high poverty percentage cutpoints used are based on the first and third quartile of Maryland ZCTA poverty rates, respectively.

Table 5 shows the characteristics of the primary caregiver for the infants who died of SUID. A biological parent was the primary caregiver in 253 (96 percent) of the cases. Twenty-seven percent of caregivers were younger than 25 years old, 53 percent were receiving social services, 50 percent had a high school education or less, 38 percent were low income, and 24 percent were unemployed. Thirty-nine percent of caregivers had a history of substance use.

<b>Table 5. Caregiver Characteristics Associated with Reviewed SUIDs, Maryland, 2015 to 2019 (n=264)</b>		
	<u>Number</u>	<u>Percent</u>
Primary caregiver was biological parent	253	95.8
Receiving social services*	139	52.7
Infant was breastfed	134	50.8
Primary caregiver obtained 12 years or less of education	131	49.6
History of substance abuse	103	39.0
Low income family	99	37.5
Primary caregiver <25 years old	72	27.3
Primary caregiver was unemployed	63	23.9
Child had open Child Protective Services (CPS) case at death	30	11.4

Source: CDRCRS, as of 3/2/2021.

\*Social services include: Medical Assistance; Temporary Assistance for Needy Families; Special Supplemental Nutrition Program for Women, Infants, and Children; and Supplemental Nutrition Assistance Program.

More than half of all sleep-related SUID cases from 2015 to 2019 occurred when the infant was bed-sharing. Table 6 compares characteristics of bed-sharing and non-bed-sharing sleep-related SUID cases.

In Maryland, SUID remains a leading cause of unexpected death among infants and a leading overall cause of infant mortality. Eighty-five percent of these deaths are sleep-related, with unsafe infant sleep practices identified upon case review. Nearly two-thirds of all sleep-related SUID cases involved bed-sharing. Racial and ethnic disparities persist in SUIDs, with the rate of these deaths being more than twice as high among NH Black infants compared to NH White infants, and more than five times higher than among Hispanic infants.

Of the SUID deaths, nearly 40 percent of caregivers had a history of substance use disorder. Many of these families were receiving social services at the time of the infant's death, providing an opportunity for health care providers and social service agencies to reinforce safe sleep practices with the parent or caregiver of an infant, and highlights the importance of identification of families with risk factors that can contribute to SUID fatalities so that they can be educated on safe sleep practices.

<b>Table 6. Comparison of Bed-Sharing and Non-Bed-Sharing Sleep-Related Reviewed SUIDs, Maryland, 2015 to 2019 (n=224)</b>		
	Non-bed-sharing (n=81) n (%)	Bed-sharing (n=143) n (%)
<b>Place:</b>		
Urban area	27 (33.3)	55 (38.5)
Suburban/rural area	53 (65.4)	87 (60.8)
Residence overcrowded	7 (8.6)	21 (14.7)
Secondhand smoke exposure	23 (28.4)	59 (41.3)
<b>Infant sleep position and environment:</b>		
Placed on stomach or side to sleep	23 (28.4)	46 (32.2)
Placed on back to sleep	48 (59.3)	71 (49.7)
Sleeping in crib or bassinet*	41 (50.6)	5 (3.8)
Sleeping in adult bed*	21 (25.9)	112 (78.3)
Sleeping on couch*	1 (1.2)	17 (11.9)
Crib or bassinet available in home	62 (76.5)	92 (64.3)
<b>Characteristics of infant:</b>		
Infant's mean age (months)	3.6	2.8
Race – NH Black	45 (55.6)	85 (59.4)
NH White	27 (33.3)	45 (31.5)
Hispanic	7 (8.6)	6 (4.2)
Breastfed	37 (45.7)	82 (57.3)
<b>Characteristics of primary caregiver:</b>		
High school education or less*	35 (43.2)	84 (58.7)
Receives social services**	44 (54.3)	79 (55.2)
Low income	30 (37.0)	56 (39.2)
<b>Characteristics of caregiver at time of death:</b>		
Biological parent*	57 (70.4)	130 (90.9)
<25 years old	22 (27.2)	32 (22.4)
Male	15 (18.5)	31 (21.7)
History of mental illness	10 (12.3)	32 (22.4)
History of substance abuse	25 (30.9)	61 (42.7)
Impaired by drugs or alcohol*	2 (2.5)	15 (10.5)

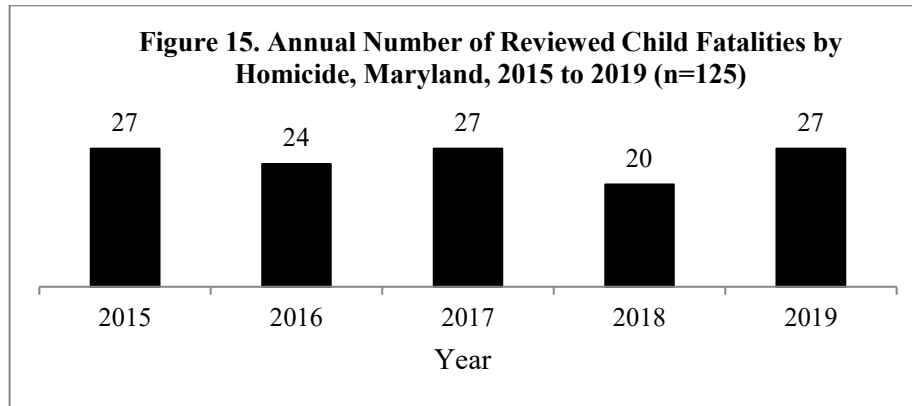
Source: CDRCRS, as of 3/2/2021.

\*Denotes differences that are greater than would be expected by chance alone, i.e., a statistically significant difference at p<0.05.

\*\*Includes Women, Infants, and Children, Home Visiting, Temporary Assistance for Needy Families, Medicaid, Food Stamps/SNAP/EBT, Section 8 housing, and Social Security Disability Insurance.

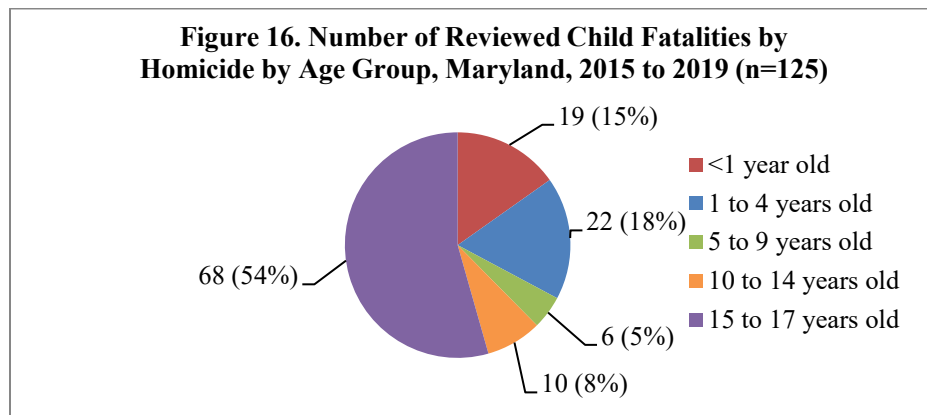
## Homicide Deaths in Maryland

Death by homicide was the fourth leading manner of reviewed unexpected child deaths during the five-year period from 2015 to 2019, accounting for 15 percent of deaths. Only deaths which were reviewed by the local teams were included in this analysis. Death by homicide was the leading manner of death for children ages 15 to 17 during the same period, accounting for 29 percent of reviewed deaths.



Source: CDRCRS, as of 3/2/2021.

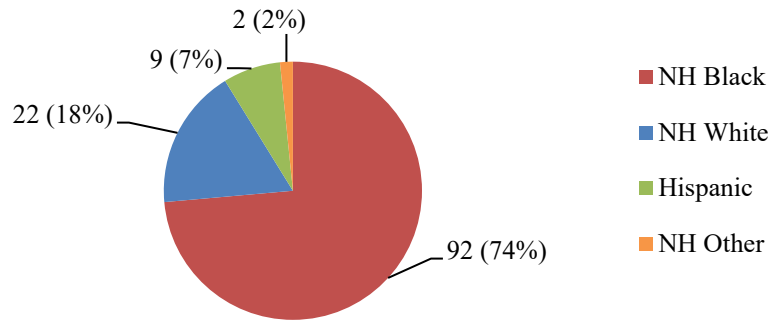
Of the 125 deaths by homicide occurring in the five-year period from 2015 to 2019, 54 percent were among teens ages 15 to 17 (Figure 16). Fifteen percent of deaths were among infants under the age of 1 year, and 30 percent were among children ages 1 to 14 years. Seventy-six percent of deaths by homicide occurred among male children and 24 percent occurred among female children.



Source: CDRCRS, as of 3/2/2021.

Seventy-four percent of deaths by homicide occurred among NH Black children, 18 percent among NH White children, and seven percent among Hispanic children (Figure 17). Deaths by homicide by jurisdiction of residence are shown in Table 7.

**Figure 17. Number of Reviewed Child Fatalities by Homicide by Race and Ethnicity, Maryland, 2015 to 2019 (n=125)**



Source: CDRCRS, as of 3/2/2021.

**Table 7. Number of Reviewed Child Fatalities due to Homicide by Jurisdiction of Residence, Maryland, 2015 to 2019 (n=125)\***

	2015	2016	2017	2018	2019	Total
Baltimore City	15	13	12	14	15	69
Baltimore	5	3	2	1	6	17
Anne Arundel	1	4	6	0	4	15
Prince George's	1	1	2	1	0	5
Charles	0	0	1	3	0	4
Cecil	1	0	1	0	1	3
Wicomico	2	0	1	0	0	3
Harford	0	0	1	0	1	2
St. Mary's	0	1	0	1	0	2
Washington	2	0	0	0	0	2
Allegany	0	1	0	0	0	1
Carroll	0	1	0	0	0	1
Howard	0	0	1	0	0	1
<b>Total</b>	<b>27</b>	<b>24</b>	<b>27</b>	<b>20</b>	<b>27</b>	<b>125</b>

Source: CDRCRS, as of 3/2/2021.

\*Calvert, Caroline, Dorchester, Frederick, Garrett, Kent, Montgomery, Queen Anne's, Somerset, Talbot, and Worcester Counties are not displayed as they had no child fatalities due to homicide from 2015-2019.

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

Table 8 shows the deaths by homicide by cause of death. Weapons were the leading cause of death by homicide (84 percent), which included firearm (56 percent of cases), assault using body parts (13 percent), and sharp or blunt instruments (6 percent). Other causes of death accounted for 16 percent of all deaths due to homicide and include: poisoning (4 percent); fire, burn, or electrocution (3 percent); motor vehicles (2 percent); and other causes (8 percent).

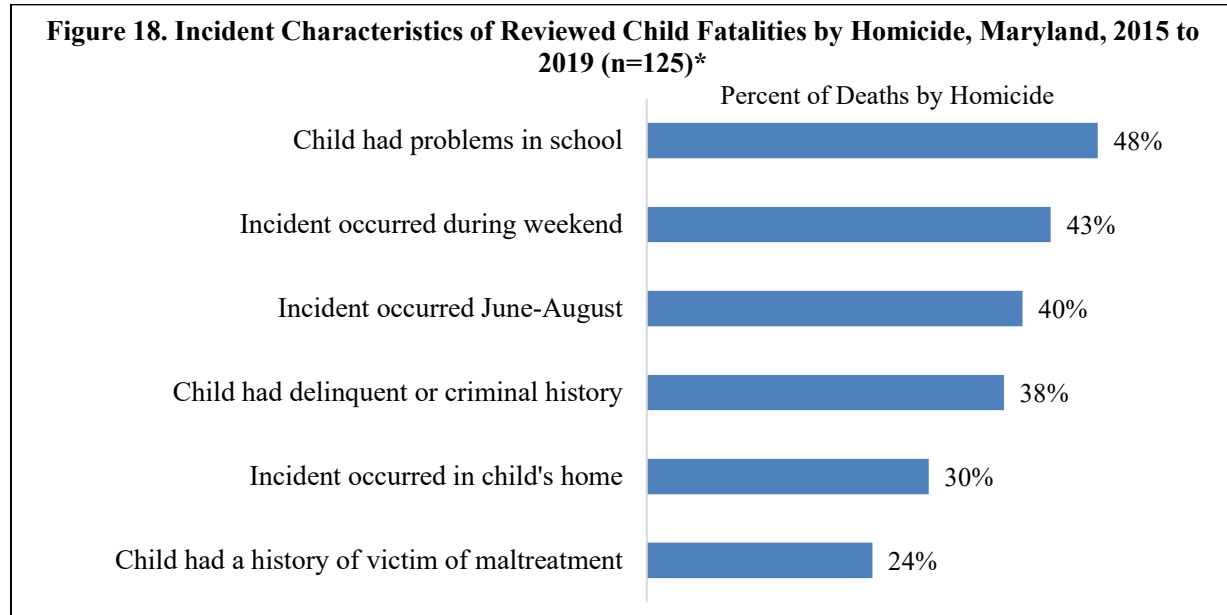
<b>Table 8. Number and Percent of Reviewed Child Fatalities by Homicide, by Cause of Death, Maryland, 2015 to 2019</b>		
	<u>Number</u>	<u>Percent</u>
External – Weapon (including body part)	105	84.0
Firearm	70	56.0
Body part (assault)	16	12.8
Sharp or blunt instrument	7	5.6
Other/unknown	12	9.6
External – Poison	5	4.0
External – Fire, burn, or electrocution	4	3.2
External – Other	4	3.2
External – Motor Vehicle Accident	3	2.4
External – Unknown cause	2	1.6
Medical – Other medical cause	1	0.8
Undetermined if medical or external cause	1	0.8
<b>Total</b>	<b>125</b>	<b>100.0</b>

Source: CDRCRS, as of 3/2/2021.

Figure 18 shows incident characteristics of children who died by homicide in Maryland. Forty-eight percent of the children had problems in school and 24 percent had a history of maltreatment. Thirty-eight percent had a history of delinquent or criminal history. Due to the large amount of missing information from the case review, these numbers are probably an underrepresentation.

In examining rates of child fatalities, including homicide deaths, it is important to consider the structural and social determinants that serve as root causes of inequities in violence. As described by the World Health Organization, the social determinants of health are the upstream social and economic conditions in which people are born, grow, live, work, and age that shape individual,

as well as group, differences in health status.<sup>4</sup> Access to high quality education, income inequality, and residential racial and economic segregation are factors that must be considered as potential root causes of differences in health status, and their relationship with violence must be explored. To reduce incidences of these deaths, statewide policy and programmatic efforts will need to be taken across agencies to address the relationship of these factors in reductions in violence.



Source: CDRCRS, as of 3/2/2021.

\*Percentages will total more than 100 percent, as multiple characteristics often applied to the same case.

Table 9 compares characteristics of firearm and non-firearm homicide deaths. Homicides caused by both firearms and non-firearms were more common among males and NH Black children. Homicides caused by firearms were more common among children ages 10 and older, while homicides caused by non-firearms were more common among children under the age of 10. Sixty-two percent of the non-firearm cases were child abuse or neglect, and in 38 percent of the non-firearm cases, the perpetrator was the biological parent. Due to the large amount of missing information from case reviews, these numbers are likely an underrepresentation of the totals.

<sup>4</sup> Solar O, Irwin A. A conceptual framework for action on the social determinants of health. Social Determinants of Health Discussion Paper (Policy and Practice)  
[https://www.who.int/sdhconference/resources/ConceptualframeworkforactiononSDH\\_eng.pdf](https://www.who.int/sdhconference/resources/ConceptualframeworkforactiononSDH_eng.pdf).

**Table 9. Differences in Characteristics of Firearm and Non-Firearm Reviewed Child Fatalities, by Homicide, Maryland, 2015 to 2019 (n=125)**

	Non-Firearm (n=55) n (%)	Firearm (n=70) n (%)
<b>Place:</b>		
Urban area	32 (58.2)	51 (72.9)
Suburban/rural area	21 (38.2)	19 (27.1)
Incident occurred in child's home*	30 (54.5)	8 (11.4)
<b>Demographic Characteristics of Child:</b>		
Gender: Male*	36 (65.5)	59 (84.3)
Race: NH Black*	33 (60.0)	59 (84.3)
Age: 10 years or older*	13 (23.6)	65 (92.9)
Insurance: Medicaid	28 (50.9)	41 (58.6)
<b>Incident Characteristics:</b>		
Child had delinquent or criminal history*	5 (9.1)	43 (61.4)
Child had problems in school*	9 (16.4)	51 (72.9)
Child had history as victim of maltreatment	15 (27.3)	15 (21.4)
Child had open CPS case at time of death	7 (12.7)	5 (7.1)
Child had history of substance abuse*	1 (1.8)	30 (42.9)
Child abuse/neglect*	34 (61.8)	2 (2.9)
Person responsible was biological parent*	21 (38.2)	3 (4.3)
Person responsible had delinquent or criminal history*	25 (45.5)	3 (4.3)

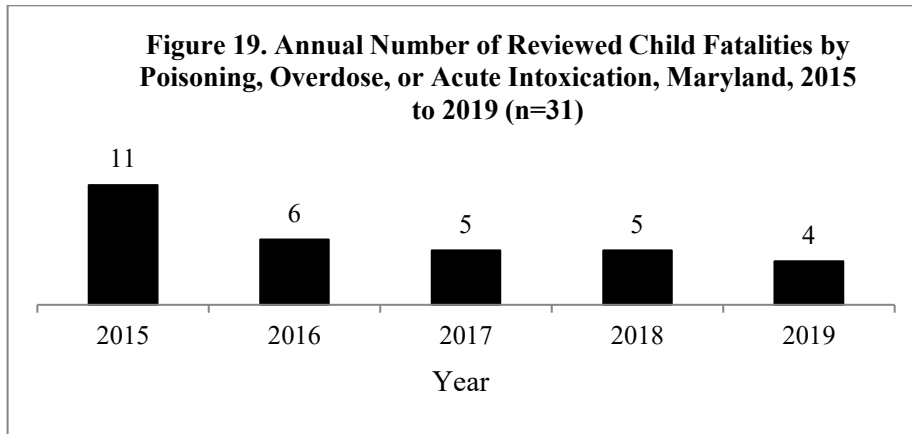
Source: CDRCRS, as of 3/2/2021.

\*Denotes differences that are greater than would be expected by chance alone, i.e., a statistically significant difference at  $p < 0.05$ .



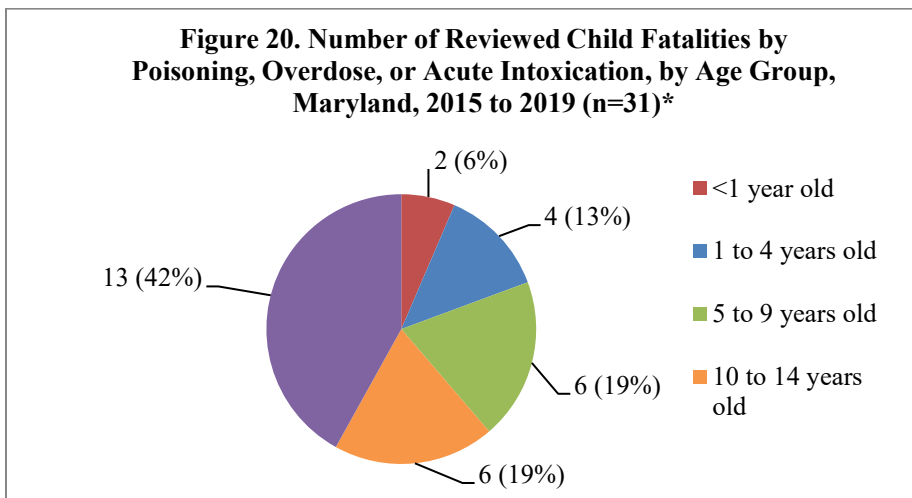
## Deaths by Poisoning, Overdose, or Acute Intoxication in Maryland

Poisoning, overdose, or acute intoxication contributed to 31 unexpected child deaths during the five-year period from 2015 to 2019 (Figure 19). Only deaths which were reviewed by the local teams were included in this analysis. Ten of these deaths (32 percent) were of an accidental manner, five (16 percent) were homicide, seven (23 percent) were suicide, and in nine cases (29 percent) the manner was undetermined.



Source: CDRCRS, as of 3/2/2021.

Of the 31 deaths by poisoning, overdose, or acute intoxication occurring in the five-year period from 2015 to 2019, 42 percent were among children ages 15 to 17 (Figure 20). Sixty-one percent of deaths by poisoning, overdose, or acute intoxication occurred among female children and 39 percent among males.

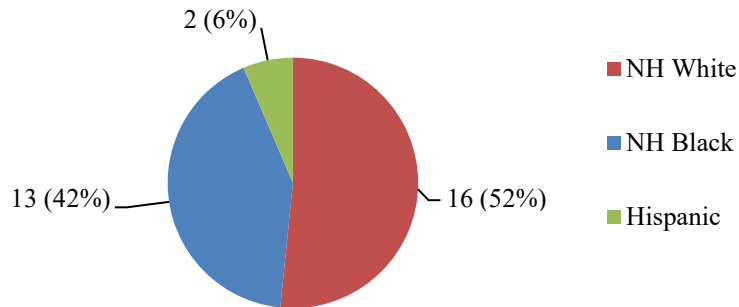


Source: CDRCRS, as of 3/2/2021.

\*Percentages will total more than 100 percent due to rounding.

Fifty-two percent of the deaths by poisoning, overdose, or acute intoxication occurred among NH White children, 42 percent among NH Black children, and six percent among Hispanic children (Figure 21). Deaths by poisoning, overdose, or acute intoxication by jurisdiction of residence are shown in Table 10.

**Figure 21. Number of Reviewed Child Fatalities by Poisoning, Overdose, or Acute Intoxication, by Race and Ethnicity, Maryland, 2015 to 2019 (n=31)**



Source: CDRCRS, as of 3/2/2021.

**Table 10. Number of Reviewed Child Fatalities by Poisoning, Overdose, or Acute Intoxication, by Jurisdiction of Residence, Maryland, 2015 to 2019 (n=31)\***

	2015	2016	2017	2018	2019	Total
Baltimore	1	0	1	3	2	7
Somerset	7	0	0	0	0	7
Baltimore City	1	1	1	1	0	4
Montgomery	0	2	1	0	0	3
Anne Arundel	1	0	0	0	1	2
Harford	0	2	0	0	0	2
Cecil	0	0	1	0	0	1
Charles	0	0	0	1	0	1
Frederick	0	1	0	0	0	1
Queen Anne's	1	0	0	0	0	1
Washington	0	0	0	0	1	1
Wicomico	0	0	1	0	0	1
<b>Total</b>	<b>11</b>	<b>6</b>	<b>5</b>	<b>5</b>	<b>4</b>	<b>31</b>

Source: CDRCRS, as of 3/2/2021.

\*Allegany, Calvert, Caroline, Carroll, Dorchester, Garrett, Howard, Kent, St. Mary's, Talbot, and Worcester counties do not appear as there were no child fatalities by poisoning, overdose, or acute intoxication from 2015 to 2019.

Table 11 shows the substances implicated in the deaths by poisoning, overdose, or acute intoxication from 2015 to 2019. Due to many of the cases involving more than one substance, the cases shown do not add up to the number of overdose deaths. Other illicit substances were implicated in 8 deaths (26 percent), and carbon monoxide, prescription antidepressants, and prescription opioids were each implicated in 7 deaths (23 percent).

<b>Table 11. Substances Implicated in Reviewed Child Fatalities, by Poisoning, Overdose, or Acute Intoxication, Maryland, 2015 to 2019</b>	
Substance	Number of Deaths (%)
Illicit – Other	8 (26)
Carbon monoxide	7 (23)
Prescription – Antidepressant	7 (23)
Prescription – Pain medication - Opioid	7 (23)
Prescription – Methadone	5 (16)
Illicit – Pain medication – Opioid	4 (13)
Illicit – Heroin	4 (13)
Prescription – Other	3 (10)
Over-the-counter medication	3 (10)
Illicit – Cocaine	3 (10)
Alcohol	1 (3)
Prescription – Pain medication - Non-opioid	1 (3)

Source: CDRCRS, as of 3/2/2021.

\*Due to many cases involving more than one substance, cases will not add up to the number of overdose deaths.

## **Summary and Recommendations**

In 2019, 176 unexpected child deaths were referred by the OCME to the Child Fatality Review Program for review. The rate of unexpected child deaths in Maryland decreased by six percent (or 11 deaths) from 2018 to 2019. For this same period, the rates of unexpected child fatalities referred for review decreased among NH Black children and all children across all ages except those 10 to 14 years old. The leading manners of unexpected child deaths in 2019 were undetermined, accident, and natural. Infants less than one year of age continue to account for the largest proportion of unexpected deaths.

In 2019, 27 percent of reviewed child fatalities were due to SUID, and 93 percent of SUIDs were sleep-related. The SUID risk peaked between one and four months of age.

Racial and ethnic disparities persist, with a disproportionate number of child deaths occurring among NH Black children, particularly among SUID cases and homicide deaths. Deaths by suicide decreased from a high of 23 cases in 2017 to 17 cases in 2019.

In response to the 2019 review of referred child deaths in Maryland, the Team puts forth the following recommendations and proposed actions for the State agencies represented on the Team.

### **Recommendations Related to SUID**

The Team supports ongoing activities to better understand why safe sleep practices are not followed, especially in communities with high SUID rates. The Team supports MDH's partnership with Morgan State University to better understand barriers to safe sleep, with the expected outcome of improved messaging to address the persistent racial disparity in sleep-related deaths. Building upon the findings from the work with Morgan State, the Team supports identifying opportunities to address some of the systemic factors that prevent safe sleep among Maryland families. Working with multi-sector partners to increase messaging and education is critical to addressing unsafe sleeping practices.

The Team also recommends improving parent teaching on safe sleep practices in all Maryland delivery hospitals. The Team supports the ongoing participation of MDH in the Centers for Disease Control and Prevention SUID Case Registry. This program increases access to high-quality and complete SUID surveillance data for program improvement and public health purposes, specifically those addressing racial disparities in SUID. The Team also supports efforts to increase community awareness of SUID associated factors, particularly in disproportionately-affected communities.

### **Recommendations Related to Homicide**

The Team recommends efforts to improve understanding of the factors contributing to the increase in youth homicides and to address potential opportunities for prevention. Jurisdictions with large numbers of youth homicides could consider investing resources in violence prevention programs that act as a deterrent for violent behavior and keep those most at risk of being a victim of youth homicide engaged in community support systems, such as Baltimore City's Supporting Our Students - Safe Streets Project and the Violence Prevention Program at the University of Maryland Medical Center.

The Team also encourages improved awareness of how young people’s online behaviors are factors in real world violence and recommends jurisdictions with large numbers of youth homicides to consider the implementation of initiatives such as the E-Responder model in New York City.<sup>5</sup> The E-Responder model uses trained responders to identify and de-escalate risky online behavior. This public health model was developed after New York City law enforcement and community-based organizations recognized that many firearm-related deaths and injuries began as taunts or threats on social media between youth “crews.” By addressing the amplification that takes place on social media, it is possible that many conflicts could be identified and de-escalated before real world violence takes place.

The Team supports the American Academy of Pediatrics (AAP) recommendation that pediatricians incorporate questions about the presence and availability of firearms during patient history collection. The AAP urges parents who possess guns to prevent children from having access to these guns. Combined with distribution of gun locks to promote safer storage of guns in homes with children, these efforts can help to limit household exposure to unlocked and loaded guns.

### **Recommendations Related to Overdose**

The Team recommends efforts to address the significant increase in overdose deaths in 2018. There were a total of 7 deaths among children ages infant to 9 years old between 2014 to 2018, all of which involved the ingestion of oxycodone or methadone. Overdose deaths among teenagers ages 15 to 17 accounted for 61 percent of all 0-17 overdose deaths between 2014 and 2018. Fentanyl was involved in 78 percent of deaths in this age group. The Team recommends consulting with the Behavioral Health Administration and the Maryland Poison Center around safe storage education. The team also recommends that physicians and providers distribute information to patients receiving methadone maintenance prescriptions. These measures would include methadone programs identifying patients who are allowed take-home doses that have children residing in or visiting their homes. The programs would then provide the patients with additional child safety-specific counseling, along with warning labels targeted towards young children, and would provide additional naloxone for households that include young children.

To address overdoses among older teens, the Team recommends:

- (1) Additional overdose education campaigns included within the school health curriculum;
- (2) Local Health Department campaigns about the risks of fentanyl;
- (3) Increased community access to naloxone, including at health offices in private schools; and
- (4) The provision of fentanyl testing strips at school-based health centers and safe access centers serving youth.

The Team supports the efforts of MDH’s Maternal and Child Health Bureau to work with interested local CFR teams to identify overdoses in their jurisdiction and conduct reviews of

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<sup>5</sup> The Citizens Crime Commission of New York City and NYU Steinhard’s Researching Inequity in Society Ecologically (R.I.S.E.) Team. E-Responder. Accessed 29 March 2021. <http://www.nycrimecommission.org/pdfs/e-responder-brief-1.pdf>.

near-fatality overdose cases. The Team will encourage local CFR teams to collaborate with local hospitals and emergency departments to identify cases of non-fatal overdose events for review and to facilitate local level interventions.

## **Appendix A: 2020 State Child Fatality Review Team Members**

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

- (1) Attorney General – Christle Sheppard Southall, Esq, designee;
- (2) Chief Medical Examiner – Ling Li, MD, designee;
- (3) Secretary of Human Resources – Jacqueline Gray, designee;
- (4) Secretary of Health – Sadie Peters, MD, 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 – Sgt. David Sexton, designee;
- (9) President of the State’s Attorneys’ Association – Debbie Feinstein, JD, designee;
- (10) Chief of the Division of Vital Records – Monique Wilson, DrPH, designee;
- (11) A Representative of the Center for Infant and Child Loss – LaToya Bates, LCSW-C, Director, Center for Infant and Child Loss;
- (12) Director of the Behavioral Health Administration – Maria-Radowski-Stanco, MD, designee;
- (13) Two pediatricians with experience in diagnosing and treating injuries and child abuse and neglect, appointed by the Governor from a list submitted by the state chapter of the American Academy of Pediatrics:  
  
Richard Lichenstein, MD, FAAP;  
Leen Dev, MD; and
- (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:  
  
Richelle J. Cricks, CNM, MSN  
Patricia K. Cronin, LCSW-C  
Mary C. Gentile, LCSW-C  
Cynthia Wright Johnson  
Ivone Kim, MD  
Sharyn King  
  
Neveen H. Kurtom, JD  
Laurel Moody, RN, MS  
Shantell Roberts  
Joyce P. Williams, DNP  
Anntinette Williams, LICSW

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

Health-General Article, §5-704 (b), sets forth the Team's 13 duties. To achieve its purpose, the State CFR Team shall:

- 1) Undertake annual statistical studies of the incidence and causes of child fatalities in the State, including an analysis of community and public and private agency involvement with the decedents and their families before and after the deaths;
- 2) Review reports from local teams;
- 3) Provide training and written materials to the local teams established under §5-705 of this subtitle to assist them in carrying out their duties, including model protocols for the operation of local teams;
- 4) In cooperation with the local teams, develop a protocol for child fatality investigations, including procedures for local health departments, law enforcement agencies, local medical examiners, and local departments of social services, using best practices from other states and jurisdictions;
- 5) Develop a protocol for the collection of data regarding child deaths and provide training to local teams and county health departments on the use of the protocol;
- 6) Undertake a study of the operations of local teams, including the State and local laws, regulations, and policies of the agencies represented on the local teams, recommend appropriate changes to any regulation or policy needed to prevent child deaths, and include proposals for changes to State and local laws in the annual report required by paragraph (12) of this subsection;
- 7) Consider local and statewide training needs, including cross-agency training and service gaps, and make recommendations to member agencies to develop and deliver these training needs;
- 8) Examine confidentiality and access to information laws, regulations, and policies for agencies with responsibility for children, including health, public welfare, education, social services, mental health, and law enforcement agencies, recommend appropriate changes to any regulations and policies that impede the exchange of information necessary to protect children from preventable deaths, and include proposals for changes to statutes in the annual report required by paragraph (12) of this subsection;
- 9) Examine the policies and procedures of the State and local agencies and specific cases that the State Team considers necessary to perform its duties under this section, in order to evaluate the extent to which State and local agencies are effectively discharging their child protection responsibilities in accordance with:
  - i) The State plan under 42 U.S.C. §5106a(b);
  - ii) The child protection standards set forth in 42 U.S.C. §5106a(b); and
  - iii) Any other criteria that the State Team considers important to ensure the protection of children;
- 10) Educate the public regarding the incidence and causes of child deaths, the public role in preventing child deaths, and specific steps the public can undertake to prevent child deaths;



- 11) Recommend to the Secretary any regulations necessary for its own operation and the operation of the local teams;
- 12) Provide the Governor, the public, and subject to §2-1257 of the State Government Article, the General Assembly with annual written reports, which shall include the State Team's findings and recommendations; and
- 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: 2019 Annual Maryland Child Fatality Review Conference**

## **Agenda**

**Tuesday, December 10, 2019**

Howard County Library System,  
Miller Branch, 9421 Frederick Rd, Ellicott City, MD 21042

<b>10:30 – 10:40 AM</b>	<b>Registration</b>
<b>10:40 – 11:10 AM</b>	<b>Greetings and Introductions/ Local Team Updates</b> <i>Rich Lichenstein, MD</i> <i>Sara Lewis</i>
<b>11:10 AM – 12:10 PM</b>	<b>Safe Infant Sleep Highlights— Lorena Kaplan, MPH, CHES</b> <i>Safe to Sleep® Campaign Lead- Eunice Kennedy Shriver National Institute of Child Health and Human Development</i>
<b>12:10 – 1:10 PM</b>	<b>Lunch</b>
<b>1:10 – 2:10 PM</b>	<b>Leveraging Successes and Reducing Barriers in Child Fatality Review</b>  <i>Susanna Joy, MA- National Center for Fatality Review and Prevention</i>
<b>2:10 – 3:10 PM</b>	<b>2019 Annual CFR Data Presentation</b> <i>Kate Schneider and Kristin Silcox, Maryland Department of Health</i>
	<b><u>SCFRT Quarterly Meeting</u></b>
<b>3:15 – 3:45 PM</b>	<b>OCME Updates/Discussion</b> <i>Michael Eagle, Office of the Chief Medical Examiner</i>
<b>3:45 – 4:00 PM</b>	<b>Break</b>
<b>4:00 – 4:30 PM</b>	<b>Closing Discussions</b> <i>Sara Lewis</i>