BALTIMORE CITY CHILD FATALITY REVIEW TEAM ANNUAL REPORT 2010

Oxiris Barbot, M.D., Chair Rebecca Dineen, MS Shaconna Gorham, MS

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GENERAL INFORMATION

Membership and Leadership of Team

Chair: Oxiris Barbot, M.D., Commissioner of Health

Baltimore City Health Department

Child Fatality Review (CFR) Staff

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Baltimore City Health Department

Baltimore City Health Department

Membership and affiliations

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Membership and affiliations (continued)

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Delmas Wood Department of Juvenile Services

Keva White, MSW, LCADC Baltimore Mental Health Systems

Crystal Young, MSW Baltimore City Department of Social Services

Meetings in 2010

CFR meetings are scheduled on the third Monday of each month. There were ten meetings held in 2010.

Case Reviews

The OCME reported forty-six fatality cases occurring in 2010 to the BC-CFR Team.

- thirteen homicide cases
- fourteen accident cases
- three undetermined cases
- sixteen sleep related infant cases

RECOMMENDATIONS AND ACTIONS: INFANT DEATHS

B'more for Healthy Babies, a citywide strategy for improving Baltimore's birth outcomes over the next three years, is being implemented. B'more for Healthy Babies has three objectives: to increase demand and utilization of high impact services, to increase access to these services, and to improve the quality of these services to high need individuals. We use B'more for Healthy Babies as a platform to improve and increase resources and services available to the City.

Recommendation 1: Educate medical and service providers about the high number of unsafe

sleep related infant deaths, so that they understand the extent of the problem and can provide patients with needed resources and education.

Actions: Letters were mailed to the Baltimore City Fire Department (BCFD) and

Baltimore City Police Department (BCPD) offering safe sleep trainings to first responders. As a result, 13 trainings were provided for fire, police, and

rescue. 190 people were trained.

The Baltimore City Health Department (BCHD) has put an emphasis on educating providers serviced through city clinics, federally qualified health centers, and hospitals. These providers serve both private and Medicaid patients. We strive to train all providers including those who treat privately insured patients. In all, 1,577 providers, including obstetricians, pediatricians, midwives, nurse practitioners, nurses, and social workers were trained in safe sleep education.

Providers (physicians, nurses) can earn CEUs for the Baltimore City Safe Sleep training. The training can also be found on the Bmore for Health Babies website. www.healthybabiesbaltimore.com

Recommendation 2: Increase educational efforts and enhance safe sleep messages that target

dads.

Actions:

A letter is sent to the hospital of birth notifying the Chair of Pediatrics when an infant born at that facility died due to unsafe sleep practices. We began sending letters to the birthing hospitals in 2007. We have revised the letter to inform the hospitals that the CFR Team has reviewed an increased number of cases where dads are sleeping with their infant or placing their infants to sleep in unsafe conditions. We encourage the hospital to provide infant safe sleep education not only to moms but also to dads and other caregivers.

Phase I (Sleep Safe) extension of the B'more for Healthy Baby media campaign will use dads to spread safe sleep messages. In radio and print ads, the dads will talk about what they do to protect their children – never smoking around pregnant women, infants, and children and making sure that infants sleep alone, on their backs, and in a crib. No exceptions.

A safe sleep DVD featuring real stories of families who have experienced an infant sleep related loss is being shown at seven of the eight birthing hospitals. For several months the DVD was shown at jury duty reaching over 20,000 people to help deliver a compelling message.

Recommendation 3: Review and update notification procedures when an infant dies

unexpectantly in an unsafe sleep environment.

Actions: When an infant death occurs, several steps are taken to notify appropriate

agencies. The steps were updated to ensure timely notification.

1. The Center for Infant and Child Loss notifies the BCHD and BHCA when a death occurs and when a death is unpended.

2. The Office of the Chief Medical Examiner faxes a Child Death Report to the Department of Social Services.

3. The BCPD notifies the Department of Social Services after investigating an infant death scene.

4. The BCHD will notify DSS when the OCME determines a cause and manner of an infant sleep related deaths.

RECOMMENDATIONS AND ACTIONS: DATA

Recommendation 4: Team members will send relevant information on all deaths scheduled for

review to the CFR Coordinator before monthly meetings.

Action: Maryland is using the National Center for Child Death Review's Internet-

based, multistate CFR Case Reporting System. It was established by House Bill 705/Senate Bill 862. The Baltimore City CFR Team began using the reporting system in January 2010. Team members will begin to complete agency appropriate questions on the National form as well as agency specific questions on supplementary forms. The forms are faxed to the

CFR Coordinator in preparation for monthly case review.

RECOMMENDATIONS AND ACTIONS: ACCIDENTS

Recommendation 5: Increase public awareness and education on bike safety during bike safety

month.

Action: The above recommendation was made at the end of 2010. During bike

safety month in May 2011, a Bike Safety Prevention Wednesday was circulated to educate the public on bike safety prevention strategies.

Recommendation 6: Increase education and resources on pedestrian safety at City schools.

Action: The above recommendation was made at the end of 2010. Beginning in

SY2011-2012, Safe Kids Baltimore will offer pedestrian safety educational

materials and resources for parents and students at Elementary schools near/where children have been killed from pedestrian related injuries.