

**BALTIMORE CITY CHILD  
FATALITY REVIEW TEAM  
ANNUAL REPORT 2009**

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**BALTIMORE CITY CHILD FATALITY REVIEW TEAM  
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**GENERAL INFORMATION**

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Membership and Leadership of Team

Chair: Olivia D. Farrow, Esq., R.S., Interim Commissioner of Health

Baltimore City Health Department

Child Fatality Review (CFR) Staff

Avril Houston, M.D., MPH  
Baltimore City Health Department

Shaonna Gorham, MS  
Baltimore City Health Department

Membership and affiliations

Alisa Ames, MHS  
Baltimore City Health Department

Karen Hardingham, RN  
Baltimore Safe Kids

Latoya Bates, MSSA, LCSW-C  
UMSOM, Center for Infant and Child Loss

Delmonica Hawkins  
Department of Juvenile Services

Tiara Braxton  
Office of the State's Attorney

Paul Kidd  
Baltimore City Police-CID Homicide

Angela Burden, MA, RN  
Baltimore Health Care Access

Leyla Layman  
Baltimore City Health Department

Wendy Dechowitz  
Baltimore Substance Abuse Systems, Inc.

Jean Lewis  
Mayor's Office of Criminal Justice

Rebecca Dineen, MS  
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Stephanie Regenold, M.D.  
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Charles Shubin, M.D.  
Children's Health Center Mercy Family Care

Kamala Green, MA  
Mayor's Office for Children, Youth & Families

Dorenzer Thomas, MSW  
Baltimore Mental Health Systems

Janet Hankin  
States Attorney's Office

Donna Vincenti, M.D.  
Office of the Chief Medical Examiner

Membership and affiliations (continued)

Harvey Webster  
Baltimore City Fire Department

Tanya Williams, Psy.D.  
Baltimore City Public School System

Delmas Wood  
Department of Juvenile Services

Crystal Young, MSW  
Baltimore City Department of Social Services

Meetings in 2008

CFR meetings are scheduled on the third Monday of each month. There were eleven meetings held in 2009.

Case Reviews

A total of fifty-one fatality cases were reviewed by CFR in 2009.

- twenty-one homicide cases
- six accident cases
- two suicide cases
- twenty SUDI/SIDS/SUDC/Asphyxia cases (27 cases were confirmed for 2009)

## **RECOMMENDATIONS AND ACTIONS: INFANT DEATHS**

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**Recommendation 1:** Gather information and conduct an analysis of sleep related deaths to inform policies and programming to prevent future infant deaths.

**Actions:** The Safe Sleep Update is distributed to and reviewed by Team members with the goal of identifying significant trends of infant deaths.

The literature demonstrates that smoking is an independent risk factor for SIDS. When made available by the police and Office of Chief Medical Examiners' (OCME) investigators, we will record information about smoking in the household and substance use. We will include this information in our analysis of infant sleep deaths.

**Recommendation 2:** Educate medical and service providers about the high number of infant deaths in Baltimore related to an unsafe sleeping environment, so that they understand the extent of the problem and can provide patients with needed resources and education to decrease sleep related deaths.

**Actions:** Two trainings have been developed to educate paraprofessionals and medical personnel on the safest way to put a baby to sleep.

A safe sleep fact sheet has been developed and distributed to public agencies.

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. As a result, many hospitals have increased staff trainings on safe sleep and implemented protocol to ensure mothers are educated on safe sleep practices before leaving the hospital.

**Recommendation 3:** The infant mortality rate is increasing. The number of infant deaths in Baltimore related to an unsafe sleeping environment has increased; a citywide effort should address the problem.

**Actions:** A citywide strategy for improving Baltimore's birth outcomes over the next three years is being implemented. The Strategy is called B'more for Healthy Babies. 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.

B'more for Healthy Babies' working groups have been formed. One of the groups' goals is to better integrate City referral systems with postpartum discharge processes in all City hospitals. This work will include implementing consistent guidelines on safe sleep education.

Assist the OCMEs', Chief Medical Investigator with their efforts to standardize statewide who responds to infant death scenes and the information collected at each scene.

**Recommendation 4:** Determine best practices of other jurisdictions to have Prenatal Risk Assessment Forms (PRAFs) completed and returned. Since the Department of Health and Mental Hygiene (DHMH) began to require that the form be faxed instead of mailed, the number of forms returned has decreased.

**Actions:** The acting Health Commissioner surveyed health officers in the other jurisdictions to see whether or not they were receiving forms and the strategies implemented to improve the number of forms returned.

**Recommendation 5:** Interview women who have experienced a loss of an infant while the infant was sleeping in an unsafe sleeping environment.

**Actions:** Letters are mailed to women who have experienced a loss requesting an interview to understand the mother's perspective of her baby's death and to offer the family resources.

#### **RECOMMENDATIONS AND ACTIONS: ACCIDENTS**

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**Recommendation 6:** Advocate for a traffic study of those intersections where a child fatality occurs due to a motor vehicle/pedestrian accident.

**Action:** A letter was mailed to the Department of Transportation requesting a traffic study for an intersection where a child fatality occurred. This intersection has been reported to have a high number of pedestrian accidents.

#### **RECOMMENDATIONS AND ACTIONS: VICTIMS OF/OR PERPETRATORS OF VIOLENCE**

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**Recommendation 7:** Invite a judge from the Juvenile courts Division to become a member of CFR.

**Actions:** A letter was mailed to the Juvenile Courts, Circuit Court requesting representation on CFR.