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CHILD FATALITIES IN BALTIMORE CITY, 2016-2020: RECOMMENDATIONS FOR PREVENTION

A Report of the Baltimore City Child Fatality Review Team

December 1, 2021

BALTIMORE CITY HEALTH DEPARTMENT

FROM THE MAYOR AND COMMISSIONER OF HEALTH

Dear Baltimore,

The Child Fatality Review Report is the product of multi-agency reviews of individual deaths for young people 17 and under to help us understand why children die and determine what interventions should be put in place to effectively prevent future fatalities. City agencies, the child welfare system, our schools, and our communities as a whole all have a part to play in preventing these tragedies.

Baltimore's 300th homicide of 2021 was a five-year-old girl who suffered from abuse and neglect. We must do better. Our young people are our leaders, doctors, innovators, and entrepreneurs of tomorrow. Each time we lose a child to violence, our city's future becomes all that more bleak. These deaths are overwhelmingly preventable.

As a city, we continue to lose too many of our young people to violence and neglect. These are children and teenagers who will never be able to grow up and realize their full potential. We have to work together to save our youth and preserve the future of our city.

This report ties directly into our shared vision for equity throughout our city. An overwhelming majority of the young people we lose to violence each year are children of color. We cannot lift our Black and Brown communities out of poverty and overcome systemic disinvestment without specifically prioritizing the safety of our youth.

One core recommendation of this report is that Baltimore City must develop a public health approach to violence, a central pillar of our Comprehensive Violence Prevention Plan. To do this, the Mayor's Office of Neighborhood Safety and Engagement (MONSE) under the leadership of Director Shantay Jackson and the Baltimore City Health Department (BHCD) will continue to partner with Baltimore City Public Schools, the Mayor's Office of Children and Family Success, the Department of Social Services, and others to support the pre-existing work associated with child fatality reviews.

While this work has been going on for years, my administration is committed to implementing new and innovative solutions to address and prevent youth fatalities. Status quo solutions have not made our city any safer for our young people. We will be the catalyst for meaningful and long-lasting change.

Additionally, as part of an unprecedented investment in public safety, we are using American Rescue Plan Act (ARPA) dollars to enact agency-level changes that shift long-term youth outcomes and prevent future fatalities; support community-based organizations doing work related to juvenile justice, social-emotional learning, and harm reduction for residents managing active addiction; and provide trauma-informed care training for Baltimore residents. We are following through on our promise to support young people and bring a trauma-informed, harm reduction approach to City government operations.

Curing Baltimore of the violence is my top responsibility as Mayor, and the dollars we invest today in this vision based on equity, healing, public health, trauma-informed practices will build safer neighborhoods today, while paying dividends in the future. We are taking seriously the recommendations contained in this report and will focus on doing everything in our power to implement social and community support services to protect our young people and ensure a better, brighter future for Baltimore.

In Service,

Brandon M. Scott
Mayor
City of Baltimore

Dr. Letitia Dzirasa
Commissioner
Baltimore City Health Department

TABLE OF CONTENTS

EXECUTIVE SUMMARY

From 2016 to 2020, 208 children from birth to age 17 living in Baltimore City died in unusual and unexpected circumstances, each a tragedy for the child's family and community. The Baltimore City Child Fatality Review Team conducted a comprehensive multidisciplinary review of each death. Contained within this report are the findings of these reviews and recommendations for prevention. Key revelations included that:

- Homicide was the leading cause of child fatality, with 45 youth ages seven to 17 killed by a non-relative third party and 24 children from birth to age seven killed by a parent or caregiver
- Victims of fatality were predominantly vulnerable infants and toddlers and 16- and 17-year-old youth struggling in school and involved in the juvenile justice system
- 90% of children who died were children of color, reflecting the structural racism that is a root cause of the harrowing social and environmental factors underlying child fatality
- Children's caregivers were struggling with substance use, mental health disorders, domestic violence, their own histories of abuse and neglect, poverty, and living in violent neighborhoods
- Two-thirds of the children were found to have four or more adverse childhood experiences (ACEs), indicating a high level of trauma and adversity in their short lives
- Baltimore City's health, child welfare, education, and criminal justice systems represent tremendous opportunity for prevention and intervention, but resources are sorely needed

Although prevention of child fatalities may conjure up reforms to the child welfare system, these fatalities are not a child welfare system problem but a whole community problem. In fact, 59% of families in the cases reviewed had never come to the attention of the child welfare system prior to the fatality. Preventing these fatalities requires a public health approach that involves all agencies and providers serving families—and all of Baltimore City's residents—and that simultaneously works on multiple fronts to change policy, improve services, and mobilize communities. It also requires a life course approach that takes into consideration all that happens in each child's life and the lives of the child's parents and caregivers, intervening as early as we can to interrupt cycles of trauma.

Tackling all of the prevention recommendations presented in this report may feel daunting, but all are shared because the urgency of this issue and the clear need for a multipronged approach warrant sharing them all. With the number of child homicides increasing over the past five years, we must especially focus on recommendations to prevent children from becoming victims of violence. Our city's youngest and most vulnerable residents are depending on us to act now to save their lives.

Where We Should Invest Our Resources

Priorities	Recommendations
Supporting parents of children from birth to 18, especially parents involved in substance use or sale	Baltimore should unequivocally be a city where city agencies, health care providers, and community-based organizations seek to understand and support adults not only as individuals but also as parents and caregivers. Policies and practices must meet the needs of adults as parents, some of whom need intensive and long-term supports to be successful, and agencies and organizations must embed supports for family safety into their routine work. *Key recommendations: A.4, A.9, B.3, B.4, B.5, B.6, B.7, B.8, C.14. C.16, K.4, K.7, K.8, K.9, L.4, L.5*
City agencies improving systems for identifying children at risk and intervening early	Families are often deeply embedded with city agencies, including schools, law enforcement, and social services. Those agencies will be better positioned to intervene early to prevent fatality if they can work together to identify children and families at greatest risk, share information appropriately, and adopt practices for helping families trust and stay engaged in the services designed to support them. *Key recommendations: A.1, A.3, A.5, A.6, A.7, A.8., A.10, A.11, B.1, B.3, C.11, F.2, H.1, J.1, L.3*
Health care agencies and providers prioritizing prevention of child fatality	When systems for patient education, screening, referral, and care coordination work effectively, they can help prevent child fatality; however, when these systems do not function properly or are not properly resourced, children and families fall through the cracks. Health care agencies and providers, including obstetricians, pediatricians, birthing hospitals, managed care organizations, and behavioral health providers, can be critical agents of change by ensuring that they prioritize making these systems work. *Key recommendations: B.9, B.10, B.11, C.2, C.3, C.4, C.8, D.7, E.1, E.2, E.3, I.1, I.2, I.4., I.6, K.1*
Creating a city where youth have hope and opportunities for a bright future	The trauma and adversity experienced by so many of the children and families in the cases reviewed by CFR and the circumstances surrounding many of the deaths led the CFR Team to suspect that the children and families lacked hope for a future in which the children graduated from high school, began to work or get post-secondary education, and thrived in the community. Hope is essential for every child, and we need to show every child and family they are worthy of hope and worthy of investment in their future. *Key recommendations: A.4, A.9, B.6, L.1, L.2, L.3, L.4, L.5*

Immediate Actions

Based on the findings and recommendations presented in this report, resources available, and the commitment of the agencies that are members of the Baltimore City CFR Team to act to prevent child fatalities, we propose tackling the following recommendations between now and the next six months.

No.	Recommendation
A.1	Provide comprehensive intervention and wraparound services for youth victims of nonfatal shootings and stabbings and hospital-based intervention to reduce risk of violence
A.4	Study Baltimore's intergenerational drug trade and create a two-generation intervention for involved families that utilizes highly credible staff
A.7	Determine the number of youth in City Schools who have multiple school-based risk factors for fatality as a first step to determining the feasibility of identifying them and intervening early on a routine basis
A.9	Offer culturally responsive and trauma-informed individual and family therapy in addition to behaviorally oriented therapy, with trauma training for the city's child- and family-serving behavioral health providers
B.9	Hold Medicaid managed care organizations accountable for adhering to existing policy requiring them to outreach and link back into care families of young children who miss two well-child visits
C.1	Continue BHB SLEEP SAFE Campaign of mass media, community outreach, provider training, and free crib distribution to families in need, ensuring that clinics and other health and social services sites are displaying updated BHB SLEEP SAFE materials
H.2	Institute an MOU outlining information sharing practices across investigative agencies and a policy for multidisciplinary staffings following deaths that are initially unexplained or suspicious for abuse
I.2	Scale up adoption of BCHD's successful pilot of the electronic Prenatal Risk Assessment (ePRA) by all major prenatal care providers in the city to increase PRA submission
I.3	Continue to outreach and train social work staff at all Baltimore City birthing hospitals to complete the Postpartum Infant & Maternal Referral (PIMR) for eligible patients

Long-Term Actions

Many recommendations included in this report involve longer-term projects that require collaboration, additional funding, and additional staffing to implement. We advise elevating the following recommendations for implementation over the next three to five years to drive down the number of child fatalities.

No.	Recommendation
A.6	Institute a consistent referral policy and robust minimum standard of support and intervention for Student Support Teams across City Schools, with an emphasis on intervening on attendance early in elementary school
A.11	Train and employ credible messengers (e.g., youth peer mental health educators) across child- and family-serving agencies to outreach and engage families, amending outreach practices and policies to keep cases open longer in order to build trust and encourage youth and family participation over time
B.3	Re-envision services and advocate for longer-term intensive services for families that meet criteria and are at risk for child fatality or serious injury
B.16	Educate the community on the importance of making reports to CPS when children are suspected to be in danger, emphasizing BCDSS's intention to collaborate with families on safety rather than remove children from their caregivers with little cause
C.2	Pass legislation in Maryland to mandate that all birthing hospitals provide and document evidence-based safe sleep counseling prior to postpartum discharge
C.11	Implement neighborhood and virtual canvassing after a sleep-related infant death in partnership with the Baltimore City Fire Department (BCFD) to alert families that free cribs are available to families in need and to provide education on safe sleep door-to-door
I.4	Pass legislation to mandate the submission of the PIMR by the birthing hospital for mothers and infants who meet criteria
J.1	Create an integrated data system across major child- and family-serving agencies (e.g., City Schools, DJS, BCDSS) with proper privacy controls that would alert agencies to youth with risk factors for fatality across systems
K.7	Provide ongoing training across health and social service systems on evidence-based and best-practice approaches to working with caregivers with substance use disorders and infants with prenatal substance exposure, ensuring that education includes information about the effects of stigma and bias on the outcomes of caregivers and their children
K.8	Integrate parenting education and support services into substance use disorder treatment, pediatric care, adult health care, and criminal justice settings (e.g., Baltimore Central Booking and Intake Center)

No.	Recommendation
L.1	Provide anti-racism training and support to leaders and staff of all city and child-serving agencies and develop concrete action plans for shifting focus toward achieving racial equity
L.2	Address the social determinants of health in Baltimore City through advocacy for local and state policies that reduce poverty and violence and support education and housing stability

Work Already Underway

Every agency that participates on Baltimore City Child Fatality Review is already acting to prevent child fatalities, and we wish to acknowledge and honor that work. Throughout this report are "Action Spotlights" that highlight just some of this work. We also know that there is much more to be done and that the children of Baltimore City are depending on us all to act.

1

BALTIMORE CITY CHILD FATALITY REVIEW

Children are not supposed to die. Each death of a child is a tragic loss to that's child's family and the entire community. It is also a marker of the health and safety of all children in that community. From a public health perspective, every

Every Child Death Is an Urgent Call to Action

Baltimore City Child Fatality Review (CFR) is an action-oriented, collaborative process that brings key people and agencies together to study the circumstances leading to each child's death and our response to that death. The goal of CFR is to conduct comprehensive, multidisciplinary reviews to better understand how and why children die and use the findings to prevent future deaths and improve the health and safety of all children in the community. CFR was established in Maryland by Senate Bill 464 of 1999, which created a state CFR Team and local CFR Teams in every jurisdiction that are operated by the local health department. All 50 states and Washington, DC have CFR programs, and more than 1,300 local teams are operating in the United States. Staffing for local CFR Teams in Maryland is funded by the Maryland Department of Health (MDH), which also operates the state CFR Team.

Data Collection and Review

The Baltimore City Health Department (BCHD) convenes the Baltimore City CFR Team monthly to review "unusual and unexpected" deaths of children from birth to age 17 who are residents of Baltimore City. "Unusual and unexpected" deaths are those that result from unintentional injury (e.g., motor vehicle accidents, fires) and intentional injury (e.g., gun violence, child abuse, suicide) and those that are of undetermined manner. The team also reviews deaths resulting from natural causes when death is an unexpected outcome (e.g., an asthma attack resulting in death). Cases are referred to the team by Maryland's Office of the Chief Medical Examiner (OCME). MDH requires that local teams review all referred cases.

For each case, the Baltimore City CFR Team gathers data including the autopsy report and health, law enforcement, school, and social services records. Authority for CFR Teams to collect this data is provided by the Code of Maryland Regulations (COMAR) Section Health-General § 5-707. As required by Maryland regulations, all case reviews are confidential and closed to the public. Following each review, CFR staff submit information on each case to the National Child Death Review Case Reporting System, which serves as a national surveillance system for child death.

Taking Action to Prevent Child Death

During each review, the Baltimore City CFR Team strives to understand the factors that contributed to the child's death and identify actions that policymakers, public agencies, community-based organizations, health providers, and families can take to prevent, investigate, and respond to child deaths. Based on the findings, members may act immediately, form working groups to develop

longer-term plans and seek funding for implementation, or identify a need for further needs assessment and team deliberation.

The citywide B'more for Healthy Babies (BHB) initiative is closely linked to the Baltimore City CFR Team and serves as its community action arm for preventing deaths of infants and young children. BHB, launched in 2009 and led by BCHD, Family League of Baltimore, and HealthCare Access Maryland (HCAM), involves more than 150 partners across the public and private sectors. BHB reviews CFR findings, prioritizes recommendations, and implements interventions to improve service systems and resources in Baltimore City, which has seen a 36% decrease in infant mortality since 2009.[1]

In 2021, Mayor Brandon Scott created the Mayor's Office of Neighborhood Safety and Engagement (MONSE), which is spearheading Mayor Scott's Comprehensive Violence Prevention Strategy. MONSE has taken a lead role on the Baltimore City CFR Team and worked with BCHD to convene the leaders of CFR Team member agencies in September 2021 to reaffirm our urgent commitment to take action to prevent child fatalities resulting from violence. This Executive CFR Team will meet quarterly to ensure progress on team recommendations and eliminate barriers to action.

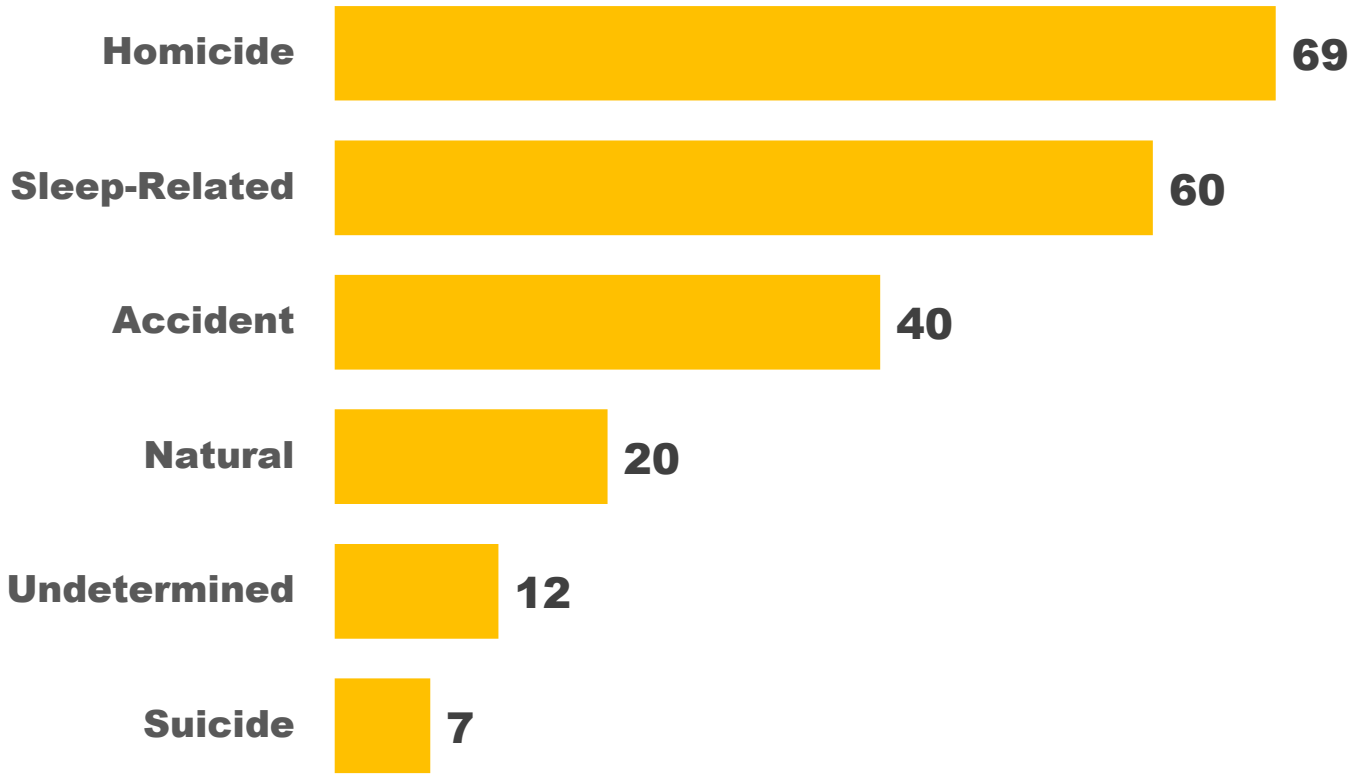
2

208 FATALITIES

From 2016 to 2020, 208 Baltimore City children from birth to age 17 died an “unusual and unexpected” death, representing nearly a quarter of all child fatalities in the State of Maryland. This is a decrease from the previous 5-year period of 2011-2015 when there were 236 child fatalities.

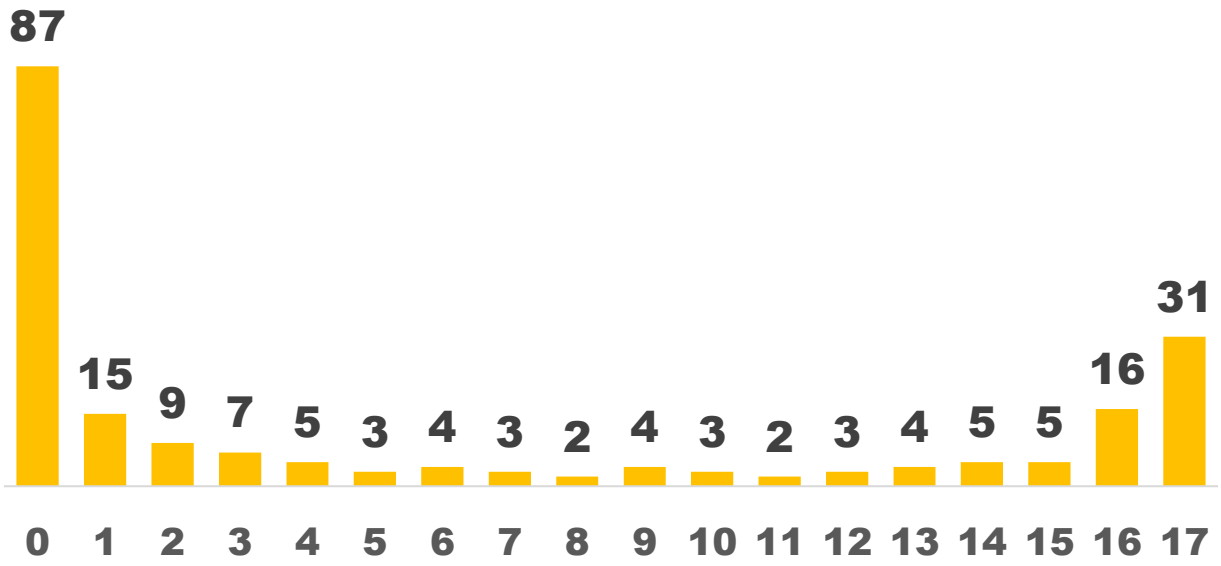
Homicide Is the Leading Cause of Child Fatality in Baltimore City

Homicide was the leading cause of child fatality in 2016-2020, with 69 children (33%) dying at the hands of a caregiver or third party. Sleep-related infant deaths, in which infants die in their sleep from suspected suffocation, accounted for 60 fatalities (29%). These are followed by 40 accidental deaths (19%), which were typically related to fires, motor vehicle crashes, drownings, and accidental firearms discharge. There were 20 unusual and unexpected deaths found after investigation to be of natural causes (10%), and these typically were related to undiagnosed cardiac conditions, infections, and asthma. There were 12 deaths of undetermined manner (6%); after autopsy and investigation, it could not be determined whether these deaths resulted from injury or natural causes. Finally, there were seven deaths in which children took their own lives (3%).



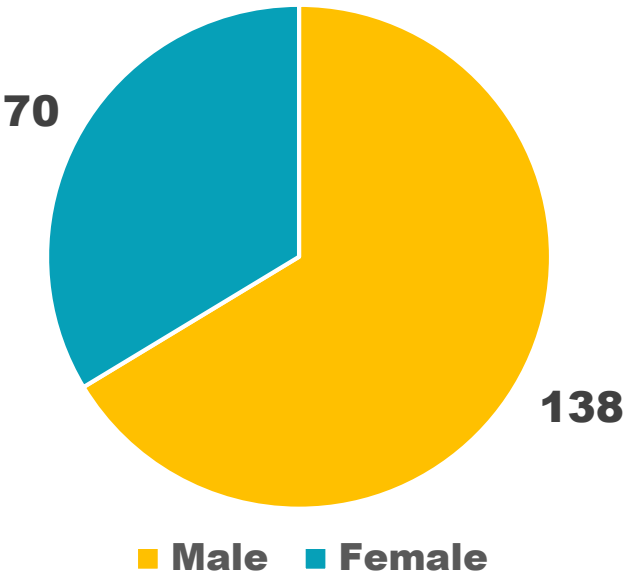
Infants, Toddlers, and Older Youth Are Most at Risk

Infants, wholly dependent upon their caregivers for their survival and safety, are most vulnerable to fatality and accounted for 87 of the 208 fatalities (42%). Toddlers are also at greater risk for similar reasons, with 31 total fatalities to 1-, 2-, and 3-year-olds (15%). From age 3 to age 15, fatalities were lowest, ranging from two to five each year. Risk then rises again for older youth who are increasingly independent, with 16 fatalities to 16-year-olds and 31 fatalities to 17-year-olds (23%).



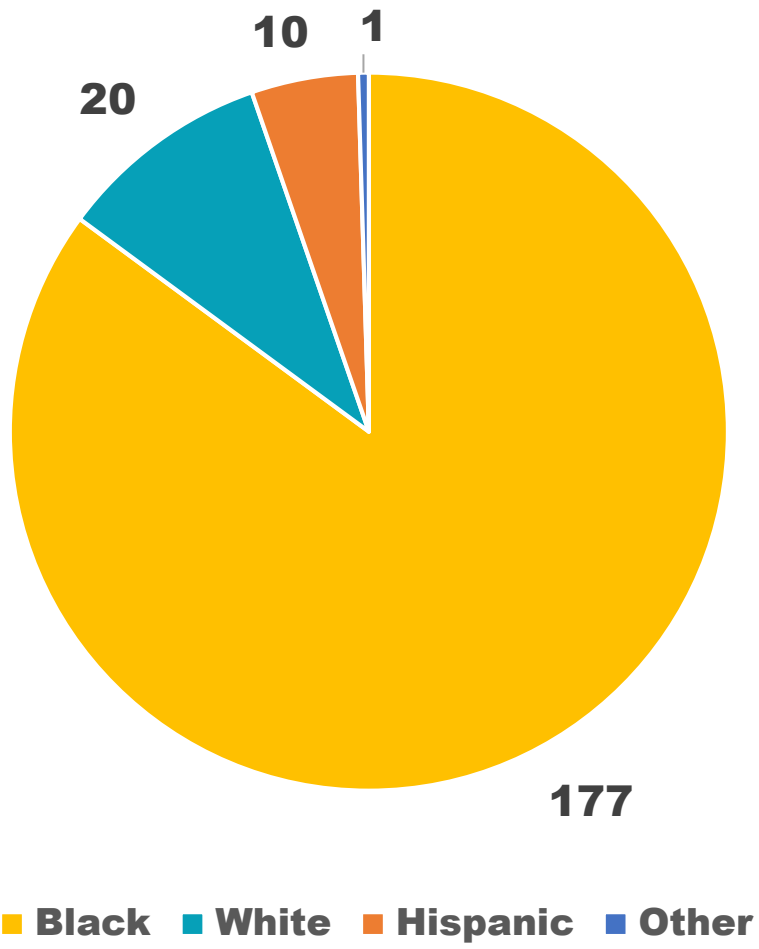
Boys Are Twice as Likely to Die as Girls

Of the 208 fatalities, 138 (66%) were to boys, and 70 (34%) were to girls. This disparity is most pronounced among homicide victims; of the 69 child homicides, 53 (77%) of the victims were boys and 16 (23%) were girls.



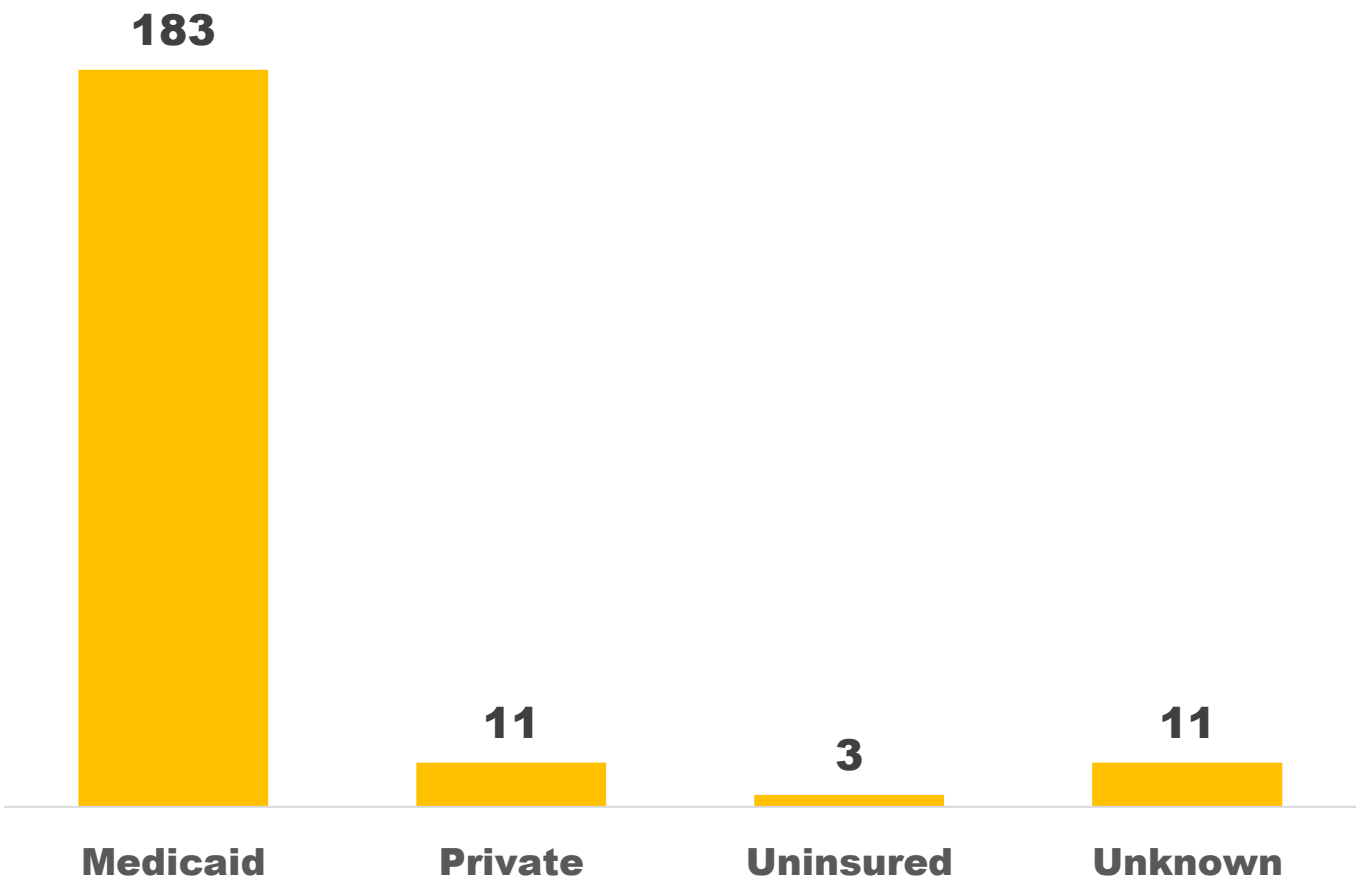
Black Families Bear a Disproportionate Burden of Child Fatalities

Although approximately 62% of the Baltimore City population is non-Hispanic Black,[2] 85% (177) of the 208 child fatalities were to non-Hispanic Black children. Ten percent (20) of fatalities were to non-Hispanic white children, 5% (10) were to Hispanic children, and less than 1% (1) were to children whose race and ethnicity were categorized as "other." This distribution reflects a significant racial disparity in child fatalities in which Black families disproportionately experience the tragic loss of a child. As with gender, this disparity is most significant among homicides; of the 69 child homicides, 64 (93%) of the victims were non-Hispanic Black children, three (4%) were non-Hispanic white children, and two (3%) were Hispanic children.



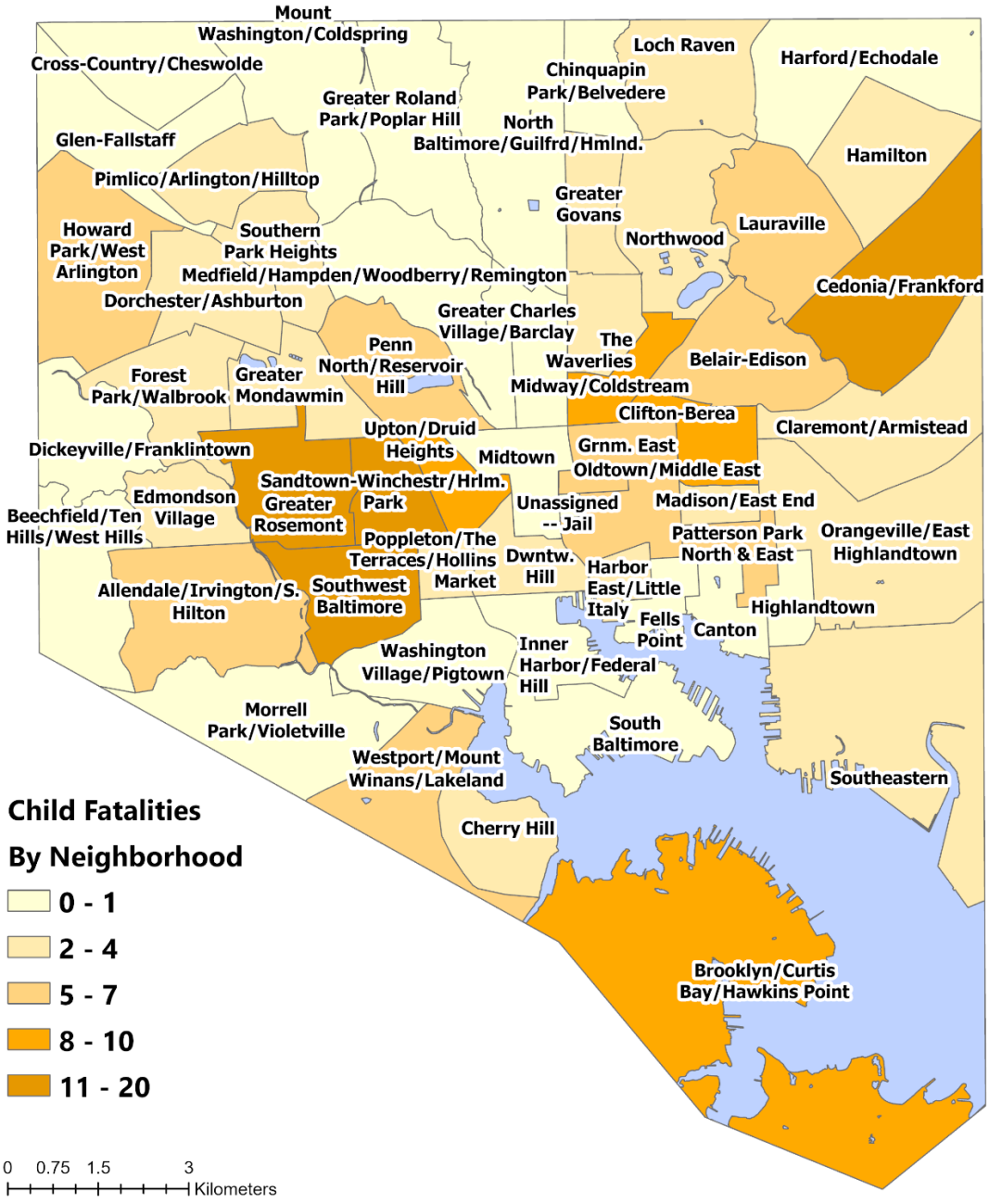
Child Fatalities Overwhelmingly Occur in Low-Income Families

Health insurance serves as an indicator of children's socioeconomic status. In Baltimore City, a little more than half of all newborns are insured through Medicaid,[3] the nation's public health insurance program for people of low income. Of the 208 fatalities, 183 children (88%) were insured through Medicaid, 11 (5%) were privately insured, and three (1%) were uninsured. In 11 cases (5%), insurance status was unknown. The high number of children with Medicaid indicates that child fatalities occurred disproportionately to low-income families that may lack access to resources such as reliable and affordable child care and stable housing, which are critical to keeping children safe.



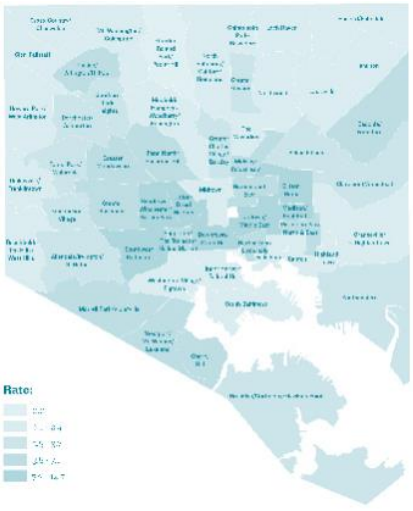
Child Fatalities Are Higher in Neighborhoods with Greater Poverty and Violence

The greatest concentration of child fatalities based on the child's neighborhood of residence is in West Baltimore, in the areas of Sandtown-Winchester/Harlem Park, Greater Rosemont, Southwest Baltimore, and Upton/Druid Heights, and in East Baltimore in Cedonia/Frankford, Midway/Coldstream, Clifton-Berea, and Belair-Edison. There is also a concentration in South Baltimore in Brooklyn/Curtis Bay/Hawkins Point.

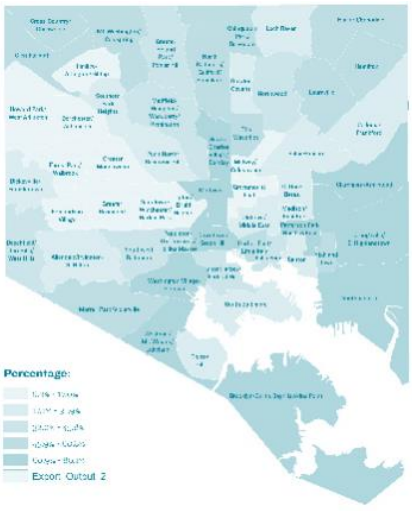


These neighborhoods trend higher in both poverty and violence, as evidenced by the comparison maps from the Baltimore Neighborhood Indicators Alliance (BNIA) showing the percentage of children living in poverty and the number of shootings per 1,000 residents by neighborhood. Further, all of these maps align with the BNIA map of Baltimore City showing racial diversity, with areas with the least diversity and greater racial residential segregation having more fatalities on the whole. Racial residential segregation is often referred to as "isolation segregation" because those living in segregated areas are often isolated from resources needed to keep families healthy and safe, including affordable and safe housing, healthy food, jobs, and accessible public transportation.

Percent of Children Living Below the Poverty Line, 2015-2019



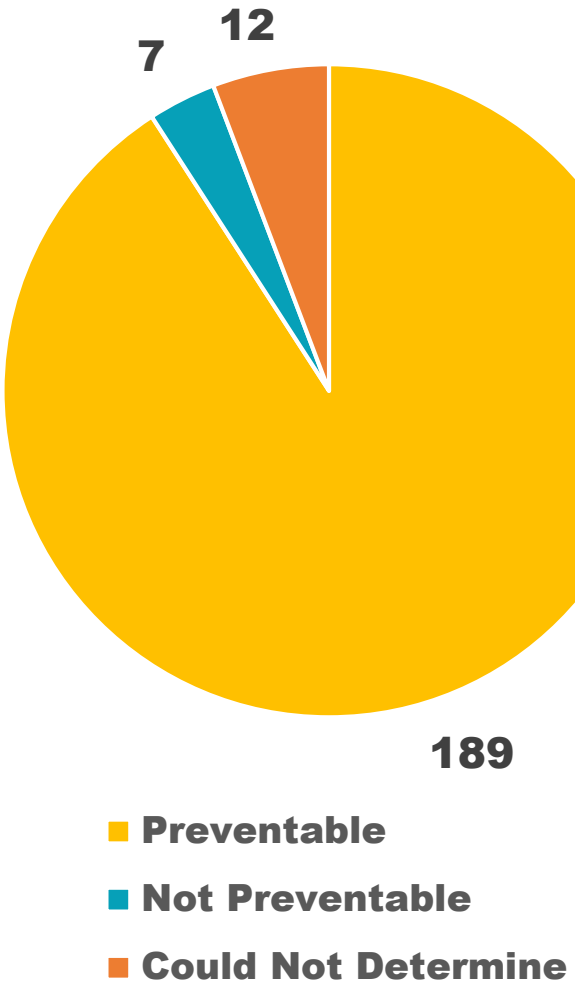
Number of Shootings Per 1,000 Residents, 2019



Racial Diversity Index, 2015-2019

Child Fatalities Are Overwhelmingly Preventable

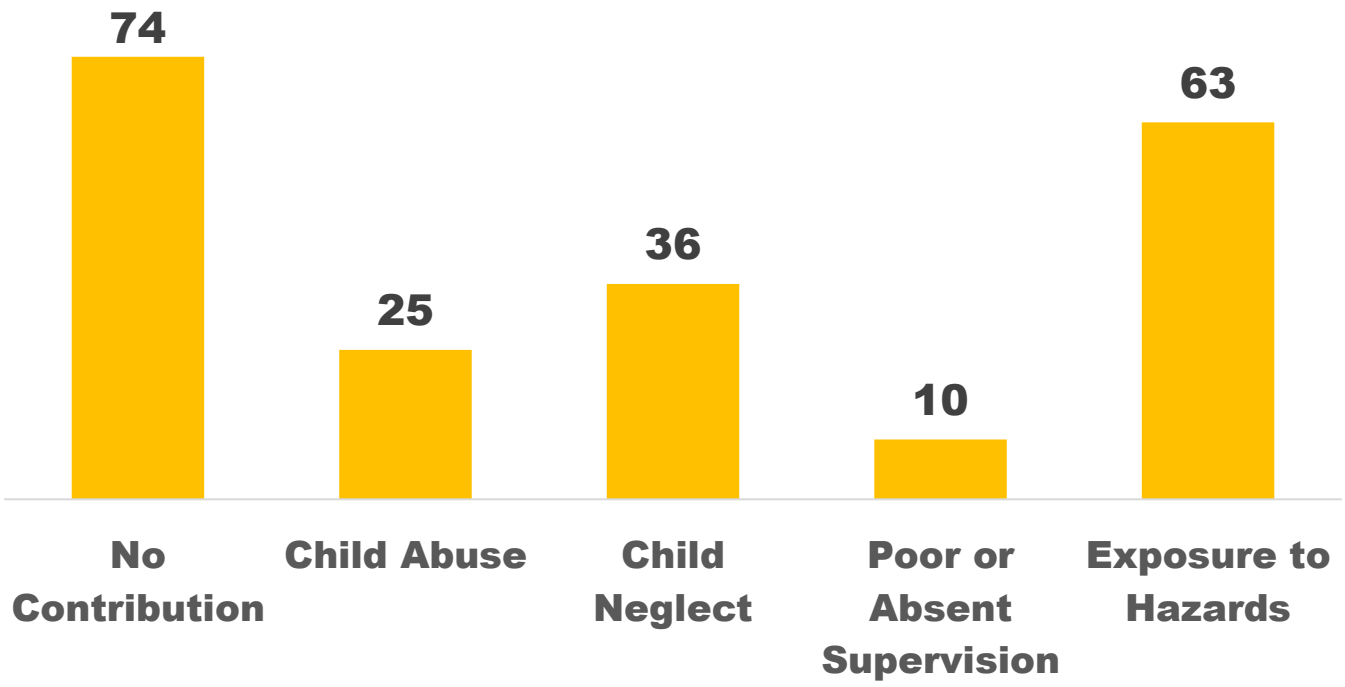
Following each case review, Baltimore City CFR Team members vote on whether the fatality was likely preventable, asking the question, "Could there have been a system, practice, policy, or individual-level intervention that could have prevented this child's death?" In 189 cases (91%), the team determined that the death was preventable. In 7 cases (3%), the team found that the death could not have been prevented. In 12 cases (6%), the team could not determine whether the death was preventable. These results reflect a strong conviction by members of the team that no death resulting from injury, particularly violence, is unpreventable.



Caregiver Behavior Contributed to More Than Half of Fatalities

Following each case review of a death that the CFR Team determines was likely preventable, the CFR Team members vote on whether the behavior of the child's caregiver at the time of death—typically a parent but sometimes another member of the household or a child care provider—contributed to the fatality. If the team finds that a caregiver's behavior did contribute to the death, the team categorizes that behavior as one of the following: 1) child abuse, which is injury inflicted on the child by the caregiver, whether intentional or not (a form of child maltreatment); 2) child neglect, which is failure on the part of a caregiver to provide for the shelter, safety, supervision, health care, and/or nutritional needs of the child that results in harm to the child (a form of child maltreatment); 3) poor or absent supervision that does not rise to the level of child maltreatment; or 4) exposure to hazards, which is behavior that exposes the child to something hazardous in the environment but does not rise to the level of child maltreatment. These determinations are compiled at the state and national levels to help public health and child welfare professionals better understand risk to children and the impact of child maltreatment on child death. These determinations do not have any impact on the fatality investigations by law enforcement or Child Protective Services (CPS) and have no repercussions for the caregivers involved.

Of the 189 cases that the CFR Team determined were likely preventable, in 134 cases (71%; 64% of the total number of cases), the CFR Team found that a caregiver's behavior contributed to the child's death, with the following breakdown: 25 attributed to child abuse, 36 attributed to child neglect, 10 attributed to poor or absent supervision, and 63 attributed to exposure to hazards.



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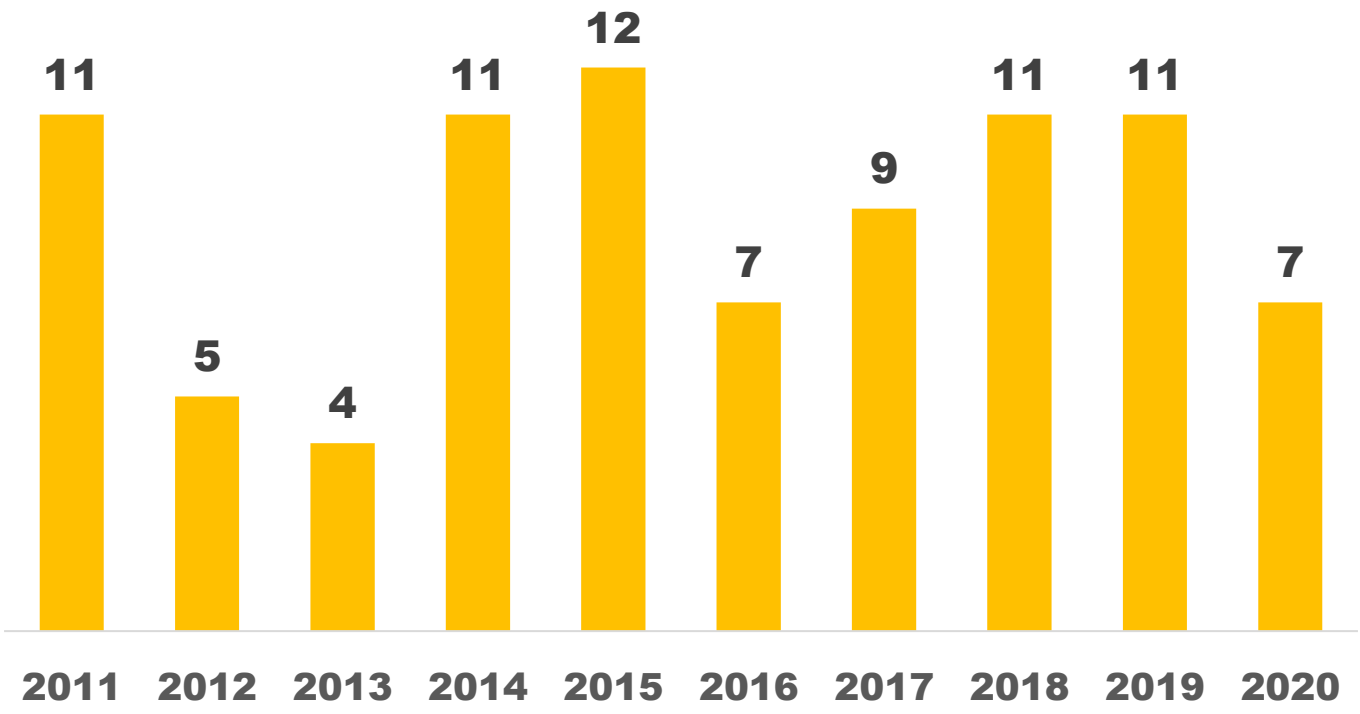
CAUSE-SPECIFIC FINDINGS AND RECOMMENDATIONS

Baltimore City CFR observed trends by manner and cause of death, identified issues that require intervention, and made recommendations to prevent child fatalities.

A. THIRD-PARTY HOMICIDES

From 2016 to 2020, there were 45 homicides committed by a third party (non-relative or caregiver). This is a slight increase from 2011-2015, when there were 43 third-party homicides. The youth's ages ranged from seven to 17 years. Forty (89%) of the children were boys, and five (11%) were girls. Forty-two (93%) of the youth were non-Hispanic Black, two (4%) were Hispanic, and one (2%) was non-Hispanic white.



Forty-two (93%) of the youth were killed by gunshot, two (4%) sustained multiple injuries, and one (2%) died in an intentionally set fire.

At the time of review, suspects had been criminally charged in only eight cases (18%), and investigations were ongoing. Frequently, the CFR Team had only limited information regarding the investigation, the motive for the violence, and the suspects under consideration, if they had been identified. Motives when known included personal disputes, disputes regarding the sale of drugs, and

robbery. In a small number of cases, gang involvement was suspected. In a small number of cases, the victim appeared to be unconnected to the suspect(s) and in the wrong place at the wrong time.

Most of the youth killed were themselves involved in illicit activity. Thirty-one (69%) of the youth had been charged prior to their deaths in the juvenile system; youth became justice-involved as early as age seven, with 16 youth having been committed at some point to the Maryland Department of Juvenile Services (DJS) and received supervision and prevention services. Involvement with the criminal justice system was often multigenerational, with 32 (71%) of the youths' caregivers having been charged in the adult system, 22 (49%) with charges related to the sale of drugs. Twelve (27%) of the youth were identified as prior victims of a nonfatal shooting or stabbing; this number is likely an undercount as CFR does not have a consistent source for this information. In a small number of cases, youth and their families had unsuccessfully sought assistance to relocate to avoid violence targeting them prior to the death. Several of the youth had lost their fathers to gun violence related to the city's drug trade.

In addition to justice system involvement, CFR identified several school-related risk factors clustered among youth victims of homicide. Forty-four of the 45 youth were confirmed to have been students at Baltimore City Public Schools (City Schools); five had withdrawn from school without graduating prior to their deaths. The youth were found to have challenges related to truancy, academics, and behavior. Forty (89%) of the youth were chronically absent from school. Twenty-three (51%) had repeated a grade, and 14 (31%) had attended one of the city's alternative schools for students who are under-credited for their age. Eighteen (40%) had been suspended at least twice in one year for behavioral problems, including attacks on other students and adults. In addition, 28 (62%) had experienced two or more exceptional school transfers (transfers to new schools beyond the expected transfers between elementary, middle, and high schools), indicating that youth may have been experiencing challenges at school or that their families may have been experiencing housing instability.

93%	**Homicide committed with a gun**
89%	**Chronically absent from school**
69%	**Charged in the juvenile justice system**
62%	**Received mental health treatment**
40%	**Suspended from school at least twice in one year**
27%	**Prior victim of a nonfatal shooting or stabbing**
27%	**Received substance use disorder treatment**
24%	**Victim of child maltreatment**

Many youth had also received behavioral health treatment. Twenty-eight (62%) had received mental health treatment for conditions including conduct disorder, oppositional defiant disorder, and attention-deficit/hyperactivity disorder, often with frequent changes in provider. Twelve (27%) had received substance use disorder treatment, typically for cannabis use. In general, the CFR Team noted that significant trauma and adversity were likely to have underpinned many of the youths' behavioral health challenges (see p. 65 for findings and recommendations related to trauma and adversity). Sixteen (36%) of the youth lived in families with CPS involvement, and CPS identified 11 (24%) as victims of maltreatment. In a small number of cases, the youth's caregiver had attempted to voluntarily place the child in foster care due to the difficulty they were having managing the child's behavior; in each case, the request was rescinded but without the family having received additional support.

Recommendations

No.	Issue	Recommendation
A.1	Youth victims of nonfatal shootings or stabbings at high risk for continued violence	Provide comprehensive intervention and wraparound services for youth victims of nonfatal shootings and stabbings and hospital-based intervention to reduce risk of violence
A.2	Clusters of youth homicides in neighborhoods without Safe Streets, an effective intervention for reducing community violence	Expand Safe Streets to additional neighborhoods with clusters of third-party youth homicides
A.3	Early involvement with DJS with limited opportunity for child and family intervention when cases are dismissed or resolved at intake and children are not committed	Provide enhanced care coordination for youth age 13 and younger charged in the juvenile system, with an emphasis on offering comprehensive supports for the youth's family
A.4	Youth engaging in selling drugs often had caregivers who were also engaged in selling drugs	Study Baltimore's intergenerational drug trade and create a two-generation intervention for involved families that utilizes highly credible staff
A.5	Families seeking to relocate due to being targeted by violence did not learn of all of the options available to them and were unable to relocate	Identify all options and sources of funds for families needing to relocate due to violence and ensure that criminal justice and family-serving organizations are aware of these options

Recommendations (cont.)

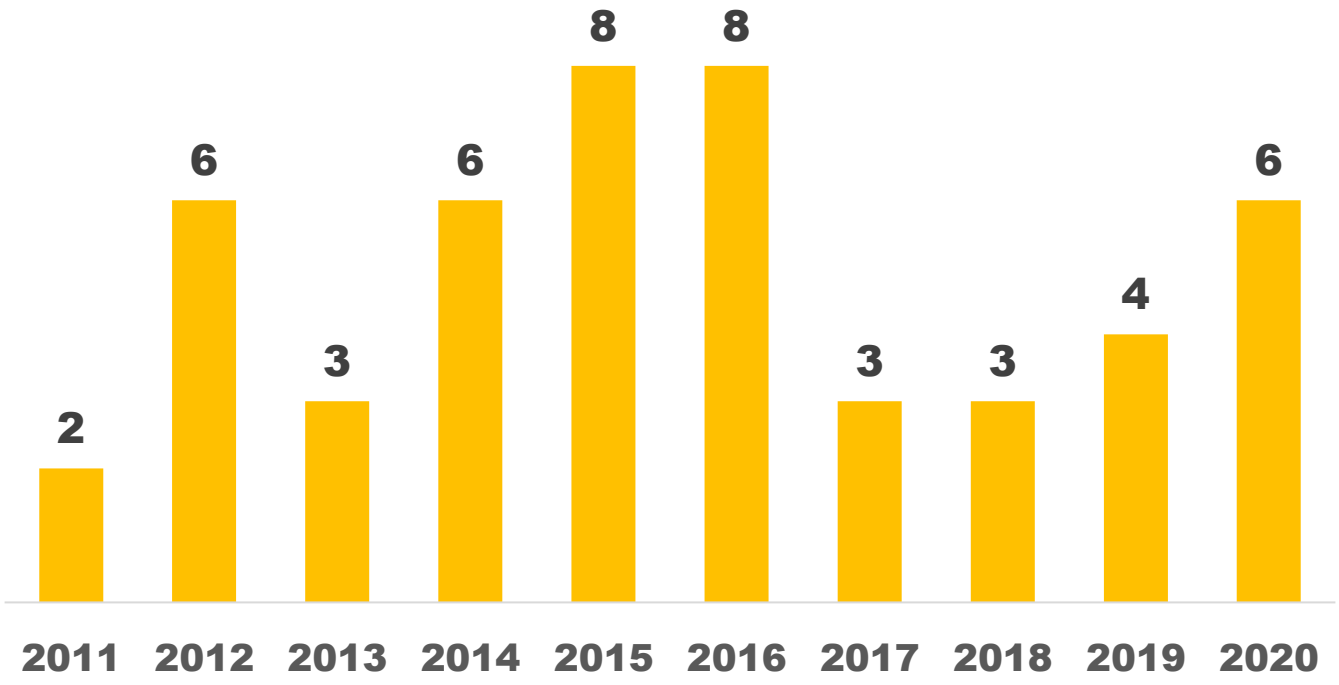
No.	Issue	Recommendation
A.6	Chronic absenteeism, often starting early in elementary school, that leads to academic problems and disengagement from school, with inconsistent and sometimes absent intervention	Institute a consistent referral policy and robust minimum standard of support and intervention for Student Support Teams across City Schools, with an emphasis on intervening on attendance early in elementary school
A.7	Common constellation of school-based risk factors for fatality (chronic absenteeism, repeated grade, multiple suspensions in one year, two or more exceptional transfers)	Determine the number of youth in City Schools who have multiple school-based risk factors for fatality as a first step to determining the feasibility of identifying them and intervening early on a routine basis
A.8	Significant trauma and adversity and unmet need for mental health support for youth, particularly for youth with behavior challenges	Provide regular Mental Health First Aid and trauma-informed care training for City Schools and the city's network of child- and family-serving agencies and organizations
A.9	Youth appeared to be receiving diagnoses and therapy for behavior challenges that may not have addressed family dynamics and underlying trauma	Offer culturally responsive and trauma-informed individual and family therapy in addition to behaviorally oriented therapy, with trauma training for the city's child- and family-serving behavioral health providers
A.10	Families overwhelmed with youth behavioral challenges and lack of support for families that initiate voluntary foster care placement but subsequently rescind	Strengthen the capacity of the Local Care Team and institute a consistent referral policy across member organizations for the Local Care Team, prioritizing youth risk factors identified by CFR and ensuring referrals for all families that initiate voluntary foster care placement even if they later rescind
A.11	Rejection of family services and mental health supports offered to youth, likely due to distrust of service systems	Train and employ credible messengers (e.g., youth peer mental health educators) across child- and family-serving agencies to outreach and engage families, amending outreach practices and policies to keep cases open longer in order to build trust and encourage youth and family participation over time

Action Spotlight—Pathways to Advocacy Against Violence Everyday

In 2019, in response to Baltimore City CFR's recommendation to provide comprehensive intervention and wraparound services for youth victims of nonfatal shootings and stabbings and meet the needs of homicide victims' siblings, the Center for Hope (formerly Baltimore Child Abuse Center) created the Pathways to Advocacy Against Violence Everyday (PAAVE) program. PAAVE provides trauma-sensitive, evidence-based, intensive case management, mental health treatment, and referrals to youth victims of a violent crime, youth who have experienced a non-fatal shooting, youth who have witnessed a homicide, and youth who have lost a sibling or close family member to homicide. The goal of PAAVE is to provide intensive support that will boost youth and family protective factors and prevent further community violence. Youth enrolled in PAAVE have weekly meetings with their case managers to address the needs related to school engagement, behavioral changes and attitude shifts, family conflict and involvement, and peer relationships. Case managers and youth work together to develop a healthy working relationship and safe space to discuss important life decisions, hopes, and goals. Referrals and support include food assistance, job development and assistance, medical support, mental health services, and housing assistance.

B. CHILD MALTREATMENT HOMICIDES

From 2016 to 2020, there were 24 child homicides committed by a caregiver. This is a slight decrease from 2011-2015, when there were 25 child maltreatment homicides. The children's ages ranged from birth to seven years old, with infants being most at risk (9; 38%). Thirteen (54%) of the children were boys, and 11 (46%) were girls. Twenty-two (92%) of the children were non-Hispanic Black, and two (8%) were non-Hispanic white.



In 16 cases (67%), the child died of multiple injuries to the head and body, in six cases (25%) the child died of intoxication (five opioid-related), and in two cases (8%), the child died of intentional asphyxia.

At the time of review, criminal charges had been brought in 19 cases (79%). In two of the remaining five cases, the child was in the care of multiple caregivers, and it was unclear who committed the abuse. In the other three cases, the perpetrator was known but had not yet been charged. Of the 25 total perpetrators identified (there were two perpetrators identified in three cases), 15 (58%) were male caregivers, and 10 (42%) were female caregivers: mother alone (4); father alone (7); mother's boyfriend alone (5); both mother and father (1), mother's boyfriend (1), or mother's girlfriend (1); child care provider (2, both female); and other relative (1, male).

In most cases, it was not known what immediately preceded the abuse that led to the child's death. In some cases in which the events were known, the caregiver perceived that the child had misbehaved in some way related to toileting or feeding or was frustrated by the child's crying; the caregiver, often but not always male, reacted impulsively with violence. In some cases, the child's mother had left the child in the care of someone known to be unsafe due to lack of child care options. In several cases, parent delay in seeking medical care for their child's injury due to fear of CPS involvement was the determining factor in the child's death.

While only four of the children had been named by CPS as a victim of child maltreatment prior to the death, 15 (63%) of the children's families had had prior contact with CPS, typically with an older sibling. In 10 cases (42%), there was evidence that the child had experienced physical abuse prior to death, most of which had never been reported to CPS. It was striking to find that in 14 cases (58%), one or both caregivers of the child had been named by CPS as a victim of maltreatment as children themselves, and in 12 cases (50%), one or both caregivers had been in foster care as children. In addition, in 12 cases (50%), one or both caregivers had been charged with domestic violence prior to the death. Intergenerational trauma and child welfare involvement underscore the violence seen in these cases. In cases in which there was long child welfare history, families often seemed to be able to function when supportive services were place, but when services ended, family life deteriorated and the family would again come to the attention of the child welfare system.

85%	**Mother did not receive a Postpartum Infant & Maternal Referral**
71%	**One or both parents had received mental health treatment**
63%	**Child's family had prior history with CPS**
58%	**One or both parents was a victim of maltreatment as a child**
58%	**One or both parents had received substance use disorder treatment**
50%	**One or both parents was in foster care as a child**
50%	**One or both parents had a record of domestic violence charges**
50%	**Mother did not receive a Prenatal Risk Assessment**
17%	**Child was a named by CPS as a maltreatment victim prior to death**

Likely highly related to family and other trauma, in 21 cases (88%), one or both caregivers had a documented mental health condition and, in 17 cases (71%), had received mental health treatment. In 19 cases (79%), one or both caregivers had a documented substance use disorder and, in 14 cases (58%), had received substance use disorder treatment. Thirteen (54%) of the children were confirmed to have been exposed to substances in utero, and five of the children had been reported to the Baltimore City Department of Social Services (BCDSS) as substance-exposed newborns (a non-CPS referral) following a positive toxicology test at delivery. In some cases of child intoxication death, prescription and illicit drugs had been left accessible to the child in the home.

The CFR Team identified significant missed opportunities for care coordination and linkage to the city's home visiting system, which is intended to promote strong families and prevent child maltreatment. (See "Supporting Infants and Young Children" on p. 54 for information and recommendations related to this system). Eighteen of the children's mothers were eligible for a Prenatal Risk Assessment (PRA), a prenatal referral for care coordination that the prenatal care provider is required to submit to the local health department at the first prenatal care visit. However, only 12 (67%) received one. Twenty of the mothers were eligible for a Postpartum Infant & Maternal Referral (PIMR), a similar postpartum referral submitted by the delivery hospital, but only three (15%) received one. Only two (8%) of these 24 high-risk families were enrolled in a home visiting program.

Recommendations

No.	Issue	Recommendation
B.1	Children in foster care returned to the care of parents by judges against the strong recommendation of BCDSS	Institute a system for notifying judges of child fatalities in cases they have adjudicated and provide additional training to judges on the risks for child fatality
B.2	Maryland's existing Birth Match law fails to match parents of newborns who have not contested the termination of their parental rights for previous children by the courts due to an administrative loophole	Pass expanded Birth Match legislation that closes the loophole so that the local DSS office is notified and a safety check is performed when a newborn is born to any parent whose rights have been terminated for another child except in the case of voluntary adoption
B.3	Systems providing intensive support for families, particularly Family Preservation services provided by local DSS offices, are not designed or funded to provide the long-term support needed by some families	Re-envision services and advocate for longer-term intensive services for families that meet criteria and are at risk for child fatality or serious injury

Recommendations (cont.)

No.	Issue	Recommendation
B.4	Lack of support for families of young children experiencing domestic violence	Provide training and resources to implement the evidence-based DOVE domestic violence intervention program to programs supporting families with young children
B.5	Lack of safe, affordable child care leading children to be in the care of unsafe caregivers	Increase access to respite and emergency child care and to child care vouchers, eliminating barriers to enrollment
B.6	Male caregivers with little support, inappropriate developmental expectations, and little knowledge of caring for young children	Engage and build the confidence and parenting skills of fathers, especially young fathers, through media and outreach efforts with partners already working to engage young men (e.g., Safe Streets)
B.7	Caregiver frustration with toileting accidents, feeding difficulties, and crying as a trigger for violence	Provide training and resources to service providers working with families of young children on developmental expectations and strategies for supporting families experiencing challenges with toilet training, feeding, and soothing children
B.8	Concerns of caregivers parenting children with special needs are not adequately addressed by mandated parenting classes	Offer parents who have been mandated to take parenting classes that tailored to the needs of parents with children who have developmental or social-emotional delays
B.9	Missed well-child visits leading to missed opportunities for pediatricians to identify ongoing abuse and caregiver challenges	Hold Medicaid managed care organizations accountable for adhering to existing policy requiring them to outreach and link back into care families of young children who miss two well-child visits
B.10	Missed well-child visits leading to missed opportunities for pediatricians to identify ongoing abuse and caregiver challenges	Encourage pediatricians to submit Local Health Services Requests (LHSRs) to HCAM to outreach and link back into care children who miss well-child visits
B.11	Virtual pediatric visits provide less opportunity for pediatricians to identify child abuse	Provide guidance and training to pediatricians on recognizing the signs and symptoms of child abuse via virtual pediatric visits based on guidance being developed for the Maryland chapter of the American Academy of Pediatrics

Recommendations (cont.)

No.	Issue	Recommendation
B.12	Prescription medications improperly stored and left accessible to young children	Encourage opioid treatment providers to screen clients for children present in the home and provide counseling on safe storage of medication
B.13	Child overdosed within hours of a call for a caregiver opioid overdose in the same home	Train first responders to provide education on safe illicit drug storage and identify funding to enable them to supply lockboxes following an overdose
B.14	Naloxone, were it present in the home, could have prevented child overdose death	Recommend co-prescription of naloxone to all people prescribed medication-assisted treatment (MAT) for opioid use disorder and train people using MAT to administer it
B.15	Lack of robust support for caregivers of substance-exposed newborns	Improve coordination among BCDSS, public health, and home visiting to provide enhanced support for substance-exposed newborns
B.16	People who suspected a child was in danger did not report the danger to CPS	Educate the community on the importance of making reports to CPS when children are suspected to be in danger, emphasizing BCDSS's intention to collaborate with families on safety rather than remove children from their caregivers with little cause

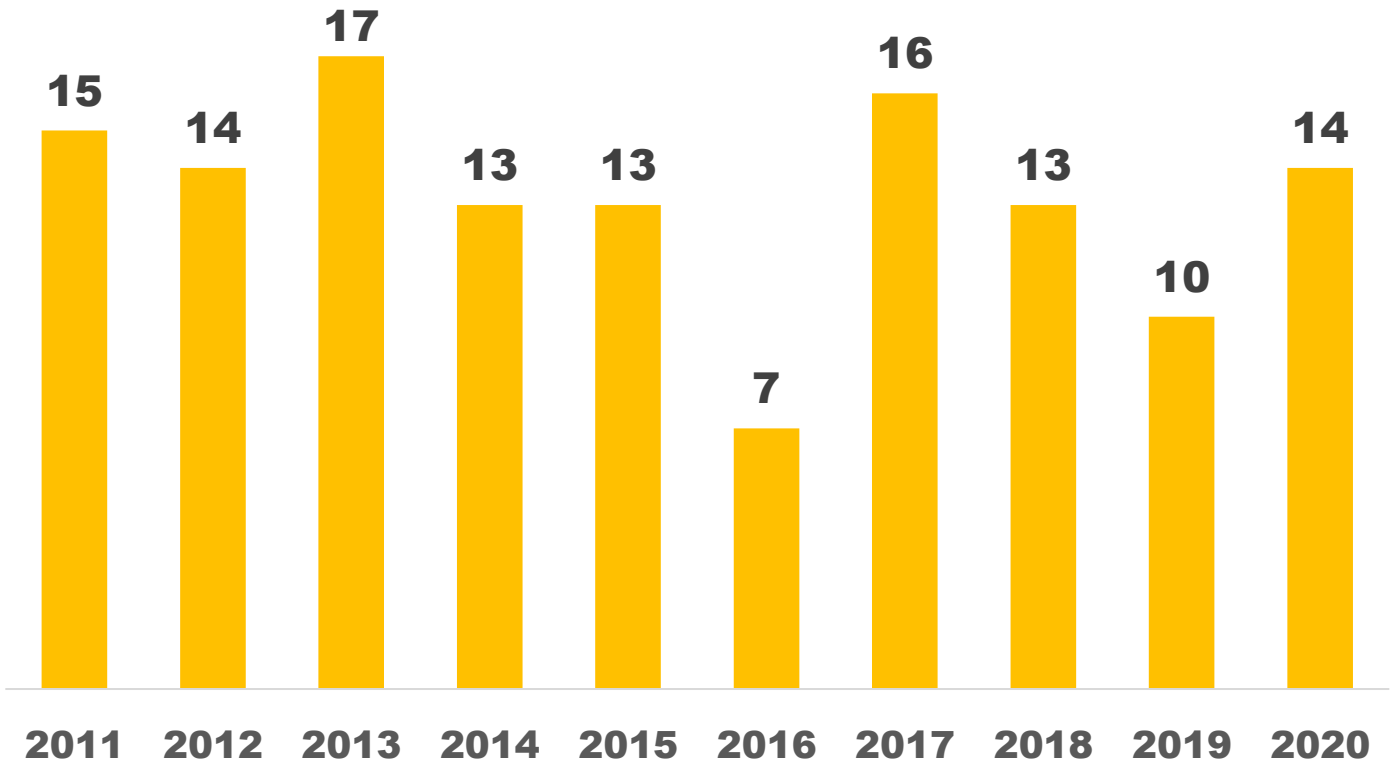
See also the recommendations contained in the 2017 report, *Eliminating Child Abuse and Neglect Fatalities in Baltimore City.*

Action Spotlight—BCDSS Policy & Practice

In 2020, BCDSS created a Fatality Prevention Specialist staff position that tracks unexpected child deaths to identify patterns, completing case and systems-level reviews to assess areas for improvement and prevention; conducts immediate and ongoing staffing meetings to ensure consistent and thorough investigations of child deaths; provides clinical support to BCDSS staff; and collaborates with local and state providers to strengthen multidisciplinary investigations and service provision to families and children. As opportunities for change are identified through CFR and internal reviews, BCDSS changes practice and procedures internally and makes recommendations for change at the state level. Changes include improved cooperation between BCDSS and the OCME to ensure timely access to information about the death and autopsy; providing medication lockboxes to families to prevent overdose deaths; developing tip sheets for workers on requesting and understanding medical records to better identify maltreatment; and collaborating to strengthen new worker training, focusing on critical thinking and assessment skills to improve worker decision-making.

C. SLEEP-RELATED INFANT DEATHS

From 2016 to 2020, there were 60 sleep-related infant deaths, ranging from seven to 16 each year. This is a decrease from 2011-2015, when there were 72 sleep-related infant deaths and these deaths were the leading cause of child fatality in Baltimore City. Thirty-six (60%) of the children were boys, and 24 (40%) were girls. Fifty-one (85%) of the children were non-Hispanic Black, five (8%) were non-Hispanic white, three (5%) were Hispanic, and the race of one (2%) was categorized as "other."



Sleep-related infant deaths undergo extensive investigation and, except in cases where clear evidence of asphyxia exists, reflect diagnoses of exclusion in which no natural or injury cause was found for a death that occurred during sleep. Unless the infant was found to be sleeping in a safe sleep environment, the suspected cause of these deaths is accidental suffocation. A safe sleep environment is defined by the American Academy of Pediatrics as the infant sleeping alone (without toys or soft bedding), on their back, in a crib or bassinet, and in a smoke-free environment.[4] In none of the 60 cases was the infant found to be in a safe sleep environment.

Fifty-two infants (87%) were sleeping outside of a crib or bassinet, and 36 (60%) were co-sleeping with adult(s) and/or child(ren) in an adult bed. Among the eight cases (13%) in which the infant was sleeping in a crib, toys and/or soft bedding were present in seven of the cribs. Of the cases in which the infant was sleeping outside of a crib, in 32 (53%), a crib was in the home, but it was almost always being used to store baby and household items. In seven cases (12%), no crib was in the home; often in these cases, the infants died in a relative or babysitter's home. In 13 cases (22%), it was unknown whether a crib was in the home.

In 39 cases (65%), the infant was confirmed to be exposed to tobacco smoke in the home; in 32 of these cases, the infant's mother smoked during pregnancy. In 29 cases (48%), the infant was exposed to illicit substances in utero, most commonly marijuana but also alcohol, opioids, and other drugs. Tobacco and substance exposure significantly increase risk for sleep-related infant death, with one-third of these deaths nationally being attributed to tobacco exposure alone. Risk is even more pronounced among infants who were born preterm/low birth weight, which was the case for 21 of the infants (35%).

In 44 cases (77%), the infant's mother placed the baby to sleep. However, in seven cases (12%), it was the father; in five (8%), it was a grandparent; and in four (7%), it was another relative or babysitter, which indicates the need for family and community safe sleep education rather than only for mothers.

87%	**Infants sleeping outside of a crib or bassinet**
80%	**Mother did not receive a PIMR**
65%	**Safe sleep education documented**
65%	**Confirmed tobacco exposure in the home**
60%	**Co-sleeping with adult(s) and/or children**
55%	**One or both caregivers were victims of maltreatment as children**
53%	**Had a crib in the home that was not being used**
50%	**Mother did not receive a PRA**
48%	**Confirmed substance exposure in utero**
35%	**Infant was born preterm/low birth weight**
27%	**Child's family had prior history with CPS**

Across review of all 60 cases, the theme that emerged was high family stress and overwhelm. Many caregivers were found to have experienced significant trauma and to have been involved with the child welfare system as children and adults. In 33 families (55%), one or both of the infant's parents

was named by CPS as a victim of maltreatment as a child, and in 16 (27%), one or both spent time in foster care as a child. In 16 cases (27%), one or both parents had been named by CPS as a perpetrator of maltreatment with this infant or a sibling prior to the death. In 22 families (37%), domestic violence was documented. In 46 families (77%), one or both parents had a history of criminal charges, and in 16 families (27%), one or both had been incarcerated. Thirty-four families (57%) were found to live in neighborhoods with high violent crime, further adding to family strain.

Likely related to the high level of family stress and history of trauma, one or both parents in 41 of the families (68%) had a documented mental health condition and, in 37 families (62%), had received mental health treatment. One or both parents in 46 of the families (77%) had documented substance use and, in 17 families (28%), had received substance use disorder treatment. Asking families to consistently follow safe sleep guidelines in stressful family environments in which one or both parents is coping with mental health and substance use disorders proves to be a difficult demand. To make it possible, health and social service systems must strive to remove all possible barriers to safe infant sleep, counsel persuasively and effectively, and connect parents to the resources they need to keep themselves and their families safe and healthy.

Unfortunately, the CFR Team identified gaps in vital services. In 21 cases (35%), there was no evidence that the family had received safe sleep counseling, whether by the birthing hospital, pediatrician, or another service provider. Fifty-six of the mothers were found to be eligible for the PRA, a critical referral for care coordination during pregnancy, and 55 were found to be eligible for a PIMR, a similar referral for care coordination following postpartum discharge. These referrals link mothers to an array of resources, including home visiting, safe sleep counseling, and, for those in financial need, a free crib. (See “Supporting Infants and Young Children” on p. 54 for more information and recommendations related to this system). However, only 28 eligible mothers (50%) received the PRA, and only 11 eligible mothers (20%) received the PIMR, leaving most of these families with limited access to supports.

Recommendations

No.	Issue	Recommendation
C.1	Infants put to sleep in unsafe sleep environments (e.g., co-sleeping in an adult bed with soft bedding)	Continue BHB SLEEP SAFE Campaign of mass media, community outreach, provider training, and free crib distribution to families in need, ensuring that clinics and other health and social services sites are displaying updated BHB SLEEP SAFE materials

Recommendations (cont.)

No.	Issue	Recommendation
C.2	Inconsistencies in providing and documenting safe sleep education at postpartum discharge despite ongoing outreach to birthing hospitals	Pass legislation in Maryland to mandate that all birthing hospitals provide and document evidence-based safe sleep counseling prior to postpartum discharge
C.3	Inconsistencies in providing and documenting safe sleep education at postpartum discharge despite ongoing outreach to birthing hospitals	Meet one-to-one with each of the seven city birthing hospitals to renew the commitment to safe sleep and ensure that safe sleep counseling and documentation is included in postpartum discharge workflow
C.4	High proportion of infants were born preterm/low birth weight and spent time in the NICU where safe sleep practices may not be modeled	Encourage the NICUs in city birthing hospitals to undertake quality improvement projects to model safe sleep practices and provide more extensive safe sleep counseling at NICU discharge
C.5	Caregivers commonly reported to the pediatrician that their infant was sleeping on their back in a crib even though investigation showed that cribs were being used for storage	Encourage pediatricians to ask questions that are more likely to yield accurate responses rather than socially desirable responses when engaging in safe sleep discussions (e.g., "How do you put your baby to sleep?")
C.6	High rate of tobacco exposure prenatally and in the home	Expand detailing of prenatal care and pediatric providers to improve tobacco smoking screening and cessation counseling, ensuring providers are trained to use Fax-to-Assist to refer to the Maryland Quitline
C.7	High rate of tobacco exposure prenatally and in the home	Develop a BHB SLEEP SAFE public service announcement (PSA) on limiting infants' exposure to tobacco smoke, to be shown on CharmTV and other television stations
C. 8	High rate of tobacco exposure prenatally and in the home	Refresh BHB's Just Hold Off secondhand smoke campaign and identify funding for mass media placements
C.9	High rate of marijuana exposure prenatally and in the home	Incorporate messaging about avoiding exposing infants to marijuana into the BHB SLEEP SAFE campaign and Just Hold Off campaign

Recommendations (cont.)

No.	Issue	Recommendation
C.10	High rate of marijuana exposure prenatally and in the home	Outreach prenatal care and pediatric providers on needs related to counseling patients on marijuana use and develop patient-facing education materials providers can disseminate
C.11	Missed opportunities for safe sleep education and awareness, especially in neighborhoods with multiple sleep-related infant deaths	Implement neighborhood and virtual canvassing after a sleep-related infant death in partnership with the Baltimore City Fire Department (BCFD) to alert families that free cribs are available to families in need and to provide education on safe sleep door-to-door
C.12	Missed opportunities to provide safe sleep education to expectant and parenting teens and to siblings of infants	Adapt BHB's SLEEP SAFE materials to address children and place them in all school health centers and suites
C.13	Missed opportunities to provide safe sleep education in the criminal justice system, where the majority of caregivers had had contact	Ensure the Baltimore Central Booking and Intake Center resumes showing BHB's SLEEP SAFE videos and ensure that they are shown at the Juvenile Justice Center
C.14	Caregivers co-sleeping with infants while under the influence of substances, particularly on weekends and holidays	Develop a PSA about safely providing care for infants and young children while under the influence of substances, to be shown on CharmTV and other television stations
C.15	Crying and fussiness at night leading caregivers to co-sleep with their infants	Develop a new short BHB SLEEP SAFE video on how to soothe a fussy baby that can be easily shared from mother to mother via social media
C.16	High levels of caregiver stress and trauma, especially for caregivers with mental health conditions and substance use disorder, make following safe sleep guidance challenging	Simplify BHB SLEEP SAFE messaging as much as possible and incorporate information and express empathy about perinatal mental health challenges and family stress and trauma
C.17	Caregivers purchasing secondhand sleeping devices that have been banned or recalled due to sleep-related infant deaths	Engage social media influencers to de-bunk myths about sleeping devices and develop materials for the BHB SLEEP SAFE campaign on banned devices and how to check whether sleep devices meet national standards

Recommendations (cont.)

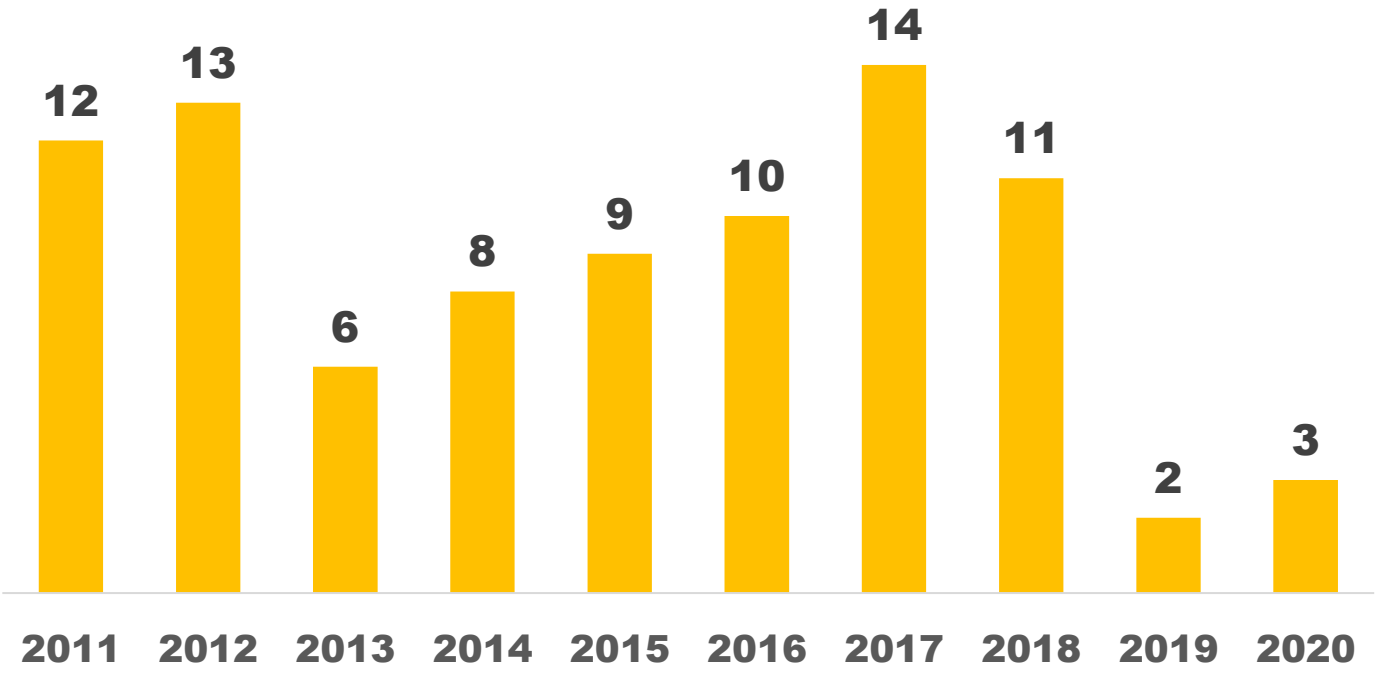
No.	Issue	Recommendation
C.18	Housing instability among families leading to challenges providing a safe sleep environment when living in a temporary arrangement	Ensure that organizations serving people experiencing homelessness show BHB's SLEEP SAFE videos and provide safe sleep education, including education on temporary safe alternatives to cribs when a portable crib is not available for the night

Action Spotlight—BHB SLEEP SAFE Campaign

In 2009, Baltimore City had 27 sleep-related infant deaths in a single year. In 2010, the BHB SLEEP SAFE Campaign was launched. SLEEP SAFE is a multipronged approach to preventing sleep-related infant death focused on the ABCDs of safe sleep—Alone, Back, Crib, Don't Smoke. From 2009 to 2020, sleep-related infant deaths have decreased by 48%. The campaign involves educating families about safe infant sleep, ensuring that health and family services providers all over the city provide consistent and evidence-based safe sleep counseling and supporting families in financial need to create safe sleep environments. The centerpiece of the campaign is a series of videos featuring real Baltimore families telling their stories of losing a baby to sleep-related death and sharing their motivation for putting babies to sleep alone, on their backs, in a crib, and in a smoke-free environment. Families receive individualized counseling through BHB's care coordination system operated by HCAM, in home visiting programs, in the hospital before they go home with their newborns, at the pediatrician's office, at WIC and DSS offices, and in the community—on billboards, on public transportation, on the radio, and on Facebook and Instagram. Families in financial need receive a free crib, and more than 600 cribs are provided to parents of newborns annually. More than 5,000 Baltimore City providers have been trained to counsel on the ABCDs of safe sleep.

D. ACCIDENTS

From 2016 to 2020, there were 40 accidental deaths (non-sleep related). This is a decrease from 2011-2015, when there were 48 accidental deaths. The children ranged in age from birth to 17 years old. Twenty-six (65%) of the children were boys, and 14 (35%) were girls. Twenty-nine (73%) of the children were non-Hispanic Black, seven (18%) were non-Hispanic white, and four (10%) were Hispanic.



Fifteen children (38%) died in six house fires; there were multiple sets of siblings among the victims. Twelve of the children were 5 years old and younger; infants and young children are least able to escape a fire or protect themselves on their own. Four of the fires were caused by electrical equipment that was used improperly or malfunctioned: two space heaters used too close to combustible material, extension cords run beneath carpeting, and a faulty air conditioning unit. One was caused by a pot left on the stove, and one was caused by unsupervised children playing with matches. In multiple cases, the smoke detectors in the home were found not to be working or without batteries, so people in the household had less or no time to evacuate.

Eleven children (28%) died in motor vehicle crashes. Nine were school-aged children with 16- and 17-year-olds in five of the cases. In no case was the child who died the driver. In five cases, speeding was the primary contributor to the crash; in two of those cases, the driver was under the influence of alcohol, and in another two cases, the driver was speeding away from police. In one case a child ran into the street in front of a car. In another, a child on a scooter without a helmet was struck by a car. In another, a child was sitting on an adult's lap when the car's accelerator malfunctioned. In another, a child was struck while standing on a highway after the car in which they were riding broke down. In cases in which the child was in a car, the child was not using a seat belt. In the two remaining cases, the children were toddlers. One ran unexpectedly into the street in front of a car. The other had unbuckled the car seat strap prior to the crash and was ejected from the car.

Six children (15%) died by drowning. Two were infants who drowned inside the home. The other four were children age 6 to 17. Two drownings occurred during pool parties at swimming pools outside of the city where there were several children in attendance and the child's condition was not noticed for several minutes. Two occurred during family outings in bodies of water outside of the city that could be dangerous to swimmers. These four children either could not swim or were poor swimmers.

Two children (5%) died of accidental discharge of a gun. One was a toddler who had easy access to a parent's gun, and one was a teen who was using the gun as a prop while recording a video.

The remaining six cases were accidents of other kinds, including choking, falling, furniture tip over, and opioid intoxication.

In 32 cases (80%), the CFR Team found that a caregiver's behavior had contributed to the accident that resulted in the child's death. In 22 cases, the caregiver had not provided adequate supervision or exposed the child to hazards, but the behavior did not rise to the level of child maltreatment. In 10 cases, the Team found that the caregiver's behavior did rise to the level of child maltreatment and was abusive or neglectful.

80%	**Caregiver behavior contributed to the death**
38%	**Children died in house fires**
28%	**Children died in motor vehicle crashes**
15%	**Children died by drowning**
5%	**Children died accidental discharge of a gun**
80%	**Caregiver behavior contributed to the death**

Recommendations

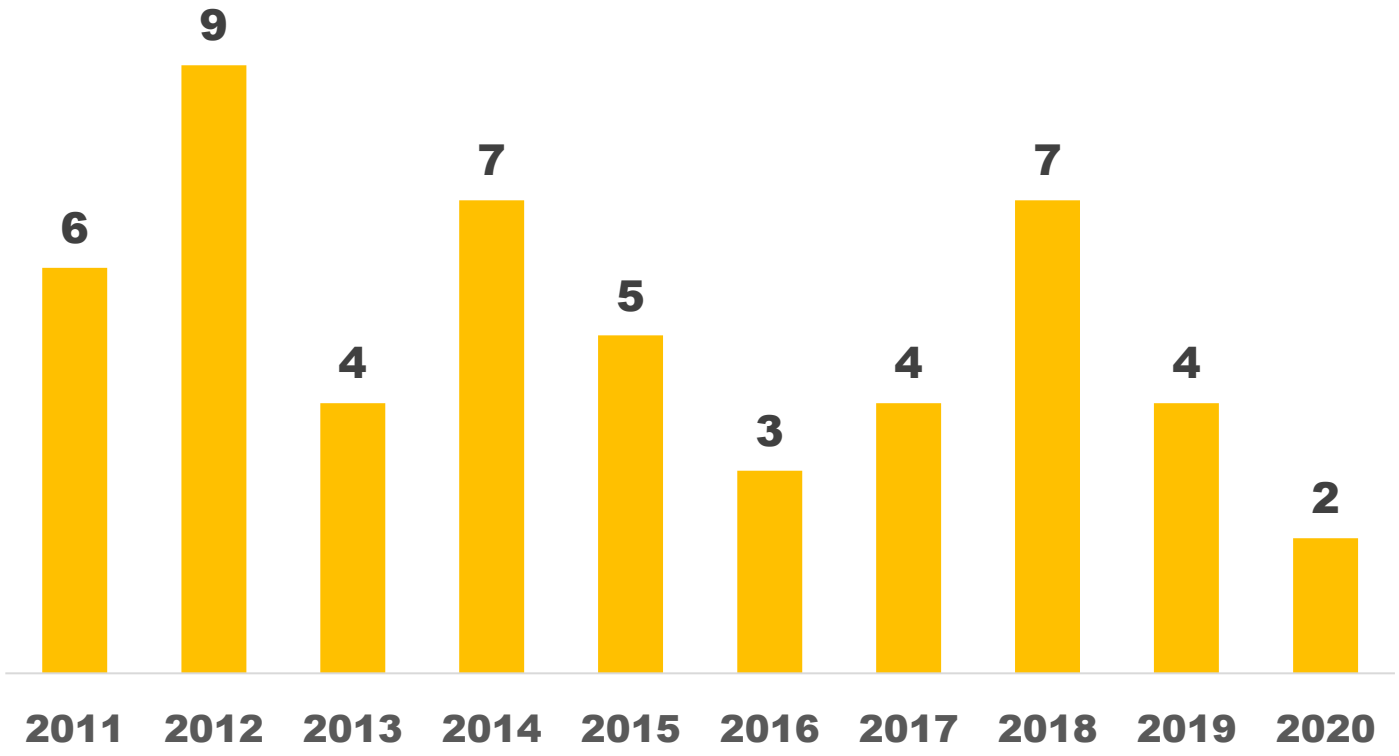
No.	Issue	Recommendation
D.1	Space heaters and extension cords used too close to combustible material	Disseminate education materials regarding safe use of space heaters and extension cords to families with young children via BHB partner organizations
D.2	Missed opportunities for fire prevention education in cold weather when people utilize space heaters	Include messaging about fire prevention in BCHD's standard Code Blue messaging
D.3	Nonfunctioning smoke detectors	Continue Baltimore City Fire Department canvassing following fire fatalities to provide free smoke detectors and installation to neighborhood residents
D.4	Nonfunctioning smoke detectors	Hold landlords of scattered-site properties accountable for having working smoke detectors in each residence
D.5	Speeding, alcohol use, lack of seatbelt use, and other behaviors that increase risk of fatality	Actively promote and provide support for Zero Deaths Maryland, the state's road safety campaign targeting speeding, seatbelt use, and other risky behaviors
D.6	Children lacked knowledge of water safety and had not been taught to swim	Increase opportunities for school-aged children in Baltimore City to learn water safety and swimming through the Department of Recreation and Parks
D. 7	Young child had easy access to a gun in the home	Encourage pediatricians to screen for guns in the home and counsel caregivers on safe gun storage

Action Spotlight—Inspector Detector Program

The Safe Kids Baltimore Coalition, led by the University of Maryland Children's Hospital, has worked for decades to prevent child injuries through car seat checkups, parenting workshops, and sports clinics. Following fatalities and injuries to young children in house fires in 2001, Safe Kids Baltimore and BCFD partnered to provide fire safety education for young school-age children in first through third grade. The Inspector Detector Program was created by a group of dedicated BCFD staff and is conducted as a highly energetic, engaging, and interactive presentation with repetition of key messages related to home fire safety. Following the presentation, children are presented with fire safety activity packets as well as a home fire safety checklist to share with the adults in their home. Between 2016 and 2020, Safe Kids Baltimore offered the program to all Baltimore City elementary schools, and an average of 24 schools (with an average of 3,800 children) chose to participate each year. Since the program's inception, more than 81,000 children have participated in the Inspector Detector Program. In 2020, the COVID-19 pandemic and related changes to City Schools and BCFD practices stimulated Safe Kids Baltimore to explore other potential avenues for delivering the key fire safety messages. Leadership within BCFD's Community Outreach and Education division is developing virtual presentations to use in the classroom, and they plan to launch the new program in 2022.

E. NATURAL DEATHS

From 2016 to 2020, 20 natural deaths occurred unexpectedly and were therefore investigated by the OCME. This is a decrease from 2011-2015, when there were 31 unexpected natural deaths. The youth's ages ranged from birth to 17, with 14 (70%) of the children age 5 or younger. Eleven (55%) of the children were boys, and nine (45%) were girls. Nineteen (95%) of the children were non-Hispanic Black, and one (5%) was non-Hispanic white.



Following investigation, the OCME determined that eight (40%) of the children died from infection, five (25%) died from a cardiac condition, five (25%) died from unexpected complications of an existing medical condition, and two (10%) died from asthma. In all but three cases, the CFR Team determined that the child's death was not preventable or that we could not determine whether the child's death was preventable. Two of the remaining three cases involved ongoing medical neglect that had not been reported to CPS. In the third, a caregiver had exposed the child to hazards that contributed to death. Twelve (60%) of the families in these cases had prior contact with CPS, and six (30%) of the children had been named as victims of maltreatment prior to the death.

30%	**Child was a victim of maltreatment prior to death**
15%	**Death determined to be preventable**
10%	**Death involved medical neglect**

Recommendations

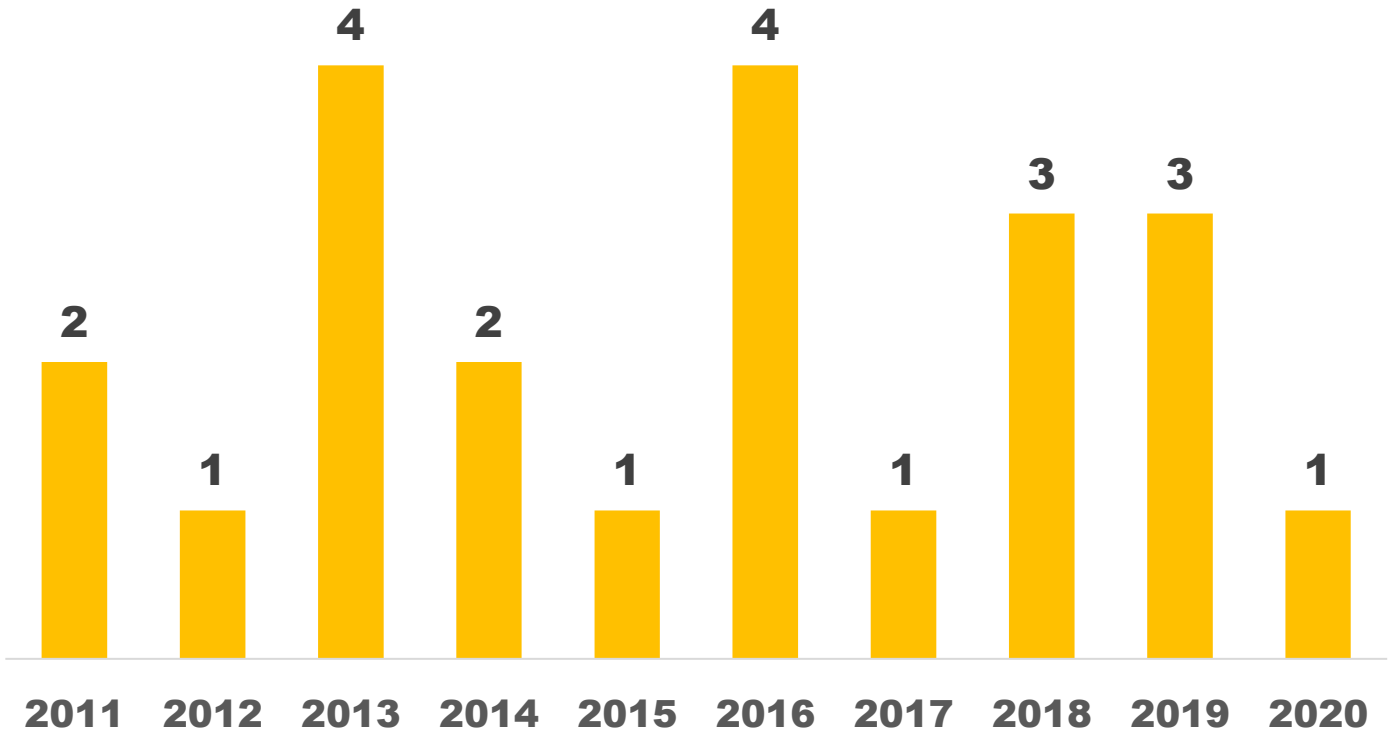
No.	Issue	Recommendation
E.1	Unfilled prescriptions for vital asthma medications	Institute more aggressive monitoring by all Medicaid managed care organizations of prescription utilization for asthma medications with earlier outreach and case management
E.2	Missed well-child and specialty care visits for children with chronic conditions needing regular follow up	Ensure that managed care organizations, pediatricians, and specialty providers submit a LHSR to HCAM when a child with Medicaid misses well-child care to initiate outreach and linkage back into care
E.3	Significant medical neglect went unreported to CPS	Ensure that content on medical neglect is included in trainings on child maltreatment for mandated reporters including health care providers and school personnel
E.4	Exposure to tobacco smoke in the home for children with asthma and other chronic conditions	Provide training and support for pediatricians to counsel caregivers on smoking cessation and harm reduction efforts

Action Spotlight—HCAM Care Coordination

HCAM provides care coordination and health care navigation services to Baltimore City residents with Medicaid through its Care Coordination Program. Managed care organizations and health care providers should submit LHSRs to HCAM when children are not receiving needed well-child and specialty health care, in order to trigger outreach to the family and linkage back into care; however, the CFR Team has found that the LHSR is often not submitted. In 2021, BCHD and HCAM presented Baltimore City CFR Team findings on missed pediatric care to the nine Medicaid managed care organizations operating in the city and pressed for the need to more closely monitor family adherence to well-child care visit schedules and utilize the LHSR for children who are not presenting for well-child care, especially children with chronic conditions. HCAM is monitoring the number of LHSRs received and continuing outreach and education to the managed care organizations in an effort to make sure children get the pediatric care they need.

F. UNDETERMINED DEATHS

From 2016 to 2020, there were 12 deaths of undetermined manner (non-sleep related). This is a slight increase from 2011-2015, when there were 10 deaths of undetermined manner. The children ranged in age from birth to 17 years old. Six (50%) of the children were boys, and six (50%) were girls. Nine (75%) of the children were non-Hispanic Black, and three (25%) were non-Hispanic white.



Deaths of undetermined manner are those that the OCME found it could not determine whether the death was due to intentional injury, unintentional injury, and/or natural causes. Eight of the deaths were to infants and young children. Six of these were to varying degrees suspicious for intentional injury. One additional case of an older child was also suspicious for intentional injury. In these cases, the children were found to have some degree of injury, but the injury did not appear severe enough to have caused the death and/or there was not sufficient evidence between the autopsy and investigation to distinguish whether the injury was intentional or unintentional. In multiple cases, the CFR Team believed that additional investigation could have led to more definitive evidence. (See "Multidisciplinary Investigation" on p. 51 for more information and recommendations

related to this issue) In the other two cases, no evidence of injury or natural cause was found on autopsy, and the deaths were unexplained. Six of the nine families had had prior contact with CPS; four of the children had been named by CPS as a prior victim of maltreatment. As with cases of child maltreatment homicides, there appeared to be significant family trauma as well as mental health and substance use concerns for the children's caregivers.

83%	**Team found the death was preventable**
58%	**Suspicious for child abuse**
25%	**Teen opioid overdose death**

Three cases (25%) were opioid overdose deaths of teens. It was undetermined whether these deaths were due to accidental overdose or intentional overdose (suicide). The CFR Team found no indication of suicide in any of the cases; however, only very limited information was available in one case. In each case, it was not known how the child obtained the drugs. None of the children had a documented history of using illicit substances, and none had received substance use disorder treatment. One had received mental health treatment.

Recommendations

No.	Issue	Recommendation
F.1	Teen who overdosed had been prescribed a benzodiazepine, which can raise the risk of overdose when taken with an opioid	Encourage all prescribers of psychiatric medication to educate patients taking benzodiazepines on the risks of opioid overdose
F.2	Lack of focus on youth in most existing opioid overdose prevention efforts	Ensure that City Schools and youth-serving organizations provide education on risks of opioid use and are included in the citywide opioid overdose prevention campaign

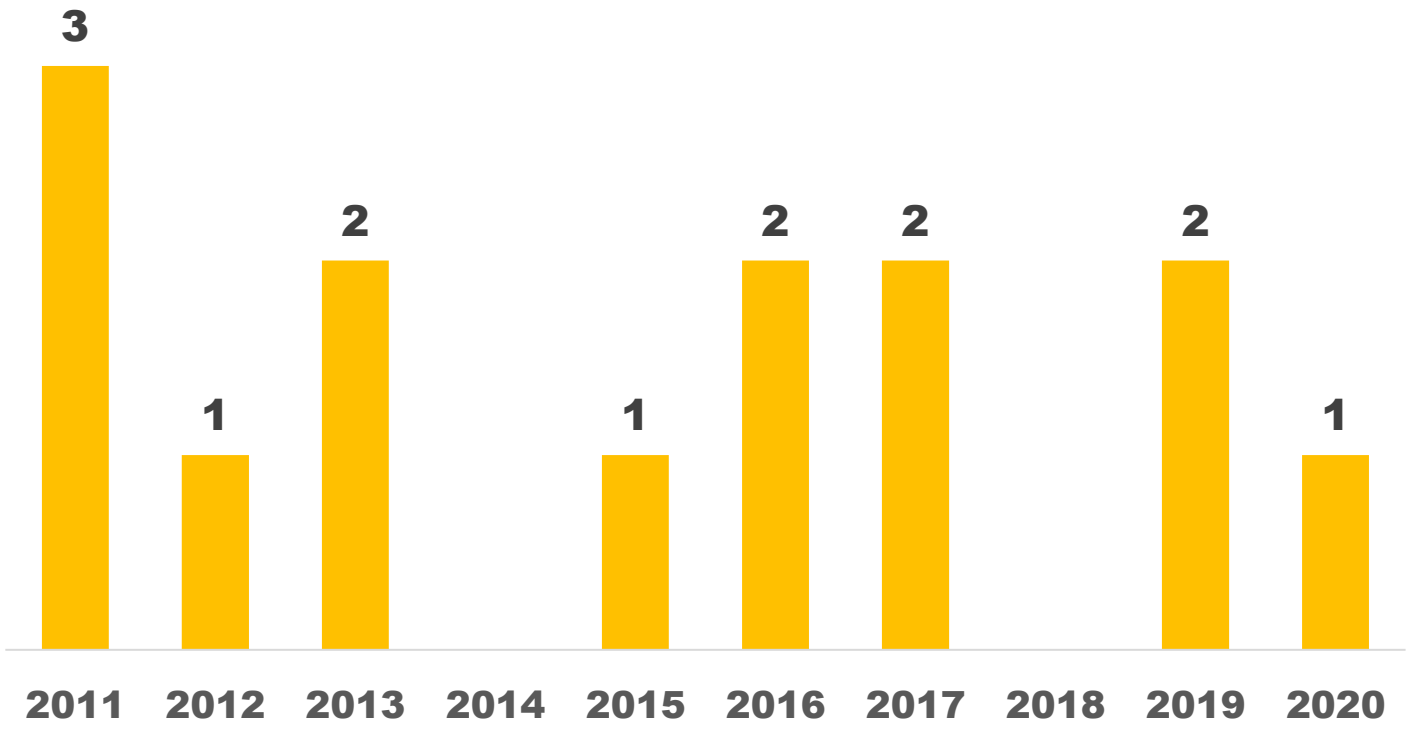
See also recommendations for the prevention of child maltreatment homicides on p. 26.

Action Spotlight—Opioid Overdose Prevention

BCHD has a five-pronged strategy for preventing opioid overdose: 1) saving lives with naloxone, 2) increasing access to on-demand, evidence-based treatment along with social and wraparound services, 3) fighting the stigma of addiction through education, 4) preventing substance use in Baltimore City's youth, and 5) utilizing data and trends to inform health strategies to increase the quality of life for residents of Baltimore. BCHD's Opioid Overdose Prevention Team is presenting across City Schools and in neighborhoods most affected by the opioid epidemic the KIDS OFF DRUGS (K.O.D) series, based on J-Cole's K.O.D album, "Kids On Drugs," to connect with youth through culture and art. There are group-led discussions on how the community and loved ones are affected by substance use disorders and what combating the epidemic looks like from the perspective of youth. The team has also partnered with Young People in Recovery to conduct outreach with youth in nontraditional settings such as barbershops, as well as to provide educational resources to youth in City Schools and youth-focused drop-in centers.

G. SUICIDES

From 2016 to 2020, there were 7 child suicides. This is equal to the number of suicides from 2011-2015. The youth's ages ranged from nine to 17. Six (86%) of the children were boys, and one (14%) was a girl. Five (71%) of the children were non-Hispanic Black, one (14%) was non-Hispanic white, and one (14%) was Hispanic.



In four (57%) of the seven cases, the child died by hanging. In two (29%), the child died by gunshot. Both guns were stored in the home and accessible to the child. In the one (14%) remaining case, the child jumped from a structure. In cases in which the information about the immediate circumstances preceding the child's death was known, the child had had an argument with a caregiver or teacher or experienced the breakup of a romantic relationship. Peers or siblings sometimes knew of the child's distress prior to the death but did not recognize the immediate danger to the child.

Although there was typically a known precipitating event, there were indications in most cases that the child had been emotionally vulnerable for some time prior to the death, experiencing either long-

term family discord or bullying in school that deeply affected them. In five (71%) of the seven cases, the child had been receiving mental health treatment that sometimes included multiple in-patient stays. Often children moved between numerous mental health providers, indicating lack of consistency with care.

71%	**Received mental health services**
71%	**Families received Family Preservation services**
43%	**Were confirmed to be bullied at school**
0%	**Had behavior problems in or DJS involvement**

All of the children were enrolled in City Schools. None had multiple suspensions in a single year or were involved with the juvenile justice system. Three (43%) were chronically absent, and two (29%) had an IEP and were receiving individualized education services. Families of five (71%) of the children had received Family Preservation services from the Baltimore City Department of Social Services for a range of supports including eviction prevention and assistance with utilities and purchasing basic necessities, indicating that the families were experiencing significant financial challenge.

Recommendations

No.	Issue	Recommendation
G.1	"Gatekeepers" who come into contact with struggling youth, including other youth themselves, are not aware of suicide risk and how to intervene	Increase access to suicide "gatekeeper training" (e.g., Mental Health First Aid) for youth, community members, families, schools, and first responders
G.2	Most children were receiving pediatric care, and pediatricians are trusted and well-positioned to screen and counsel on suicide prevention	Train pediatricians in primary care and emergency department settings to screen for suicide risk and provide brief suicide prevention interventions, such as counseling on reducing access to lethal means and safety planning
G.3	Children with multiple in-patient psychiatric stays are at high risk and require more coordination and follow up	Use technology such as CRISP (Maryland's regional health information exchange) to alert pediatricians when youth have had in-patient psychiatric stays to enable them to coordinate follow-up care

Recommendations (cont.)

No.	Issue	Recommendation
G.4	Missed opportunities by behavioral health providers to screen for suicide risk and intervene	Institute suicide screening and lethal means counseling policies in behavioral health care settings that serve youth and train providers to screen and counsel
G.5	Family resistance to obtaining mental health services and supports	Implement messaging campaigns focusing on reducing stigma and awareness of suicide and behavioral health needs as well as the behavioral health services available in Baltimore City across service sectors, including youth- and family-serving systems, schools, and communities
G.6	Bullying in school that appeared to go unreported and/or unaddressed	Operationalize processes for identifying, addressing, and reporting bullying in City Schools, highlighting the link between bullying, behavioral health needs, and suicide
G.7	Longstanding emotional and mental health challenges experienced by the children	Implement universal, evidence-based early interventions for emotional and behavioral health across all schools and Head Start programs

Action Spotlight—School Wellness Support Teams

To support students' social and emotional well-being, all of City Schools' traditional schools have at least one full-time equivalent school social worker on staff, with some schools having up to four, based on the size of the school. School psychologist time is based on a formula of 1:850 students. Although the primary role of the school social workers and psychologists is to provide services to students with IEPs or 504 plans, supports are also provided to the overall school community. For the 2021-2022 school year, with the return to full-time in-person learning, school social workers and psychologists are working collaboratively as members of the School Wellness Support Team in each school. The team also includes the Student Wholeness Specialist, Expanded School Mental Health providers, the school counselor, and the school nurse as they are available in each school. These teams make school-wide presentations and morning announcements and hang posters in the building with QR codes linked to Google Classrooms for resources and connections to the team members for individual appointments. Each team also created a video featuring the supportive services it offers and shared the video with students. In addition, school social workers and psychologists hold trainings with staff on child abuse, suicide prevention, and bullying every year. Go Guardian/Beacon is a program that alerts clinicians and school administrators when students are searching online using terms that indicate self-harm or violence. The clinicians follow up with the students and/or family members to assess safety and offer additional supports. When a crisis such as the death of a student does occur, City Schools has a crisis response plan to support the school community. Clinicians from surrounding schools are called in for support, as are Employee Assistance Plan services for staff.

4

CROSSCUTTING ISSUES AND RECOMMENDATIONS

Several crosscutting issues emerged over the course of case review that relate to how we as a city investigate deaths, support young children and school-age children and their caregivers, and address the significant trauma and adversity that families face.

H. MULTIDISCIPLINARY INVESTIGATION

When cases of serious child injury not resulting in death that are suspicious for child abuse are investigated in Baltimore City, there is typically a multidisciplinary team meeting—medical professionals, CPS workers, police detectives in the Baltimore Police Department (BPD) Child Abuse Unit, and the State's Attorney's Office (SAO) Special Victims Unit collaborate to share investigative information and ensure the safety of the child and other children in the home (see Action Spotlight—Multidisciplinary Teams below).

However, when a child dies and the death is either initially unexplained or there is injury suspicious for child abuse, these cases are instead investigated by the OCME and BPD's Homicide Unit. Following a policy change in 2019, in part stemming from CFR Team recommendations, Baltimore City CPS opens an investigation for each of these cases as well; previously, CPS typically declined to investigate most cases in which there was not visible injury. Recently, in special circumstances, there have been multidisciplinary team meetings in which the investigative agencies meet to share information and collaborate on a fatality investigation; however, these meetings remain rare for fatalities.

86% **Fatalities of infants and toddlers that were initially unexplained or suspected to be related to child maltreatment**

The CFR Team identified cases in which investigation of deaths that were initially unexplained was inadequate and, in a few cases, jeopardized the safety of other children in the home as a result. In one particularly tragic case, a toddler's death was unexplained and without visible injury, but the child had internal injuries that the medical examiner suspected resulted from abuse. The medical examiner requested that police interview the other children in the home at the time of the child's death to learn more about the circumstances surrounding the death. Police declined, indicating that they believed the explanation of the child's caregiver. The death was ruled to be undetermined, and no action was taken regarding the child's caregiver. A year and a half later, the child's mother put her new infant in the care of the same caregiver, believing the caregiver had not been responsible for the toddler's death, and the new infant died in her care, again under highly suspicious circumstances.

It has been observed by the team that in the case of many infant and toddler deaths, if there is no clear bruising or physical trauma, the investigating agencies wait for the autopsy report before they

thoroughly investigate. It is not uncommon for the medical examiner to see no physical evidence of injury in suffocation deaths of a young child. It often takes weeks and sometimes months for autopsies and related testing to be completed. Vital information that could aid in investigation is lost during that time. Further, CFR found that agencies often do not share investigative information with each other. In cases in which a young child's death was determined to be caused by opioid intoxication, for example, the child's death is usually initially unexplained with no visible injury. When the toxicology test comes back positive several weeks later, there is no procedural expectation that the OCME notify CPS so that it can re-assess the safety of other children in the home and make a maltreatment determination. In some cases, CPS has only learned that a death has been ruled a homicide from reports in the media.

Several jurisdictions around the country have implemented multidisciplinary team meetings within 48 to 72 hours following a child fatality to improve communication and information sharing between medical professionals and investigative agencies. New York City's Instant Response Team and Philadelphia's Act 33 Team, named for its enabling legislation, offer potential models for implementation of such team meetings in Baltimore City.

Recommendations

No.	Issue	Recommendation
H.1	Inadequate investigation of deaths of young children that are initially unexplained	Provide thorough training to investigative agencies in infant and young child death investigation
H.2	Challenges with information sharing across investigative agencies	Institute an MOU outlining information sharing practices across investigative agencies and a policy for multidisciplinary staffings following deaths that are initially unexplained or suspicious for abuse

Action Spotlight—Multidisciplinary Teams

In an effort to reduce child trauma, gather evidence, share information and professional expertise, and coordinate the most effective response possible, multidisciplinary approaches to child abuse investigations were created in the 1980s. Today, rather than each agency responding to child abuse and neglect by conducting their own investigation, agencies collaborate. Multidisciplinary team (MDT) investigations facilitate communication between investigating entities and experts from partner agencies that are engaged with victims of maltreatment and their families. The goal is to improve care, decrease bias in assessment and reporting of maltreatment, and support education of the community and medical providers regarding identification of signs of abuse and neglect. Ultimately, this effort provides all parties with the critical information they need in a time sensitive manner to respond to an allegation and help a child and family. MDTs are codified into law under Maryland Family Law 5-706 and their use is considered a best practice by the U.S. Department of Justice and the National Children's Alliance.

The Pediatric Emergency Department at Johns Hopkins Hospital (JHH) is the designated center for the assessment of physical child abuse for Baltimore City. More than 1,000 children who are suspected to have been abused present for assessment annually. In addition, JHH is the regional pediatric trauma and burn center. It is critical, in such a medical environment, to recognize that children are specifically vulnerable to inflicted trauma. The Johns Hopkins Child Protection Team is an MDT that includes providers from emergency medicine, child abuse pediatrics, social work, and child life. They provide specialized consultation, comprehensive physical exams, and forensic interviews, and they liaison with community-based investigators from the Baltimore Police Department (BPD), CPS, and the Office of the State's Attorney (SAO), as well as medical personnel.

At LifeBridge Health's Center for Hope (CFH; formerly known as Baltimore Child Abuse Center) is the designated response center for all child sexual abuse, sexual assault, and witness to homicide investigations in Baltimore City. CFH's medical team provides non-acute evaluations for children with suspected sexual abuse, and they coordinate with the University of Maryland Medical Center and Mercy Medical Center, which perform acute sexual abuse exams. The CFH medical team also provides medical examinations for children entering foster care. CFH is also the state's designated Regional Human Trafficking Coordinator for Baltimore City. Both MDTs utilize forensic interviewers to assist investigative units from BPD, CPS, and the SAO. CFH hosts all interviews on site, providing child life, social work, and case management for children and families, as well as connections to mental health treatment (both onsite and with partner agencies) and other resources.

I. SUPPORTING INFANTS AND YOUNG CHILDREN

In Baltimore City, with funding from Maryland Medicaid as well as public health dollars, HCAM operates a centralized intake system for all pregnant women and infants who are recipients of or eligible for Medicaid. This safety net system is the bedrock for the success of the city's BHB infant mortality prevention initiative. It is the single point of entry for critical health and community-based services for families, including prenatal and early childhood home visiting, perinatal mental health care, substance use disorder treatment, smoking cessation programs, and WIC. Baltimore City prenatal and early childhood home visiting services include the evidence-based Nurse-Family Partnership and Healthy Families America programs, which are widely considered frontline prevention strategies for child abuse and neglect, and the Healthy Start model for preventing infant mortality.

Pregnant women are referred to the centralized intake system by their prenatal care providers, who are required by Maryland Medicaid regulations to submit a PRA for each pregnant woman at her first prenatal care visit. Mothers and infants may also be referred following delivery; birthing hospitals are requested to submit a PIMR at postpartum discharge when mothers have psychosocial risk factors and/or deliver infants who are born at low birth weight or have had a stay in the NICU. Upon receipt of a PRA or PIMR, HCAM nurses, social workers, and care coordinators outreach each woman, assess her needs for care and eligibility for health care and community services, and link her to these services. Each woman is also assessed for eligibility for a free crib, which is delivered to her home if she is eligible, and all are provided with safe sleep education.

86%	**Eligible for a PRA and PIMR**
84%	**Did not receive a PIMR**
62%	**Rate of successful prenatal outreach**
60%	**Rate of successful postpartum outreach**
44%	**Did not receive a PRA**
11%	**Enrolled in home visiting services**

CFR closely examines mothers and infants' path through the centralized intake system and utilization of home visiting services; data analysis by BCHD has shown that mothers who do not receive a PRA,

and therefore are not linked to services, are 5.1 times more likely to experience a fetal or infant death. In 95 (86%) of the 111 cases in which the child was under the age of 3, mothers were determined to have been eligible for the PRA and PIMR. However, only 53 received a PRA, a submission rate of only 56%. Worse, only 15 received a PIMR, a submission rate of only 16%.

After HCAM received these referrals, many mothers proved difficult to outreach. HCAM successfully outreached 33 (62%) of the 53 mothers who received a PRA and nine (60%) of the 15 mothers who received a PIMR. Women who are unable to be located during outreach often have recently disconnected cell phones or unstable housing; they may also be avoiding contact as a result of distrust, sometimes believing that the outreach worker is affiliated with CPS, or fear of being stigmatized as a result of experiencing a substance use or mental health disorder. With public health dollars, HCAM employs a community health advocate who is able to use creative tactics and work outside of otherwise strict Medicaid outreach timelines to improve engagement of hard-to-reach pregnant women and mothers.

Only 12 mothers (11% of all 111 cases) were ultimately enrolled in home visiting services. Many mothers who were successfully outreached refused home visiting due to lack of interest. Prioritizing access to home visiting services for families at highest risk is a key national recommendation for preventing child fatalities. As documented by the Pew Charitable Trusts, Baltimore City is ahead of the curve with its coordinated home visiting system utilizing evidence-based models and a centralized intake system for assessing eligibility. Following ongoing findings and recommendations from Baltimore City CFR, several projects have been long underway to improve the centralized intake system, starting with extensive outreach to prenatal care providers and birthing hospitals to improve completion rates for PRAs and PIMRs and efforts to pilot and now scale up an electronic version of the PRA.

Recommendations

No.	Issue	Recommendation
I.1	PRA not submitted leading to missed opportunities for care coordination	Advocate for Maryland Medicaid to hold prenatal care providers accountable for submitting PRAs at the first prenatal care visit according to existing Medicaid regulations
I.2	Barriers to completing the PRA	Scale up adoption of BCHD's successful pilot of the ePRA by all major prenatal care providers in the city to increase PRA submission
I.3	PIMR not submitted leading to missed opportunities for care coordination	Continue to outreach and train social work staff at all Baltimore City birthing hospitals to complete the PIMR for eligible patients

Recommendations (cont.)

No.	Issue	Recommendation
I.4	PIMR not submitted leading to missed opportunities for care coordination	Pass legislation to mandate the submission of the PIMR by the birthing hospital for mothers and infants who meet criteria
I.5	Mothers unable to be successfully outreached using traditional methods	Increase the capacity of HCAM's community health advocate workforce to use creative strategies to outreach women who are unable to be located through traditional outreach
I.6	Telephonic outreach less successful for highest risk families	Fully fund HCAM's prenatal and infant care coordination system so that a higher-touch model incorporating face-to-face visits can be implemented
I.7	Lack of interest in home visiting among high-risk mothers	Emphasize to eligible mothers that home visits can be conducted anywhere the mother chooses and frame home visiting services as personal coaching services

Action Spotlight—Care Coordination Hubs

In response to CFR findings that pregnant women and mothers who are unable to be located through traditional outreach have children who are at higher risk of fatality, BHB worked to expand HCAM's small community health advocate workforce. Through a partnership of Family League of Baltimore, HCAM, City Schools, and BCHD, with funding from the Governor's Office of Children, HCAM hired five additional community health advocates in 2020. Each one is embedded in one of the city's 12 Judy Centers—early childhood centers operated by City Schools charged with connecting with pregnant women and young children in the school's catchment area to increase their readiness for school. Together the community health advocates and Judy Center staff proactively outreach pregnant women and families with young children in the community, building trust through events such as community baby showers. HCAM care coordinators refer pregnant women and mothers they are unable to successfully outreach through traditional means to the community health advocates, who use creative strategies to locate the women at a rate of more than 90%. Then they provide care coordination services through these community hubs, linking women who would otherwise have been lost to the system to home visiting programs and other critical health and community services.

J. SUPPORTING SCHOOL-AGE CHILDREN

Although most school-aged children appear to be at lower risk of fatality than young children, at least until age 16, there may be clusters of risk factors for fatality that emerge when looking across public systems that serve families. During 2016-2020, 84 school-aged children (5 to 17 years) died. Two were never enrolled in City Schools, and six had withdrawn from school at the time of their death.

Many of the children struggled with both attendance and academics. (Note that the following school-related data is likely an undercount due to a period when the CFR Team had difficulty obtaining data from City Schools.) Fifty-seven children (68%) were chronically absent from school. Thirty-four (40%) had repeated at least one grade, and many others were noted to be failing all or most classes. Twenty-four children (29%) had been referred to their school's Student Support Team for intervention for attendance and/or academics; children who were not referred to the Student Support Team may have received other interventions, but these were not reported to the CFR Team. Twenty children (24%) had attended an alternative school for children who are under-credited for their age.

Seventeen children (20%) had an IEP for a developmental, intellectual, or emotional disability and were receiving special education and other individualized supports. A larger proportion of children were receiving mental health care; 45 children (54%) had

68%	**Chronically absent**
61%	**Received BCDSS Family Preservation services**
54%	**Received mental health treatment**
45%	**Involved with the juvenile justice system**
40%	**Had repeated a grade**
29%	**Received a Student Support Team referral**
24%	**Enrolled in an alternative school**
20%	**Had an IEP**
15%	**Received substance use disorder treatment**

received mental health care in the public behavioral health system. Thirteen (15%) had received substance use disorder treatment. A significant proportion of the children were involved with the juvenile justice system. Thirty-eight (45%) had been charged in the juvenile system, and 17 (20%) were at some point committed to DJS. The families of 51 children (61%) had received Family Preservation services from BCDSS, including eviction assistance and non-CPS challenges involving the children and/or siblings.

Only 12 children (14%) were not chronically absent, had not repeated a grade, and were not involved with the juvenile justice system. Of those, only four children (5%) were in families that also had not received BCDSS Family Preservation services. Though the total number of school-age children in Baltimore City struggling with any one of these issues may be large, the accumulation of risk factors across public systems should alert us to risk of fatality and prompt us to act to ensure that children get the support they need to survive and thrive.

Recommendations

No.	Issue	Recommendation
J.1	No single agency has the full picture of what is happening for youth; each agency has a partial picture that if combined would reveal youth at high risk for fatality and in need of intervention	Create an integrated data system across major child- and family-serving agencies (e.g., City Schools, DJS, BCDSS) with proper privacy controls that would alert agencies to youth with risk factors for fatality across systems

Action Spotlight—Local Care Team

Baltimore City's Local Care Team (LCT) strives to pair the families of children and youth with intensive needs with the resources and solutions to thrive and be successful. This interagency team is convened by Family League of Baltimore and has been maintaining case reviews virtually during COVID. Partners include BCHD, City Schools, BHSB, the Department of Disabilities Administration, DJS, BCDSS, the Mayor's Office of Children and Family Success, and the Maryland Coalition of Families. Family League's LCT manager works with parents, guardians, and other adults on children's behalf to coordinate administrative needs to get before the LCT and assist in connecting interagency care, as recommended by the Team. The purpose is to educate families and communities, provide clear navigation though the city's agencies, brainstorm, share knowledge, advocate, and develop strategies to help children thrive. All children for whom caregivers are seeking a voluntary foster care placement are required to be referred to the LCT. The LCT has membership with the Crossover Youth Workgroup and the Baltimore City Children's Cabinet to help ensure that the LCT stays ahead of emerging needs and trends and connect with key stakeholders.

K. ADDRESSING PARENTAL SUBSTANCE USE

Across nearly every major cause of child fatality, caregiver substance use played a significant role. In 132 cases (63%), one or both caregivers of the child who died were documented to use substances and, in 62 cases (30%), had received substance use disorder treatment.

The CFR Team confirmed that nearly half (48%; 53) of the 111 infants and one- and two-year-olds who died had been exposed to substances in utero, and one in five (20%; 22) had been reported to BCDSS as a substance-exposed newborn following a positive toxicology test at delivery. At a national level, it is estimated that 10-11% are exposed to substances in utero.[5] Substance exposure in utero has been demonstrated to increase risk for sleep-related infant death.[6] Further, an infant co-sleeping with someone who is impaired in the ability to arouse due to sedating medications including alcohol and illicit drugs is at high risk of suffocation.[7] Several caregivers in cases of sleep-related infant death reported having used alcohol or illicit drugs prior to co-sleeping with their infants; in others, evidence of recent substance use was found in the home.

Substance use appeared to play a role in several homicides and accidental deaths of young children. In 19 of 24 child maltreatment homicides, one or both caregivers were found to use substances. In one infant homicide, for example, a substance-exposed newborn home from the hospital was severely burned by a caregiver

63%	**One or both caregivers used illicit substances**
48%	**Infants, one-, and two-year-olds exposed to substances in utero**
45%	**One or both caregivers had been charged with drug possession**
34%	**One or both caregivers had been charged with selling drugs**
30%	**One or both caregivers received treatment for substance use disorder**
20%	**Infants, one-, and two-year-olds reported as substance-exposed**

under the influence of illicit drugs who then delayed medical care for fear of CPS involvement. In another infant homicide, a 5-month-old who had been a substance-exposed newborn was found to have numerous new injuries and injuries in various stages of healing indicative of ongoing abuse; both caregivers were polysubstance users who sold drugs in the presence of the infant. Seven children age nine and younger died of opioid intoxication; in six cases, a caregiver was found to have, intentionally or unintentionally, exposed the child to the drugs. In two cases, one ruled a homicide and the other an accident, the child's caregiver was driving under the influence of alcohol and caused the child's death.

Overall, caregiver substance use had led to significant involvement with the criminal justice system. One or both caregivers in 94 cases (45%) had been charged with drug possession, and, in 70 cases (34%), with the sale of drugs. Intergenerational involvement in the city's drug trade was a theme among child victims of third-party homicides; most youth who were believed to be selling drugs had a caregiver who had been charged with selling drugs. Drug use and sale appeared to be a major source of family instability and intergenerational child welfare involvement across the range of child fatality cases.

Substance use disorder is highly associated with having experienced trauma, especially trauma in childhood.[8] Although the CFR Team frequently had little information about the childhoods of the caregivers in child fatality cases, we did learn of their child welfare history with BCDSS. Of the 132 cases in which one or both caregivers used substances, in 72 cases (55%), one or both caregivers had been named by CPS as a victim of maltreatment as a child. In 38 (29%) of those cases, one or both caregivers had been in foster care, many for several years or more. This data offers just a narrow window into the life experiences of these caregivers but portends of significant trauma and adversity. Parents and caregivers using substances need compassionate support to address their substance use and help them keep their children safe and healthy.

Recommendations

No.	Issue	Recommendation
K.1	Missed opportunities to identify and intervene with pregnant women and caregivers using substances	Conduct universal screening using SBIRT (Screening, Brief Intervention, and Referral to Treatment) of pregnant women and caregivers by prenatal care providers, birthing hospitals, and pediatricians

Recommendations (cont.)

No.	Issue	Recommendation
K.2	Provider uncertainty about how to get their patients help as a barrier to screening for substance use	Promote the city's Here2Help Line to prenatal care providers, birthing hospitals, and pediatricians as a resource to help pregnant women and caregivers access substance use disorder treatment
K.3	Positive toxicology found at delivery but infant not reported by the hospital as a substance-exposed newborn	Provide clear training to birthing hospitals in the state on the law and practices related to reporting substance-exposed newborns covering recent changes in law
K.4	Simultaneous but uncoordinated outreach by BCDSS and the centralized intake system at HCAM to families of substance-exposed newborns	Enhanced care coordination for substance-exposed newborns with collaboration between the centralized intake system at HCAM, home visiting programs, and BCDSS
K.5	Pregnant women and mothers using substances unable to be located by the centralized intake system at HCAM	Ensure that all pregnant women and mothers with substance use who are unable to be located by the centralized intake system at HCAM receive creative, longer-term outreach
K.6	Substance-exposed newborns at greater risk of sleep-related infant death	Provide more extensive safe sleep counseling support when BCDSS is assessing safety and needs for families of substance-exposed newborns
K.7	Lack of provider knowledge and skills for working effectively with caregivers with substance use disorder	Provide ongoing training across health and social service systems on evidence-based and best-practice approaches to working with caregivers with substance use disorders and infants with prenatal substance exposure, ensuring that education includes information about the effects of stigma and bias on the outcomes of caregivers and their children
K.8	Missed opportunities to address the needs of people with substance use disorder in their role as caregivers	Integrate parenting education and support services into substance use disorder treatment, pediatric care, adult health care, and criminal justice settings (e.g., Baltimore Central Booking and Intake Center)

Recommendations (cont.)

No.	Issue	Recommendation
K.9	Lack of trust in traditional service providers and demonstrated effectiveness of peer models	Widely utilize models such as recovery coaches, peer mentors, navigators, and other forms of parent support that connect caregivers using substances with other people who have similar lived experience and are able to provide credible, trusted guidance and support

Action Spotlight—Substance-Exposed Newborns Collaborative

Recognizing the need for a comprehensive, collaborative approach to supporting families of substance-exposed newborns, BCDSS partnered with BCHD, HCAM, Family League of Baltimore, BHSB, and health care organizations to form the Substance-Exposed Newborns (SENs) Collaborative. The partners are entering into an MOU with the goals of building a cross-system collaboration to improve communication, coordination, and sharing of resources; jointly proposing and implementing plans to improve the SEN assessment and services; identifying and addressing gaps in service delivery; and increasing access to services to achieve positive outcomes and preserve families. Several partners have participated in comprehensive multidisciplinary training on substance-exposed newborns created by the University of Maryland Baltimore County Home Visiting Training Center to deepen their understanding of addiction and recovery, enhance communication and relationship skills, and develop approaches to engage, retain, and meet the needs of substance-exposed pregnant and postpartum women.

L. RECOGNIZING TRAUMA AND ADVERSITY

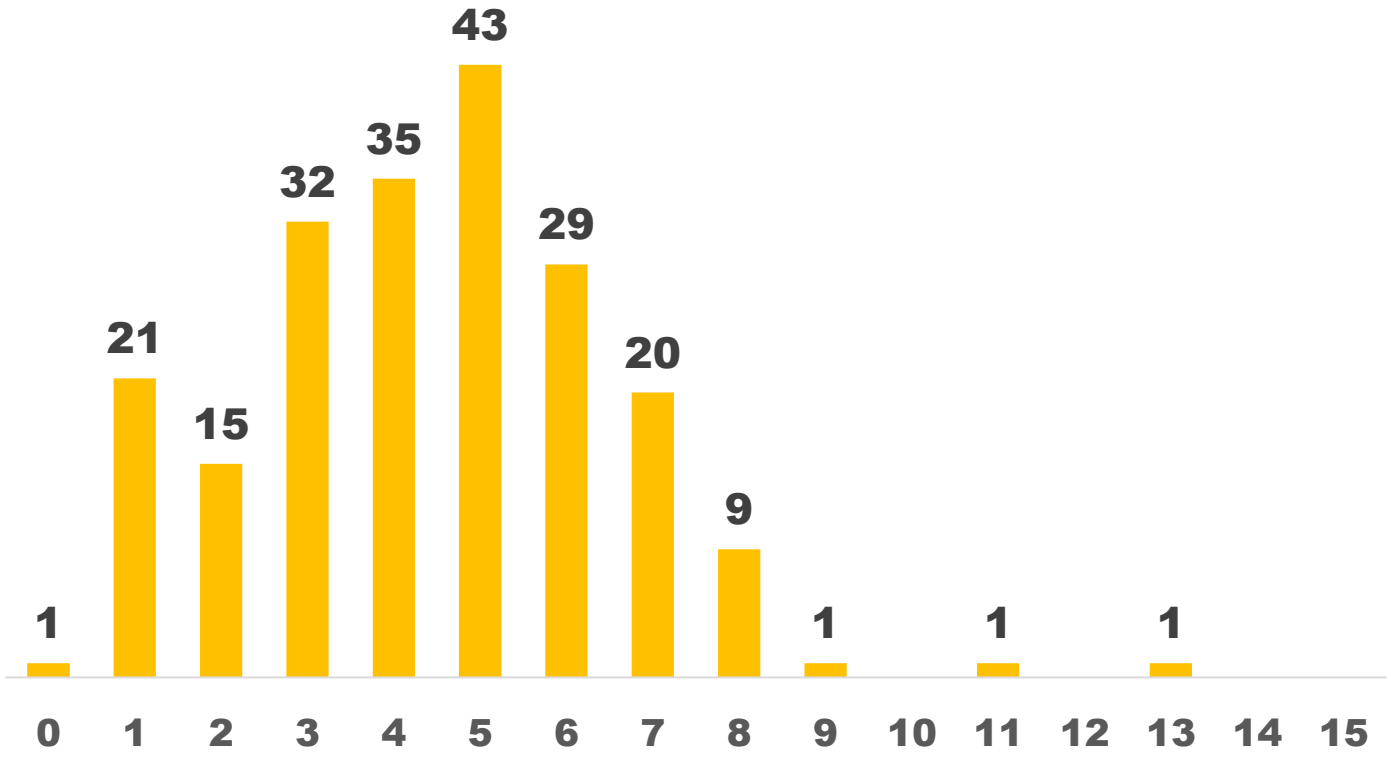
Since 2016, the Baltimore City CFR Team has been tracking the adverse childhood experiences (ACEs) of the children whose cases we review. From the groundbreaking ACE Study conducted by the U.S. Centers for Disease Control and Prevention (CDC), we know that children who experience adversity are at risk for a broad range of later health challenges, from depression to heart disease to cancer to early death.[9] The risk is cumulative; as the number of ACEs a child experiences accumulates (the ACE score), so does that child's risk for later poor outcomes increase. The CDC has found that 61% of U.S. adults have experienced at least one ACE and that about one in six U.S. adults (17%) has experienced four or more of the 10 types of ACEs covered by the study. Experiencing four ACEs has been shown to be a tipping point, where risk for poor outcomes rises sharply.

Baltimore City CFR tracks 15 ACEs—the 10 ACEs included in the original CDC study related to child maltreatment and household dysfunction as well as the five additional "urban" ACEs first identified by the city of Philadelphia during its citywide ACEs study.[10] The urban ACEs include living in a violent neighborhood, witnessing violence, experiencing bullying, experiencing racism, and being in foster care. When attributing an ACE to a child, the team only did so when there was documented evidence (e.g.,

90%	**Racism**
63%	**Caregiver substance use**
63%	**Violent neighborhood**
56%	**Caregiver mental illness**
42%	**Caregiver separation or death**
35%	**Caregiver domestic violence**
30%	**Physical neglect**
30%	**Caregiver incarceration**
10%	**Physical abuse**
7%	**Witnessing violence**
7%	**Foster care**
3%	**Sexual abuse**
3%	**Bullying**
1%	**Emotional neglect**
0%	**Emotional abuse**

attributed the ACE of physical abuse when BCDSS or medical records indicated the child had been physically abused). Because it is highly likely that many children experienced adverse events that went undocumented, the numbers reported here should be considered an undercount. The one exception to this rule was the ACE of experiencing racism, which is almost never documented in any record. The team made the across-the-board assumption that if the child was a child of color then the child had experienced racism.

Child fatality victims were found to have high ACE scores, despite that a large number of them were only infants and toddlers. Only one child was found to have experienced no documented ACEs prior to the incident that caused the child's death. One hundred thirty-nine children (67%) were found to have experienced four or more documented ACEs, the tipping point for the poorest outcomes. For comparison purposes, in a 2018 survey of Maryland adults, 33% of adults in Baltimore City reported that they had experienced three or more of the 10 originally studied ACEs; that percentage would grow if the urban ACEs had been included.[11]



Racism was the most common ACE, with 90% of child fatalities occurring to children of color. Racism is a root cause of child fatality. Social and environmental factors account for much of the risk for early death, and we know that children of color disproportionately experience poorer health, poverty, violence, poorer educational opportunities, housing instability, lack of resources needed for health such as healthy food and transportation, and child welfare involvement. Racism is at the root of these disparities. CFR Team recommendations have the potential to target racism and the social determinants of health and galvanize communities for action. City agencies and community-based

organizations must push toward racial equity to implement recommendations that will eliminate the disparity in preventable deaths of children of color.

Caregiver substance use and mental illness, loss of caregiver through family separation or death, caregiver domestic violence, and caregiver incarceration were all common ACEs among child fatality victims. One-hundred eighty children (87%) had one or more of these ACEs, indicating significant stress in the family. In addition, 63% of children were found to be living in one of Baltimore City's more violent neighborhoods, an additional stressor.

Recognizing that much of the adversity the children had experienced was likely to be intergenerational, the CFR Team attempted to determine an ACE score for each caregiver as well as the child; however, the Team usually did not have enough information about the caregiver's childhood to determine a meaningful score. We did learn, however, that one or both caregivers of 98 of the children (47%) had been named by CPS as a victim of maltreatment as a child and that one or both caregivers of 50 of the children (24%) had spent time in foster care as a child. For comparison purposes, nationally, it is estimated that about 6% of all children spend time in foster care prior to age 18. This is evidence that the caregivers in many child fatality cases had themselves experienced significant trauma and adversity.

Recommendations

No.	Issue	Recommendation
L.1	Racism as the root cause of the racial disparity in child fatality	Provide anti-racism training and support to leaders and staff of all city and child-serving agencies and develop concrete action plans for shifting focus toward achieving racial equity
L.2	Social and economic factors driving risk for child fatality	Address the social determinants of health in Baltimore City through advocacy for local and state policies that reduce poverty and violence and support education and housing stability
L.3	High ACE scores of children and significant family trauma and adversity	Transform Baltimore City into a trauma-informed city that is responsive to the needs of all families, support the Healing City efforts to train leaders and staff of all city agencies and child-serving agencies on trauma-informed care and the science of ACES, and provide support for all city agencies and child-serving agencies to adopt the principles of trauma-informed care in policy and practice

Recommendations (cont.)

No.	Issue	Recommendation
L.4	High ACE scores of children and significant family trauma, and adversity	Build protective factors and promote community norms for protecting children through broad implementation of strengths-based models of family support (e.g., Strengthening Families)
L.5	High prevalence of caregivers with experience in foster care	Increase access to trauma therapies for children involved in child welfare and the foster care system, as well as trauma-informed parenting education and support to young adults aging out of the foster care system

Action Spotlight—Citywide Trauma Training

In 2018, BCHD's Office of Youth and Trauma Services formed the Trauma Training and Technical Assistance Center (OYTSTTAC) to provide training and technical assistance on trauma-informed care through in-person organizational technical assistance, virtual learning networks, technical assistance materials, and links to other resources supported by the federal government. OYTSTTAC aids organizations and city agencies with moving toward a trauma-informed approach by conducting an agency-wide Organizational Trauma-Informed Self-Assessment. The assessment gauges the agency's and staff's preparedness for incorporating trauma-informed practices. Then, OYTSTTAC provides feedback based on the assessment and works with staff and stakeholders to adopt the agency policies and practices that are the foundation of a trauma-informed approach. In practice, trauma-informed care affects many aspects of service delivery, from how services are provided to the layout of physical spaces. OYTSTTAC has been instrumental in implementing the Elijah Cummings Healing City Act focused on training all of Baltimore City's nearly 14,000 employees, with the pilot having been started in June 2021. BCHD with its partners has trained the Mayor, the leadership of more than 20 municipal agencies and quasi-agencies, City Council, and some media outlets and library staff, totaling more than 400 individuals. A deeper-dive training and technical assistance project with libraries will start in February 2022.

5

CALL TO ACTION

The entire purpose of reviewing child fatalities is to learn what we as a city need to do to prevent them from happening to other children in the community. Now is the time to act on behalf of those children we have lost and those who are at risk of fatality right now.

It's Time to Act

Two-hundred and eight children in Baltimore City lost their lives suddenly and unexpectedly from 2016 to 2020. The vast majority of these deaths were to children of color and children who had experienced a great deal of trauma and adversity in their short lives. These deaths were overwhelmingly preventable.

We can prevent child fatalities in Baltimore City if we take thoughtful action now. The recommendations offered in this report can serve as a starting point. City agencies, policymakers, health care providers, child- and family-serving organizations, and city residents must take this opportunity to pool their talents, expertise, and determination to save children's lives.

Case review findings by the Baltimore City CFR Team make it clear that preventing these fatalities is not simply a child welfare agency problem but a whole community problem. Solving it requires a public health approach and a life course approach—one that involves the whole community in identifying children and families most at risk, intervening early with services and supports, and enacting policies that enable children and families to build resilience and thrive.

There is a role for each of us to play, and now is the time to act.

APPENDIXES

A. BALTIMORE CITY CFR TEAM AND STAFF

The Mayor's Office and BCHD wish to acknowledge the members of the Baltimore City CFR Executive and Case Review Teams and BCHD staff who support the work of the teams.

Members Mandated by COMAR

Member	Executive Team	Case Review Team
Baltimore City Health Department	Letitia Dzirasa (Chair)	Letitia Dzirasa (Chair)
Baltimore City Department of Social Services	Brandi Stocksdale	Emily Harris
Baltimore City State's Attorney's Office	Marilyn Mosby	Michele Lambert
Baltimore City Public Schools	Sonja Santelises	Debra Brooks and Patricia Roberts-Rose
Baltimore Police Department	Michael Harrison	Ray Bennett and David Bomenka
Behavioral Health System Baltimore	Crista Taylor	Shameka Thomas-Habersham and Alexandra Wykowski
Pediatrician with expertise in child abuse and neglect	Wendy Lane	Wendy Lane
Psychologist with expertise in child abuse and neglect	Kerry Hannan	Kerry Hannan

Members Appointed by the Commissioner of Health

Member	Executive Team	Case Review Team
Annie E. Casey Foundation	Gena O'Keefe	Gena O'Keefe
Baltimore Child Abuse Center	Adam Rosenberg	Lisa Jones and Denielle Randall
Baltimore City Fire Department	Niles Ford	Shana Haughton and Anita Hagley
Baltimore Healthy Start	Lashelle Stewart	Lashelle Stewart
Family League of Baltimore	Demaune Millard	Khalilah Slater Harrington
HealthCare Access Maryland	Traci Kodeck	Janelle Olaibi
Johns Hopkins Hospital Child Protection Team	Simone Thompson	Simone Thompson
Maryland Department of Juvenile Services	Scott Beal	Oluseun Adetayo
Mayor's Office of Children and Family Success	Faith Leach	Faith Leach
Mayor's Office of Neighborhood Safety and Engagement	Shantay Jackson	Shantay Jackson
Office of the Chief Medical Examiner	Victor Weedn	Victor Weedn
Roberta's House	Annette March-Grier	Veronica Land-Davis
Safe Kids Baltimore	Karen Hardingham	Karen Hardingham

Baltimore City Health Department Staff

Office	Staff
Bureau of Maternal & Child Health	Rebecca Dineen, Cathy Costa, Sinmidele Badero, Jana Goins, and Jennifer Kirschner
Office of Youth & Trauma Services	William Kellibrew

B. FULL LIST OF RECOMMENDATIONS

No.	Recommendation
A.1	Provide comprehensive intervention and wraparound services for youth victims of nonfatal shootings and stabbings and hospital-based intervention to reduce risk of violence
A.2	Expand Safe Streets to additional neighborhoods with clusters of third-party youth homicides
A.3	Provide enhanced care coordination for youth age 13 and younger charged in the juvenile system, with an emphasis on offering comprehensive supports for the youth's family
A.4	Study Baltimore's intergenerational drug trade and create a two-generation intervention for involved families that utilizes highly credible staff
A.5	Identify all options and sources of funds for families needing to relocate due to violence and ensure that criminal justice and family-serving organizations are aware of these options
A.6	Institute a consistent referral policy and robust minimum standard of support and intervention for Student Support Teams across City Schools, with an emphasis on intervening on attendance early in elementary school
A.7	Determine the number of youth in City Schools who have multiple school-based risk factors for fatality as a first step to determining the feasibility of identifying them and intervening early on a routine basis
A.8	Provide regular Mental Health First Aid and trauma-informed care training for City Schools and the city's network of child- and family-serving agencies and organizations
A.9	Offer culturally responsive and trauma-informed individual and family therapy in addition to behaviorally oriented therapy, with trauma training for the city's child- and family-serving behavioral health providers
A.10	Strengthen the capacity of the Local Care Team and institute a consistent referral policy across member organizations for the Local Care Team, prioritizing youth risk factors identified by CFR and ensuring referrals for all families that initiate voluntary foster care placement even if they later rescind

No.	Recommendation
A.11	Train and employ credible messengers (e.g., youth peer mental health educators) across child- and family-serving agencies to outreach and engage families, amending outreach practices and policies to keep cases open longer in order to build trust and encourage youth and family participation over time
B.1	Institute a system for notifying judges of child fatalities in cases they have adjudicated and provide additional training to judges on the risks for child fatality
B.2	Pass expanded Birth Match legislation that closes the loophole so that the local DSS office is notified and a safety check is performed when a newborn is born to any parent whose rights have been terminated for another child except in the case of voluntary adoption
B.3	Re-envision services and advocate for longer-term intensive services for families that meet criteria and are at risk for child fatality or serious injury
B.4	Provide training and resources to implement the evidence-based DOVE domestic violence intervention program to programs supporting families with young children
B.5	Increase access to respite and emergency child care and to child care vouchers, eliminating barriers to enrollment
B.6	Engage and build the confidence and parenting skills of fathers, especially young fathers, through media and outreach efforts with partners already working to engage young men (e.g., Safe Streets)
B.7	Provide training and resources to service providers working with families of young children on developmental expectations and strategies for supporting families experiencing challenges with toilet training, feeding, and soothing children
B.8	Offer parents who have been mandated to take parenting classes that tailored to the needs of parents with children who have developmental or social-emotional delays
B.9	Hold Medicaid managed care organizations accountable for adhering to existing policy requiring them to outreach and link back into care families of young children who miss two well-child visits
B.10	Encourage pediatricians to submit Local Health Services Requests (LHSRs) to HCAM to outreach and link back into care children who miss well-child visits
B.11	Provide guidance and training to pediatricians on recognizing the signs and symptoms of child abuse via virtual pediatric visits based on guidance being developed for the Maryland chapter of the American Academy of Pediatrics
B.12	Encourage opioid treatment providers to screen clients for children present in the home and provide counseling on safe storage of medication
B.13	Train first responders to provide education on safe illicit drug storage and identify funding to enable them to supply lockboxes following an overdose

No.	Recommendation
B.14	Recommend co-prescription of naloxone to all people prescribed medication-assisted treatment (MAT) for opioid use disorder and train people using MAT to administer it
B.15	Improve coordination among BCDSS, public health, and home visiting to provide enhanced support for substance-exposed newborns
B.16	Educate the community on the importance of making reports to CPS when children are suspected to be in danger, emphasizing BCDSS's intention to collaborate with families on safety rather than remove children from their caregivers with little cause
C.1	Continue BHB SLEEP SAFE Campaign of mass media, community outreach, provider training, and free crib distribution to families in need, ensuring that clinics and other health and social services sites are displaying updated BHB SLEEP SAFE materials
C.2	Pass legislation in Maryland to mandate that all birthing hospitals provide and document evidence-based safe sleep counseling prior to postpartum discharge
C.3	Meet one-to-one with each of the seven city birthing hospitals to renew the commitment to safe sleep and ensure that safe sleep counseling and documentation is included in postpartum discharge workflow
C.4	Encourage the NICUs in city birthing hospitals to undertake quality improvement projects to model safe sleep practices and provide more extensive safe sleep counseling at NICU discharge
C.5	Encourage pediatricians to ask questions that are more likely to yield accurate responses rather than socially desirable responses when engaging in safe sleep discussions (e.g., "How do you put your baby to sleep?")
C.6	Expand detailing of prenatal care and pediatric providers to improve tobacco smoking screening and cessation counseling, ensuring providers are trained to use Fax-to-Assist to refer to the Maryland Quitline
C.7	Develop a BHB SLEEP SAFE public service announcement (PSA) on limiting infants' exposure to tobacco smoke, to be shown on CharmTV and other television stations
C. 8	Refresh BHB's Just Hold Off secondhand smoke campaign and identify funding for mass media placements
C.9	Incorporate messaging about avoiding exposing infants to marijuana into the BHB SLEEP SAFE campaign and Just Hold Off campaign
C.10	Outreach prenatal care and pediatric providers on needs related to counseling patients on marijuana use and develop patient-facing education materials providers can disseminate
C.11	Implement neighborhood and virtual canvassing after a sleep-related infant death in partnership with the Baltimore City Fire Department (BCFD) to alert families that free cribs are available to families in need and to provide education on safe sleep door-to-door

No.	Recommendation
C.12	Adapt BHB's SLEEP SAFE materials to address children and place them in all school health centers and suites
C.13	Ensure the Baltimore Central Booking and Intake Center resumes showing BHB's SLEEP SAFE videos and ensure that they are shown at the Juvenile Justice Center
C.14	Develop a PSA about safely providing care for infants and young children while under the influence of substances, to be shown on CharmTV and other television stations
C.15	Develop a new short BHB SLEEP SAFE video on how to soothe a fussy baby that can be easily shared from mother to mother via social media
C.16	Simplify BHB SLEEP SAFE messaging as much as possible and incorporate information and express empathy about perinatal mental health challenges and family stress and trauma
C.17	Engage social media influencers to de-bunk myths about sleeping devices and develop materials for the BHB SLEEP SAFE campaign on banned devices and how to check whether sleep devices meet national standards
C.18	Ensure that organizations serving people experiencing homelessness show BHB's SLEEP SAFE videos and provide safe sleep education, including education on temporary safe alternatives to cribs when a portable crib is not available for the night
D.1	Disseminate education materials regarding safe use of space heaters and extension cords to families with young children via BHB partner organizations
D.2	Include messaging about fire prevention in BCHD's standard Code Blue messaging
D.3	Continue Baltimore City Fire Department canvassing following fire fatalities to provide free smoke detectors and installation to neighborhood residents
D.4	Hold landlords of scattered-site properties accountable for having working smoke detectors in each residence
D.5	Actively promote and provide support for Zero Deaths Maryland, the state's road safety campaign targeting speeding, seatbelt use, and other risky behaviors
D.6	Increase opportunities for school-aged children in Baltimore City to learn water safety and swimming through the Department of Recreation and Parks
D. 7	Encourage pediatricians to screen for guns in the home and counsel caregivers on safe gun storage
E.1	Institute more aggressive monitoring by all Medicaid managed care organizations of prescription utilization for asthma medications with earlier outreach and case management
E.2	Ensure that managed care organizations, pediatricians, and specialty providers submit a LHSR to HCAM when a child with Medicaid misses well-child care to initiate outreach and linkage back into care

No.	Recommendation
E.3	Ensure that content on medical neglect is included in trainings on child maltreatment for mandated reporters including health care providers and school personnel
E.4	Provide training and support for pediatricians to counsel caregivers on smoking cessation and harm reduction efforts
F.1	Encourage all prescribers of psychiatric medication to educate patients taking benzodiazepines on the risks of opioid overdose
F.2	Ensure that City Schools and youth-serving organizations provide education on risks of opioid use and are included in the citywide opioid overdose prevention campaign
G.1	Increase access to suicide "gatekeeper training" (e.g., Mental Health First Aid) for youth, community members, families, schools, and first responders
G.2	Train pediatricians in primary care and emergency department settings to screen for suicide risk and provide brief suicide prevention interventions, such as counseling on reducing access to lethal means and safety planning
G.3	Use technology such as CRISP (Maryland's regional health information exchange) to alert pediatricians when youth have had in-patient psychiatric stays to enable them to coordinate follow-up care
G.4	Institute suicide screening and lethal means counseling policies in behavioral health care settings that serve youth and train providers to screen and counsel
G.5	Implement messaging campaigns focusing on reducing stigma and awareness of suicide and behavioral health needs as well as the behavioral health services available in Baltimore City across service sectors, including youth- and family-serving systems, schools, and communities
G.6	Operationalize processes for identifying, addressing, and reporting bullying in City Schools, highlighting the link between bullying, behavioral health needs, and suicide
G.7	Implement universal, evidence-based early interventions for emotional and behavioral health across all schools and Head Start programs
H.1	Provide thorough training to investigative agencies in infant and young child death investigation
H.2	Institute an MOU outlining information sharing practices across investigative agencies and a policy for multidisciplinary staffings following deaths that are initially unexplained or suspicious for abuse
I.1	Advocate for Maryland Medicaid to hold prenatal care providers accountable for submitting PRAs at the first prenatal care visit according to existing Medicaid regulations
I.2	Scale up adoption of BCHD's successful pilot of the ePRA by all major prenatal care providers in the city to increase PRA submission

No.	Recommendation
I.3	Continue to outreach and train social work staff at all Baltimore City birthing hospitals to complete the PIMR for eligible patients
I.4	Pass legislation to mandate the submission of the PIMR by the birthing hospital for mothers and infants who meet criteria
I.5	Increase the capacity of HCAM's community health advocate workforce to use creative strategies to outreach women who are unable to be located through traditional outreach
I.6	Fully fund HCAM's prenatal and infant care coordination system so that a higher-touch model incorporating face-to-face visits can be implemented
I.7	Emphasize to eligible mothers that home visits can be conducted anywhere the mother chooses and frame home visiting services as personal coaching services
J.1	Create an integrated data system across major child- and family-serving agencies (e.g., City Schools, DJS, BCDSS) with proper privacy controls that would alert agencies to youth with risk factors for fatality across systems
K.1	Conduct universal screening using SBIRT (Screening, Brief Intervention, and Referral to Treatment) of pregnant women and caregivers by prenatal care providers, birthing hospitals, and pediatricians
K.2	Promote the city's Here2Help Line to prenatal care providers, birthing hospitals, and pediatricians as a resource to help pregnant women and caregivers access substance use disorder treatment
K.3	Provide clear training to birthing hospitals in the state on the law and practices related to reporting substance-exposed newborns covering recent changes in law
K.4	Enhanced care coordination for substance-exposed newborns with collaboration between the centralized intake system at HCAM, home visiting programs, and BCDSS
K.5	Ensure that all pregnant women and mothers with substance use who are unable to be located by the centralized intake system at HCAM receive creative, longer-term outreach
K.6	Provide more extensive safe sleep counseling support when BCDSS is assessing safety and needs for families of substance-exposed newborns
K.7	Provide ongoing training across health and social service systems on evidence-based and best-practice approaches to working with caregivers with substance use disorders and infants with prenatal substance exposure, ensuring that education includes information about the effects of stigma and bias on the outcomes of caregivers and their children
K.8	Integrate parenting education and support services into substance use disorder treatment, pediatric care, adult health care, and criminal justice settings (e.g., Baltimore Central Booking and Intake Center)

No.	Recommendation
K.9	Widely utilize models such as recovery coaches, peer mentors, navigators, and other forms of parent support that connect caregivers using substances with other people who have similar lived experience and are able to provide credible, trusted guidance and support
L.1	Provide anti-racism training and support to leaders and staff of all city and child-serving agencies and develop concrete action plans for shifting focus toward achieving racial equity
L.2	Address the social determinants of health in Baltimore City through advocacy for local and state policies that reduce poverty and violence and support education and housing stability
L.3	Transform Baltimore City into a trauma-informed city that is responsive to the needs of all families, support the Healing City efforts to train leaders and staff of all city agencies and child-serving agencies on trauma-informed care and the science of ACES, and provide support for all city agencies and child-serving agencies to adopt the principles of trauma-informed care in policy and practice
L.4	Build protective factors and promote community norms for protecting children through broad implementation of strengths-based models of family support (e.g., Strengthening Families)
L.5	Increase access to trauma therapies for children involved in child welfare and the foster care system, as well as trauma-informed parenting education and support to young adults aging out of the foster care system

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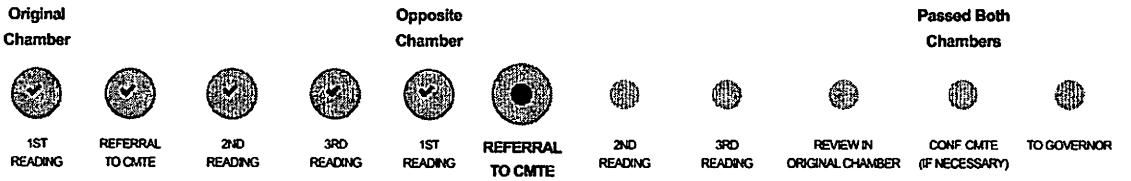
Session: 2024 Regular Session

SB0089



Title Child Abuse and Neglect - Reports and Records - Disclosure

Sponsored by Senator James

Status In the House - Hearing 3/21 at 1:00 p.m.

Analysis Fiscal and Policy Note (Revised)

Synopsis Requiring a local director of a local department of social services or the Secretary of Human Services to disclose certain reports and records of child abuse and neglect within 30 days after receiving a request if certain conditions are met; requiring the Secretary to notify the State's Attorney's office of a request to disclose certain reports and records of child abuse and neglect; requiring the State's Attorney's office to be given 30 days during which the office is authorized to redact certain portions of the reports and records; etc.

Committees

Original:	Opposite:
Judicial Proceedings	Judiciary

Committee Testimony Witness List

Details Introduced in a prior session as: SB0631 Session: 2023 Regular Session

Bill File Type: Pre-Filed

Effective Date(s): October 1, 2024

History

Chamber	Calendar Date	Legislative Date	Action	Proceedings
Senate	11/01/2023	11/01/2023	Pre-filed	
Senate	1/10/2024	1/10/2024	First Reading Judicial Proceedings	
			Text - First - Child Abuse and Neglect - Reports and Records - Disclosure	
Senate	1/15/2024	1/15/2024	Hearing 2/07 at 2:00 p.m.	
			Vote - Senate - Committee - Judicial Proceedings	
Senate	3/04/2024	3/04/2024	Favorable with Amendments Report by Judicial Proceedings	
Senate	3/05/2024	2/22/2024	Favorable with Amendments (543529/1 Adopted	38
Senate	3/05/2024	2/22/2024	Second Reading Passed with Amendments	38
			Text - Third - Child Abuse and Neglect - Reports and Records - Disclosure	
Senate	3/07/2024	2/24/2024	Third Reading Passed (46-0)	40

Chamber	Calendar Date	Legislative Date	Action	Proceedings
House	3/08/2024	2/29/2024	Referred Judiciary	39
House	3/19/2024	3/19/2024	Hearing 3/21 at 1:00 p.m.	

File Code ⌄

Subjects ⌄

Statutes ⌄

Last Updated: 4/15/2024 3:10 PM

SB0089/543529/1

BY: Judicial Proceedings Committee

AMENDMENT TO SENATE BILL 89
(First Reading File Bill)

On page 2, in line 12, after "law" insert "**AND SUBJECT TO PARAGRAPHS (2) AND (3) OF THIS SUBSECTION**"; and after line 31, insert:

"**(2) INFORMATION DISCLOSED IN ACCORDANCE WITH PARAGRAPH (1) OF THIS SUBSECTION SHALL BE LIMITED TO ACTIONS OR OMISSIONS OF THE LOCAL DEPARTMENT, THE DEPARTMENT OF HUMAN SERVICES, OR AN AGENT OF THE DEPARTMENT OF HUMAN SERVICES.**".

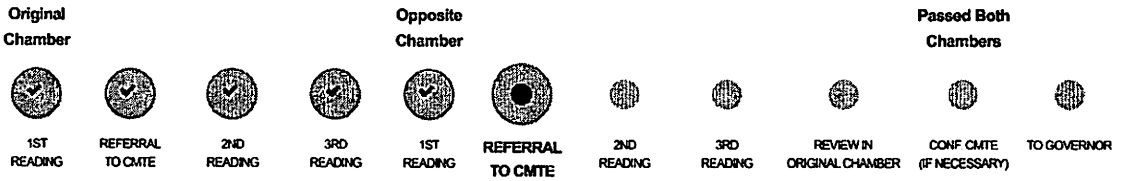
On page 3, in lines 1 and 10, strike "**(2)**" and "**(3)**", respectively, and substitute "**(3)**" and "**(4)**", respectively; in line 14, strike "**(2)(II)**" and substitute "**(3)(II)**"; and strike beginning with the bracket in line 20 down through the period in line 23.

2924 SB089 Voting History.pdf
Uploaded by: Darlyn McLaughlin
Position: FAV

Legislation

Session: 2024 Regular Session

SB0089



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File Code ⌄

Subjects ⌄

Statutes ⌄

Last Updated: 4/15/2024 3:10 PM

SB0089/543529/1

BY: Judicial Proceedings Committee

AMENDMENT TO SENATE BILL 89
(First Reading File Bill)

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HB1209 Testimony in Support .pdf
Uploaded by: Darlyn McLaughlin
Position: FAV

SUSAN K. MCCOMAS
Legislative District 34B
Harford County

DEPUTY MINORITY WHIP

Appropriations Committee
Subcommittees
Public Safety and Administration
Oversight Committee on Pensions

Joint Committees
Administrative, Executive, and Legislative Review
Legislative Ethics

Past President
Women Legislators of Maryland

The Maryland House of Delegates
ANNAPOLIS, MARYLAND 21401

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Susan.McComas@house.state.md.us

HB1209 - Child Abuse and Neglect – Reports and Records

HB1209 is a very simple bill that clarifies Maryland's obligations under federal law to release to the public DHS records when a child who has history with the Department suffers a fatality or a serious, near-fatality injury. Under the federal Child Abuse Prevention and Treatment Act (CAPTA), every state is required to ensure that the public is informed about cases of child abuse or neglect that result in the death or near death of a child.[1] The state must make public the child's age and gender, the cause of the fatality or near fatality, information describing any prior reports of child abuse or neglect involving the family, information regarding investigations pertinent to the child abuse or neglect that led to the child's death or injury, and services provided and actions of the State on behalf of the child.

The problem with the current Maryland law is that while it provides for the release of this information, it has an exception that swallows the entire rule. Under current law, the State's Attorney of the jurisdiction can block the release of this required information merely by stating that release of the information would harm any related investigation or prosecution. Of course, there will always be an investigation into a child abuse-related fatality, and the presence of an investigation should not allow the agency to avoid its legal duty to the public.

[1] https://www.acf.hhs.gov/cwpm/public_html/programs/cb/laws_policies/laws/cwpm/policy_dsp.jsp?citID=68

DHS contends that releasing this information will infringe on the privacy of these families. Privacy must not be the determining factor when the very life of a child is at stake.

In 2011, the Federal Government Office of Accountability issued an extensive report to the Chairman of the Committee on Ways and Means of the House of Representatives. The title, "Child Mistreatment: Strengthening National Data on Child Fatalities Could Aid In Prevention," speak volumes. The report analyzed the deaths from maltreatment involving a failure on the part of the adults who were responsible for protecting them. Prevention is the key word here. Arizona has a website that provides the public with notice about the incident at the time of the initial report. The site is updated after the investigation with a subsequent report that provides the findings of the agency indicating the person(s) responsible. By making such preliminary reports, the public is on notice and alert to make subsequent reports should they observe further alarming evidence of abuse or neglect. Thus, the public becomes an active participant in the prevention of child fatalities in aid of the already caseload laden DHS.

While I have complete confidence in the work of the fatality review board, keeping these reports from the public only hurts the children, as the vigilant eyes and ears of the public are not utilized to protect our greatest legacy to the future. Federal law requires such disclosures, and failure to follow that law may result in the federal government withholding our State's CAPTA grant, while opening the door to future litigation.

The GAO Report on Child Mistreatment asserts a powerful conclusion. Without the collection and routine sharing of child maltreatment fatalities, opportunities are lost to develop prevention strategies and to learn the risk factors associated with such maltreatment. "As a society, we should be doing everything in our collective power to end child deaths and near deaths due to maltreatment. The collection and reporting of comprehensive data on these tragic situations is an important step toward that goal." Where is the "it takes a village mentality"? YOU Must read this powerful Conclusion.

PLEASE ENTER A FAVORABLE REPORT FOR HB1209.

Susan K. McGraw

HB 1209 - MSAA Favorable.pdf
Uploaded by: Patrick Gilbert
Position: FAV

Maryland State's Attorneys' Association
3300 North Ridge Road, Suite 185
Ellicott City, Maryland 21043
410-203-9881
FAX 410-203-9891

Rich Gibson
President

Steven I. Kroll
Coordinator

DATE: **February 18, 2025**

BILL NUMBER: **HB 1209**

POSITION: **Favorable**

The Maryland State's Attorney's Association (MSAA) supports House Bill 1209, and urges this committee to issue a favorable report.

HB 1209 is drafted to bring MD. CODE ANN., HUM. SERVS. § 1-203 into compliance with the federal Child Abuse Prevention and Treatment Act ("CAPTA"), and strikes the appropriate balance between transparency in matters that are of significant importance to Marylanders with the need of the State to afford an accused a fair trial by an impartial jury of their peers in the jurisdiction where the offense is alleged to have occurred.

The language in HB 1209 requires the release of certain information related to incidents resulting in the death or near death of children in the custody of the State or in the care of a foster parent, and provides for notice to the local State's Attorney's Office prior to the release of such information. The State's Attorney's Office is afforded the opportunity to review the information prior to its release and to redact portions that would, if made public, "seriously hinder the ability of the State's Attorney's Office to prosecute a criminal case arising from the incident."

These types of cases – cases in which a child in the custody of the State or the care of a foster parent has died or has almost died – already attract a great deal of attention from the community and from the press. This is precisely why HB 1209 is needed, and one of the reasons why CAPTA was enacted in the first place: to increase transparency into these significant and tragic incidents. Some of the information HB 1209 requires to be disclosed, though – like the findings of the Department of Social Services' investigation into the incident and the number of times the alleged perpetrator has been referred for professional services – has the potential to prejudice potential jurors, and could preclude the trial of the offense in the jurisdiction where it is alleged to have occurred. As ministers of justice, prosecutors have an ethical obligation to scrupulously observe the due process rights of an accused, and communities have an interest in observing and participating in the trial of such important cases.

MSAA expresses its gratitude to the sponsors of this legislation for including the necessary language to ensure prosecutors can protect the integrity of their cases and afford the accused a fair trial, and urges this Committee to issue a favorable report on HB 1209.

maryland testimony 2025.pdf
Uploaded by: Thomas Rawlings
Position: FAV

Child Welfare & Justice Transformation International

675 Ponce de Leon Ste 8500 ▫ Atlanta, Georgia, USA 30308 ▫ (478) 357-8542

CWJT
delivering better outcomes for children in adversity

February 20, 2025

Maryland General Assembly
Judiciary Committee

RE: Support for HB 1209

Dear Members of the Committee,

I am pleased to present this written testimony in support of SB 89, which I believe is an important step to ensuring transparency and accountability in Maryland's child protection system.

I write based on almost 25 years' experience working in every aspect of child welfare: as a juvenile court judge, Georgia's independent child protection ombudsman, policy advocate, board-certified child welfare law attorney, and former director of the Georgia Division of Family and Children Services. I write a regular newsletter on child welfare issues, https://tomrawlings.substack.com, in which I cover national issues in child protection.

What I have seen in my years is that when the system fails to protect a child, state agencies often hide behind "confidentiality." The problem is that confidentiality prevents the public and the policymaker from understanding *what* happened and how the system might be improved to better protect children. Most child welfare tragedies do not involve a single failure by a single caseworker but rather result from systemic issues that can best be addressed by a comprehensive review.

Fortunately, federal law allows – even requires – that state child welfare agencies provide greater public transparency in cases involving deaths of and severe injuries to children who have current or previous contact with the child protection system. The Child Abuse Prevention and Treatment Act, 42 USC § 5106a, requires each state to have "provisions which allow for public disclosure of the findings or information about the case of child abuse or neglect which has resulted in a child fatality or near fatality."

Highlighting the mandatory nature of the CAPTA requirements, I would specifically like to draw the committee's attention to the federal government's guidance on this issue reflected in its Child Welfare Policy Manual:[1]

> **Question 2**.
> The requirement for public disclosure states that "findings or information" about a case must be disclosed. Does this mean that States have the option to disclose either the

[1] https://www.acf.hhs.gov/cwpm/public_html/programs/cb/laws_policies/laws/cwpm/policy_dsp.jsp?citID=68#:~:text=A%20%22near%20fatality%22%20is%20defined,%22near%20fatality%22%20under%20CAPTA.

findings of the case, or information which may be general in nature and address such things as practice issues rather than provide case-specific information?

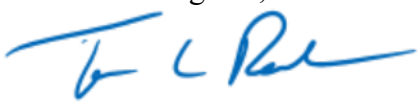
Answer
No. The intent of this provision was to assure that the public is informed about cases of child abuse or neglect which result in the death or near death of a child. As with the use of the other "or's" in this provision ("child abuse or neglect" and "child fatality or near fatality"), we understand the language to be inclusive and not limiting. Specifically, the reference to "findings or information" requires the disclosure of information about such a case even if there are no findings, in accordance with section 2.1A.4, Q/A #8 of the CWPM. Thus, when child abuse or neglect results in the death or near death of a child, the State must provide for the disclosure of the information required by section 2.1A.4, Q/A #8 of the CWPM. However, nothing in this provision should be interpreted to require disclosure of information which would fall within the specific exceptions that states are allowed to establish under section 2.1A.4, Q/A #8 of the CWPM.

We adopted a law allowing such transparency in Georgia 15 years ago, and in my opinion it has worked well to give the public and our state leaders better insight into the challenges child protection agencies face. Face it: when you tell a journalist or a state legislator that you can't share information about a child death that was just publicized on the news due to "confidentiality," the natural human tendency is to think you're hiding something. Creating greater transparency leads to greater public confidence in the child protection system, increased understanding of the difficult job child protection workers have, and increased ability to diagnose and fix the system when it fails.

In enacting this legislation, Maryland is joining other states that are moving to create this needed window into how child protection agencies work. Kansas, West Virginia, New Mexico, and other states are making progress in these areas.

This particular bill properly balances the need for public disclosure against the desire to ensure that some details of a family's struggle remain private or that a criminal investigation not be hindered. I commend the committee and the sponsor on this valuable legislation.

Kind regards,



Tom C. Rawlings

HB1209_INFO_DHS final.pdf
Uploaded by: Rachel Sledge Government Affairs
Position: INFO

Maryland
DEPARTMENT OF HUMAN SERVICES
Wes Moore, Governor · Aruna Miller, Lt. Governor · Rafael López, secretary

February 20, 2025

The Honorable Luke Clippinger, Chair
House Judiciary Committee
100 Taylor House Office Building
6 Bladen Street
Annapolis, Maryland 21401

RE: TESTIMONY ON HB1209 - CHILD ABUSE AND NEGLECT - REPORTS AND RECORDS - DISCLOSURE - POSITION: INFORMATIONAL ONLY

Dear Chair Clippinger and members of the Judiciary Committee:

The Maryland Department of Human Services (DHS) thanks the Committee for its consideration and is respectfully providing a letter of information for House Bill 1209 (HB 1209).

With a presence in every jurisdiction, the Department of Human Services (DHS) connects Marylanders with vital resources, including preventative and supportive services, economic assistance, and pathways to employment and career advancement. HB 1209 impacts our Social Services Administration (SSA) and its implementation of the Child Protective Services program.

HB 1209 aligns well with our goal to prioritize transparency, honesty, and openness. The bill establishes a process for the public to request and potentially receive Child Abuse and Neglect reports and records. By facilitating access to this information, HB 1209 demonstrates the Administration's commitment to increasing transparency and openness.

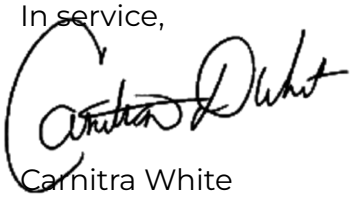
HB 1209 proposes a framework for requesting child abuse and neglect reports and records from DHS, with a specific focus on cases involving the fatality or near fatality of children who were under DHS care during a critical incident. Upon receiving a request, DHS will promptly inform the local jurisdiction's State's Attorney's Office (SAO) of the request. The local SAO then has 30 days to review the records, redact

sensitive information, and determine if the case record is suitable for sharing, taking into consideration any ongoing criminal investigations or prosecutions.

HB 1209 aims to further strengthen the Department's transparency by establishing a clear process for requesting and potentially obtaining relevant reports and records. This enhanced level of openness supports the Department's goals of transparency and building trust with the community.

We appreciate the opportunity to provide a letter of information to the Committee for consideration during your deliberations. If you require additional information, please contact Rachel Sledge, Director of Government Affairs, at rachel.sledge@maryland.gov.

In service,



Carnitra White
Principal Deputy Secretary