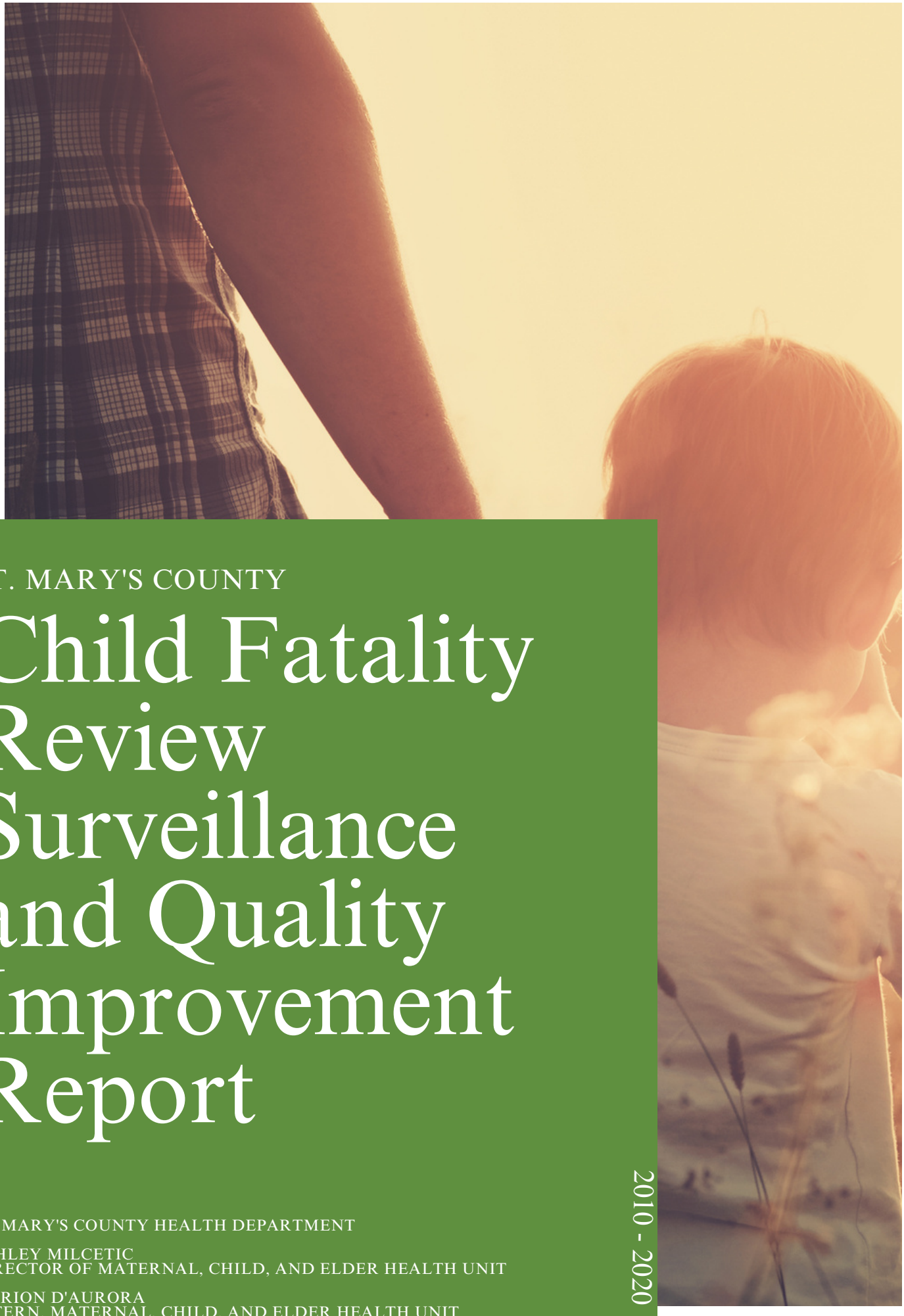


ST. MARY'S COUNTY

# Child Fatality Review Surveillance and Quality Improvement Report

2010 - 2020


ST. MARY'S COUNTY HEALTH DEPARTMENT

ASHLEY MILCETIC
DIRECTOR OF MATERNAL, CHILD, AND ELDER HEALTH UNIT

MARION D'AURORA
INTERN, MATERNAL, CHILD, AND ELDER HEALTH UNIT

# Table of Contents

# Abbreviations

| | |
|---|---|
| CFR | Child Fatality Review |
| MDH | Maryland Department of Health |
| MVA | Motor Vehicle Accident |
| OCME | Office of the Chief Medical Examiner |
| SIDS | Sudden Infant Death Syndrome |
| SMCHD | St. Mary’s County Health Department |

# Overview of St. Mary's County Child Fatality Review

The Maryland State Child Fatality Review Guidelines has a mission to "review child deaths to understand the circumstances around those deaths and to recommend strategies to prevent future child deaths." The St. Mary's County Health Department (SMCHD) coordinates a Child Fatality Review Team (CFR) for the county that meets quarterly. The SMCHD CFR Program Coordinator monitors for death notifications weekly. When a death notification is received SMCHD reviews the information provided in the Office of the Chief Medical Examiners (OCME) database and begins requesting additional medical information. The SMCHD Medical Records Supervisor enters data into the National Center for Fatality Review and Prevention database. The CFR members are notified of deaths to be reviewed at upcoming meetings. Committee members provide information on their involvement with the deceased child's family, and the group identifies broader public health issues and discusses child fatality prevention strategies. Team members implement strategies as a group and within their organizations. SMCHD submits quarterly reports with required statistics to the Maryland Department of Health (MDH) Bureau of Maternal Child Health.

CFR follows state guidelines:

1. We work cooperatively with other state and local review systems.
2. We base our recommendations on findings and consensus analysis from child death reviews.
3. Our understanding of child deaths must be based on both quantitative and qualitative information from child death reviews and observations.
4. Child fatality review must represent and consider the entire community.
5. Child fatality review must be both multidisciplinary and multi-agency.
6. Support of and advocacy for local child death review is a priority function of the State Child Death Review Team.
7. The State Child Fatality Review Team will build on the work of the local teams.
8. Reviews are conducted with respect for the child and family.
9. Confidentiality must be adhered to in all reviews.

# Unexpected Deaths in St. Mary's County, MD 2010-2020

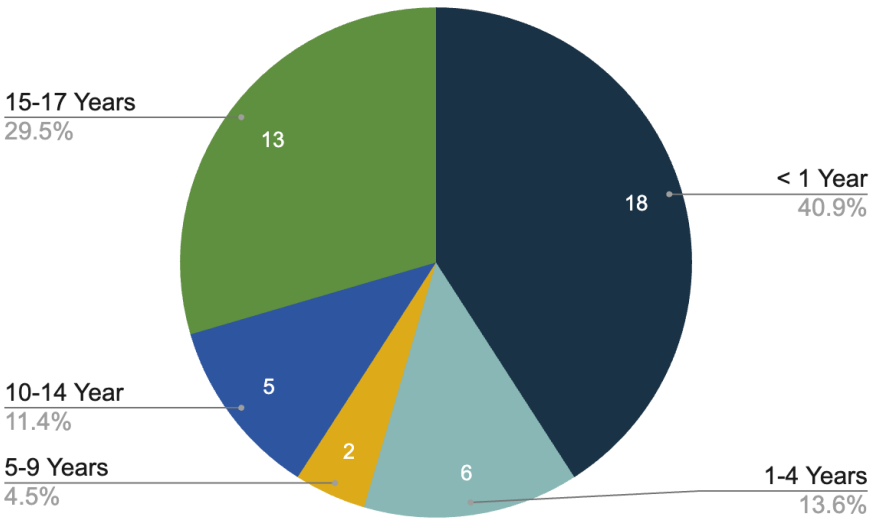
St. Mary's County CFR reviews acknowledge that unexpected child deaths are a significant public health concern. Collecting and analyzing the county data allows public health professionals and community stakeholders to assess the magnitude of the problem and make appropriate recommendations to prevent further deaths.

This data profile contains a summary of unexpected child deaths occurring in the St. Mary's County jurisdiction from 2010-2020. The data profile includes demographic information, age, sex, cause, and manner of death for unexpected deaths.

*This statistical compilation of data does not contain any information that would permit the identification of any person to be ascertained.*

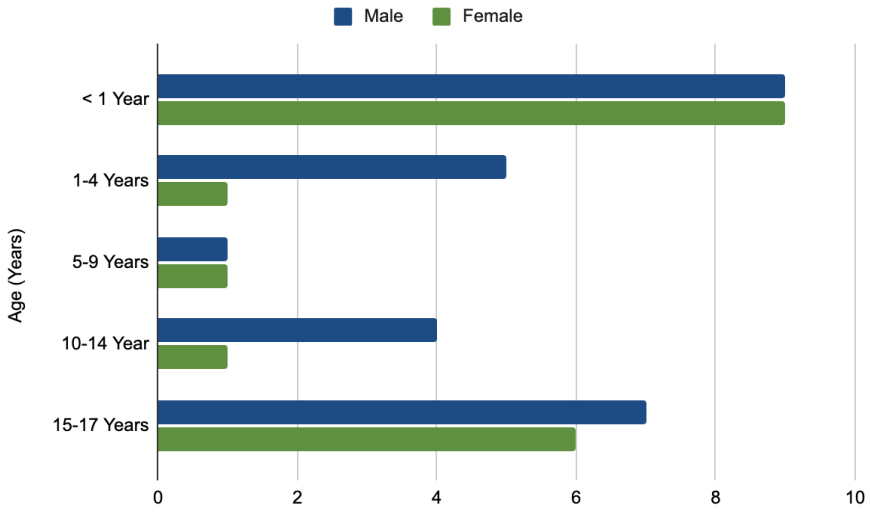
From 2010 - 2020, OCME referred 44 unexpected deaths to the St. Mary's CFR Team to review. Figure 1 depicts the distribution of deaths by age. Of the 44 deaths, 18 (40.9%) were in children under one year of age, with the second-highest number of 13 deaths occurring in the 15-17 Years age group. Out of the 44 deaths, 26 (59.1%) were males, while 18 (40.9%) were females. The distribution by both age and sex can be seen in figure 2.

**Figure 1. Number of Unexpected Child Deaths by Age Group: St. Mary's County 2010-2020**




Source: CFRP Database, 2010-2020

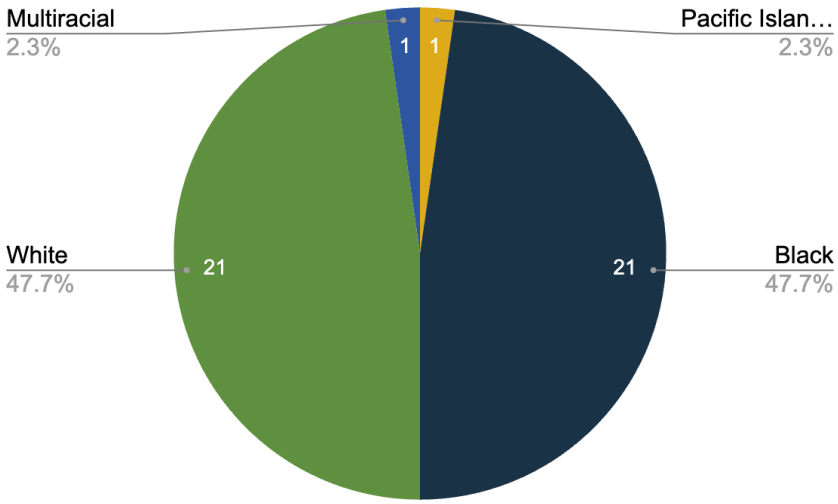
## Figure 2. Deaths by Age and Sex: St. Mary's County, 2010-2020




Source: CFRP Database, 2010-2020

Figure 3 depicts the distribution of unexpected child deaths by both race and ethnicity. Out of 44 deaths, 21 (47.7%) occurred among black children and the same number occurred among white children (47.7%). One death occurred among Pacific Islanders and one among Multiracial. (2.3%). According to the US Census Bureau, in 2021, Black or African Americans made up 15.2% of the total population in St. Mary's County, while White individuals made up 77.5% of the population in St. Mary's County.

## Figure 3. Number of Unexpected Child Deaths by Race: St. Mary's County, 2010-2020




Source: CFRP Database, 2010-2020

Table 1 presents the manner and cause of death of the 44 unexpected child deaths referred. The manner of death categories are broken into natural, accidental, suicide, homicide, undetermined, pending, and unknown. The leading manner of death from 2010-2020 was Natural, followed by accidental and undetermined. Any sleep-related deaths are classified under Undetermined.

## Table 1: Manner of Death: St. Mary's County 2010-2020

| | Number | Percent |
|---|---|---|
| Natural* | 18 | 40.9 |
| Accident | 10 | 22.7 |
| Undetermined | 10 | 22.7 |
| Suicide | 3 | 6.8 |
| Homicide | 2 | 4.5 |
| Pending | 1 | 2.3 |
| Unknown | 0 | 0 |
| **Total** | **44** | **100** |

Source: CFRP Database, 2010-2020

*Natural Death is defined as A death caused solely by disease and/or illness

The manner of death is then broken down into their cause of death categories in table 2. The most frequent manner of death is natural at 40.9%. The most frequent natural causes of death are cardiovascular (9.1%) and prematurity (6.8%). Accidents and Undetermined Sleep-related deaths are the next most common. In the accidental category the most common cause of death overall is Motor Vehicle Accident (MVA), at 11.4%.

## Table 2. Cause of Death and Manner of Death: St. Mary's County 2010-2020

| Manner | Cause | Number | Percent |
|---|---|---|---|
| Natural (n=18) | Cardiovascular | 4 | 9.1 |
| | Prematurity | 3 | 6.8 |
| | Other medical condition | 3 | 6.8 |
| | Unknown | 2 | 4.5 |
| | Congenital anomaly | 2 | 4.5 |
| | Asthma/Respiratory | 1 | 2.3 |
| | Influenza | 1 | 2.3 |
| | Neurological/seizure disorder | 1 | 2.3 |
| | Other infection | 1 | 2.3 |
| Undetermined (Sleep Related) (n=10) | Unknown | 7 | 15.9 |
| | Any Medical Cause | 3 | 6.8 |
| Accident (n=10) | Motor Vehicle | 5 | 11.4 |
| | Fire, Burn, or Electrocution | 2 | 4.5 |
| | Asphyxia | 2 | 4.5 |
| | Drowning | 1 | 2.3 |
| Suicide (n=3) | Asphyxia | 1 | 2.3 |
| | Bodily Force or Weapon | 1 | 2.3 |
| | Other Injury | 1 | 2.3 |
| Homicide (n=2) | Bodily Force or Weapon | 1 | 2.3 |
| | Other Injury | 1 | 2.3 |
| Pending (n=1) | | 1 | 2.3 |
| Total | | 44 | 100 |

Source: CFRP Database, 2010-2020

# Sleep-Related Deaths in St. Mary's County 2010-2020

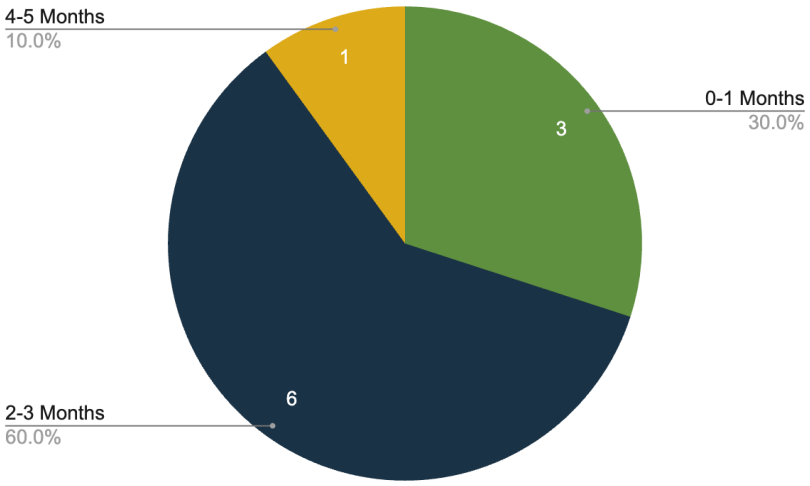
According to the CDC, there are about 3,500 sleep-related deaths in the United States per year. Sleep-related deaths include sudden infant death syndrome (SIDS), accidental suffocation, and deaths from unknown causes. Unsafe sleeping environments are a major risk factor and can be mitigated using safe sleep practices such as having the child sleep on their back, without any toys/stuffed animals/soft bedding, and in their own crib.

Local teams meet at least quarterly to review cases and make recommendations for local level systems changes to statute, policy, or practice to prevent future child deaths, and work to implement these recommendations.

Pursuant to Health-General Article, §5-704(b)(12) and Senate Bill 464 (Chapter 355 of the Acts of 1999), the Maryland State Child Fatality Review team creates an annual report on its progress and accomplishments for the calendar year. The St. Mary's County Child Fatality Review Committee and the state level CFR team address recommendations on improving safe sleep practices in hospitals in the Annual State CFR Legislative Report. The CFR will work with Medstar St. Mary's Hospital to assess their current safe sleep education and provide resources to increase education. The team will also promote safe sleep education in our community through client interactions and encourage additional community partners/programs to promote education. The CFR will inventory current education programs and encourage new programs to prioritize adding safe sleep education into their curriculum. Child death data will be provided to the public, and safe sleep education will be advertised in the community.

Out of the 44 unexpected child deaths in St. Mary's County from 2010-2020, 10 were sleep-related deaths. Figure 4 shows the age distribution of the ten sleep-related deaths. There were no deaths in the 6-7 month and 8-11 month age groups. Most sleep-related deaths occurred in the 2-3 month age group. (60%) The sex distribution of these can be seen in figure 4.

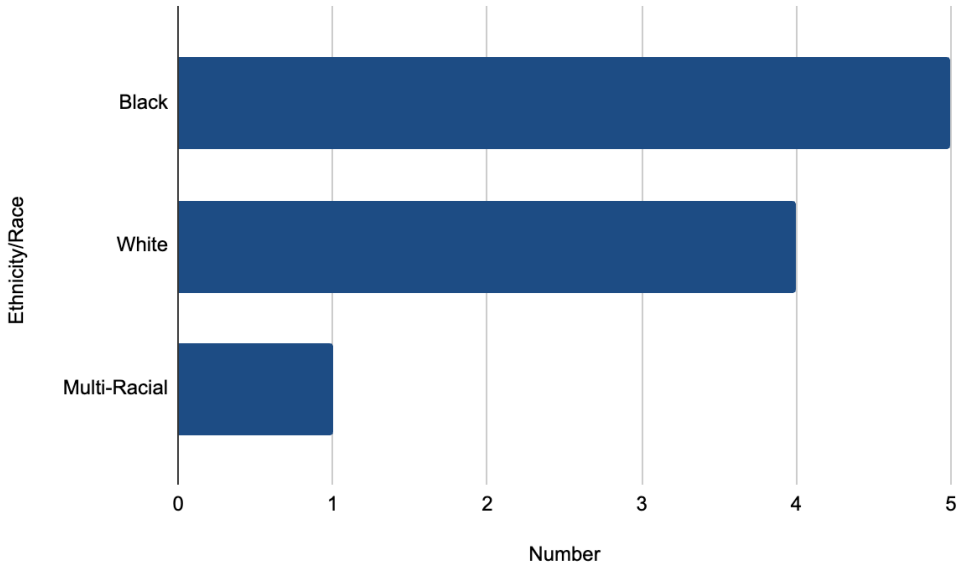
## Figure 4. Sleep-Related Deaths by Age: St. Mary's County 2010-2020




Source: CFRP Database, 2010-2020

Figure 5 depicts the demographic distribution of the ten-sleep related deaths in St. Mary's County. The highest distribution of death was in the Black or African American population (50%) followed by White (40%).

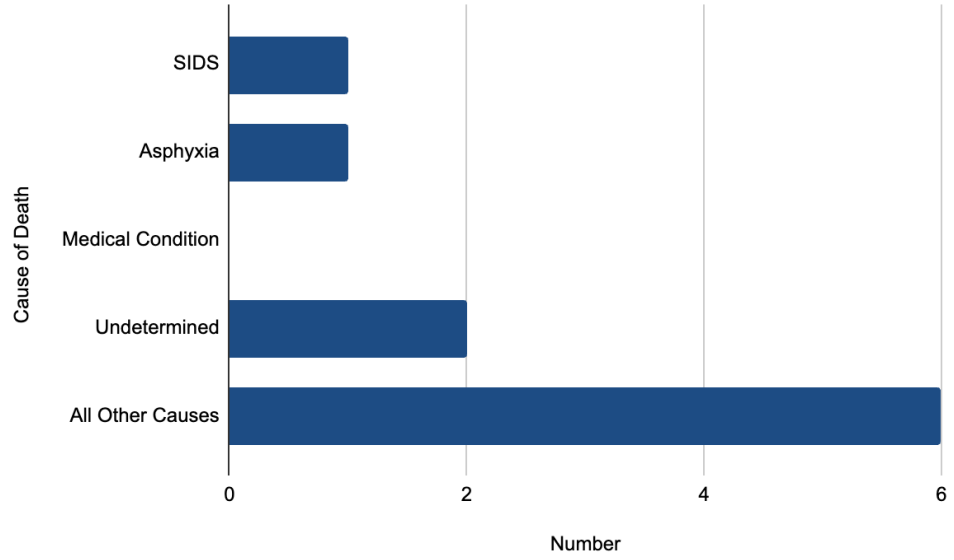
## Figure 5. Number of Sleep-Related Deaths by Race (n=10): St. Mary's County 2010-2020




Source: CFRP Database, 2010-2020

Figure 6 breaks down sleep-related deaths into their cause of death. Undetermined included undetermined deaths from both medical and injury causes. All other causes include deaths from other unknown causes and undetermined injury or medical causes and cases where the cause was left blank.

**Figure 6. Sleep-Related Deaths by Cause (n=10): St. Mary's County 2010-2020**




Source: CFRP Database, 2010-2020

# Community Organization Prevention Strategies

The Child Fatality Review committee is made up of various community organizations, including the St. Mary's County Health Department, St. Mary's County Public Schools, St. Mary's County Department of Social Services, the States Attorney's Office, Maryland State Police, Center for Children, Maryland Department of Health, Medstar St. Mary's Hospital, and St. Mary's County Sheriff's Office.

Current child fatality prevention strategies include various home-visiting programs such as Nurse-Family Partnership, Thrive By Three, and Healthy Families. These programs address child abuse and neglect, provide prenatal care to women to improve their infant's health, and assist pregnant women with behavioral health or substance use concerns to improve their positive parenting skills. The SMCHD also supports pregnant women through their community baby

showers which offer giveaway items to attendees, including diapers, baby wipes, bath thermometers, pacifiers, and safe sleep booklets, and several special door prizes, including strollers, car seats, and pack ‘n plays. Additionally, expecting parents will be connected to community resources and information relating to healthy eating and safe exercise during pregnancy.

Since most child deaths occur in children less than one year of age, safe sleep education is an essential prevention strategy. The distribution of pack ‘n plays aids in reinforcing the safe-sleep education delivered. Organizations conduct in-home safety evaluations with families to address home safety concerns. They also work with families to provide car seat education and help parents have an age/weight-appropriate car seat for their children.

The Violence, Injury, Trauma (VIT) Unit at the St. Mary's County Health Department is a newly developed unit committed to preventing injury and violence, promoting safe environments, and utilizing evidence-based practices to enhance public safety. Within the past two years, the VIT unit has collaborated with the St. Mary's County Sheriff's Office and the National Network of Safe Communities to implement Group Violence Intervention (GVI), a strategy focused on reducing homicidal and gun violence, strengthening law enforcement-community relations, and providing social services to high-risk families. Partnering with local organizations such as the Department of Social Services, Department of Juvenile Services, and faith-based organizations has yielded effective solutions to reduce crime in our community. We also established the VIT Action Team in 2020, as part of the local health improvement coalition, Healthy St. Mary's Partnership (HSMP), to address community-focused concerns through data-driven approaches. Recently, we launched campaigns on violence prevention and safe gun ownership, reaching many community members through social media and outreach events, with the ultimate goal of promoting a safe community and providing support to those affected by violence.

Other current prevention measures include youth-targeted behavioral health programs, social-media awareness campaigns, and school-based health centers which address school-aged children. These programs address the growing issue of mental health concerns in children, as well as other health and wellness needs of youth. Community organizations work together to ensure children can access health care, health insurance, and vaccinations. Other programs exist and are ongoing through different community organizations.

Going forward, the data provided in the data profile will help community organizations implement programs or campaigns that help prevent child fatalities in St. Mary’s County.

# Citations

CDC Newsroom. (2016, January 1). CDC. https://www.cdc.gov/media/releases/2018/p0109-sleep-related-deaths.html#:~:text=There%20are%20about%203%2C500%20sleep

Maryland State Child Fatality Review Guidelines for Local Case Review. (2017). https://health.maryland.gov/phpa/mch/Documents/CFR/LCFR%20Guidelines%202017.pdf
natural death. (n.d.). TheFreeDictionary.com. Retrieved August 2, 2022, from https://medical-dictionary.thefreedictionary.com/natural+death

SMCHD. (2022, May 31). Community Baby Shower Announced for Expecting Parents. St. Mary's County Health Department. https://smchd.org/2022/05/community-baby-shower-announced-for-expecting-parents/