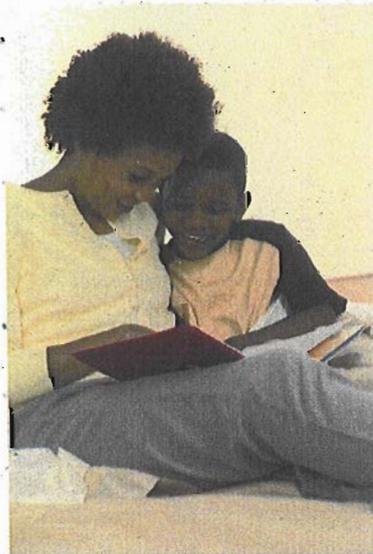


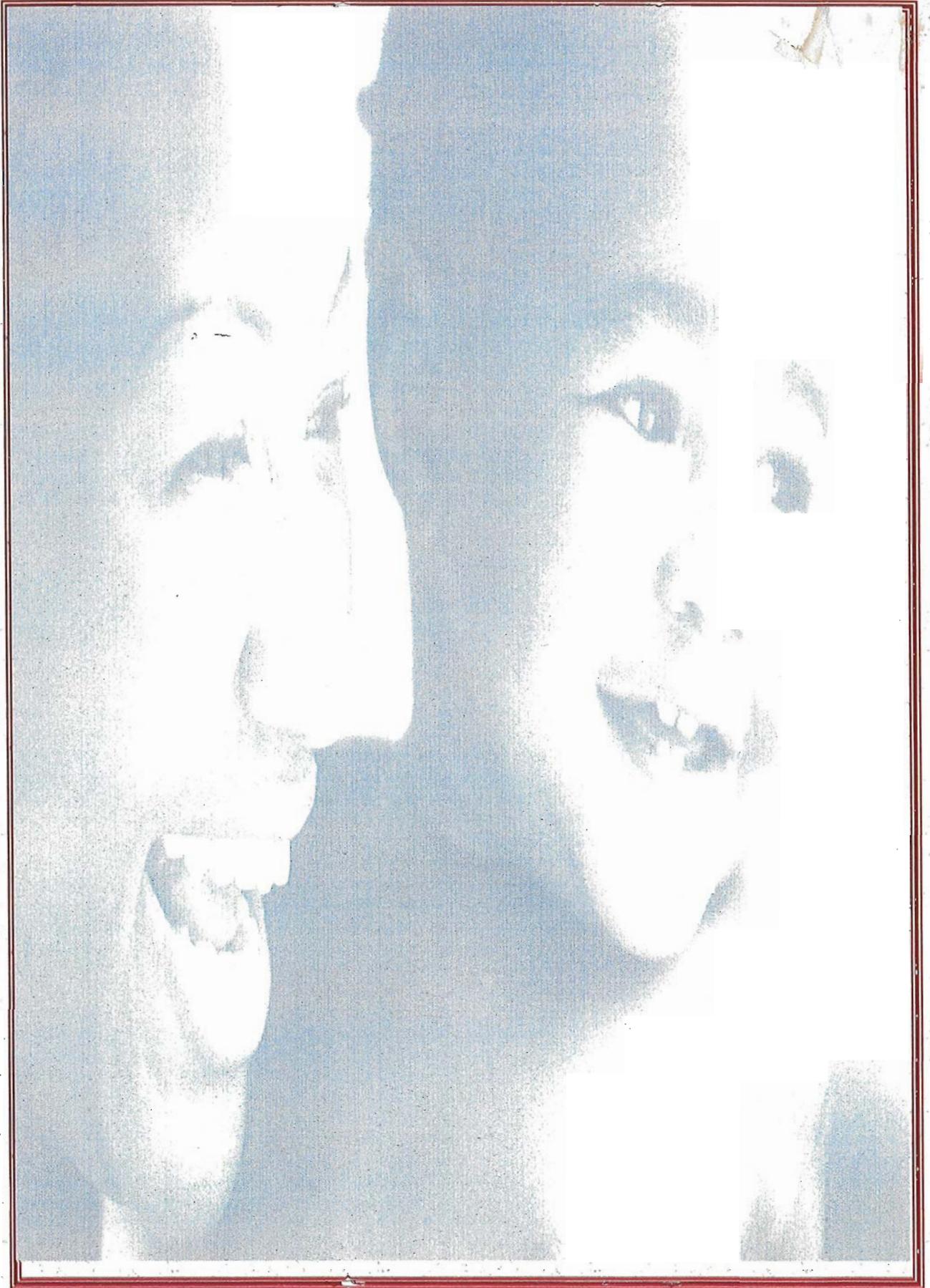
**DISTRICT OF COLUMBIA  
CHILD FATALITY REVIEW COMMITTEE**

**2006 Annual Report**



Adrian M. Fenty, Mayor  
District of Columbia Government

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**DISTRICT OF COLUMBIA  
CHILD FATALITY REVIEW COMMITTEE**

**2006 ANNUAL REPORT**

**MISSION:**

To reduce the number of preventable child fatalities in the District of Columbia through identifying, evaluating and improving programs and systems responsible for protecting and serving children and their families

**PRESENTED TO:**

**The Honorable Adrian Fenty, Mayor, District of Columbia  
The Council of the District of Columbia**

**DECEMBER 2007**



# ***Dedication***

In keeping with the tradition of the Child Fatality Review Committee, this Annual Report is dedicated to the memory of the children/youth who continue to lose their lives to medical problems, senseless acts of violence, accidents and suicide.

It is Our Vision that as we learn lessons from circumstances surrounding the deaths of the District's children, we can succeed in positively affecting the future of other District of Columbia children by reducing the number of preventable deaths and promoting quality of life for all residents.

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## EXECUTIVE SUMMARY

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*“Never doubt that a small group of thoughtful, committed citizens can change the World. Indeed, it’s the only thing that ever has.”*  
*Margaret Meade*

The District of Columbia child Fatality Review Committee is pleased to present its 14th Annual Report. This Report covers data that resulted from reviews of 157 child/youth fatalities from calendar year 2006.

### KEY CHILD FATALITY REVIEW DATA FINDINGS

#### DECEDENT DEMOGRAPHICS

- ◆ The ages of the 2006 decedents ranged from birth through 23 years.
- ◆ Consistent with previous years, the majority of the decedents were under the age of one year. Ninety-three infants died in 2006, representing 59% of the overall CFRC child death population.
- ◆ The second leading population of District child deaths was youth over the age of 14 years (n = 42 or 27%).
- ◆ Black/African American children/youth continue to be disproportionately represented in the District’s death population. In 2006, 93% (n = 146) of the deaths involved Black/African American children.
- ◆ Also consistent with previous years’ data, males continued to dominate the CFRC fatality population. There were 109 male decedents in 2006 and 48 females.
- ◆ The majority of the 2006 decedents were residents of Wards Five, Six, Seven and Eight, with the largest number being residents of Ward Eight (n = 40 or 25%).

#### MANNERS OF DEATH

##### *Natural Deaths*

- ◆ A review of death certificates indicated that the majority of District children/youth continued to die from natural causes during the 2006 calendar year. There were a total of 98 Natural deaths. The majority of these deaths involved children under the age of one (n = 77).
- ◆ The majority of Natural infant deaths was associated with prematurity, low gestational age and birth weight.
- ◆ The leading cause of death for the 21 children one year of age or older was respiratory system disease (n = 7), followed by cancer and infection (n = 3 each).

### ***Violent Deaths***

Thirty-seven child and youth deaths from 2006 were attributed to acts of violence. All of these deaths were determined to be Homicides. There were no Suicide deaths of District children/youth in 2006.

**Homicides** continued to decrease in 2006. There were 37 Homicide deaths compared to 43 in 2005. The decrease was apparent in all of the following Homicide categories:

- ◆ **Fatal Abuse** - there were three fatal abuse and neglect deaths in 2006. Investigations of these deaths directly linked the fatalities of these children to the caregiver at the time of the deaths. The ages of the children were under the age of two years. Two thirds of the children were Black/African American (n = 2) and one was Hispanic and all of the children were male.
- ◆ **Youth Violence** - Youth violence Homicides accounted for 34 or 92% of the 2006 child/youth Homicides. The majority of the deaths were caused by firearms (94%). Similar to previous years, the ages of the youth ranged from 14 to 23 years of age. Also similar to prior CFRC years, 100% of the victims were Black/African American and the majority (n = 33) were male.

### ***Unintentional Injuries***

Accidental or unintentional injuries continued to decrease in 2006. there were nine unintentional injuries during this year. The causes of accidental deaths in all age groups were:

- ◆ Four Motor Vehicle Related
- ◆ Two Fire Related
- ◆ Two Falls
- ◆ One Choking

### ***Undetermined Deaths***

- ◆ In 2006, there were 12 deaths where the manner was Undetermined.
- ◆ All of these deaths involved children under the age of one year.
- ◆ The majority of the decedents were Black/African American (n = 11) and there were equal numbers of male and female deaths (n = 6).
- ◆ In 58% of the deaths the infants were co-sleeping with one or more adults and/or children at the times of the death.

## **Top CFRC Recommendations from Calendar Years 2006**

Key factors considered during case reviews are the identification of contributing factors, systemic issues/gaps and strategies/recommendations for preventing child deaths and improving the quality of the lives of District residents. As membership is broad, covering multiple public, private and community organizations, recommendations are also wide-ranging. Each case yields recommendations that include improving policies and practices, expanding programs and resources and furthering public outreach efforts. Twelve of the most critical 2006 CFRC recommendations are provided as part of the Appendices (see appendix A).

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## INTRODUCTION

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The Child Fatality Review Committee (CFRC) is a citywide collaborative effort that is authorized by the Child Fatality Review Committee Establishment Act of 2001 (see Appendix B; DC Code, § 4-1371). The Committee was established for the purpose of conducting retrospective examinations of the circumstances that contributed to the deaths of infants, children and youth who were residents or Wards of the District. The primary goals of the District's child death review process are identifying risk reduction, prevention and system improvement factors; recommending strategies to reduce the number of preventable child deaths; and improving the quality of life of District residents.

The District's child death review process is the only formally established mechanism for tracking child/youth fatalities, assessing the circumstances surrounding their deaths and evaluating associated risk factors. This process assists in identifying family and community strengths; as well as deficiencies and improvements needed in service delivery systems to better address the needs of children and families served. It is an opportunity for self-evaluation, through a multi-agency, multidisciplinary approach. As such, it provides a wealth of information regarding ways to enhance services and systems in an effort to reduce the number of preventable deaths and improve the quality of children's lives.

When a child dies in the District, the Committee is notified through several established sources. Once notified, the Committee obtains copies of the decedent's birth certificates (minimally for infant deaths) and death certificates. The Committee also obtains copies of records from the medical examiner, police, hospitals and other major child and family serving agencies (child protective services, mental health, education, etc.) Records are reviewed and a summary is developed for presentation during the case review meetings that are held twice monthly.

Committee membership is multidisciplinary, representing public and private child service agencies, programs and institutions. Membership is also unique in that it includes, by law, a community member for each of the eight District Wards. The number of participants for each meeting varies and depends greatly on the type of review being planned. ***All fatality review meetings are confidential.*** Based on written and verbal information presented during a review meeting, Committee members seek to clarify specific issues related to the services and interventions provided to the child and/or family and the systems responses to their needs and the death. More importantly, the Committee also identifies areas for systems improvements and makes recommendations for the prevention of such deaths.

This Annual Report summarizes data collected from case reviews conducted on infant, child and youth fatalities that occurred during the 2006 calendar year (Endnote #1, see page 39). Coupled with other data measures, CFRC data are designed to benefit agencies in determining patterns related to family characteristics and needs. It also helps formulate strategies that may assist in improving programs and services to District residents. By understanding the ways children/youth are dying and the contributing risk factors, policies, programs can be better targeted towards prevention initiatives and funding more appropriately allocated to address the needs of District Residents.

During the 2006 calendar, the Committee identified 157 deaths as meeting the criteria for review. While this represents a slight increase from the 2005 calendar year (n = 154), the Committee believes this incline is directly associated with changes in the CFRC case identification practices and may not be reflective of an actual increase in District child/youth fatalities.

This report contains two major parts. Part I, *Case Review Findings*, provides a general description of the 157 decedents, their demographics and the causes and manners of death. Part II, *CFRC Subcategories*, provides information on three distinct special fatality populations. This includes deaths of infants and children/youth known to the child welfare and juvenile justice systems. Additionally, illustrated throughout the Annual Report are text boxes that include *Case Vignettes and Educational Facts*. It is our hope that this information will not only bring greater attention and understanding to the ways that District children are dying; but it will also highlight some of the associated trends and risk factors as well as national and local prevention strategies. (Educational facts were abstracted from literature reviewed and the sources of the information are contained within the text box.)

***Case Vignette: A Two Month Old Undetermined Death***

AB was a 2 month old African American Black female, born by C-Section, at 38 weeks gestation, with a birth weight of 7 lbs. 3 oz and Apgars of 8 @ 1 minute and 9 @ 5 minutes. She was born to a 26 year old mother of 4 other children who was single and unemployed. Her pregnancy with AB was complicated by preeclampsia. Hospital records indicated that the mother did not use drugs, alcohol or smoke cigarettes; however mental health records indicated that she smoked but did not smoke during her pregnancy with AB. After the birth of AB, discharge planning included appropriate postpartum education and referrals for follow-up medical care for the mother and infant. The discharge nutritional plan was breast-feeding. The medical record noted positive bonding between the mother and infant.

On a warm morning in June, MPD officers responded to a radio assignment for a report of an unconscious infant located at a District hospital. It was learned that the infant had been transported from the SE quadrant of the District by ambulance. Upon arrival, the officer's were informed that the infant was pronounced dead at 11:50 AM. Medical records noted the 911 call was made at 11:16 AM by the child's father who indicated that his 2 month old baby had stopped breathing. He further indicated that the baby was "throwing up at first but was now not breathing". The father was given instructions to provide CPR which was initiated prior to EMS arrival. The ambulance arrived in approximately 8 minutes and medics observed a female infant lying on the bed (supine) with the father lying beside her pressing on her stomach and squeezing her nose. EMS records also noted that it appeared that a substance was coming from both the infant's nose and mouth. The child was noted to be unconscious, pulseless and apneic. Medics continued CPR and made several attempts to suction infant's airway. The infant was then placed on ventilator; and vital signs were documented as no blood pressure, pulse or respiration. The child was transported to the hospital with CPR in progress, however, despite aggressive resuscitation efforts she died shortly after arrival.

The scene of the incident was an apartment which was noted to be unkempt and dirty. Records indicated that the entire apartment had soiled clothing, trash, food and other debris strewn about. On one side of the closet door at the entry to the apartment was a bassinet filled with clothing, toys, trash and other items. Standing in the middle of the room was a folded baby stroller, and an infant seat was turned upside down in the middle of the living room floor. There were several used empty baby bottles strewn amidst the clothes, trash, shoes, and other items on the floor. Reports noted that the mattresses on the beds were uncovered, and that none of the baby items in the apartment were being used for their intended purposes, as these items were either covered or filled with clothes, trash and/or debris. Reports further revealed that drug paraphernalia were located several places throughout the living room, on a television stand, in the kitchen on top of the refrigerator, in the bathroom; and in the middle bedroom.

**Cause/Manner of Death:** Undetermined/Undetermined

**PART I: 2006 CASE REVIEW FINDINGS**

**SUMMARY OF TOTAL CHILD/YOUTH FATALITIES (YEARS 2000 - 2006)**

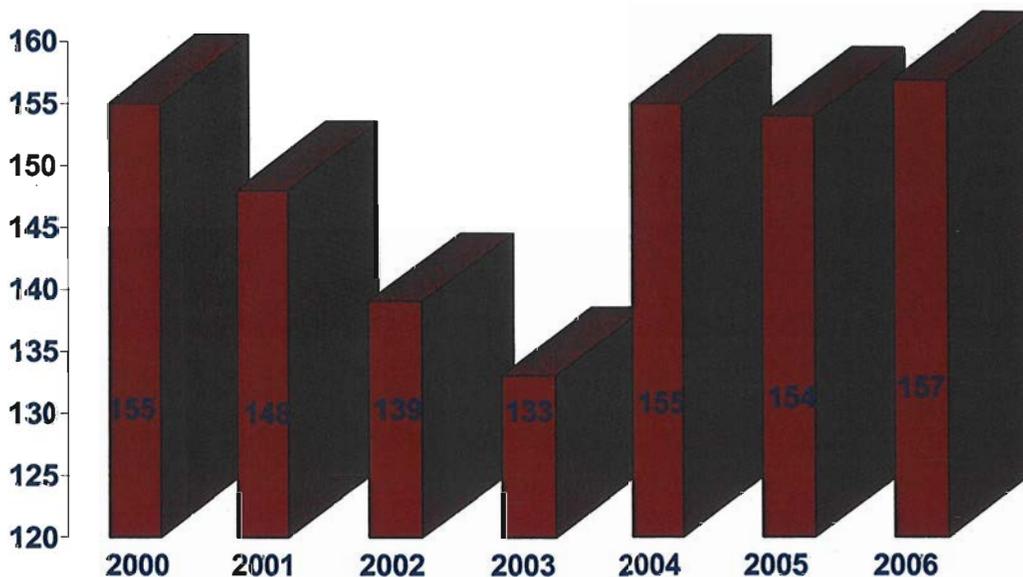


Figure 1: CFRC Total Child/Youth Fatalities (2000 - 2006)

- ◆ In 2006, CFRC identified 157 child/youth deaths that met the criteria for review.
- ◆ As Figure 1 illustrates, over a six year period the number of child deaths identified by CFRC fluctuated between 133 and 157.

**DESCRIPTION OF DECEDENT POPULATION**

**AGES OF DECEDENTS**

- ◆ The ages of the 157 decedents ranged from birth through 23 years
- ◆ Data from 2006 supports several consistent trends related to the ages of the decedents. As with previous CFRC years, the two largest categories of child deaths from 2006 continued to be infants (under the age of one year) and youth over 14 years of age.
- ◆ There were 93 infant deaths from the 2006 calendar year. Although the number of infant deaths is greater, this increase may be more reflective of changes in CFRC practices (i.e., extension of the data collection period) and may not reflect an actual increase in the total number of District infant fatalities (see Endnote #2).

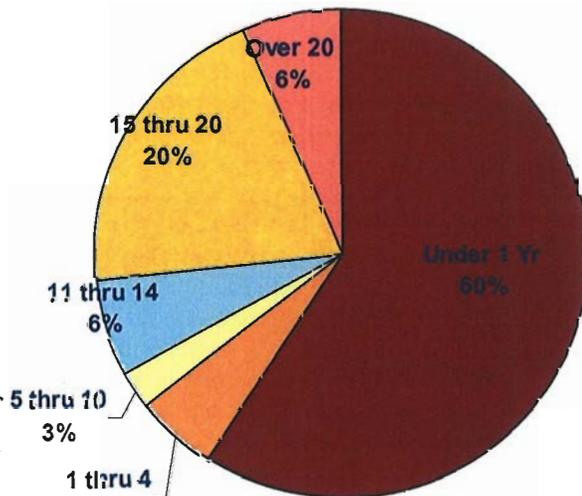


Figure 2: Ages of 2006 Decedents

- ◆ Consistent with previous years the majority of the 2006 infant fatalities identified involved neonatal deaths (birth through 28 days). Of the 93 CFRC infant deaths, 57 or 61% were under 29 days and 45 of these infants died within one day of life. Thirty-six deaths involved infants between 29 and 364 days.
- ◆ Also consistent with previous years the second largest population of CFRC fatalities involved youth over 14 years of age. In 2006, there were 42 youth deaths (27%) identified as meeting the CFRC criteria. Ten of the 42 youth decedents were over 20 years of age.
- ◆ Twenty-two child/youth deaths were between the ages of one and 14 years of age.

**RACE AND GENDER OF DECEDENTS**

- ◆ CFRC data from 2006 continued to support the fact that the majority of the fatalities involve Black/African American and male children/youth.
- ◆ As Figure 3 illustrates, Black/African American children/youth represented 93% of the 157 fatalities identified from calendar year 2006 (n = 146). During the 2000 through 2005 calendar years, Black/African American children/youth represented between 83 and 93% of CFRC deaths.
- ◆ Also consistent with historical CFRC data, White and Hispanic children/youth have represented the second and third leading child death populations, respectively.

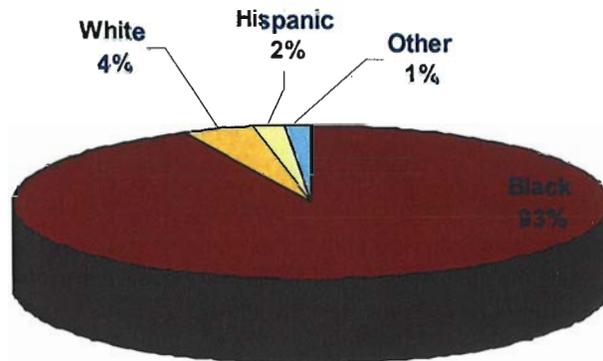


Figure 3: Race of 2006 Decedents

**Case Vignette: Two Accidental Death in 2006**

During the early morning hours of a spring day, a parent reported awakening to an unusually bright light. She got up to investigate and quickly realized that their apartment was on fire. She reported “grabbing” her infant and running down three flights of stairs. She further reported that when she attempted to return for the other two children, the apartment was “dark and smokey” and the fire was too intense preventing her from entering the home. The mother reported that on the night prior, there were also 2 guests who had stayed over following a large family celebration. One left at about 10:30 PM, at which time “the children” went to bed in their parents bedroom. He reported remaining in the living room with the remaining male guest, who stayed overnight. The father remained in the living room watching television until 1:00 AM, when he reported going to bed. He reported being awakened at 2:30 AM to a bright light and found a fire glistening in the living room near the patio door. The father awakened the male friend who was sleeping on the sofa across from the fire. According to a police interviews, both the father and the male friend reported being disoriented. They attempted to extinguish the fire with water, making trips from the kitchen to the balcony. However, the fire increased in intensity. Both men stated that when they realized the fire was intensifying, they began evacuating the apartment. The father stated he left with the infant, thinking that the other 2 children were out of the home. He further stated that he did not realize that his other children were upstairs until he was outside. At the time that the father attempted to reenter the apartment, the FEMSD arrived on the scene. Both children were found on the floor of the bedroom where they had been sleeping. The fire investigation revealed that the fire originated in the living/family room area; the source of the fire was an undetermined smoking material; and the first item ignited was an “upholstered sofa or chair.” It was also determined that there were working smoke detectors in the home.

**Cause of Death:** Asphyxia Due to Soot and Smoke Inhalation/Accident

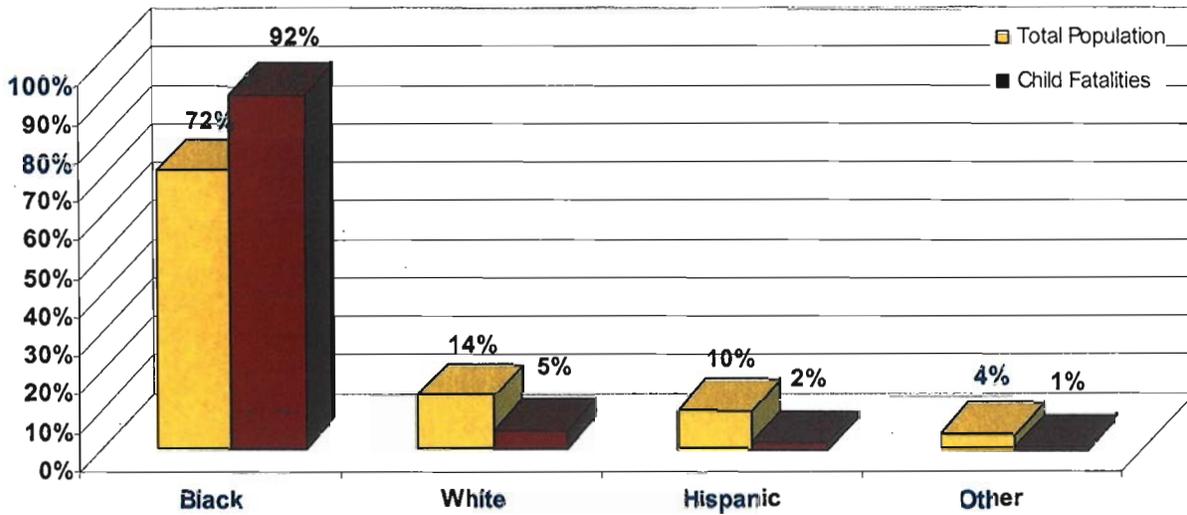


Figure 4: Race of Population Compared to Fatalities (Birth thru 17 Years)

- ◆ Historically, Black/African American children/youth in the District of Columbia have been over-represented among CFRC fatalities. Figure 4 above illustrates the racial composition of the total population of children (under 18 years of age) residing in the District compared to the child deaths.
- ◆ Based on 2004 census data, Black/African American children under the age 18 years represented 72% of the total District child population while in 2006 they represented 92% of the same age category of child deaths. While White and Hispanic children comprise 14% and 10% of the population of children in the District they represent 5% and 2% of the child deaths respectively. (Figure 4)
- ◆ As in previous years, males were also disproportionately represented in CFRC child/youth fatality data. In 2006, males represented 69% of the 157 decedents. The increased risk for males was even greater in the adolescent age population where they represented 88% of the decedent population over the age of 14 years. (Figure 5)

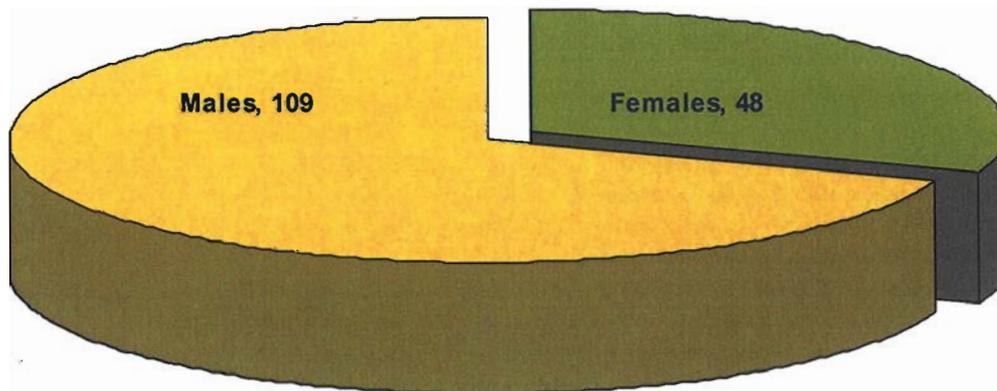


Figure 5: Gender of 2006 Decedents

**AGE OF DECEDENTS BY RACE AND GENDER**

- ◆ Table 1 below illustrates the disparity among Black/African Americans in all age categories.
- ◆ In 2006, 71% (n = 103) of the 146 Black/African American decedents were males. Although Black/African American males ranked higher in all categories, there was a significantly larger number of females in the Black/African American decedent population under the age of one year than in any other age category (n = 35, 42%).
- ◆ In the White and Hispanic racial categories all the deaths were of children under the age of one year. There were more White male and Hispanic female decedents among 2006 fatalities.

Race/Gender	<1 Year	1 thru 4 Yrs	5 thru 10	11 thru 14	Over 15 Yrs	Total
Black Male	48	6	4	8	37	103
Black Females	35	2	0	2	4	43
White Males	4					4
White Females	2					2
Hispanic Males	1					1
Hispanic Females	2					2
Other Males	1					1
Other Females					1	1
<b>Totals</b>	93	8	4	10	42	157

***Educational Fact: Call to Action—Pedestrian Motor Vehicle Accidents***

**For Parents and Caregivers:**

- Do not allow children under 10 to cross the street alone.
- Teach children proper pedestrian behavior, such as crossing the street at a corner, using traffic signals or crosswalks whenever possible. Instruct children to look left, right and left again when crossing a street and to continue looking as they cross.
- Dress children in reflective materials and instruct them to carry a flashlight in low-light situations, or in rainy or foggy weather.
- Don't let children play in driveways, streets, parking lots or unfenced yards adjacent to busy streets.

**For Policy Makers, Injury Prevention Advocates and Community Organizations:**

- Educate parents and caregivers to teach children ages 10 and older proper pedestrian behavior, such as crossing streets at a corner and obeying traffic signals. Educate parents to provide physical supervision for street-crossing for children under age 10.
- Establish pedestrian safety components in State Strategic Highway Safety Plans. Ensure adequate financial support for pedestrian safety programs.
- Enact state and local laws that require environmental modifications, such as more signage, lights, crosswalks, and traffic calming devices to slow vehicle speeds and enable safe walking.
- Enact state and local laws that impose stiffer penalties and fines for those who violate traffic laws.
- Increase use of speed and/or red light cameras; install blinking countdown lights at traffic intersections; widen road shoulders in rural areas for biking/walking lanes; pass "no turn on red" laws in local communities.

Source: Safe Kids Worldwide: Safe kids U.S. Summer Safety Ranking Report, 5/2007

### DECEDENTS' WARD OF RESIDENCY

Decedents' residency and/or District Ward are primarily determined based on the information contained on the death certificate. However, based on additional supporting documentation, other forms of verification may be used (i.e., child welfare, public assistance records/databases, etc.).

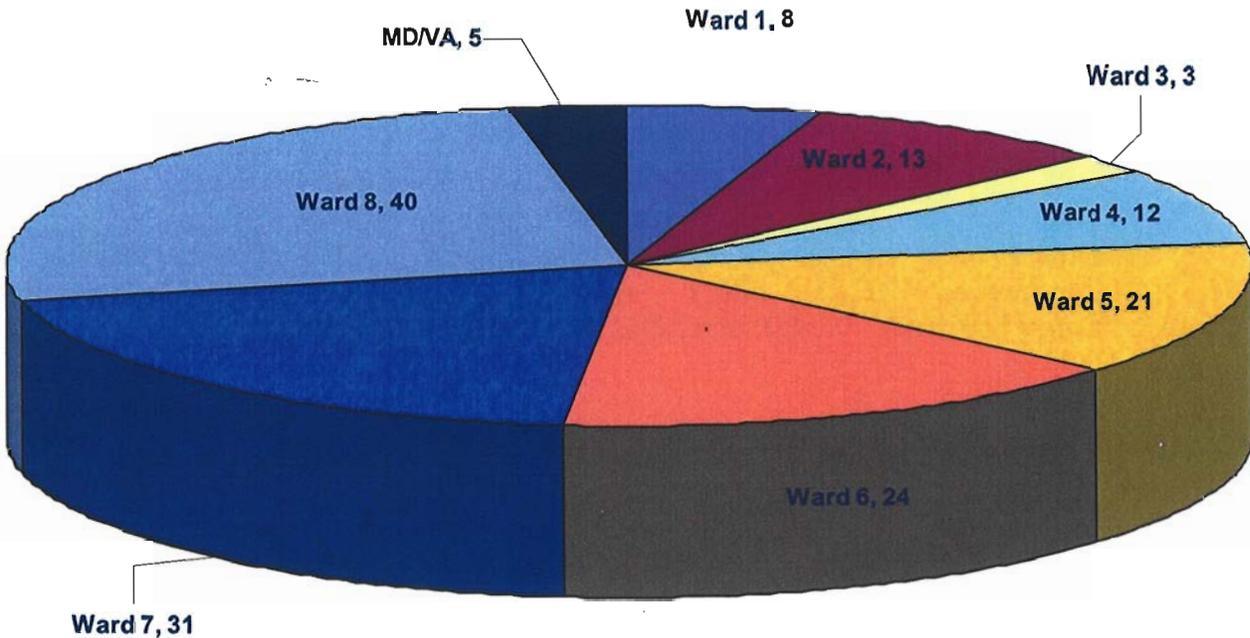


Figure 6: Ward of Residence - 2006 Decedents

- ◆ In 2006, five of the 157 decedents were residents of other states. These children were known to the child welfare and/or juvenile justice systems and based on the decedents' or families' involvement with these programs met the CFRC review criteria.
- ◆ As illustrated in Figure 6 above, the majority of the 2006 decedents were residents of Wards Five, Six, Seven and Eight, which accounted for 74% of 2006 deaths (n =116). The largest number of decedents resided in Ward Eight (25%), followed by Ward Seven (20%).
- ◆ Wards Two and Four had 13 and 12 deaths respectively, followed by eight in Ward One. Ward Three continued to have the lowest number of deaths with 3 fatalities.
- ◆ Figure 7 (see page 8) illustrates the Wards of residence for CFRC fatality cases from calendar years 2003 through 2006.

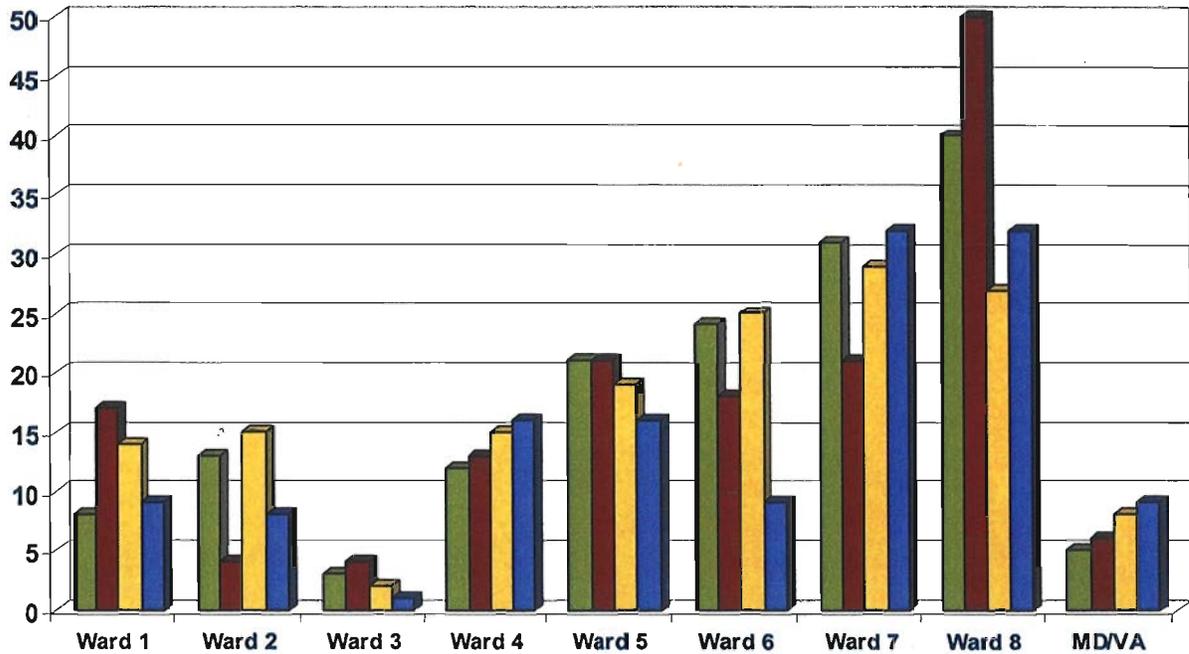


Figure 7: Ward of Residence - Comparative CFRC Data (2003 - 2006)

■ 2006 ■ 2005 ■ 2004 ■ 2003

### MANNER AND CAUSE OF 2006 FATALITIES

The cause of death refers to the underlying pathological condition or injury that initiated the chain of events resulting in the death (e.g., Asthma, gunshot wound, asphyxia.) The manner of death relates to the circumstances under which the death occurred. Manners of death are categorized as Natural, Accidental, Homicide, Suicide or Undetermined. The manner is determined based on specific information and details that are available on each case. Unlike the cause of death, manner can differ depending on the conditions and contributing factors revealed during the investigation and/or autopsy. Both the cause and manner of death are obtained primarily from the death certificate. However, in cases where the child died in other states/jurisdictions and the death certificate was not provided, other records (i.e., hospital, nursing homes, etc.) were used as the source of documentation or the cause and/or manner of death remains unknown. For the 2006 calendar year, causes and manners of death were obtained for 156 (99%) of the 157 fatalities.

### MANNER OF DEATH

- ◆ Figure 8 illustrates the manners of death for the 156 deaths from calendar year 2006 where manner was known.
- ◆ Consistent with historical CFRC data, District children continued to die primarily from Natural causes followed by Homicides. In 2006 there were 98 Natural deaths and 37 Homicides.
- ◆ Similar to 2005 data, Undetermined fatalities ranked third with 12 deaths and Accidents ranked fourth, with nine child deaths.

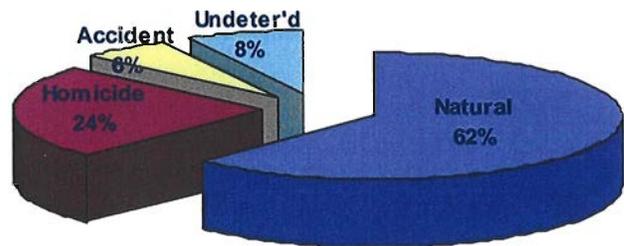
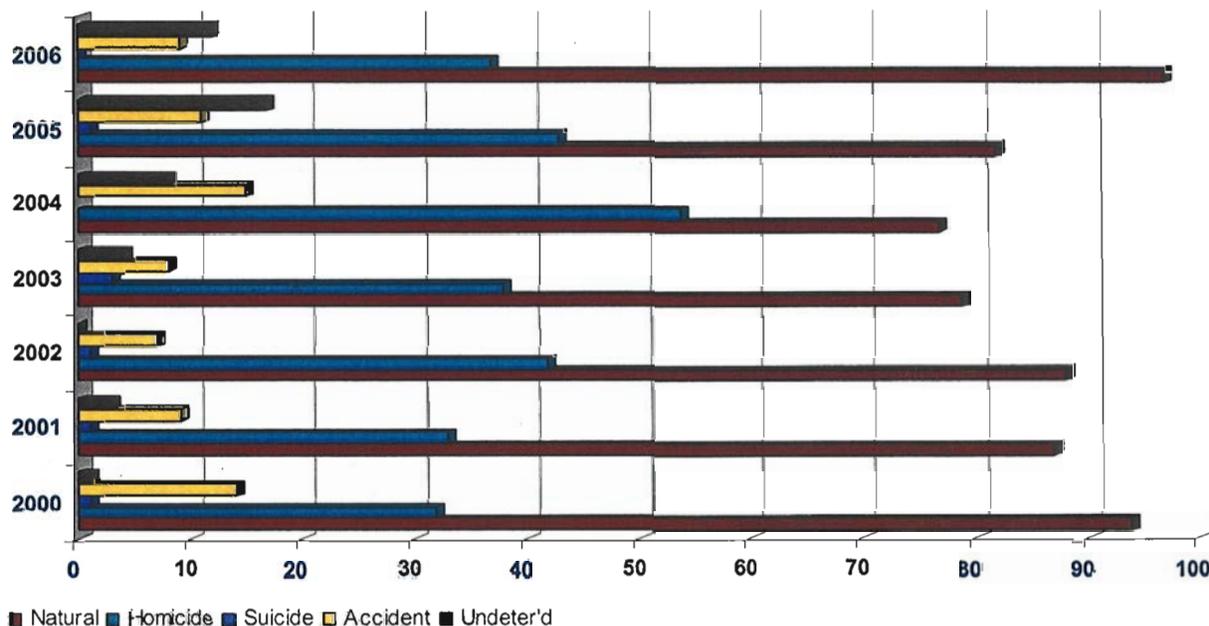


Figure 8: Manners of Death - 2006

- ◆ Figure 8 depicts the manners of death for CFRC identified children and youth for a seven year period.

Figure 8: Comparison of Manners of Death (2000 - 2006)



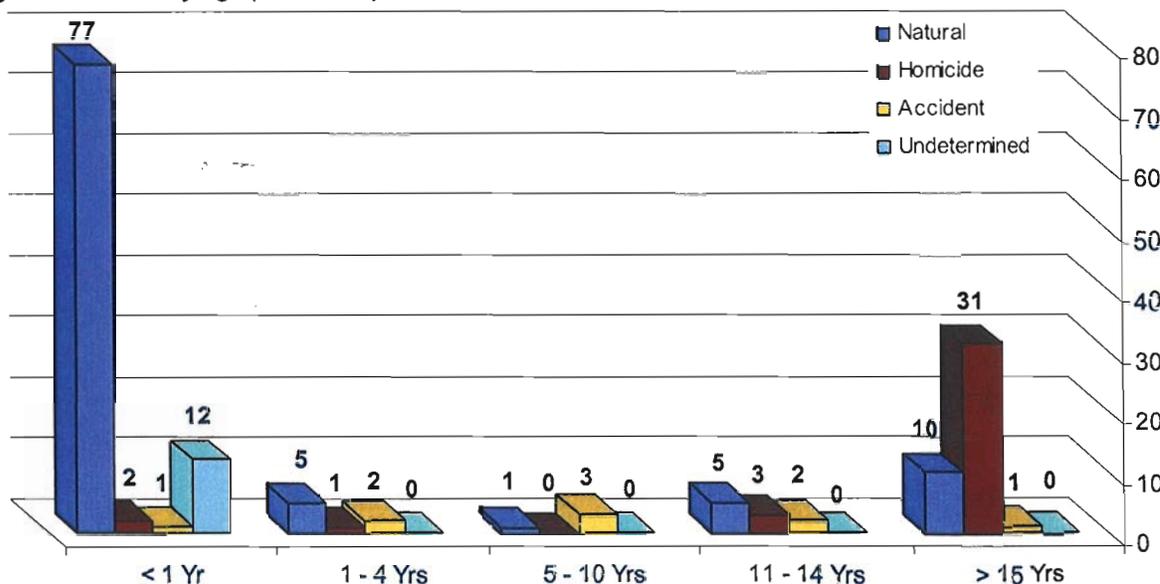
- ◆ This graph supports findings that the overall leading manner of death for District children/youth is Natural followed by Homicide. Historically, CFRC data shows that this has been a reliable trend since 1998. Data supports the fact that the number of Natural child deaths have consistently fluctuated. However, between 2004 and 2006, Natural deaths increased by 27%. These deaths have always predominantly involved infants under 29 days and the causes have primarily been attributed to issues associated with prematurity. During this same period, after the peak in Homicides in 2004; the number of children/youth dying violently has steadily and significantly. The 37 violent deaths in 2006 represent a 31% decline since 2004..
- ◆ One noteworthy trend change that began in 2005 and continued in 2006 data is the number of Undetermined deaths replaced Accidents as the third largest population of child deaths in the District. In 2006, there were 12 children who died from Undetermined manners of death. Although this represents a 25% reduction from the 16 (Endnote # 3), Undetermined 2005 fatalities, it continued to rank third.
- ◆ Accidental deaths also decreased in 2006. The nine children who died accidentally in 2006 represent 18% less than the 11 who died from unintentional injuries in 2005.
- ◆ There were no 2006 deaths that were attributed to Suicide that met the CFRC criteria for review.

**Manner By Age of Decedent**

- ◆ As Figure 9 (page 10) illustrates, the 2006 manners of death varied by age of the decedents.
- ◆ When reviewing the three leading manners of death, data support the fact that infants continued to dominate fatalities attributed to Natural and Undetermined manners; while youth over the age of 14 were the primary victims of Homicide in the District.

- ◆ Seventy-eight percent (n = 77) of the 98 Natural deaths from calendar year 2006 involved children under the age of one year and the majority (n = 53) of these deaths involved neonates (under 29 days old).
- ◆ One hundred percent of the 12 Undetermined deaths from 2006 were infants.
- ◆ Eighty-four percent (n = 31) of the 2006 Homicides were over the age of 14 years and 100% of the victims were Black/African American males.

Figure 9: Manner By Age (2006 Data)



### Manner By Race and Gender

- ◆ Table 2 reiterates the fact that Black/African American males continued to dominate all manners of death categories, followed by Black/African American females. For 2006 data this trend is more conspicuous in the Homicide and Accident manners of death. Manners of death for the White and Hispanic children were predominately attributed to Natural deaths.

Race/Gender	Natural	Homicide	Accident	Undetermined	Total
Black Male	54	35	8	5	102
Black Females	35	1	1	6	43
White Males	3			1	4
White Females	2				2
Hispanic Males		1			1
Hispanic Females	2				2
Other Males	1				1
Other Females	1				1
<b>Totals</b>	<b>98</b>	<b>37</b>	<b>9</b>	<b>12</b>	<b>156</b>

### Manner By Ward of Residence

- ◆ Table 3 below, illustrates the Ward of the decedents' residence by manner of death for calendar years 2006.

WARD	Natural	Homicide	Accident	Undeter-	Total
Ward One	7	1			8
Ward Two	8	3	1		12
Ward Three	3				3
Ward Four	9	2	1		12
Ward Five	18	2		1	21
Ward Six	14	7	1	2	24
Ward Seven	17	12	1	1	31
Ward Eight	19	8	5	8	40
MD/	3	2			5
<b>Totals</b>	<b>98</b>	<b>37</b>	<b>9</b>	<b>12</b>	<b>156</b>

- ◆ Ward Eight had the highest number of fatalities in all manners of death with the exception of Homicides. Ward Seven had the highest number of Homicides in calendar year 2006.
- ◆ The majority of the 2006 Natural deaths involved children from Wards Five, Six, Seven and Eight (n = 68, or 70%).

### CAUSE OF DEATH

In 2006, there were 156 (99%) fatalities where the cause of death was known. This included two of 12 Undetermined deaths in which the cause of death remained, "Undetermined" after the autopsy. CFRC was unable to obtain copies of the death certificates for one of the 2006 child/youth fatality, thus the cause and manner of the death remains unknown.

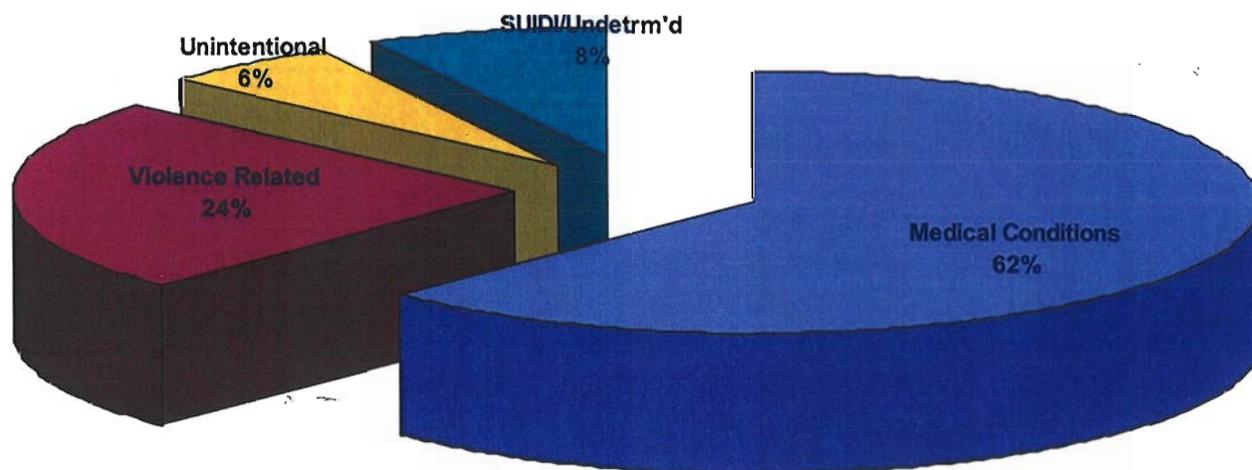
For the purposes of this Report and to ensure consistency in evaluating Committee data, the causes of death have been grouped in the following four categories: Medical conditions, Violence Related, Sudden Unexplained Infant Death (SUID)/Undetermined and Unintentional Injuries. These categories do not always reflect the actual causes as stated on the death certificate. However, specific information on the actual cause of death is provided as each category is discussed throughout this Section of the Report and is depicted in Appendix C, 2006 Calendar Year Fatality Listing By Age, Cause and Manner of Death.

#### *Case Vignette: A 2006 Natural Death*

A 13 year old youth, with a medical history of cerebral palsy and mental retardation, was found by a relative in his NE home, along with his mother in an unconscious state on the floor. The youth was transported by emergency medical services to a local hospital. It was determined that he was suffering from pneumonia, dehydration and malnutrition. Based on the investigation, it was also determined that the mother had died from a drug overdose at least one day prior, leaving the youth without any means of care or support.

**Cause/Manner of Death:** Lung Collapse due to Pneumonia, Sepsis, Renal Failure/Natural

Figure 10: Causes of Death - 2006 Data



### MEDICAL CONDITIONS

- ◆ As Figure 10 illustrates, the leading causes of death in the District continued to be associated with medical conditions. In calendar year 2006, of the 156 CFRC deaths where causes were determined/known, 98 involved children/youth who died from medical related problems (62%).
- ◆ The ages of the 2006 decedents who died from medically related causes ranged from birth through 21 years of age, with an average age of three years.

**Children Under One Year of Age (Infants)** – In 2006, data indicates that 77 or 79% of the medically related deaths involved infants (under the age of one year). Of infant deaths, 53 (69%) occurred within the first 28 days after birth and 81% of these children died within the first day of life (n = 43).

### *Findings Associated with Medically Related Causes of Infant Deaths*

- ◆ As with previous CFRC years, based on a review of death certificates, the leading cause of death among infants who died from medical related causes was prematurity and associated complications. Prematurity as the primary cause of death accounted for 43% (n = 32) of the 2006 infant deaths. However, 20 additional death certificates also included prematurity as a contributor to the fatality. Combined, prematurity, as a primary and/or contributing cause of District infant fatalities, accounted for 67% of the 2006 medically related infant deaths.
- ◆ Of the 52 deaths where prematurity cause and/or contributed to the death, extremely low birth weight (less than 500 grams) was a factor in 50% (n = 26) of the infant deaths. Twenty additional cases involved infants with birth weights between 500 and 1000 grams (40%).
- ◆ Respiratory System disease ranked second with 19 infant death certificates that highlighted this problem as the primary cause of death.
- ◆ Congenital anomalies ranked third with eight deaths in the category.
- ◆ Maternal complications were documented on death certificates as underlying causes for 31 or 40% of the 77 medically related infant deaths from 2006. Maternal complications included premature rupture of membranes, Chorioamnionitis, Preeclampsia, placental abruption, Incompetent Cervix, maternal substance abuse, Hypertension, etc.

### ***Educational Fact: Premature Births***

Most infants are born after a term gestation, that is, the birth occurs between 38 and 42 weeks of pregnancy. A premature infant is born before 37 completed weeks of gestation. Premature births account for 12.5% (over a half million) of the births in the United States. A premature birth gives a baby less time to develop and mature in the womb. The result is an increased risk of various medical, developmental problems and death. For unknown reasons, Black women are more than twice as likely to experience preterm labor and premature birth than are women of other races. However, preterm labor and premature birth can happen to any one. In fact, even if a woman exhibits one or more risk factor, it does not mean she will have a preterm birth and there are also women who have a premature birth and have no known risk factors. Often, the specific cause of preterm labor or premature birth isn't clear. However, the most common risk factors include:

- Previous preterm labor or premature birth
- Pregnancy with twins, triplets or other multiple births
- Problems with the uterus, cervix or placenta
- Smoking cigarettes, drinking alcohol or using illicit drugs
- Some infections, particularly of the amniotic fluid and lower genital tract
- Some chronic conditions, such as high blood pressure and diabetes
- Weight problems (under or overweight) before pregnancy
- Stressful life events, such as the death of a loved one or domestic violence
- Multiple miscarriages or abortions.

Preconception health education and counseling is needed to improve pregnancy outcomes by insuring that mother is in good health prior to conception. Addressing high blood pressure, diabetes, infections, obesity and other health problems, prior to pregnancy may reduce some risk factors for premature births. There is also the need to educate potential mothers of the need to lower stress in their lives and to plan the intervals between pregnancies. The need to refrain from smoking, use of alcohol and illicit drugs are also factors to be stressed for a positive pregnancy outcome.

Source: March of Dimes Quick Reference and Fact Sheets, 12/11/07, Fact Sheet: Preterm Birth. Mayo Clinic, Tools for Healthier Lives; Pregnancy, Premature Birth.

### ***Case Vignettes: Two 2006 Deaths Associated with Premature Births***

A 30 year-old Black mother delivered a premature infant in April 2006. Her medical history was remarkable for Thyroid goiter, Asthma, hypertension and prior diabetes with medication. Social history was significant for substance abuse and prior incarceration related to drug possession and intent to distribute. The mother received prenatal care beginning at 14 weeks with a total of 5 visits. The pregnancy was complicated by preeclampsia and maternal Candidiasis infection. The infection was treated with antibiotics and the mother was placed on bed rest because of concerns related to hypertension and the need to monitor for gestational diabetes. The mother presented to the hospital in active labor at 22 weeks gestation. She had a temperature of 100°F and bulging membranes. Delivery was considered imminent and she had spontaneous birth at 22 weeks gestation. The birth weight was 464 grams. Apgar scores were 1 and 1 at one and five minutes respectively. The infant had poor respiratory effort and minimal activity. He expired in the delivery suite at 9 minutes of age.

**Cause/Manner of Death:** Cardio Respiratory Failure, Extreme Immaturity at 22 weeks/Natural

A 20-year-old Black mother delivered a premature infant in March 2006. This was her 3<sup>rd</sup> pregnancy with obstetrical history of one voluntary abortion and one spontaneous abortion attributed to preeclampsia. Mother's medical history was remarkable for hypertension, previous sexually transmitted diseases and obesity. Mother had prenatal care beginning at 10 weeks and received 9 visits. The pregnancy was complicated by preeclampsia and GBS. She presented to the hospital with complaint of decreased fetal movement noted at a prenatal visit. Sonogram showed non-reassuring fetal heart rate. Subsequently mother had a C/section delivery secondary to fetal distress and concerns for preeclampsia. Mother was observed to have placenta abruptio at 20%. The infant was 25 weeks gestation with birth weight of 500 grams. The infant had respiratory distress and despite aggressive medical intervention expired at 33 days of age.

**Cause/Manner of Death:** Respiratory Failure, Cardiovascular Failure, Candida Sepsis/Natural.

**Children/Youth One Year of Age or Older** – In 2006, 21 children and youth, between the ages of one through twenty-one met CFRC's criteria for review in the category of natural deaths. Ninety-five percent (n = 20) were Black/African American and sixty-two percent (n = 13) were males.

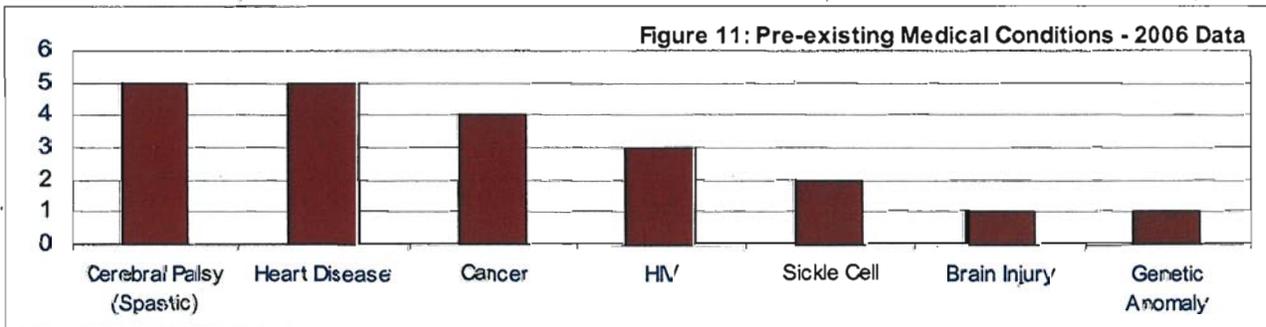
***Case Vignette: HIV/AIDS Natural Deaths***

As an African American teenage male born HIV positive, JB longed to be reunified with his mother and infant sibling. JB was known to the District's child welfare system since the age of 10, as he was left alone while his mother was shoplifting. A total of six neglect allegations were reported between 1998 and 2003. As a result, JB experienced multiple living arrangements between foster care placements, and relatives. JB worried frantically about his mother, who was homeless, and a substance abuser. He absconded from placements on numerous occasions in order to search for his mother, and exhibited unpredictable behaviors, such as excessive crying and biting. Child welfare services had difficulty arranging both medical and mental health services for JB, who at the age of 12, refused to participate in services offered. A relative became his legal guardian, however he continued to refuse medical treatment. JB also experienced school failure; and school officials reported that he did attend he was "ill, and sick looking". Concerned about other kids knowing about his illness, he completely withdrew from school in 2005, and was reportedly uncooperative with the home schooling program. In the summer of 2006, JB presented to a local emergency room with a five-day history of coughing, chest pains and chills. He coded, and medical interventions were futile. Although child welfare services were being provided to the family at the time of his death, records indicate that services for JB terminated in 2003, without specific reasoning. The review confirmed that JB's medical needs were not properly addressed, and multi-disciplinary planning was not implemented for JB and his caretakers, which should have included community-based resources for teens living with HIV/AIDS.

**Cause/Manner of Death:** Respiratory Failure, Septic Shock, AIDS/HIV Infection/Natural

***Findings Associated with Medical Related Causes of Deaths of Children One and Over***

- ◆ Data from calendar year 2006 indicate that Respiratory System Disease was the leading cause of medical deaths in this age group (n = 7), followed by Neoplasms and Infection with equal numbers of death in each category (n = 3).
- ◆ All of the children/youth reviewed in the one year of age and over category had pre-existing medical conditions that ultimately lead to their deaths. As Figure 11 indicates, both Cerebral Palsy and Heart Disease were the leading pre-existing conditions, each encompassing 24% of the Natural deaths for this age category.
- ◆ Four of the five decedents with a history of Cerebral Palsy were maternally exposed to illicit drugs at the time of their birth. Two of the five children with Heart Disease were not diagnosed until the time of the fatal events.
- ◆ Nineteen percent of the decedents (n = 4) were diagnosed with Cancer, however one of the four was diagnosed during the fatal event and at autopsy.



- ◆ The three decedents diagnosed with HIV were maternally exposed at birth, as were the two decedents with Sickle Cell Disease.
- ◆ One 2006 decedent was diagnosed with a brain injury at birth and one with a genetic anomaly (Trisomy 13).

**Educational Fact: Prevention—HIV Related Deaths**

Research indicates that perinatally acquired HIV disease, that is infection transmitted from the mother to her unborn child, is significantly decreased when the mother is identified early and receives appropriate care and medications during her pregnancy and intrapartum period. The infant at risk of HIV disease then receives appropriate monitoring and antiviral medications beginning shortly after birth to six weeks of age or longer depending on the infant's condition and follow-up laboratory studies. The transmission of HIV infection to the infant can be reduced from 25% to less than 8%. Also, the advancement in HIV/AIDS treatment has dramatically increased the survival rate. Individuals living with HIV/AIDS, who delay medical treatment or do not comply with their retroviral medication protocol, may forfeit approximately 14 years of life, as opposed to those who comply with medication and treatment, who may lose up to nine years of life. Using the Years of Potential Life Lost (YPLL) calculations (indicator of premature mortality), with proper prenatal care, use of antiviral medications and adherence to medical treatments, the CFRC decedents living with HIV/AIDS could have lived until the age of 50.

Sources: 1. Disparities in Life Expectancy Due to Suboptimal HIV Care in the US: Impact of Gender, Ethnicity, and Race, National AIDS Treatment Advocacy Project, February 2007; 2. Center for Disease Control, National Center for Health Statistics; 3. National Center for Health Statistics, Center for Disease Control, YPLL for Persons Under the Age of 75

**Categorization of Underlying Medical Causes of Death**

Based on the review of the death certificates of all children who died from medically related causes, Table 4 depicts the leading causes for the 98 medically related deaths for 2006 decedents of all ages (because the majority of the death certificates included multiple related causes, the numbers represent only the primary cause of death.)

<b>TABLE 4: MEDICAL CAUSES OF DEATH—2006 DECEDENTS</b>			
<b>PRIMARY CAUSES OF DEATH</b>	<b>Infants &lt; 1 Yr</b>	<b>1—21 Yrs</b>	<b>Total</b>
<b>Infections</b>	7	3	<b>10</b>
<b>Neoplasms</b>	0	3	<b>3</b>
<b>Respiratory System Disease</b>	19	7	<b>26</b>
<b>Hemorrhage</b>	5	2	<b>7</b>
<b>Congenital Anomalies</b>	8	2	<b>10</b>
<b>Prematurity</b>	32	0	<b>32</b>
<b>Maternal Complications</b>	2	0	<b>2</b>
<b>Metabolic Disorders</b>	2	0	<b>2</b>
<b>Cardiac Disorder</b>	2	2	<b>4</b>
<b>Neurological Disorder</b>		2	<b>2</b>
<b>Totals</b>	<b>77</b>	<b>21</b>	<b>98</b>

- ◆ Prematurity was the leading cause of death for the 97 medically related deaths .
- ◆ The second leading cause of death was related to Respiratory System Disease/Disorder. Sixteen infants and seven children one year of age or older died from respiratory problems.
- ◆ Equal numbers of children died from infection and Congenital Anomalies. These deaths were followed by deaths associated with Hemorrhages (n = 6) and two of these deaths were associated with intraventricular hemorrhages.

## **VIOLENCE RELATED DEATHS**

Since 1996, the number of child/youth deaths attributed to some form of violence has ranked second in the District. For the purposes of this Report, violence related deaths include Homicides and Suicides. Based on a review of death certificates for calendar year 2006, there were 37 Homicides of District children/youth. There were no 2006 deaths attributed to Suicides compared to two youth Suicides that occurred in 2005.

### ***A 2006 Youth Violence Homicide***

On 3/1/06, MPD responded to a report of a shooting in the rear of a residential area in the SE quadrant of the city. Upon arrival on the scene, officers located the body of an unidentified Black male suffering from an apparent gunshot wound to the head. FEMSD responded to the scene and found no signs of life. The decedent was transported to OCME for pronouncement and autopsy. Based on information from the investigation, the victim was shot while standing on the street with several other youth. The location of the fatal incident was determined to be a factor in the homicide, as the area was known for drugs, gangs and other criminal activity. The motive for the death was retaliation and was related to a previous robbery. There were witnesses to the fatal crime, and a 20 year old, Black male suspect was identified. Records indicate that the victim and perpetrator were acquaintances and resided in the same neighborhood. Additionally, both the suspect and the victim were known to the District's juvenile justice systems. The perpetrator was charged with 1<sup>st</sup> Degree Murder. At the time of the death, the victim was in abscondence from the juvenile justice system and was also known to the District's mental health, substance abuse treatment and public assistance programs. He also had a known history of gang related behavior/activity. The victim was academically 2 grades behind grade level and had a history of truancy with the DC public school system. Records indicate that he aspired to be a basketball player and he reported that his greatest challenge was "the world." Records also document that he had experienced the loss of two significant family during the recent years of his life.

**Cause/Manner of Death:** Gunshot Wound of the Head/Homicide

### ***Educational Fact: Predictors of Youth Violence***

Identifying and addressing the predictors of youth violence is critical to determining appropriate prevention strategies. Based on a study conducted by the Office of Juvenile Justice and Delinquency Prevention, US Department of Justice, the larger the number of risk factors an individual is exposed to, the greater the probability that they will engage in violent behavior. Some of the key factors highlighted in this study include:

- Individual Factors (physical, medical, developmental and psychological health)
- Family Factors (parental criminality, child maltreatment, poor family management practices, family bonding, parental attitude/involvement, parent-child separation)
- School Factors (level of educational achievement, interest in education, dropping out of school, truancy and quality of schools)
- Peer Factors (delinquent siblings, delinquent peers, gang membership)
- Community and Neighborhood Factors (poverty, community disorganization, availability of drugs and firearms, neighborhood adults involved in crime)
- Situational Factors (circumstances that surround a violent event and influence the outcome)

Source: "Predictors of Youth Violence", US Department of Justice, Office of Juvenile Justice and Delinquency Prevention, April, 2000

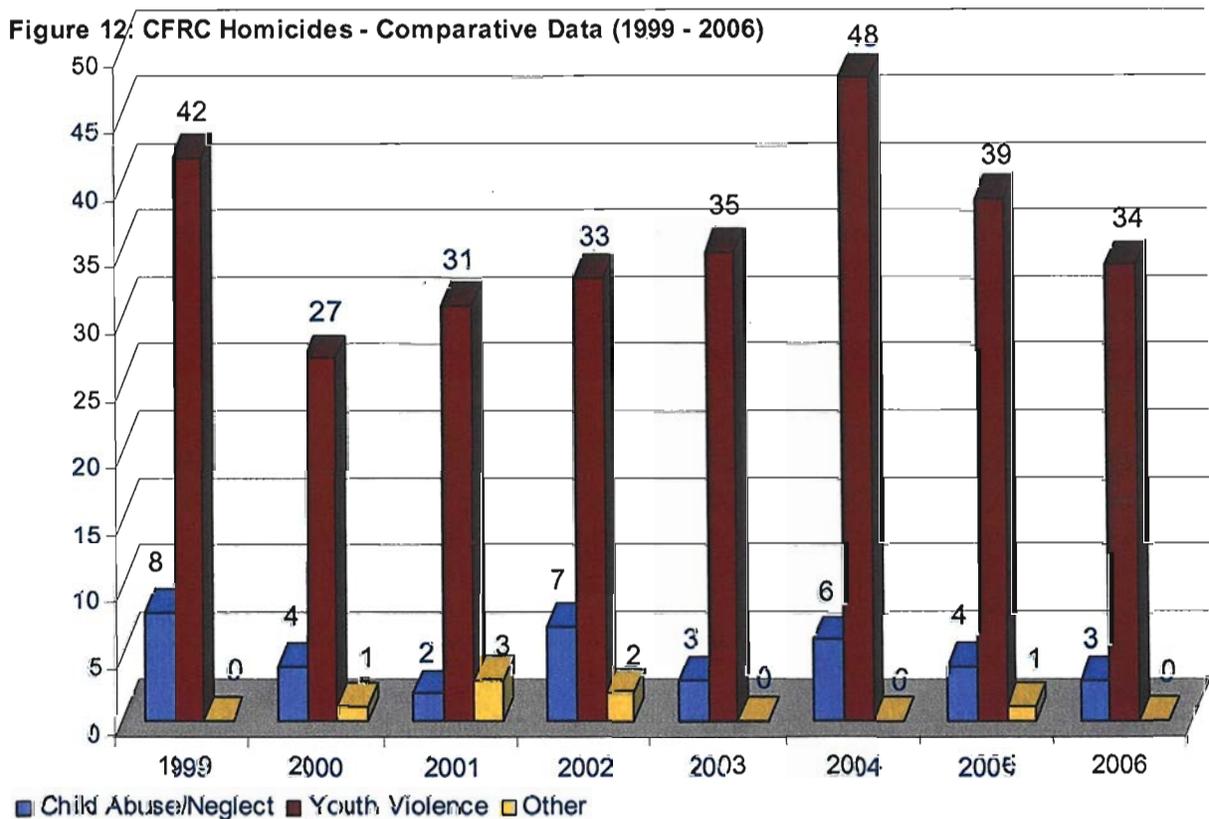
**Homicides**

CFRC maintains child/youth Homicide data in three categories: youth violence, fatal child abuse/neglect and other. For the purposes of this Report, youth violence refers to those Homicides where another juvenile or young adult usually was the perpetrator and/or the motive for death was usually related to gang activity/behavior, drug use/sales or retaliation/argument/conflict. Fatal child abuse and neglect deaths included those Homicides where the death occurred at the hands of a parent, legal custodian or person responsible for the child's care at the time of the fatal incident. The "Other" category includes children/youth of any age where the death was the result of a deliberate act of violence by either a related or unrelated adult not in a caretaker role.

During calendar year 2006, the number of child/youth Homicides continued to decrease. There were 37 Homicides in 2006 compared to 43 in 2005 and 54 in 2004:

- ◆ As with 2005 data, the reduction in Homicides was represented in both youth violence and fatal abuse data. However, as in previous CFRC years, Homicide data continued to be dominated by acts of violence perpetrated by youth on youth violence.

Figure 12: CFRC Homicides - Comparative Data (1999 - 2006)



**Fatal Abuse and Neglect Fatalities**

- ◆ Since 1999 fatal child abuse/neglect related deaths have continued to fluctuate between three and eight; the highest number of deaths occurred during 1999 and 2002 (n = 8 and 7 respectively).
- ◆ In 2006, the number of fatal abuse deaths decreased by one (n = 3), representing eight percent of the total Homicide fatalities for this calendar year.

- ◆ The causes of death for the majority (n = 2) of the three 2006 fatal abuse/neglect Homicides were associated with “blunt impact injuries”. One fatal abuse death was caused by “Acute Doxylamine Poisoning”, which is a substance found in over the counter cold medication.
- ◆ The ages of the victims of fatal abuse/neglect were between one month and one year.
- ◆ Consistent with data from previous years, the majority of the 2006 victims of fatal abuse and neglect were Black/African Americans (n = 2, or 67%); one 2006 fatal abuse/neglect Homicide was a Hispanic infant. All of the 2006 fatal abuse/neglect deaths involved male victims.
- ◆ The decedents resided in Wards One, Two and Six. Two of the fatal incidents occurred in Ward One at the home of a relative and day care provider. One incident occurred in the decedent’s home in Ward Six.

***Case Vignette: A 2006 Fatal Abuse/Neglect Homicide***

At approximately 7:15 PM on a winter evening, members of the MPD and FEMSD responded to an apartment building for a report of an unconscious child. Upon arrival on the scene, MPD found a toddler in an unresponsive state. CPR was immediately initiated and the child was transported to a local hospital where he was pronounced dead approximately 7 hours later. Reports indicated that at the time of the fatal injury, the child was in the care of the mother’s paramour who reported that the victim had fallen from a seated position on a chair onto the uncarpeted tiled floor. It was further indicated that when the child was picked up he smiled and was subsequently placed back onto the chair. Moments later when the child was checked by the paramour, her eyes were reportedly rolling into the back of her head and she had labored breathing. The paramour immediately administered several puffs of Albuterol medication, thinking that the child was having an asthma attack. He then called 911 for medical assistance. Based on interviews with family members, it was reported that the victim was capable of walking, jumping and climbing( including on and off of sofas/beds, etc). The chair that the victim allegedly fell from was 1’4” from seat top to the floor.

**Cause/Manner of Death:** Hypoxic-ischemic Cerebral Injury and Cerebral Edema due to Blunt Impact of Head/ Homicide

***Educational Fact: Effective Fatal Abuse Death Reviews***

The National Center for Child Death Review identified the following 8 risk factors for completing effective reviews of child abuse and neglect deaths:

- Young children under the age of 5 years
- Parents or caregivers under the age of 30 years
- Low income, single parent families experiencing major stresses
- Children left with male caregivers who lack emotional attachment to the child
- Child with emotional and health problems
- Lack of suitable child care
- Substance abuse among caregivers
- Parents and caregivers with unrealistic expectations of child development and behavior

The review of the above toddler’s death met at least 5 of the 8 risk indicators.

Source: National Center for Child Death Review, A Program Manual for Child Death Review, 2005

- ◆ All of the perpetrators were in caregiver roles at the times of the deaths. One was a parent, one was the mother’s paramour (served as the caregiver while the mother worked); and one was the mother’s maternal aunt. The ages of the perpetrators ranged from 29 to 60 years; with an average age of 42.
- ◆ None of the decedents who died as a result of abuse or neglect nor their families was known to the District’s child protective services system prior to the fatal event.

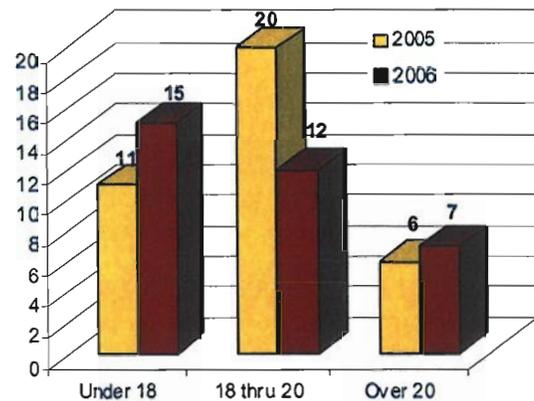
- ◆ Two of the deaths were the result of negligence on the part of the caregiver and the perpetrators were not prosecuted. One was the result of physical abuse and neglect by the caregiver. This perpetrator was arrested and charged with murder. She had a prior history with the criminal justice system, a substance abuse problem and after the death was evaluated and determined to have a mental health problem.

**Youth Violence Homicides**

Thirty-four, or 92% of the 2006 Homicides were associated with youth violence. This represents a 13% decrease from the 39 youth violence deaths from 2005.

- ◆ **Age of Decedent** – During 2006, the ages of the victims of youth violence ranged from 13 to 23 years. As shown in Figure 12, the number of Homicides increased in the under 18 and in the over 20 age categories and decreased in the 18 through 20 age group. Despite these changes in age related trends, consistent with 2005, the majority of decedents were over the age of 17 years (n = 19, or 56%). The average age of the 2006 Homicide victims was 16 years, however the youngest age was 13 and the most frequent age was 17 years (n = 7).

Figure 12: Ages of Youth Homicide Victims



- ◆ **Race/Gender of Decedent** – Black/African American males continued to dominate the youth violence fatalities in the District. Similar to 2004 and 2005, 100% of the 2006 victims were Black/African American. Between 2002 and 2005, males represented between 85 and 91% of the youth violence Homicides. In 2006, 97% of the youth Homicide victims were males. Data from 2006 revealed a shift in trend in that only one of the 34 youth homicide victims was female, which is an 80% decrease from the five CFRC female victims in 2005.

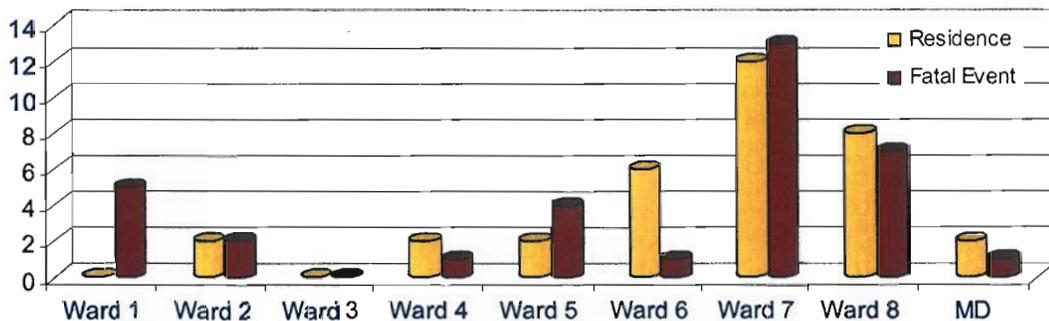


Figure 13: Ward of Residence/Fatal Event - 2006 Data

- ◆ **Ward of Residence/Fatal Incident** – As Figure 13 illustrates, the majority of the decedents from calendar years 2006 were residents of Ward Seven followed by Wards Eight and Six. The combined total for these Wards represented 76% (n = 26) of the total number of youth violent deaths for 2006. Similarly, the majority of the fatal events during 2006 occurred in

Ward Seven, followed by Ward Eight with seven and 13 deaths respectively. Fifty-nine percent (n = 20) of the youth Homicides occurred in these Wards. Eighty-five percent (n = 29) of the victims of youth violence were found in public areas (i.e., streets, alleys, parking lots, ravine, etc.); four of these deaths occurred on school grounds. Four youth were found in vehicles and one fatal incident occurred in the home of the victim's friend. See Page 21 for a map plotting the Ward of resident of the 2006 youth violence decedents and the location of the fatal incident.

***Case Vignette: A Benning Heights Youth Homicide in 2006***

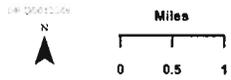
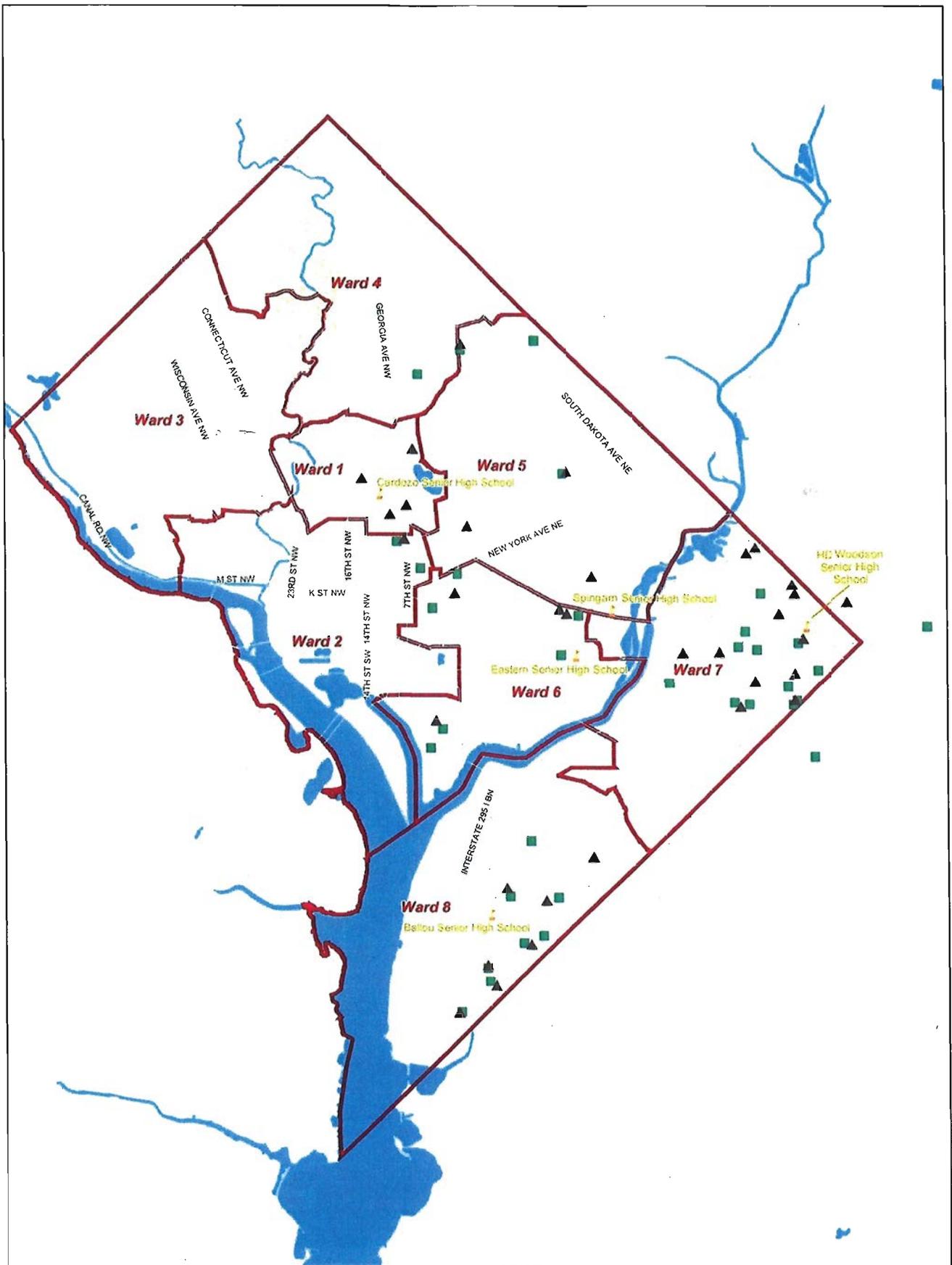
One a brisk morning in the SE quadrant of the District, MPD 6<sup>th</sup> District officers were called to the scene of an apparent shooting of two young African-American males. Victim #1 was suffering from a gunshot wound to the right side of the chest, and Victim #2 was suffering from a gunshot wound to the head. The two youth were transported to a hospital in Prince Georges County Maryland. Despite aggressive resuscitation efforts, the state of Maryland Chief Medical Examiner's autopsy report stated that both were pronounced dead on the afternoon of the day of the shooting. Toxicology screens at the time of death for both victims were negative for drugs and alcohol. Seven months after the shooting two suspects were arrested and charged with the murder of these youth. The investigation determined that the location of the fatal incident was a factor in the deaths, in that the neighborhood was known for drug, gang and other criminal activity. The deaths were associated with multiple motives however retaliation was noted as the primary motive.

Victim #1 was over 18 years of age and at the time of his death was not a District resident. He was known to the juvenile justice system and his case had terminated approximately 1 year prior to his death. At the time that his case terminated, he had withdrawn from high school but was attempted to enroll in an alternative/trade program. He also had a history of drug use and criminal behavior. As a result of his involvement with the juvenile justice system, he had received a range of services within the District. His mentor had reported that "he was a strong individual with endless possibilities."

Victim #2 was known to the District's child welfare and juvenile justice systems at the time of his death. As a three-year old, he witnessed the violent death of his father. Later, he would experience the grief of losing three younger siblings to premature birth; he also witnessed the fatal stabbing of an uncle. In 2001, due to his poor behavior as a 5th grade student, school officials referred him to the Persons in Need of Supervision Program (PINS) through the DC Superior Court and he began a series of inpatient psychiatric hospital stays. Records indicated that his mother was emotionally and physically unstable, which created an unstable home environment. At the age of 12, Victim #2 admitted to watching his mother abuse drugs. He also admitted that he used Marijuana and PCP. At the age of 13, he began to commit criminal acts, which led to his commitment to the District's juvenile justice system. After having escaped from residential treatment at the age of 14, he was involved in a physical altercation and received serious injuries that required hospitalization. He again returned to the custody of the juvenile justice system, and was subsequently returned to his home. His mother reported to government officials that she knew "he had a gun". He continued to participate in criminal activities that led to further juvenile arrests and remained committed to the juvenile justice system until his death at the age of 16.

The Committee's review of Victim #2 found that he had been referred for numerous community-based and government services however there were several systemic concerns associated with the services provided. Records indicated that providers and government agencies did not share information regarding the services provided, and providers were not evaluated for their effectiveness. Victim #2 never gained the ability to appropriately cope with the loss of significant persons in his life, and continued to abuse drugs. Due to his poor mental health and criminal history, he never maintained regular school attendance. At age 13, he began his first of three admissions to Oak Hill between 2002 through 2005. He absconded from custody on multiple occasions, eluding government officials while participating in criminal activities in his neighborhood. The Committee was able to associate Victim #2 to the death of two other CFRC 2006 homicides.

**Causes/Manners of Death:** (1) Gunshot Wound of Chest and (2) Gunshot Wound of Head/Homicide



Government of the District of Columbia  
 Adrian M. Fenty, Mayor

Office of Planning - November 28, 2007

This map was created for planning purposes from a variety of sources. It is neither a survey nor a legal document. Information provided by other agencies should be verified with them where appropriate.

### Youth Violence Homicides 2006

- Public Schools
- Place of Fatal Event
- Place of Residence
- 2002 Wards
- Water
- Parks

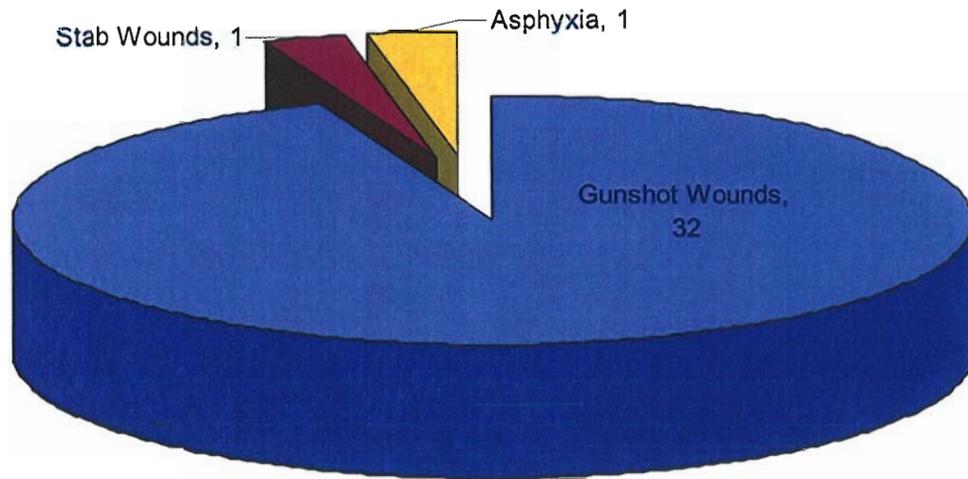
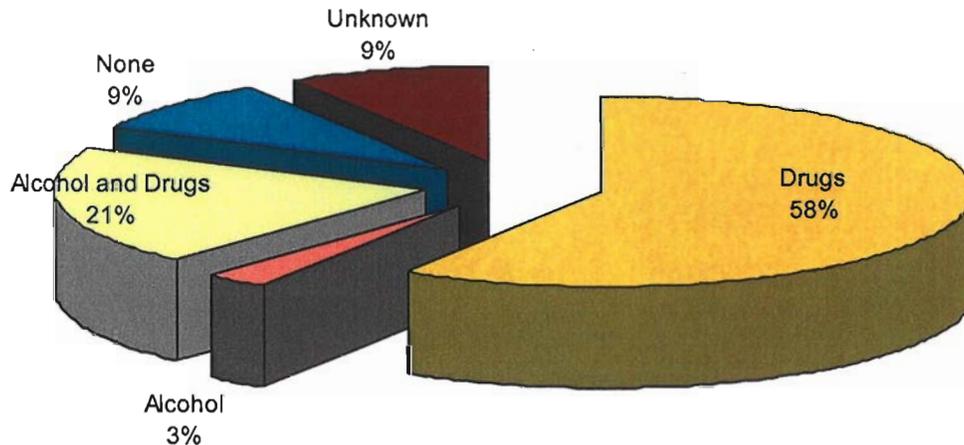


Figure 14: Causes of Death - 2006 Youth Homicides

- ◆ **Cause of Death** – As with all other CFRC years, 2006 data support the fact that guns are the weapons of choice in youth violence homicides. In 2006, 94% (n = 32) of the 34 youth violence Homicides were caused by firearms. While the majority of the 2006 firearm victims (n = 17, or 53%) were shot once in a major part of their bodies (head, chest, abdomen, etc); 15 victims were shot multiple times (between two and seven gunshots). The remaining two 2006 youth Homicides were caused by “Multiple Stab Wounds” and “Asphyxia”.

Figure 15: Prevalence of Substance and Alcohol Abuse Among CFRC Youth Violence Homicide Victims

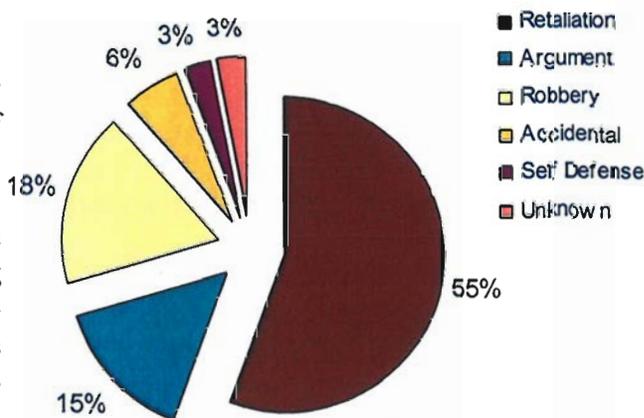


- ◆ **Toxicology Screen** – Based on the results of toxicology screens conducted at the time of autopsy, nine, or 26% of the 34 decedents were positive for drugs and/or alcohol at the time of the fatal incident. Although the number of decedents who tested positive for substance use was low compared to 2005 CFRC data (n = 16), records of youth violence homicide victims indicate that at least 82% of these youth were abusing illicit drugs, alcohol or both, in the years preceding their death. Drug use included marijuana, PCP, methamphetamine, and cocaine. However, records indicate that marijuana appeared to be the drug of choice, as 19 youth

admitted to abusing marijuana, some beginning as early as age 10 and 12. Through the review of the youth violence homicide cases, the Committee discovered that although substance abuse treatment services had been recommended for youth by various agencies, most programs provided generalized substance abuse education that were not specific to their needs.

- ◆ **Motive for the Fatality** - Based on MPD Reports, in 2006, motives were known for 33 of the 34 youth Homicides. Data indicates that retaliation was the leading known motive among 2006 homicides (n = 19, or 56%). Robbery was associated with six of the Homicides followed by arguments. Two of the Homicides were determined to be accidental deaths, both incidents involved youth playing with guns. Drugs and gang activity were noted as a factor in the investigation for 10 of the deaths. Self defense was associated with one 2006 fatality; this incident involved an altercation with law enforcement.

Figure 16: Motives of Youth Homicides



- ◆ **Risk Factors/Indicators** - In an effort to better understand, from a national perspective, why children die and to take action to prevent future deaths, the National Center for Child Death Review has established guidelines to facilitate a more effective review process. Based on these guidelines, the Center identified specific risk factors for reviewing teen homicides in the United States. In accordance with these guidelines as well as other CFRC risk indicators, District data revealed the following trends for 2006 youth violence Homicide victims:

- ◆ *Easy availability and access to firearms* - 94% of the youth fatalities were caused by gunshot wounds and 48% of the decedents were victims of multiple gunshot wounds.
- ◆ *Youth living in neighborhoods with high rates of poverty, social isolation and family violence* - CFRC records indicate that 28 of the 34 youth (n = 82%) received some form of public assistance (TANF, Food Stamps and/or medical assistance) through the District.
- ◆ *Youth residing/active in drug and gang activity* - 18 of the 34 youth victims (n = 53%) resided in areas designated by MPD as "Hot Spots". Sixty percent of the youth were killed less than a half mile from their homes. Victims who were residents of Wards Seven and Eight resided in small, concentrated high-crime areas of the city, known for drugs, gang and other criminal activity.
- ◆ *Youth dealing with mental health, behavioral and other emotional problems* - 52% of the youth victims had a diagnosed mental illness and received public mental health services. Three of the youth had documented suicide attempts. Twenty-four percent of the victims had documented behavior problems within their homes, schools and/or communities. Forty-four percent (n = 15) of the 34 victims experienced losses of parents, significant family members and friends.
- ◆ *Youth with early academic failure and truancy* - Based on a review of public agency records and death certificates, of the 19 youth violence Homicide victims who were be-

tween the ages of 18 and 23 years of age, only four had graduated from high school or received a GED. The remaining 15 youth (n = 78%) had dropped out of high school prior to their deaths and the last grade completed ranged from the seventh to the 11th grades. Of the remaining 15 youth victims who were compulsory school age, 6 had dropped out of school. Education placement was known for 23 of the 34 youth victims; 16 of the 23 decedents were enrolled in special education programs either at the time of their death, or at the time that they dropped out of school.

- ◆ *Youth with delinquent/criminal justice history* - 23, or 76% of the youth Homicide victims were known to the District's juvenile justice program and had prior histories of delinquent and criminal behaviors.
- ◆ *Youth with neglect, abuse and lack of supervision history* - 19, or 56% of the youth were known to the District's child welfare system and had long histories of chronic neglect/abuse and/or lack of adult supervision concerns.

**UNINTENTIONAL INJURIES**

For the purpose of this report, unintentional injuries are those incidents where the deaths were not the result of deliberate acts. This category may include violent or non-violent acts or non-violent conditions that were determined by the autopsy to be accidental. The nine child/youth fatalities associated with unintentional injuries from calendar year 2006 represent an 18% decrease from the 11 unintentional 2005 deaths, and a 40% decrease from the 15 accidental deaths from 2004. Figure 17 below illustrates accidental child/youth deaths involving District residents over a six year period. As this Figure illustrates, the major cause of unintentional District child/youth deaths was associated with motor vehicle accidents.

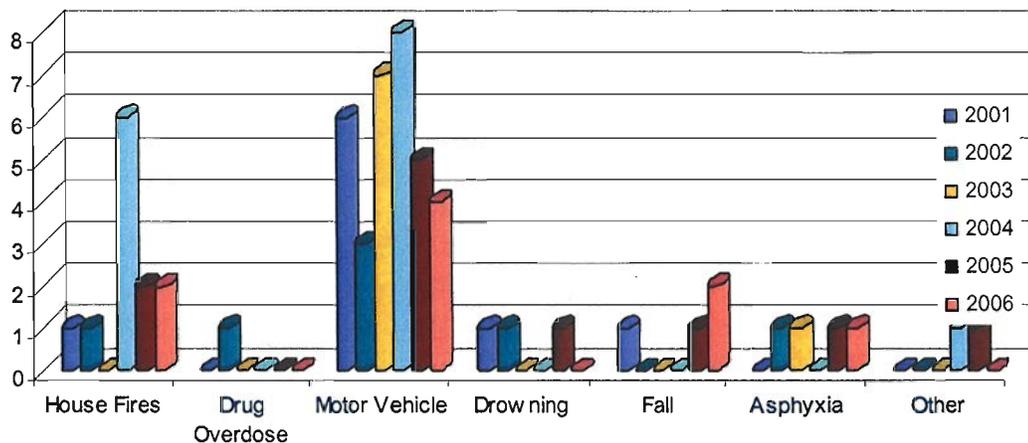


Figure 17: CFRC Accidental Deaths (2001 thru 2006)

- ◆ The ages of the 2006 victims of unintentional injuries ranged from 11 days to 19 years.
- ◆ 100% of the 2006 unintentional deaths involved Black/African American victims.
- ◆ In 2006, eight, or 89% of the victims were males.
- ◆ Consistent with previous CFRC years, the majority of the 2006 unintentional injuries were associated with motor vehicle accidents (n = 5, or 44%).
- ◆ Deaths associated with house fires and falls ranked second with two deaths in each category.

### Motor Vehicle Accidents

- ◆ Motor vehicle accidents represented 44% of the nine accidental deaths from calendar year 2006. All four of these incidents involved vehicles; there were no deaths that involved a motorcycle/motorbike during 2006. The four 2006 motor vehicle related accidents involved pedestrian injuries.
- ◆ *Pedestrian Related Accidents* - The four pedestrian motor vehicle deaths in 2006 represent a 300% increase from the one pedestrian accident that occurred in 2005. The 2006 pedestrian related accidents were as follows:
  - ◆ The victims ages ranged from four to 14 years, with an average age of nine.
  - ◆ All of the victims were Black/African American males.
  - ◆ Three of the victims were residents of Ward Eight and one was a resident of Ward Seven.
  - ◆ Two of the fatal incidents occurred in Ward Eight, one in Wards Seven and Five.
  - ◆ One incidents involved driver violations, as the driver ran a red light while the pedestrian was attempting to cross at the light within the crosswalk.
  - ◆ Two of the incidents involved pedestrian violations/error. Both of these incidents involved the decedent attempting to cross the street outside the crosswalk after exiting public or contract transportation. One incident involved an unaccompanied child with a long chronic mental health history that included suicide ideation. The second involved a child accompanied by his mother who had a chronic/serious mental health history that included suicide ideation/attempts. In this incident both the mother and child died from the motor vehicle accident.
  - ◆ One incident involved both driver and pedestrian violations/error. The investigative report showed that the decedent was struck by a vehicle as he darted into ongoing traffic. The driver, who was reported to be speeding, left the scene prior to the arrival of emergency response and law enforcement.
  - ◆ Alcohol was not a factor in three of the incidents and was unknown in one incident.
  - ◆ The time of the incidents for three of the motor vehicle accidents occurred in the evening after 7:00 PM. One incident occurred at 1:00 PM. In all of the accidents, the street conditions were noted as clear without any type of road obstructions or inclement weather.
  - ◆ Based on the Department of Transportation's analysis of the locations of three of the four pedestrian motor vehicle accidents, the following was noted:
    - ◇ Ward Seven Incident - Report indicated there were six prior accidents that had occurred between 2001 through 2005. As a result, a traffic light had been previously added and no additional changes were noted to be necessary.
    - ◇ Ward Eight Incident - Report indicated that there were four prior accidents during 2001 through 2005. Traffic calming devices and a stop sign were added as a result of the 2006 accident.
    - ◇ Ward Eight Incident—Report indicated that there had been 19 accidents that resulted in 10 injuries during 2005. As a result of the 2006 accident a bus stop was moved and traffic calming devices were planned.

### House Fires/Smoke Inhalation

- ◆ Two of the 2006 accidental deaths occurred in the same house fire.
- ◆ The victims were siblings and their ages were three and six years. Both were male and Black/African American.
- ◆ The location of the fire was the apartment of the decedents' family home in Ward Eight.

- ◆ Based on investigative reports, the source of the fire was “an undetermined smoking material.” The fire originated in, and was confined to the living room of the family’s apartment and the first item ignited was an upholstered sofa or chair.
- ◆ The Investigative Report indicated that the apartment was equipped with smoke/heat detectors that were hardwired with battery backup.
- ◆ The incident occurred during the night when the family was asleep (between 2:00 and 2:30 AM). Three other family members and guests (two adults and one child), who were in the home, suffered non-fatal injuries and several evacuated without injury.

***Case Vignette: Two 2006 Deaths Associated with Unintentional Injuries***

One evening in the spring of 2006, an unidentified male was operating a dark colored vehicle, with unknown registration, traveling southwest bound on a major street in the SE quadrant of the District. At the same time, a 5 year old pedestrian on foot, accompanied by several family members, was walking toward the east on the same street in SE. According to the children, the 5 year old separated from his family and darted out into the marked crosswalk in an attempt to cross the roadway. He was struck by the vehicle and after the impact, it was reported that his body was dragged by the vehicle. Eventually the victim became dislodged and came to a final rest roughly 70 feet from the crosswalk. As witnesses were rendering aid to the victim, the vehicle was observed decelerating toward the curb; coming to a brief stop and then suddenly speeding from the scene of the accident. The victim was transported to a local hospital by emergency medical personnel and was pronounced dead approximately 30 minutes later. The traffic report indicated that the streetlights were on, however the area was dark and the road conditions were dry. The intersection had a crosswalk for pedestrians, and a sign warning drivers of vehicles of the pedestrian walkway. The traffic report further indicates that there was no signal at the crosswalk. It was determined that the accident was the result of both pedestrian and driver violations.

**Cause/Manner of Death:** Multiple Blunt Impact Injuries, Fracture of Cervical Spine, Transection of Cervical Cord/Accident

One winter evening in the NW quadrant of the city, MPD officers were flagged down and informed that an individual had fallen out of the 8<sup>th</sup> floor window of a high rise apartment building. Upon arrival the victim was found unconscious and was subsequently transported by emergency medical services to a local hospital where he was pronounced dead. The investigation revealed that prior to the accident, the teen victim had been involved in a carjacking in the state of Maryland. The description of the car was dispatched from a Maryland police helicopter that was tracking the car by “Lojack” signal. The vehicle shortly afterward was observed (by an unmarked cruiser) in the NW area of the District. The dispatcher was alerted and a request for back-up assistance was made. The vehicle was followed to the eastside of the apartment building. The victim and a friend were observed exiting the vehicle and entering the apartment building. After a search of the building and contact with several residents, the police officers were unable to locate the suspect and returned to the rear of the building’s parking lot where the stolen vehicle was located. A short time later, citizens approached them to advise that a subject had just fallen out of a window in front of the apartment building. MPD responded and observed a male subject lying on the sidewalk and notified the dispatcher to have the fireboard respond. Upon observing the subjects, MPD noted that he had tattoos on his hands and neck matching the description provided. The victim/suspect, was transported to a local hospital where he was pronounced dead at 7:54 p.m. The investigation revealed that the victim/suspect, in an effort to elude police, fell while attempting to hang outside the window until police left the building. At the time of the death, the victim/suspect had two outstanding bench warrants.

**Cause/Manner of Death:** Multiple Blunt Impact Injuries/Accident

**Other**

- ◆ **Choking** - One 2006 unintentional death involved a seven year old, Black/African American male who choked on a toy while playing outside in his neighborhood. The toy became lodged in his throat and impeded with emergency resuscitation efforts.

- ◆ **Fall** - There were two deaths associated with falls in 2006. Consistent with 2005 data, one 2006 accidental death involved an 11 day old, Black/African American female. The infant was born prematurely due to the mother falling and injuring her abdomen. At the time of birth, the infant was 25 weeks gestation and weighed 610 grams. The cause of death was determined to be "Complications of Prematurity due to Placental Abruption due to Maternal Blunt Impact Abdominal Trauma". The mother was a resident of Ward Two.

The second fall incident involved a 19 year old, Black/African American male who fell from the ledge of an apartment building on the 10th floor while attempting to elude law enforcement. The decedent was known to the District's child welfare and juvenile justice systems. He was a resident of Ward Four, however the fatal incident occurred in Ward Two.

#### ***Case Vignette: Two 2006 Deaths Associated with Unintentional Injuries***

One evening in the spring of 2006, an unidentified male was operating a dark colored vehicle, with unknown registration, traveling southwest bound on a major street in the SE quadrant of the District. At the same time, a 5 year old pedestrian on foot, accompanied by several family members were walking toward the east on the same street. According to the children, the 5 year old separated from his family and darted out into the marked crosswalk in an attempt to cross the roadway. He was struck by the vehicle and after the impact, it was reported that his body was dragged by the vehicle. Eventually the victim became dislodged and came to a final rest roughly 70 feet from the crosswalk. As witnesses were rendering aid to the victim, the vehicle was observed decelerating toward the curb; coming to a brief stop and then suddenly speeding from the scene of the accident. The victim was transported to a local hospital by emergency medical personnel and was pronounced dead approximately 30 minutes later. The traffic report indicated that the streetlights were on, however the area was dark and the road conditions were dry. The intersection had a crosswalk for pedestrians, and a sign warning drivers of vehicles of the pedestrian walkway. The traffic report further indicates that there was no signal at the crosswalk. It was determined that the accident was the result of both pedestrian and driver violations.

**Cause/Manner of Death:** Multiple Blunt Impact Injuries, Fracture of Cervical Spine, Transection of Cervical Cord/Accident

On winter evening in the NW quadrant of the city, MPD officers were flagged down and informed that an individual had fallen out of the 8<sup>th</sup> floor window of a high rise apartment building. Upon arrival the victim was found unconscious and was subsequently transported by emergency medical services to a local hospital where he was pronounced dead. The investigation revealed that prior to the accident, the teen victim had been involved in a carjacking in the state of Maryland. The description of the car was dispatched from a Maryland police helicopter that was tracking the car by "Lojack" signal. The vehicle shortly afterward was observed (by an unmarked cruiser) in the NW area of the District. The dispatcher was alerted and a request for back-up assistance was made. The vehicle was followed to the eastside of the apartment building. The victim and a friend were observed exiting the vehicle and entering the apartment building. After a search of the building and contact with several residents they were unable to locate the suspect and returned to the rear of the building's parking lot where the stolen vehicle was located. A short time later, citizens approached them to advise that a subject had just fallen out of a window in front of the apartment building. MPD responded and observed a male subject lying on the sidewalk and notified the dispatcher to have the Fire Department respond. Upon observing the subject, MPD noted that he tattoos matching the description provided. The victim/suspect was transported to a local hospital where he was pronounced dead at 7:54 p.m. The investigation revealed that the victim/suspect, in an effort to elude police, fell while attempting to hang outside the window until police left the building. At the time of the death, the victim/suspect had two outstanding bench warrants.

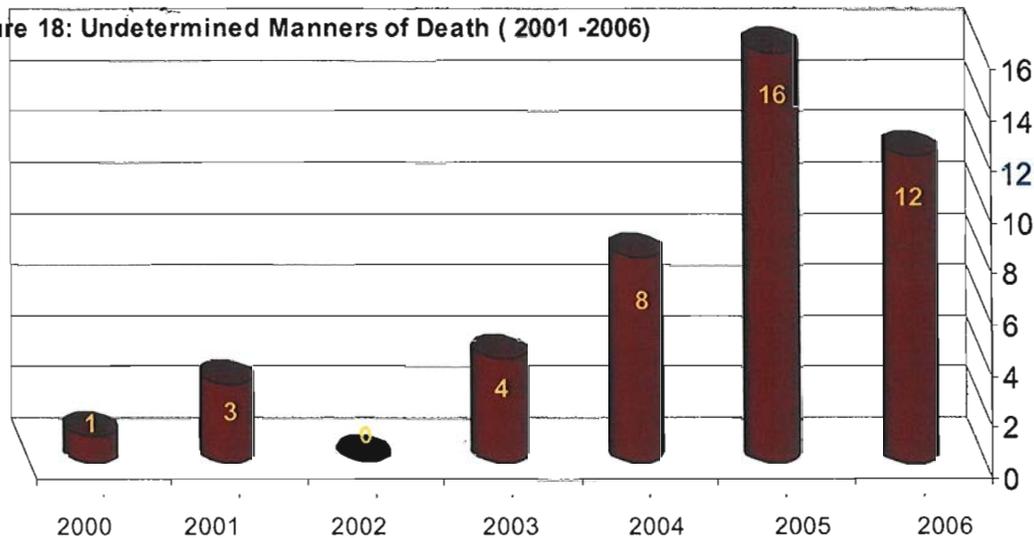
**Cause/Manner of Death:** Multiple Blunt Impact Injuries/Accident

**SUID/UNDETERMINED CAUSES OF DEATH**

Sudden Unexplained Infant Death (SUID) and Undetermined causes of death fall within the "Undetermined" manner of death category. "Undetermined" as a final manner of death is declared when a reasonable classification of manner cannot be established after a full and comprehensive analysis of the post-mortem examination, police and forensic investigations, toxicology screens and any other social, familial, medical and other specific events leading or surrounding the fatal incident.

Figure 18 below provides a historical view of the number of Undetermined child deaths that have occurred with District residents (Endnote # 4). In 2006, the number of child fatalities in which the autopsy rendered an "Undetermined" manner of death declined by 25% from calendar year 2005.

**Figure 18: Undetermined Manners of Death ( 2001 -2006)**



In 2006 there were 12 child/youth fatalities where the manner of death was Undetermined.

- ◆ The majority (10, or 83%) of the Undetermined deaths had a cause of SUID and two had an Undetermined cause of death.
- ◆ All of the decedents with Undetermined manners of death were under the age of one year.
- ◆ The majority were Black/African American (n = 11, or 92%) and there were equal numbers of male and female decedents (n = 6).
- ◆ The majority of the decedents were residents of Ward eight (n = 8). The four remaining decedents resided in Wards Six (n = 2), Five (n = 1) and Seven (n = 1).
- ◆ 50% of the infants were full term and the majority had birth weights greater than 1800 grams (n = 11).
- ◆ 92% of the mothers received prenatal care and 10 of these women received routine care during pregnancy. One mother did not receive prenatal care.
- ◆ Three of the mothers reported breast feeding at the time of the infants' deaths.
- ◆ In seven (n = 58%) of the cases there was either a history of parental substance abuse or evidence of drug use found on the scene.
- ◆ In five (n = 42%) of the cases the investigations revealed that one or both of the parents smoked tobacco.

- ◆ Based on a review of death certificates, hospital records and the death scene investigations, in seven , or 58% of the deaths, the infant was co-sleeping with one or more adults and/or children at the time of deaths.
- ◆ Ten, or 83% of the 12 deaths involved infants sleeping in adult beds or on a sofa, even though in six of these cases there were cribs in the homes. Eight of the decedents slept in inappropriate environments that included excessive and/or loose covers, pillows, stuffed animals, bottle propped, etc.
- ◆ Of the 12 Undetermined infant deaths, four parents/caregivers reported placing their children on their stomachs to sleep; four on their side and three reported placing infants on their backs.

**“Two 2006 SUID Death”**

A 4 month old male infant was left in the care his father while the mother was out of the home. The father reported that he played with the child and placed him on the sofa. At 6:00 PM, he fed the baby 8 ounces of formula and played with him again. At approximately 8:00 p.m. the baby became fussy and appeared to be tired. The father placed him on his stomach with his head turned to one side and between two pillows. He left the room and fell asleep for “a while”. At 12:10 PM, the father awakened and went into the bedroom to check on the baby. The baby was in the same position as placed. He laid down next to the baby and felt the baby’s back, which was cold. He then put his ear to the baby’s chest and did not hear any breathing. He breathed into the baby’s nose and mouth and noticed some regurgitated formula. He called 911. He did not perform CPR. The medic team arrived in a timely manner and CPR was initiated. The infant was transported to the nearest hospital. Upon arrival to the emergency room of the hospital the infant was in full cardiac arrest with no heartbeat or pulse. Despite resuscitation efforts, the infant was not revived and was pronounced deceased at 1:34 AM. The infant was 4 months/20 days of age and weighed 20 pounds at the time of death. No trauma was observed to the body. The investigative report indicated that the father and mother were subletting their residence from a friend. The scene was described as “just short of squatters”. There was evidence of drug paraphernalia: zip bags, and “blunts”. There was also evidence of alcohol and tobacco use. Records indicated that the infant had three pediatrician visits and there were no problems noted.

**Cause/Manner of Death:** Sudden Unexplained Infant Death While Sleeping in Prone Position on Inappropriate Bedding/Undetermined

Emergency medical services records indicated that during the early morning of a winter morning, a call was received by a frantic mother reporting that she had found her infant not breathing. The dispatcher instructed the mother to perform CPR on the child until medics arrived approximately 5 minutes later. Medics continued CPR enroute to the hospital. Upon arrival aggressive resuscitation efforts continued. However, medical intervention failed and the physician pronounced the female infant dead at 5:10 AM. The death investigation revealed that the mother had last fed her child 3 ounces of formula at 3:00 AM. She burped her and placed her on her back to sleep in her crib which was located in the mother’s bedroom. Inside the crib was an unfitted sheet, an infant pillow and a teething ring. The proximity of the pillow and teething ring to the infant could not be determined. Social history determined that the mother had a prior history of drug and current history of tobacco use. She was also known to the District’s child welfare and the healthy start programs prior to the death. Medical records indicate the infant was last seen by the pediatrician 3 days prior to the fatal incident. At that time of this visit, the infant had cold-like symptoms that included a fever. The mother received a prescription for over the counter medication. The investigation indicated that less than ½ ounces of the medication was missing from the bottle. Pediatric reports indicated that the child was behind in her immunization shots because the mother did not consistently follow through with medical appointments. Fatality review and MPD records indicated that the mother had another child who died in 2003; the cause of death for this child was meningitis. The contributing factors associated with the death included unfitted sheet and pillow in crib.

**Cause/Manner of Death:** Sudden Unexplained Infant Death/Undetermined

**Educational Fact: Sudden Unexplained Infant Death**

Sudden Unexplained Infant Death (SUID) is the term recommended by the Center for Disease Control to describe what was formerly known as Sudden Infant Death Syndrome (SIDS) or crib death. SUID is the death of a healthy child less than one year of age where there is no obvious cause. A cause of SUID is made after a thorough case investigation, including performance of a complete autopsy, examination of the death scene (with a retrospective doll reenactment), and review of the clinical history.



Placing infants on their backs to sleep has been nationally recommended to reduce the risk of Sudden Infant Death Syndrome (SIDS). As a result of the "Back to Sleep" campaign, which promotes safe sleeping to parents, child care providers and other infant care givers, the incidence of SIDS has fallen significantly. "Among the theories supporting the Back to Sleep concept is the idea that small infants with little or no control of their heads may, while face down, inhale their exhaled breath (high in carbon dioxide) or smother themselves on their bedding — the brain-stem anomaly research suggests that [some] babies do not react "normally" by moving away from the pooled [carbon dioxide], and thus smother. Another theory is that babies sleep more soundly when placed on their stomachs, and are unable to rouse themselves when they have an incidence of sleep apnea which is thought to be common in infants."

Here are 10 recommended ways that you and others who care for your baby can reduce the risk of SUID/SIDS:

- ◆ **Always place your baby on his or her back to sleep, for naps and at night.** The back sleep position is the safest, and every sleep time counts.
- ◆ **Place your baby on a firm sleep surface, such as on a safety-approved crib mattress, covered by a fitted sheet.** Never place your baby to sleep on soft surfaces (i.e., pillows, quilts, sheepskins).
- ◆ **Keep soft objects, toys, and loose bedding out of your baby's sleep area.** Don't use pillows, blankets, quilts, sheepskins, and pillow-like crib bumpers in your baby's sleep area, and keep any other items away from your baby's face.
- ◆ **Do not allow smoking around your baby.** Don't smoke before or after the birth of your baby, and don't let others smoke around your baby.
- ◆ **Keep your baby's sleep area close to, but separate from, where you and others sleep.** Your baby should not sleep in a bed or on a couch or armchair with adults or other children, but he or she can sleep in the same room as you. If you bring the baby into bed with you to breastfeed, put him or her back in a separate sleep area, such as a bassinet, crib, cradle, or a bedside cosleeper (infant bed that attaches to an adult bed) when finished.
- ◆ **Think about using a clean, dry pacifier when placing the infant down to sleep,** but don't force the baby to take it. (If you are breastfeeding your baby, wait until your child is 1 month old or is used to breastfeeding before using a pacifier.)
- ◆ **Do not let your baby overheat during sleep.** Dress your baby in light sleep clothing, and keep the room at a temperature that is comfortable for an adult.
- ◆ **Avoid products that claim to reduce the risk of SIDS** because most have not been tested for effectiveness or safety.
- ◆ **Do not use home monitors to reduce the risk of SIDS.** If you have questions about using monitors for other conditions talk to your health care provider.
- ◆ **Reduce the chance that flat spots will develop on your baby's head:** provide "Tummy Time" when your baby is awake and someone is watching; change the direction that your baby lies in the crib from one week to the next; and avoid too much time in car seats, carriers, and bouncers.

Source: National Institute of Child Health and Human Development, SIDS: "Back to Sleep" Campaign. CDC, MMWR: Recommendations and Reports, June 21, 1996/45 (RR-10); 1-6; Guidelines for Death Scene Investigation of Sudden, Unexplained Infant Deaths: Recommendations of the Interagency Panel on Sudden Infant Death Syndrome.

## PART II: SUMMARY OF CFRC SUBCATEGORIES

### INFANT MORTALITY DATA

Infant mortality is a very complex issue. Because this problem is affected by medical, socioeconomic, psychological, ethical and political factors, infant deaths have been utilized as a comparable measurement of overall health. The infant mortality death review process "puts a face" on statistics by compiling information from various sources (prenatal and delivery records, pediatric and emergency room records, emergency medical services and police reports, autopsy findings and maternal interviews) to develop a comprehensive account of the factors that contributed to the poor pregnancy outcome and/or deaths. The process humanizes the statistics; provides IMR participants with greater insight into the problems facing their communities and encourages participants to propose recommendations based on case review findings, their expertise, and pertinent research to lessen the impact of contributory factors.

#### *Case Vignette: A 2006 Natural Death*

A 17-year-old mother came to the delivery hospital in the summer of 2007 with complaint of uterine contractions. Vital signs were: temperature of 97.4, pulse of 108, blood pressure of 115/47 and respiration of 20. Weight was 119 pounds; height was 5 feet and 8 inches. OB history was significant for voluntary abortions and medical history was negative for serious illnesses, drug and alcohol use. The mother had prenatal care at the delivery hospital; with the first visit at week 13. The prenatal course was complicated by sexually transmitted disease and hyper-emesis. At the time of hospital arrival, the mother admitted to having contractions for several hours. Pelvic assessment in triage revealed mother to have bulging membranes. During the assessment mother complained of intense abdominal pain and a feeling of pressure in her bladder. She pushed and the infant was delivered in the afternoon. The mother was transported to the postpartum unit. Placenta pathology showed mild chorioamnionitis. The infant was determined to be preterm at 19 weeks; birth weight was 268 grams. The infant was considered non-viable and resuscitation was not performed. The infant expired on the afternoon of the day of birth. The mother held the infant until her death. Mother was discharged home the next day. Prior to discharge she was given an appointment to be seen by the OB/GYN clinic in 2 weeks and for 6 week check-up. The mother returned to the clinic for postpartum visit the next month. She was treated for STD and counseled on safe sex practices. She was also determined to have postpartum depression.

**Cause/Manner of Death:** Prematurity, Respiratory Failure/Natural

### 2006 INFANT DEATH DATA

In calendar year 2006, 93 infant deaths were identified by CFRC. This represents a 15% increase from the 81 deaths identified in 2005. However, this increase is more directly associated with several changes in CFRC practices and may not be reflective of an increase in the overall number of 2006 infant deaths in the District (Endnote # 5). The 93 infant deaths identified by the Committee represent 59% of the total CFRC deaths for 2006 (n = 157). Based on a review of the 93 CFRC infant deaths, the following information represents trends/observations documented during the Infant Mortality Review process:

#### **Decedent/Family Demographics**

- ◆ In 2006, the ages of the decedents ranged from birth through nine months. Over half (n = 55, or 60%) of the infant population died within the first 28 days of life (neonates) and 78% of these infants (n = 43) died within the first day of life.

- ◆ Figure 19 illustrates the race of the 2006 CFRC infant decedent population. Consistent with the overall CFRC data, the majority of the infant deaths are Black/African American. Eighty-three, or 89% of the infant decedents were Black/African American. White and Hispanic decedents ranked second and third respectively.
- ◆ As Figure 20 depicts, the majority of the infant deaths were male. Fifty-eight percent (n = 54) of the 93 decedents were males and 39 were females.

Figure 19: Race of 2006 Infants

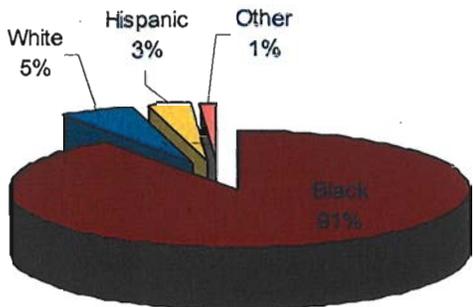
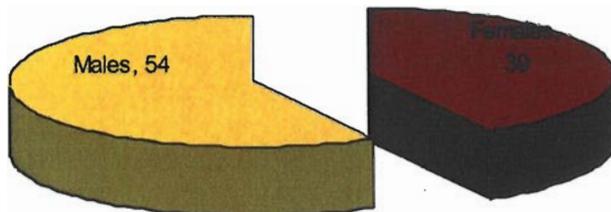


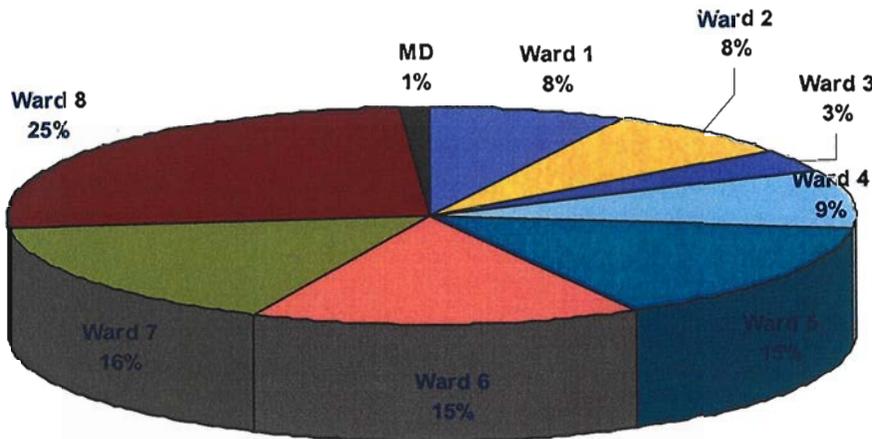
Figure 20: Gender of 2006 Infant Decedents



◆ **District Ward of Decedents**

- ◆ As Figure 21 illustrates, consistent with the majority of prior CFRC years, there were infant deaths from all Wards of the District during calendar year 2006.
- ◆ Data indicates that the majority of the infant deaths involved residents of Ward Eight (n = 24), followed by Ward Seven (n = 15). The combined deaths for these two Wards represented 42% of the total infant deaths for 2006 (n = 39).
- ◆ Ranked third were Wards Five and Six with equal numbers of deaths (n = 14). Ward Four ranked fourth and Wards One and Two ranked fifth with equal number of deaths (n = 7).
- ◆ Ward three, which consistently represents the lowest number of deaths in the District, had three infant deaths.
- ◆ In 2006, there was one infant death that involved a resident of Maryland. This child/family was known to the District's child welfare system.

Figure 21: Ward of Residence - 2006 Data



*Message from CFRC Co-Chair*

Dr. Yvette Clinton-Reid

In the District, Black/African American women tend to have a higher incidence of premature births and subsequently an increased number of infants who die from severe prematurity and/or complications associated with decreased gestational age. This finding is not unique to the District; studies in other localities have demonstrated similar findings. Black/African American women also tend to have a high rate of infants weighing greater than 1500 grams who die after the first month on life. A significant number of these infants die as a result of inappropriate sleeping environment and/or poor living conditions. The majority of the mothers who experienced an infant death were single, receiving Medicaid or Medicaid eligible and residing in areas of the city characterized by an increased number of citizens less than 18 years old, lower family income levels, decreased economic development, increased public and substandard housing, academically underachieving schools, increased crime and decreased access to critical services.

Utilizing the Perinatal Periods of Risk (Endnote #6), District statistics suggest that maternal health factors and problems related to the infant after hospital discharge contribute significantly to the infant mortality rate. The Infant Mortality Review (IMR) Team (one of two review teams under CFRC) has recommended increased emphasis on preconceptual health to assess overall health/nutritional status, identify social risks and institute interventions, stabilize chronic conditions and identify any gynecological problems that may adversely affect a pregnancy. This will also provide an opportunity to discuss reproductive awareness and the impact of various medications and toxins on the developing fetus. Social workers should be available in gynecological and obstetrical clinics to provide appropriate psychosocial assessments and referrals to appropriate services. Because many of these women received Medicaid or were Medicaid eligible during their pregnancy, policies should be altered to provide preconceptual health care to this population.

Based on IMR Team findings, a significant number of infants who expired lacked adequate newborn care. The Team has recommended that discharge planners assist in the follow-up of at-risk and/or high-risk infants and that a mechanism be instituted to identify all infants who have not been evaluated by a pediatrician/health care professional by one month after hospital discharge. The Team has further recommended the increase of nurses available to do home visitation and follow-up. The IMR Team has also recommended the formation of a Perinatal Consortium composed of health care professionals who can address problems such as quality of prenatal care, capacity to adequately care for high-risk obstetrical and neonatal patients, and malpractice issues.

◆ **Gestational Age/Birth Weight**

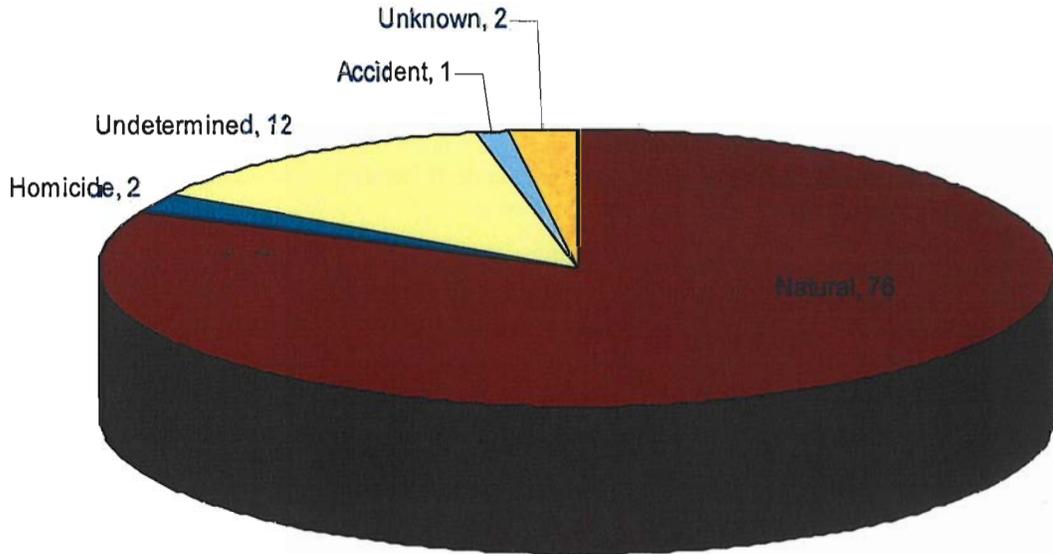
It is nationally recognized that infants with low gestational age and birth weight are at much higher risk of mortality. Historically, CFRC data have consistently documented these parameters as contributing to the high number of infant deaths in the District. Data from 2006 continues to support the severity and significance of this problem in the District.

Gestational age and birth weight are obtained from the birth certificate and birth records. This information was known for 90 of the 93 infant decedents from 2006. As Table 5 illustrates, low gestational age and birth weight continues to be a contributor to infant deaths in the District. Data from 2006 indicates that 75, or 83% of the 90 infants where gestation weight was known were born premature. Approximately one third (27) of these children were born with gestational ages of 22 weeks

<b>TABLE 5: Gestational Age/Low Birth Weight</b>	
<b>Gestational Age</b>	<b>2006</b>
< 38 Weeks	75/83%
< 23 Weeks	27
<b>Low Birth Weight</b>	<b>2006</b>
< 1500 Grams	58/ 64%
< 500 Grams	26

or below. Also consistent with previous years, 2006 data indicate that the majority (58, or 64%) of the 90 infants had birth weights under 1500 grams and 26 of these infants weighted less than 500 grams. Thirty-two of the 2006-infant decedents were full term births.

Figure 22: 2006 Manners of Death



◆ **Manner of Death**

Natural deaths of infants continued to comprise the largest group of infant deaths in the District. As with previous years, the greater majority of the 2006 infants died from Natural causes. Eighty-three percent (n = 77) of children under the age of one year died during 2006 from Natural causes. As previously discussed in the *Medical Conditions* section of this report (see page 12), although death certificates for 32 infants listed premature births as the primary cause of death, 52 or 68% of the 77 Natural deaths included prematurity as either a primary or contributing to the fatality. Table 6 below, illustrates the primary causes of the 77 Natural infant deaths for 2006.

PRIMARY CAUSES OF DEATH	Infants < 1 Yr
Infections	7
Respiratory System Disease	19
Hemorrhage	5
Congenital Anomalies	8
Prematurity	32
Maternal Complications	2
Metabolic Disorders	2
Cardiac Disorder	2
<b>Totals</b>	<b>77</b>

- ◇ Consistent with the past three CFRC calendar years (2003 through 2005), the second leading manner of 2006 infant deaths was "Undetermined." Twelve, or 13% of the 2006 infant deaths were attributed to Undetermined manner of death. Two of these deaths also had Undetermined causes of death. Ten of the deaths that were attributed to Undetermined manners had causes of Sudden Unexplained Deaths in Infancy; and the official autopsy reports for six (n = 60%) directly linked co-sleeping/bed sharing and/or inappropriate sleep environments to the cause of death.
- ◇ Two of the 2006 deaths were fatal abuse Homicides. The perpetrators of these deaths were parents or others in a caregiver role.
- ◇ The one 2006 death attributed to Accident involved a 29 year old Black/African American mother who fell during her second trimester, injuring her abdomen and causing premature labor.

◆ ***Decedent's Maternal Demographic Data***

- ◇ Age of the mother at the time of the 2006 death was known for all of the 93 CFRC infant fatalities. Their ages ranged from 16 to 45 years, with an average age of 27. The age of the mothers at the time of the first birth was known for 87 cases. The ages ranged from 13 to 45, with an average age at the time of the birth of the first child as 22.5 years.
- ◇ Race was known for 92 of the 93 mothers. Eighty-eight percent of the mothers (n = 81) were Black/African American. Five of the mothers who experienced infant deaths in 2006 were Hispanic and four were White.
- ◇ The majority of the mothers for calendar year 2006 infant deaths (n = 74) were single and had never married. Fifteen mothers were married at the time of the death and two were separated. Marital status was unknown for three mothers.
- ◇ Educational level was known for 57, or 61% of the 93 mothers of 2006 infant decedents. Eighty-two percent (n = 47) of the mothers where educational level was known had at least a high school education and 14 of these women had participated in college level educational programs; two of these mothers completed undergraduate level and three had completed graduate school. Ten mothers had less than a high school education.
- ◇ Of the 92 mothers where employment history was known, 23 were employed; and 69 mothers were unemployed at the time of the infant death.

***Case Vignette: A 2006 Congenital Anomaly Death***

In September 2006, a mother came to the hospital complaining of rupture of her membranes. Sonogram showed twin gestation at 30 weeks with both fetuses in the breech presentation. Subsequently, the mother had a C/Section delivery related to breech presentations of the twins and rupture of the membranes (Twin B) with concerns for possible maternal infection and associated risk factors. The birth weight for Twin B was 600 grams. Apgar scores were 1 at both 5 and 10 minutes. The infant was found to have multiple congenital anomalies that were considered non-compatible with life. Physical assessment showed dysmorphic features, enlarged chest cavity, a large omphalocele and complex cardiac anomalies. He was determined to have Trisomy 18. The infant received comfort care only. He expired at 4 hours of life. Twin A survived. This infant was the 2nd twin born to a 29 year old Black mother who had 2 prior pregnancies with no history of congenital anomaly births. Medical history was significant for morbid obesity and Asthma. Mother had late entry into prenatal care and had 5 visits. Initial sonogram showed twin gestation at 26 weeks with observed cardiac anomalies and elevated amniotic fluid for the decedent.

**Cause/Manner of Death:** Cardiopulmonary failure, Severe Trisomy 18 and Extreme Prematurity/Natural

◆ **Maternal Risk Factors**

Based on the review of hospital medical records, birth and death certificates, the following data on maternal risk factors were highlighted:

◇ **Prenatal Care**

- Prenatal care information was known for 87 or 94% of the mothers. Twelve mothers did not received prenatal care during their pregnancies with the 2006 decedents. Based on the number of visits documented in the medical record or the decedents' birth certificates, the majority of the remaining 77 mothers received prenatal care (n = 60).
- In cases where the week of the initial visit was documented, 33 (n = 52%) mothers received early prenatal care beginning in the first trimester. Sixteen mothers began prenatal care during the second and three during the third trimester.

◇ **Physical Health**

Of 89 cases where mothers' health status was known, 38 were diagnosed with physical health conditions. Some of the health problems included anemia (n = 11), asthma (n = 10), allergies (n = 7), diabetes (n = 5), cancer, obesity (n = 11), thyroid problems, sickle cell trait/disease (n = 5), and hypertension (n = 10).

◇ **Mental Health/Developmental Problems**

- Fifteen mothers had documented histories of mental health disorders, including depression, bi-polar disorder and suicide ideation.
- Four mothers were diagnosed with mental retardation.

◇ **STD/Maternal Infections**

Thirty-five women had histories of sexually transmitted diseases and/or maternal infections during their pregnancies with the decedent (i.e., preeclampsia, urinary tract infections, gonorrhea, HIV, Chorioamnionitis, Chlamydia, etc.)

◇ **Substance Abuse/Tobacco Use**

- Nineteen mothers had problems with substance abuse; 11 reported illicit drug use only; four alcohol and four reported problems with both drugs and alcohol.
- Seven mothers had positive toxicology screens for illicit substances at the time of the decedents' birth.
- Nineteen mothers also reported tobacco use.

◆ **Sibling Data**

- ◇ Most 2006 infant decedents had siblings. Of the 59 (n = 63%) families known to have other children, the number ranged from one to seven, with an average of two siblings.
- ◇ Eleven decedents were part of multiple births; ten were twins and one was a triplet. Data from 2006 includes two families where both twins died.
- ◇ Five mothers also had previous child deaths, including one mother who was pregnant twice and lost both children. Twenty-five women had prior fetal deaths (stillbirths, miscarriages). Thirty-seven women reported having at least one abortion prior to the birth of the 2006 decedent.

## JUVENILE JUSTICE FATALITY DATA

Twenty-eight (15%) of the 157 fatalities from 2006 were youth known to the juvenile justice system. Reviews of these cases revealed the following findings:

### DECEDENT DEMOGRAPHIC DATA

- ◆ *Age/Race/Gender* – The decedents' ages ranged from 13 through 22 years with an average age of 17 years. Consistent with 2004 and 2005, one hundred percent of the 2006 juvenile justice decedents were Black/African American and 96% were males (n=27).
- ◆ *Ward of Residence* – The majority (61%) of the 2006 juvenile justice deaths involved residents of Wards Seven (n = 10) and Eight (n = 7).
- ◆ *Substance Abuse/Involvement* – As with previous years, substance abuse continued to be a major concern in the majority of the 2006 juvenile justice fatalities. Eighty-six percent of the decedents (n = 24) had known histories of substance use or involvement.
- ◆ *Educational Level* – Based on reviews of public school, other public records and death certificates three juvenile justice decedents from 2006 had received a high school education or GED. Of the 25 remaining decedents, 17 had withdrawn from school; however, records document that one of these youth was enrolled in a GED program at the time of his death. Seven youth were attending DC Public Schools at the times of their deaths. Their ages ranged from 13 to 19 and their grades of enrollment at the times of their deaths ranged from the seventh to 12<sup>th</sup> grade. Educational information was unknown for one youth.
- ◆ *Mental Health Problems* - Fifteen of the youth had mental health disorders/conditions. Two case records documented that the youth had attempted suicide.
- ◆ *Public Services* – Consistent with 2005 data, the full population of juvenile justice decedents (n = 28) were known to the District's public assistance program; 23 of these youth were actively receiving services at the times of their deaths. All decedents who were active with the public assistance program were receiving medical assistance; four were receiving TANF and 12 youth were receiving food stamps at the times of their deaths. Additionally, 14 of the juvenile justice youth were also known to the District's child welfare agency.

### Manner/Cause of Death

- ◆ Consistent with prior CFRC years the majority of the 2006 juvenile justice fatalities were caused by violence related incidents. In Ninety-six percent (n = 27) of the 28 juvenile justice deaths from 2006 were Homicides, and 100% of these deaths were caused by firearms. The manner for one death was Accident.
- ◆ Similar to data related to the decedents' Wards of residence data, 17 or 61% of the fatal incidences also occurred in Wards Seven and Eight.

### Juvenile/Court History

- ◆ The majority of the juvenile justice decedents had numerous charges/arrests. Of the 28 decedents from the 2006 calendar year, 24 (86%) had multiple arrests. The types of charges included gun/ammunition possession, drug possession, assault, unauthorized use of a vehicle, and destruction of property.
- ◆ Seventy-one percent (n = 20) of the juvenile justice decedents had active cases at the time of the deaths. Nine of the youth were committed to the District; three were on detained status

and in some type of community-based facility under the supervision of the court; seven youth were on probation and one was in a pre-disposition status.

- ◆ In seventy percent of the active committed cases, the youth had a history of abscondence from the juvenile system.

## CHILD WELFARE FATALITY DATA

Child welfare deaths include those decedents who were known or whose families were known to the protective services, foster care and adoption programs within four years prior to their deaths. During 2006, 59 or 38% of the 157 deaths identified were children who met the definition for review as a child welfare fatality. Reviews of the 2006 child welfare fatalities revealed the following trends/observations:

### DECEDENT DEMOGRAPHIC

- ◆ **Age of Decedent** – The ages of the decedents ranged from birth through 23 years, with an average age of nine years. Consistent with overall child fatality data, the majority of the children were infants (n = 25) or older than 14 years of age (n = 24). Combined, these categories represented 83% of the total child welfare fatalities.
- ◆ **Race and Sex of Decedents** – One hundred percent of the 2006 child welfare deaths represent children/youth of Black/African American descent. Males continued to represent the majority of the child welfare fatality population. Seventy-two percent (n = 43) of the decedents were males.
- ◆ **Health/Mental Health of Decedents** – Over 50% of the 2006 child welfare youth over 13 years of age had histories of drug use (n = 14 or 54%). Eighteen (n = 31%) of the decedents were diagnosed with mental health and behavioral disorders. Seventeen 2006 decedents (n = 29%) had diagnosed chronic health problems/congenital anomalies or physical/developmental disabilities.
- ◆ **Educational Level of Decedents** - Over half (n = 32, or 54%) of the 2006 decedents were school age (over 4 years of age). Seventy-eight percent of these children/youth were over 14 years of age (n = 25) and 10 were over 18. The educational levels (last grade completed) for the children/youth over the age of 14 ranged from the seventh through 12<sup>th</sup> grades. At the time of their deaths, three youth had graduated from high school and one 15 year old disabled youth had never attended school. Sixteen of the 32 school age children/youth were enrolled in special education or alternative programs.

### CAUSE/MANNER OF DEATH

- ◆ **Natural** - The majority of the 2006 child welfare fatalities were attributed to Natural deaths. Thirty children died from medical related causes and over half of these children were under the age of one year (n = 18, 60%). The remaining 12 children were between the ages of one through 19 years. This represents 57% of the total number of children/youth one year of age or older who died from medical related causes in 2006 (n = 21). Based on a cluster review of older youth (over the age of 12) known to the child welfare system, of the nine cases reviewed, four were historically non-compliant with medications and also experienced a higher degree of social turmoil (parental substance abuse, unsafe living conditions and parental/caretaker educational deficits).
- ◆ **Homicide** - Seventeen (n = 30%) of the child welfare decedents died violently during 2006 (most from gunshot wounds). All of these deaths were Homicides and involved youth 14

years of age or older. There were no child welfare Homicides caused by parent/caregiver abuse (fatal abuse).

- ◆ **Accident** - Over half of the accidental deaths from 2006 involved children/youth known to the child welfare system (n = 5, or 56%). Four of these deaths resulted from motor vehicle accidents and one from Asphyxia due to choking on a toy.
- ◆ **Undetermined** - Fifty-eight percent of the total 2006 "Undetermined" fatalities involved decedents or their families who were known to the child welfare system (n = seven). Two of these cases also had Undetermined causes of death. Five included causes of Sudden Unexplained Death in Infancy and two of the decedent's death certificates included co-sleeping or inappropriate sleep environment as a factor in the death.

### Number and Reasons for Child Protection Services Referral and Case Status

- ◆ The majority of the 2006 families referred to the child welfare system were reported multiple times (n = 44, or 75%). The number of reports ranged from one to 49, with an average of four reports per family.
- ◆ In 54% of the child welfare fatalities, the decedents were part of the family cases (n= 32).
- ◆ Based on the last child abuse/neglect report received, the primary reason for families being referred was "general neglect". Thirty-two (54%) families were reported for general neglect issues and physical abuse ranked second (n = 10).
- ◆ At the time of death, 15 (25%) of the 2006 child welfare fatalities were families with active cases. Nineteen cases had closed within two years prior to death.

#### Case Vignette: A 2006 Juvenile Justice/Child Welfare Fatality

On a cold winter morning as a 16 year old female while attempting to cross the street with an infant in her arms, was shot when a vehicle passed and opened fire. Emergency medical services arrived within minutes of the call and transported her to a local hospital where she was pronounced dead. According to investigation information, the motive for the murder was retaliation. The incident occurred with 2 blocks of her home. Although the neighborhood was known for criminal activity, the locations of the shooting was considered to be a factor in the death. The perpetrator, who was an acquaintance of the victim, was arrested and charged with the death, however charges were later dropped due to insufficient evidence.

The victim was known to multiple agencies including child welfare, juvenile justice, mental health and educational programs. She had a history of exhibiting aggressive behaviors in both her neighborhood school and in the community where she resided. She became known to the juvenile justice system following a violent physical altercation in school. She was court ordered to participate in anger management. Her case successfully terminated approximately 1 year prior to her death. Her brief history with the child welfare program was related to issues of parental control and respect. The more recent reports were closed as unsupported. Several years prior to her death, the victim received school based psychiatric services. Although she did not have a history of school attendance problems, she did have a history of academic failure. Following concerns related to suicide attempt, the victim was referred for mental health services several years prior to her death. However, records documented problems with missed appointments. Records also documented that the victim was in a relationship with another CFRC decedent, who was murdered one month prior to her death.

**Causes/Manners of Death:** Multiple Gunshot Wounds/Homicide

# ENDNOTES

Endnote # 1 (Page 1)	Information presented in all CFRC annual reports represents raw data that results from the case review process and should not be used as the only tool for measuring true changes in child deaths in the District. This information should be evaluated within the context of other statistical measures that are also critical to understanding the overall trends and patterns that are consistently occurring in the child death population.
Endnote # 2 (Page 3)	For the 2006 calendar year, CFRC modified case identification practices to ensure that a higher number of child deaths are captured. Changes in practice included extending the closure of the year for case identification purposes from June to September and matching infant deaths with the Department of Health. Statistical reviews were completed on all cases identified as a result of these practice modifications.
Endnote # 3 (Page 9)	2005 Undetermined deaths decreased from the 17 reported in the 2005 Annual Report to 16 due to one autopsy that was amended to reflect Suicide as the manner of death.
Endnote # 4 (Page 28)	As prior CFRC Annual Reports have documented, the steady increase in "Undetermined" fatalities is directly associated with a change in autopsy practice for deaths where the investigations reveals that the infants were co-sleeping or sleeping in inappropriate environments (sofas, floor, etc.) at the time of the fatal event. Prior to the 2004 calendar year, the cause of death for the majority of these deaths were determined to be "Sudden Infant Death Syndrome" with a "Natural" manner of death. The practice change was made by the Office of the Chief Medical Examiner in collaboration with and the support of physicians from the CFRC's Infant Mortality Review Team.
Endnote # 5 (page 31)	The infant mortality rate for the District of Columbia is not developed by the Child Fatality Review Committee. CFRC deaths are determined based on definitions that are specific to the CFRC process/population and may be inconsistent with statistics obtained from the Department of Health, Office of State Center for Health Statistics. In addition to the definitions that vary, the numbers of death are also affected by the process.
Endnote # 6 (Page 33)	Perinatal Periods of Risk (PPOR) is a community planning tool to help better understand and address fetal and infant deaths in states and communities. It involves the collection and analysis of data that can be used by programs, agencies and the community to refine or develop strategies, policies and programs to reduce infant mortality and improve overall health of women and children.

# APPENDICES

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## 2006 CFRC RECOMMENDATIONS

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### POLICY AND PRACTICE STANDARDS

- Given the high numbers of fatalities that continue to be reviewed by CFRC in which children and youth have little or no documented pediatric and/or specialty medical care (children with chronic illnesses), the Deputy Mayor for Children Youth, Families and the Elderly (CYFE), in collaboration with the Department of Health, Medical Assistance Administration (DOH/MAA) and the Department of Human Services, Income Maintenance Administration should:
  - Develop a strategy to educate parents/guardians who receive Medicaid, TANF and other public benefits on the importance of following-through with general pediatric and specialty medical care of children.
  - Develop and/or enforce a requirement that Managed Care Organizations (MCO) must ensure that EPSDT and other health care services are provided based on the American Academy of Pediatric recommended schedule. This requirement should be linked to financial penalty and/or incentive in the MCO Contracts.  
(This recommendation was issued during the prior Mayoral Administration/Structure)
- Due to the high number of cases reviewed by CFRC where youth involved with the juvenile justice system are released to the community without adequate risk assessments, services, supports and monitoring, the Department of Youth and Rehabilitation Services (DYRS) should improve transitional planning procedures and resources (group homes) for juveniles who are stepped-down from Oak Hill or other secured facilities to the community. The procedures should include but not be limited to:
  - Timely psychiatric/psychological intervention including medication management for youth receiving such services prior to release;
  - An adequate range of individualized services (including placement options) to address specific needs of youth as outlined in educational, vocational, medical and/or other specialized evaluations; and
  - Specialized services for youth who were confined for violent or gun related charges/adjudication.
- In an effort to reduce the number of youth who have been released to the community and are not complying with their aftercare plans, the DYRS should assess the current revocation process to determine the adequacy and proficiency of the overall process. Appropriate changes should be made to ensure an appropriate revocation panel (including appropriate clinical and administrative members), adequate procedures, protocols, timeframes and outcomes, and adequate process for implementing, enforcing and monitoring compliance.
- DMH in collaboration with DYRS and CSSD should enhance assessments and resources for youth at risk of homicidal and/or suicidal behavior.

- In view of the fact that the CFRC Infant Mortality Review Team continues to review the deaths of high risk infants and mothers where discharge planning was inadequate, DOH, in collaboration with hospitals that provide obstetrical and pediatric services, MCO's, and local chapters of American College of Obstetrics and Gynecology and American Academy of Pediatrics (AAP) should develop discharge guidelines and resources to improve the follow-up for this population, especially infants with multiple medical problems and mothers whose psychosocial conditions may significantly impair their parenting skills.
- DMH should collaborate with the Unified Communications Office and other appropriate emergency response Offices to establish policy, protocol, and training to ensure age appropriate 911 response when calls are received from children/youth or communities impacted by violent or other traumatic events. The strategy should include training to enhance UCO operators' ability to assess the level of trauma of the caller(s) and to provide immediate age appropriate crisis intervention (Crisis Mobile Services) to individual residents (children, youth and adults) who witness fatalities and other persistent acts of violence.
- DOH should provide and promote smoke cessation programs and encourage health care providers to routinely refer mothers who smoke (as well as other household smokers) to these programs. Referral for such services should be documented in the clinical record.

#### **RESOURCE DEVELOPMENT/EXPANSION**

- Department of Health (DOH), in collaboration with Department of Mental Health (DMH) should strengthen and/or expand substance abuse treatment services/resources to include the following:
  - Out-patient services for women of child bearing years that provide co-located or coordinated services (mental health, medical, substance abuse and GYN/prenatal care) in a location that is accessible to the target population;
  - Residential substance abuse treatment for women and their children.

#### **PUBLIC EDUCATION/TRAINING**

- DOH and the Licensing Office should amend current District Day Care Regulations to mandate the following:
  - That all day care providers receive "Back to Sleep/Safe Sleeping" training. Training should be available in Spanish and other languages and should be consistent with AAP guidelines. Information should also be available verbally (tapes, etc.) in order to accommodate the literacy levels of all care providers;
  - That family day care providers complete daily progress notes delineating activities, such as infant's time of arrival, time of departure and care given during the infant's stay in the facility (practice should be consistent to child development centers); and
  - That parents receiving services in any child development facility is given a Bill of Rights' stipulating the quality of care to be expected and phone numbers to register a complain for negligent care.
- DOH in conjunction with physicians, certified nurse midwives, nurse practitioners, nurses, and social workers who provide care to pregnant and/or postpartum women and infants should educate women on the benefits of inter-conceptual health care. Inter-conceptual care

would address the need to stabilize chronic medical conditions, improve diet, utilize child spacing techniques, etc in order to enhance the probability of delivering a healthy term infant.

- In view of the high number of infant fatalities that continue to be reviewed by CFRC where the fatal incident occurred while co-sleeping or sleeping in inappropriate environments, DOH in collaboration with community/faith-based organizations, hospitals, sports organizations, local media and CFRC/Infant Mortality Team should launch a 'safe sleeping campaign' that recognizes the cultural barriers and emphasizes the "back to sleep" message – that infants are safest when they sleep on their backs and in a crib/bassinet. The campaign should also highlight the dangers of infants bed sharing and the factors emphasized in national guidelines (including AAP) which place infants at extreme high risk when bed sharing (i.e., sleeping on a sofa/couch/armchair and soft sleeping surfaces; cluttered sleeping area; and sleeping with parents/caregivers who are overly tired or under the influence of medications, illicit drugs, or alcohol or who smoke).
- Because of the proven benefits of breast milk, DOH in cooperation with DC Hospital Association should encourage hospitals to develop strategies to routinely provide mothers with breastfeeding information/education as a preferred feeding option.

## SUBCHAPTER V. CHILD FATALITY REVIEW COMMITTEE.

### § 4-1371.01. Short title.

This subchapter may be cited as the "Child Fatality Review Committee Establishment Act of 2001".

(Oct. 3, 2001, D.C. Law 14-28, § 4601, 48 DCR 6981.)

### Historical and Statutory Notes

#### Legislative History of Laws

For Law 14-28, see notes following § 4-344.01.

### § 4-1371.02. Definitions.

For the purposes of this subchapter, the term:

(1) "Child" means an individual who is 18 years of age or younger, or up to 21 years of age if the child is a committed ward of the child welfare, mental retardation and developmental disabilities, or juvenile systems of the District of Columbia.

(2) "Committee" means the Child Fatality Review Committee.

(Oct. 3, 2001, D.C. Law 14-28, § 4602, 48 DCR 6981.)

### Historical and Statutory Notes

#### Temporary Addition of Section

Section 2 of D.C. Law 14-20 added this section.

Section 22(b) of D.C. Law 14-20 provides that the act shall expire after 225 days of its having taken effect.

#### Emergency Act Amendments

For temporary (90 day) addition of section, see § 2 of Child Fatality Review Committee Establishment Emergency Act of 2001 (D.C. Act 14-40, April 25, 2001, 48 DCR 5917).

## § 4-1371.04

## PUBLIC CARE SYSTEMS

research, with due consideration given to representation of ethnic or racial minorities and to geographic areas of the District of Columbia. The appointments shall include representatives from the following:

- (1) Superior Court of the District of Columbia;
- (2) Office of the United States Attorney for the District of Columbia;
- (3) District of Columbia hospitals where children are born or treated;
- (4) College or university schools of social work; and
- (5) Mayor's Committee on Child Abuse and Neglect.

(c) The Mayor, with the advice and consent of the Council, shall appoint 8 community representatives, none of whom shall be employees of the District of Columbia.

(d) Governmental appointees shall serve at the will of the Mayor, or of the federal or judicial body designating their availability for appointment. Community representatives shall serve for 3-year terms.

(e) Vacancies in membership shall be filled in the same manner in which the original appointment was made.

(f) The Committee shall select co-chairs according to rules set forth by the Committee.

(g) The Committee shall establish quorum and other procedural requirements as it considers necessary.

(Oct. 3, 2001, D.C. Law 14-28, § 4604, 48 DCR 6981; Mar. 13, 2004, D.C. Law 15-105, § 36, 51 DCR 881; Apr. 13, 2005, D.C. Law 15-354, § 85(c), 52 DCR 2638.)

### Historical and Statutory Notes

#### Effect of Amendments

D.C. Law 15-105, in subsec. (f), validated a previously made technical correction.

D.C. Law 15-354, in subsec. (f), validated a previously made technical correction.

#### Temporary Addition of Section

Section 2 of D.C. Law 14-20 added this section.

Section 22(b) of D.C. Law 14-20 provides that the act shall expire after 225 days of its having taken effect.

#### Emergency Act Amendments

For temporary (90 day) addition of section, see § 4 of Child Fatality Review Committee Establish-

ment Emergency Act of 2001 (D.C. Act 14-40, April 25, 2001, 48 DCR 5917).

For temporary (90 day) addition of section, see § 4 of Child Fatality Review Committee Establishment Legislative Review Emergency Act of 2001 (D.C. Act 14-82, July 9, 2001, 48 DCR 6355).

#### Legislative History of Laws

For Law 14-20, see notes following § 4-1302.03.

For Law 14-28, see notes following § 4-344.01.

For Law 15-105, see notes following § 4-204.08.

For Law 15-354, see notes following § 4-204.55.

## § 4-1371.05. Criteria for case review.

(a) The Committee shall be responsible for reviewing the deaths of children who were residents of the District of Columbia and of such children who, or whose families, at the time of death:

(1) Or at any point during the 2 years prior to the child's death, were known to the juvenile justice or mental retardation or developmental disabilities systems of the District of Columbia; and

(2) Or at any point during the 4 years prior to the child's death, were known to the child welfare system of the District of Columbia.

(b) The Committee may review the deaths of nonresidents if the death is determined to be accidental or unexpected and occurs within the District.

(c) The Committee shall establish, by regulation, the manner of review of cases, including use of the following approaches:

- (1) Multidisciplinary review of individual fatalities;
- (2) Multidisciplinary review of clusters of fatalities identified by special category or characteristic;
- (3) Statistical reviews of fatalities; or
- (4) Any combination of such approaches.

## PUBLIC CARE SYSTEMS

## § 4-1371.06

(d) The Committee shall establish 2 review teams to conduct its review of child fatalities. The Infant Mortality Review Team shall review the deaths of children under the age of one year and the Child Fatality Review Team shall review the deaths of children over the age of one year. Each team may include designated public officials with responsibilities for child and juvenile welfare from each of the agencies and entities listed in § 4-1371.04.

(e) Full multidisciplinary/multi-agency reviews shall be conducted, at a minimum, on the following fatalities:

- (1) Those children known to the juvenile justice system;
- (2) Those children who are known to the mental retardation/developmental disabilities system;
- (3) Those children for which there is or has been a report of child abuse or neglect concerning the child's family;
- (4) Those children who were under the jurisdiction of the Superior Court of the District of Columbia (including protective service, foster care, and adoption cases);
- (5) Those children who, for some other reason, were wards of the District; and
- (6) Medical Examiner Office cases.

(Oct. 3, 2001, D.C. Law 14-28, § 4605, 48 DCR 6981; Apr. 12, 2005, D.C. Law 15-341, § 4, 52 DCR 2315.)

### Historical and Statutory Notes

#### Effect of Amendments

D.C. Law 15-341 rewrote subsec. (a) which had read as follows:

"(a) The Committee shall be responsible for reviewing the deaths of children who were residents of the District of Columbia and of such children who, or whose families, at the time of death, or at any point during the 2 years prior to the child's death, were known to the child welfare, juvenile justice, or mental retardation or developmental disabilities systems of the District of Columbia."

#### Temporary Addition of Section

Section 2 of D.C. Law 14-20 added this section.

Section 22(b) of D.C. Law 14-20 provides that the act shall expire after 225 days of its having taken effect.

#### Emergency Act Amendments

For temporary (90 day) addition of section, see § 5 of Child Fatality Review Committee Establishment Emergency Act of 2001 (D.C. Act 14-40, April 25, 2001, 48 DCR 5917).

For temporary (90 day) addition of section, see § 5 of Child Fatality Review Committee Establishment Legislative Review Emergency Act of 2001 (D.C. Act 14-82, July 9, 2001, 48 DCR 6355).

#### Legislative History of Laws

For Law 14-20, see notes following § 4-1302.03.

For Law 14-28, see notes following § 4-344.01.

For Law 15-341, see notes following § 4-1303.51.

### § 4-1371.06. Access to information.

(a) Notwithstanding any other provision of law, immediately upon the request of the Committee and as necessary to carry out the Committee's purpose and duties, the Committee shall be provided, without cost and without authorization of the persons to whom the information or records relate, access to:

(1) All information and records of any District of Columbia agency, or their contractors, including, but not limited to, birth and death certificates, law enforcement investigation data, unexpurgated juvenile and adult arrest records, mental retardation and developmental disabilities records, medical examiner investigation data and autopsy reports, parole and probation information and records, school records, and information records of social services, housing, and health agencies that provided services to the child, the child's family, or an alleged perpetrator of abuse which led to the death of the child.

(2) All information and records (including information on prenatal care) of any private health-care providers located in the District of Columbia, including providers of mental health services who provided services to the deceased child, the deceased child's family, or the alleged perpetrator of abuse which led to the death of the child.

(3) All information and records of any private child welfare agency, educational facility or institution, or child care provider doing business in the District of Columbia who provided services to the deceased child, the deceased child's immediate family, or the alleged perpetrator of abuse or neglect which led to the death of the child.

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(4) Information made confidential by §§ 4-1302.03, 4-1303.06, 7-219, 7-1203.02, 7-1305.12, 16-2331, 16-2332, 16-2333, 16-2335, and 31-3426.

(b) The Committee shall have the authority to seek information from entities and agencies outside the District of Columbia by any legal means.

(c) Notwithstanding subsection (a)(1) of this section, information and records concerning a current law enforcement investigation may be withheld, at the discretion of the investigating authority, if disclosure of the information would compromise a criminal investigation.

(d) If information or records are withheld under subsection (c) of this section, a report on the status of the investigation shall be submitted to the Committee every 3 months until the earliest of the following events occurs:

- (1) The investigation is concluded;
- (2) The investigating authority determines that providing the information will no longer compromise the investigation; or
- (3) The information or records are provided to the Committee.

(e) All records and information obtained by the Committee pursuant to subsections (a) and (b) of this section pertaining to the deceased child or any other individual shall be destroyed following the preparation of the final Committee report. All additional information concerning a review, except statistical data, shall be destroyed by the Committee one year after publication of the Committee's annual report.

(Oct. 3, 2001, D.C. Law 14-28, § 4606, 48 DCR 6981.)

### Historical and Statutory Notes

#### Temporary Addition of Section

Section 2 of D.C. Law 14-20 added this section.

Section 22(b) of D.C. Law 14-20 provides that the act shall expire after 225 days of its having taken effect.

#### Emergency Act Amendments

For temporary (90 day) addition of section, see § 6 of Child Fatality Review Committee Establish-

ment Emergency Act of 2001 (D.C. Act 14-40, April 25, 2001, 48 DCR 5917).

For temporary (90 day) addition of section, see § 6 of Child Fatality Review Committee Establishment Legislative Review Emergency Act of 2001 (D.C. Act 14-82, July 9, 2001, 48 DCR 6355).

#### Legislative History of Laws

For Law 14-20, see notes following § 4-1302.03.

For Law 14-28, see notes following § 4-344.01.

## § 4-1371.07. Subpoena power.

(a) When necessary for the discharge of its duties, the Committee shall have the authority to issue subpoenas to compel witnesses to appear and testify and to produce books, papers, correspondence, memoranda, documents, or other relevant records.

(b) Except as provided in subsection (c) of this section, subpoenas shall be served personally upon the witness or his or her designated agent, not less than 5 business days before the date the witness must appear or the documents must be produced, by one of the following methods, which may be attempted concurrently or successively:

(1) By a special process server, at least 18 years of age, designated by the Committee from among the staff of the Committee or any of the offices or organizations represented on the Committee; provided, that the special process server is not directly involved in the investigation; or

(2) By a special process server, at least 18 years of age, engaged by the Committee.

(c) If, after a reasonable attempt, personal service on a witness or witness' agent cannot be obtained, a special process server identified in subsection (b) of this section may serve a subpoena by registered or certified mail not less than 8 business days before the date the witness must appear or the documents must be produced.

(d) If a witness who has been personally summoned neglects or refuses to obey the subpoena issued pursuant to subsection (a) of this section, the Committee may report that fact to the Superior Court of the District of Columbia and the court may compel obedience to the subpoena to the same extent as witnesses may be compelled to obey the subpoenas of the court.

(Oct. 3, 2001, D.C. Law 14-28, § 4607, 48 DCR 6981.)

**Historical and Statutory Notes****Temporary Addition of Section**

Section 2 of D.C. Law 14-20 added this section.

Section 22(b) of D.C. Law 14-20 provides that the act shall expire after 225 days of its having taken effect.

**Emergency Act Amendments**

For temporary (90 day) addition of section, see § 7 of Child Fatality Review Committee Establish-

ment Emergency Act of 2001 (D.C. Act 14-40, April 25, 2001, 48 DCR 5917).

For temporary (90 day) addition of section, see § 7 of Child Fatality Review Committee Establishment Legislative Review Emergency Act of 2001 (D.C. Act 14-82, July 9, 2001, 48 DCR 6355).

**Legislative History of Laws**

For Law 14-20, see notes following § 4-1302.03.

For Law 14-28, see notes following § 4-344.01.

**§ 4-1371.08. Confidentiality of proceedings.**

(a) Proceedings of the Committee shall be closed to the public and shall not be subject to § 1-207.42, when the Committee is discussing cases of individual child deaths or where the identity of any person, other than a person who has consented to be identified, can be ascertained. Persons other than Committee members who attend any Committee meeting which, pursuant to this section, is not open to the public, shall not disclose what occurred at the meeting to anyone who was not in attendance, except insofar as disclosure is necessary for that person to comply with a request for information from the Committee. Committee members who attend meetings not open to the public shall not disclose what occurred with anyone who was not in attendance (except other Committee members), except insofar as disclosure is necessary to carry out the duties of the Committee. Any party who discloses information pursuant to this subsection shall take all reasonable steps to ensure that the information disclosed, and the person to whom the information is disclosed, are as limited as possible.

(b) Members of the Committee, persons attending a Committee meeting, and persons who present information to the Committee may not be required to disclose, in any administrative, civil, or criminal proceeding, information presented at or opinions formed as a result of a Committee meeting, except that nothing in this subsection may be construed as preventing a person from providing information to another review committee specifically authorized to obtain such information in its investigation of a child death, the disclosure of information obtained independently of the Committee, or the disclosure of information which is public information.

(c) Information identifying a deceased child, a member of the child's immediate family, the guardian or caretaker of the child, or an alleged or suspected perpetrator of abuse or neglect upon the child, may not be disclosed publicly.

(d) Information identifying District of Columbia government employees or private health-care providers, social service agencies, and educational, housing, and child-care providers may not be disclosed publicly.

(e) Information and records which are the subject of this section may be disclosed upon a determination made in accordance with rules and procedures established by the Mayor. (Oct. 3, 2001, D.C. Law 14-28, § 4608, 48 DCR 6981.)

**Historical and Statutory Notes****Temporary Addition of Section**

Section 2 of D.C. Law 14-20 added this section.

Section 22(b) of D.C. Law 14-20 provides that the act shall expire after 225 days of its having taken effect.

**Emergency Act Amendments**

For temporary (90 day) addition of section, see § 8 of Child Fatality Review Committee Establish-

ment Emergency Act of 2001 (D.C. Act 14-40, April 25, 2001, 48 DCR 5917).

For temporary (90 day) addition of section, see § 8 of Child Fatality Review Committee Establishment Legislative Review Emergency Act of 2001 (D.C. Act 14-82, July 9, 2001, 48 DCR 6355).

**Legislative History of Laws**

For Law 14-20, see notes following § 4-1302.03.

For Law 14-28, see notes following § 4-344.01.

**§ 4-1371.09. Confidentiality of information.**

(a) All information and records generated by the Committee, including statistical compilations and reports, and all information and records acquired by, and in the possession of, the Committee are confidential.

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(b) Except as permitted by this section, information and records of the Committee shall not be disclosed voluntarily, pursuant to a subpoena, in response to a request for discovery in any adjudicative proceeding, or in response to a request made under subchapter II of Chapter 5 of Title 2, nor shall it be introduced into evidence in any administrative, civil, or criminal proceeding.

(c) Committee information and records may be disclosed only as necessary to carry out the Committee's duties and purposes. The information and records may be disclosed by the Committee to another child fatality review committee if the other committee is governed by confidentiality provisions which afford the same or greater protections as those provided in this subchapter.

(d) Information and records presented to a Committee team during a child fatality review shall not be immune from subpoena or discovery, or prohibited from being introduced into evidence, solely because the information and records were presented to a team during a child death review, if the information and records have been obtained through other sources.

(e) Statistical compilations and reports of the Committee that contain information that would reveal the identity of any person, other than a person who has consented to be identified, are not public records or information, and are subject to the prohibitions contained in subsection (a) of this section.

(f) The Committee shall compile an Annual Report of Findings and Recommendations which shall be made available to the Mayor, the Council, and the public, and shall be presented to the Council at a public hearing.

(g) Findings and recommendations on child fatalities defined in § 4-1371.05(e) shall be available to the public on request.

(h) At the direction of the Mayor and for good cause, special findings and recommendations pertaining to other specific child fatalities may be disclosed to the public.

(i) Nothing shall be disclosed in any report of findings and recommendations that would likely endanger the life, safety, or physical or emotional well-being of a child, or the life or safety of any other person, or which may compromise the integrity of a Mayor's investigation, a civil or criminal investigation, or a judicial proceeding.

(j) If the Mayor or the Committee denies access to specific information based on this section, the requesting entity may seek disclosure of the information through the Superior Court of the District of Columbia. The name or any other information identifying the person or entity who referred the child to the Department of Human Services or the Metropolitan Police Department shall not be released to the public.

(k) The Mayor shall promulgate rules implementing the provisions of §§ 4-1371.07 and 4-1371.08. The rules shall require that a subordinate agency director to whom a recommendation is directed by the Committee shall respond in writing within 30 days of the issuance of the report containing the recommendations.

(l) The policy recommendations to a particular agency authorized by this section shall be incorporated into the annual performance plans and reports required by subchapter XIV-A of Chapter 6 of Title 1.

(Oct. 3, 2001, D.C. Law 14-28, § 4609, 48 DCR 6981.)

### Historical and Statutory Notes

#### Temporary Addition of Section

Section 2 of D.C. Law 14-20 added this section.

Section 22(b) of D.C. Law 14-20 provides that the act shall expire after 225 days of its having taken effect.

#### Emergency Act Amendments

For temporary (90 day) addition of section, see § 9 of Child Fatality Review Committee Establish-

ment Emergency Act of 2001 (D.C. Act 14-40, April 25, 2001, 48 DCR 5917).

For temporary (90 day) addition of section, see § 9 of Child Fatality Review Committee Establishment Legislative Review Emergency Act of 2001 (D.C. Act 14-82, July 9, 2001, 48 DCR 6355).

#### Legislative History of Laws

For Law 14-20, see notes following § 4-1302.03.

For Law 14-28, see notes following § 4-344.01.

**§ 4-1371.10. Immunity from liability for providing information to Committee.**

Any health-care provider or any other person or institution providing information to the Committee pursuant to this subchapter shall have immunity from liability, administrative, civil, or criminal, that might otherwise be incurred or imposed with respect to the disclosure of the information.

(Oct. 3, 2001, D.C. Law 14-28, § 4610, 48 DCR 6981.)

**Historical and Statutory Notes****Temporary Addition of Section**

Section 2 of D.C. Law 14-20 added this section.

Section 22(b) of D.C. Law 14-20 provides that the act shall expire after 225 days of its having taken effect.

**Emergency Act Amendments**

For temporary (90 day) addition of section, see § 10 of Child Fatality Review Committee Estab-

lishment Emergency Act of 2001 (D.C. Act 14-40, April 25, 2001, 48 DCR 5917).

For temporary (90 day) addition of section, see § 10 of Child Fatality Review Committee Establishment Legislative Review Emergency Act of 2001 (D.C. Act 14-82, July 9, 2001, 48 DCR 6355).

**Legislative History of Laws**

For Law 14-20, see notes following § 4-1302.03.

For Law 14-28, see notes following § 4-344.01.

**§ 4-1371.11. Unlawful disclosure of information; penalties.**

Whoever discloses, receives, makes use of, or knowingly permits the use of information concerning a deceased child or other person in violation of this subchapter shall be subject to a fine of not more than \$1,000. Violations of this subchapter shall be prosecuted by the Corporation Counsel or his or her designee in the name of the District of Columbia. Subject to the availability of an appropriation for this purpose, any fines collected pursuant to this section shall be used by the Committee to fund its activities.

(Oct. 3, 2001, D.C. Law 14-28, § 4611, 48 DCR 6981.)

**Historical and Statutory Notes****Temporary Addition of Section**

Section 2 of D.C. Law 14-20 added this section.

Section 22(b) of D.C. Law 14-20 provides that the act shall expire after 225 days of its having taken effect.

**Emergency Act Amendments**

For temporary (90 day) addition of section, see § 11 of Child Fatality Review Committee Estab-

lishment Emergency Act of 2001 (D.C. Act 14-40, April 25, 2001, 48 DCR 5917).

For temporary (90 day) addition of section, see § 11 of Child Fatality Review Committee Establishment Legislative Review Emergency Act of 2001 (D.C. Act 14-82, July 9, 2001, 48 DCR 6355).

**Legislative History of Laws**

For Law 14-20, see notes following § 4-1302.03.

For Law 14-28, see notes following § 4-344.01.

**§ 4-1371.12. Persons required to make reports; procedure.**

(a) Notwithstanding, but in addition to, the provisions of any law, including § 14-307 and Chapter 12 of Title 7, any person or official specified in subsection (b) of this section who has knowledge of the death of a child who died in the District of Columbia, or a ward of the District of Columbia who died outside the District of Columbia, shall as soon as practicable but in any event within 5 business days report the death or cause to have a report of the death made to the Registrar of Vital Records.

(b) Persons required to report child deaths pursuant to subsection (a) of this section shall include every physician, psychologist, medical examiner, dentist, chiropractor, qualified mental retardation professional, registered nurse, licensed practical nurse, person involved in the care and treatment of patients, health professional licensed pursuant to Chapter 12 of Title 3, law-enforcement officer, school official, teacher, social service worker, day care worker, mental health professional, funeral director, undertaker, and embalmer. The Mayor shall issue rules and procedures governing the nature and contents of such reports.

(c) Any other person may report a child death to the Registrar of Vital Records.

(d) The Registrar of Vital Records shall accept the report of a death of a child and shall notify the Committee of the death within 5 business days of receiving the report.

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(e) Nothing in this section shall affect other reporting requirements under District law.  
(Oct. 3, 2001, D.C. Law 14-28, § 4612, 48 DCR 6981.)

### Historical and Statutory Notes

#### Temporary Addition of Section

Section 2 of D.C. Law 14-20 added this section.

Section 22(b) of D.C. Law 14-20 provides that the act shall expire after 225 days of its having taken effect.

#### Emergency Act Amendments

For temporary (90 day) addition of section, see § 12 of Child Fatality Review Committee Estab-

lishment Emergency Act of 2001 (D.C. Act 14-40, April 25, 2001, 48 DCR 5917).

For temporary (90 day) addition of section, see § 12 of Child Fatality Review Committee Establishment Legislative Review Emergency Act of 2001 (D.C. Act 14-82, July 9, 2001, 48 DCR 6355).

#### Legislative History of Laws

For Law 14-20, see notes following § 4-1302.03.

For Law 14-28, see notes following § 4-344.01.

## § 4-1371.13. Immunity from liability for making reports.

Any person, hospital, or institution participating in good faith in the making of a report pursuant to this subchapter shall have immunity from liability, administrative, civil, and criminal, that might otherwise be incurred or imposed with respect to the making of the report. The same immunity shall extend to participation in any judicial proceeding involving the report. In all administrative, civil, or criminal proceedings concerning the child or resulting from the report, there shall be a rebuttable presumption that the maker of the report acted in good faith.

(Oct. 3, 2001, D.C. Law 14-28, § 4613, 48 DCR 6981.)

### Historical and Statutory Notes

#### Temporary Addition of Section

Section 2 of D.C. Law 14-20 added this section.

Section 22(b) of D.C. Law 14-20 provides that the act shall expire after 225 days of its having taken effect.

#### Emergency Act Amendments

For temporary (90 day) addition of section, see § 13 of Child Fatality Review Committee Estab-

lishment Emergency Act of 2001 (D.C. Act 14-40, April 25, 2001, 48 DCR 5917).

For temporary (90 day) addition of section, see § 13 of Child Fatality Review Committee Establishment Legislative Review Emergency Act of 2001 (D.C. Act 14-82, July 9, 2001, 48 DCR 6355).

#### Legislative History of Laws

For Law 14-20, see notes following § 4-1302.03.

For Law 14-28, see notes following § 4-344.01.

## § 4-1371.14. Failure to make report.

Any person required to make a report under § 4-1371.12 who willfully fails to make the report shall be fined not more than \$100 or imprisoned for not more than 30 days, or both. Violations of § 4-1371.12 shall be prosecuted by the Corporation Counsel of the District of Columbia, or his or her agent, in the name of the District of Columbia.

(Oct. 3, 2001, D.C. Law 14-28, § 4614, 48 DCR 6981.)

### Historical and Statutory Notes

#### Temporary Addition of Section

Section 2 of D.C. Law 14-20 added this section.

Section 22(b) of D.C. Law 14-20 provides that the act shall expire after 225 days of its having taken effect.

#### Emergency Act Amendments

For temporary (90 day) addition of section, see § 14 of Child Fatality Review Committee Estab-

lishment Emergency Act of 2001 (D.C. Act 14-40, April 25, 2001, 48 DCR 5917).

For temporary (90 day) addition of section, see § 14 of Child Fatality Review Committee Establishment Legislative Review Emergency Act of 2001 (D.C. Act 14-82, July 9, 2001, 48 DCR 6355).

#### Legislative History of Laws

For Law 14-20, see notes following § 4-1302.03.

For Law 14-28, see notes following § 4-344.01.

## CHILD FATALITY REVIEW COMMITTEE 2006 CALENDAR YEAR FATALITY LISTING

<i>Age Years/Months/Days</i>	<i>Cause of Death</i>	<i>Manner of Death</i>
0/0/0	Unknown ( Birth and Death Certificates unavailable)	Unknown
0/0/0	Previable Fetus of Unknown Etiology	Natural
0/0/0	Severe Pulmonary Immaturity due to Extreme Prematurity 22-22 Weeks of Unknown Etiology	Natural
0/0/0	Extreme Prematurity @ 22 weeks due to Preterm Rupture of Membranes due to Status Post Cervical Cerclage due to Maternal Cervical Insufficiency	Natural
0/0/0	Extreme Prematurity @ 20 Weeks due to Preterm Labor Complicated by Chorioamnionitis and Funisitis	Natural
0/0/0	Prematurity due to Preterm Labor of Unknown Etiology	Natural
0/0/0	Prematurity due to Multiparity Complicated by Maternal Incompetent Cervix	Natural
0/0/0	Prematurity due to Multiparity Complicated by Maternal Incompetent Cervix	Natural
0/0/0	Extreme Prematurity due to Previability @ 20-21 Weeks, Etiology Unknown	Natural
0/0/0	Cardiac and Respiratory Arrest due to Sepsis due to Respiratory Insufficiency	Natural
0/0/0	Extreme Prematurity of 21-22 Weeks Gestation, Etiology Unknown	Natural
0/0/0	Previable Fetus, Etiology Unknown	Natural
0/0/0	Respiratory Failure due to Premature Rupture of Membranes @ 24 Weeks Gestation of Unknown Etiology	Natural
0/0/0	Extreme Prematurity @ 20 Weeks due to Acute Chorioamnionitis with Acute Funisitis	Natural
0/0/0	Preterm Premature Rupture of Membranes, Extreme Prematurity	Natural
0/0/0	Previable Neonate due to Premature Birth @ 20 2/7 Weeks Gestation of Unknown Etiology	Natural
0/0/0	Premature Preterm Rupture of Membranes due to Incompetent Cervix, Maternal	Natural
0/0/0	Premature Preterm Rupture of Membranes due to Incompetent Cervix, Maternal	Natural
0/0/0	Anencephaly	Natural
0/0/0	Preterm Labor due to Incompetent Cervix	Natural
0/0/0	Complications of Premature Birth due to Maternal Abruptio Placentae of Unknown Etiology	Natural
0/0/0	Non-immune Fetal Hydrops of Unknown Etiology	Natural
0/0/0	Cardiopulmonary Failure due to Severe Trisomy 18 due to Extreme Prematurity	Natural
0/0/0	Cardio-respiratory Failure due to Extreme Immaturity @ 22 Weeks due to Preterm Labor due to Premature Rupture of Membranes of Unknown Etiology	Natural
0/0/0	Congenital Heart Disease	Natural
0/0/0	Respiratory Failure due to Extreme Prematurity due to Pregnancy Induced Hypertension	Natural
0/0/0	Extreme Prematurity of Unknown Etiology	Natural
0/0/0	Chorioamnionitis	Natural
0/0/0	Extreme Prematurity @ 21 5/7 Weeks due to Maternal Cervical Incompetence	Natural
0/0/0	Respiratory Distress due to Sepsis due to Prematurity of Undetermined Etiology	Natural
0/0/0	Previable Female Fetus due to Premature Ruptured Membranes, Etiology Unknown	Natural
0/0/0	Extreme Prematurity @ 19 6/7 Weeks of Unknown Origin	Natural
0/0/0	Cardio-respiratory Failure due to Fetal Depression due to Cardio-respiratory Depression	Natural
0/0/0	Premature Rupture of Membranes @ 21-22 Weeks, Prematurity	Natural
0/0/0	Previable newborn @ 22 Weeks Gestation due to Incompetent Cervix	Natural
0/0/0	Cardiopulmonary Failure due to Prematurity due to Preterm Labor due to Rupture of Membranes of Unknown Etiology	Natural
0/0/0	Extreme Prematurity due to Preterm Rupture of Membranes due to Prolapse Cord	Natural
0/0/0	Previable Delivery due to Preterm Labor and Delivery due to Maternal Chronic Hypertension, Gestational Diabetes due to Morbid Obesity	Natural
0/0/0	Extreme Prematurity of Unknown Etiology	Natural
0/0/0	Previable Preterm Delivery of Previable Infant due to Maternal Incompetent Cervix	Natural
1 Day	Non-viable Newborn Male @ 21 Weeks Gestation	Natural
1 Day	Previable @ 20 Weeks Gestation, Etiology Unknown	Natural
1 Day	Extreme Prematurity due to Premature Birth @ 23 Weeks Gestation due to Maternal	Natural

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1 Day	Preterm Labor and Spontaneous Rupture of Membranes of Unknown Etiology Respiratory Failure due to Lung Hypoplasia due to Oligohydramnios- (Potter's Syndrome)	Natural
5 Days	Congestive Heart Failure due to Congenital Hypertrophic Cardiomyopathy	Natural
5 Days	Pulmonary Hemorrhage due to Septic Shock due to Extreme Prematurity of Unknown Etiology	Natural
6 Days	Cardiorespiratory Failure and Arrest due to Bilateral Pneumothorax due to Respiratory Distress and Prematurity due to Alveolar Capillary Dysplasia	Natural
6 Days	Cardiac Tamponade due to Pericardial Effusion due to Acute Chronic Pericarditis due to Patent Ductus Arteriosus	Natural
9 Days	Undetermined	Undetermined
11 Days	Complications of Prematurity due to Placental Abruption due to Maternal Blunt Impact Abdominal Trauma	Accident
13 Days	Hyperkalemia due to Severe Metabolic Acidosis due to Hypotension with Poor Perfusion due to Clinical Sepsis of Unknown Etiology	Natural
14 Days	Necrotizing Enterocolitis due to Prematurity due to Twin Gestation	Natural
15 Days	Grade IV Intraventricular Hemorrhage due to E.Coli Sepsis due to Extreme Prematurity due to Preterm Labor	Natural
20 Days	Tonsillar Herniation due to Hypoxic Ischemic Encephalopathy due to Placental Abruption	Natural
23 Days	Respiratory Distress Syndrome due to Prematurity of Unknown Etiology	Natural
23 Days	Sudden Unexpected Death in Infancy Associated with Co-sleeping and Soft Bedding	Undetermined
27 Days	Necrotizing Enterocolitis due to Complications of Prematurity due to Preterm Birth of Undetermined Etiology	Natural
29 Days	Cardiorespiratory Failure due to Extreme Prematurity due to Maternal Pre-eclampsia due to Chronic Maternal Hypertension	Natural
30 Days	Cardiogenic Shock due to Complex Congenital Heart Anomaly (Unbalanced Atrioventricular Canal with Left Ventricular Flow Obstruction	Natural
31 Days	Central Apnea due to Chromosomal Abnormality	Natural
1 Month	Respiratory Failure due to Prematurity due to Maternal HELLP Syndrome due to Fetal Long Chain Fatty Acid Syndrome	Natural
1 Month 1Day	Cardiorespiratory Failure due to Sepsis due to Necrotizing Enterocolitis	Natural
1 Month 2 Days	Bacterial Sepsis	Natural
1 Month 3 Days	Respiratory Failure due to Cardiovascular Failure due to Candida Sepsis due to Patent Ductus Exteriorize	Natural
1 Month 6 Days	Pneumothoraces Multiple due to Sepsis due to Extreme Prematurity due to Preterm Rupture of Membranes and Preterm Labor of Undetermined Etiology	Natural
1 Month 6 Days	Acute Doxylamine Poisoning	Homicide
1 Month 7 Days	Lung and Gastrointestinal Hemorrhage due to Disseminated Intravascular Coagulation due to Metabolic Acidosis of Unknown Etiology	Natural
1 Month 15 Days	Brain Hemorrhage due to Extra Corporeal Membrane Oxygenation due to Congenital Heart Disease (Clinical)	Natural
1 Month 29 Days	Sudden Unexpected Death in Infancy Associated with Sleeping in Prone Position	Undetermined
2 Months 2 Days	Sudden Unexpected Infant Death While Sleeping in Prone Position on Inappropriate Bedding	Undetermined
2 Months 8 Days	Sudden Unexpected Death in Infancy	Undetermined*
2 Months 10 Days	Anascara due to Renal Failure and Bronchopulmonary Dysplasia due to Extreme Prematurity of Unknown Etiology	Natural
2 Months 11 Days	Sepsis due to Bacterial Meningitis	Natural
2 Months 12 Days	Otahara Syndrome	Natural
2 Months 13 Days	Sudden Unexplained Death of Infant Associated	Undetermined
2 Months 15 Days	Massive Intracranial Hemorrhage due to Sepsis due to Hypoplastic Left Heart	Natural
2 Months 24 Days	Staphylococcus Aureus Sepsis due to Complicating Neurodevelopmental Delay Associated with Maternal Polyhydramnios of Unknown Etiology	Natural
3 Months 11 Days	Hyperkalemia due to Necrotizing Enterocolitis due to 29 Week Gestation Age due to Maternal Hypertension and Large Uterine Fibroid	Natural
3 Months 15 Days	Complications of Prematurity of Unknown Etiology	Natural
3 Months 19 Days	Pulmonary Hemorrhage due to Extreme Prematurity	Natural
4 Months	Sudden Unexplained Infant Death	Undetermined*
4 Months	Undetermined	Undetermined
4 Months	Respiratory Distress due to Chronic Lung Disease due to Prematurity due to Multiple Gestation- Triplet	Natural

4 Months 7 Days	Sepsis due to Pneumonia due to Prematurity	Natural
4 Months 25 Days	Sudden Unexpected Death in Infancy	Undetermined
5 Months	Sudden Unexplained Death in Infancy	Undetermined
5 Months	Sudden Unexpected Death in Infancy Associated with Co-sleeping and Soft Bedding	Undetermined
5 Months	Blunt Impact of Head with Subdural Hemorrhage	Homicide
6 Months	Sudden Unexplained Infant Death While Sleeping in Prone Position on Inappropriate Bedding	Undetermined
8 Months	Intracranial Hemorrhage due to Extra Corporeal Membrane Oxygenation due to Severe Combined Immunodeficiency	Natural
8 Months 2 Days	Acute Exacerbation of Reactive Airway Disease due to Asthma	Natural
8 Months 27 Days	Complications Following Multiple Surgical Procedures for Treatment of Hirschprung's Disease	Natural
9 Months	Streptococcus Pneumonia due to Leptomeningitis due to Bronchopneumonia and Otitis Media	Natural
1 Year	Respiratory and cardiac Arrest due to Multi-organ Failure due to Genetic Anomalies	Natural
1 Year	Respiratory Arrest Complicating Brain Injury Secondary to Intraventricular Hemorrhage due to Prematurity due to Maternal Placental Abruption	Natural
1 Year	Hypoxic Ischemic Cerebral Injury and Cerebral Edema due to Blunt Impact of Head	Homicide
2 Years	Cardiopulmonary Arrest	Natural
2 Years	Thoracic Hemorrhage due to Extra Corporeal Membrane Oxygenation (ECMO) due to Surgical Repair of Congenital Heart Defects	Natural
2 Years	Neuroblastoma	Natural*
3 Years	Asphyxia due to Soot and Smoke Inhalation	Accident
4 Years	Multiple Blunt Impact Injuries with Fracture of cervical Spine and Transection of Cervical Cord	Accident
5 Years	Herniation due to Mestatic Retinoblastoma	Natural
6 Years	Asphyxia due to Soot and Smoke Inhalation	Accident
7 Years	Asphyxia due to Choking	Accident
7 Years	Blunt Impact Injuries of Head, Neck, Torso and Left Lower Extremity	Accident
11 Years	Septic Shock due to Acute respiratory Distress Syndrome due to Acquired Deficiency Syndrome	Natural
11 Years	Blunt Impact Head Trauma including basilar Skull Fracture, Subdural Hemorrhage, Brain Contusions and Compression Injury	Accident
12 Years	Complications of Erosive and Hemorrhagic Tracheobronchitis due to Tracheostomy for Treatment of Chronic Aspiration Pneumonia due to Schizencephaly	Natural
13 Years	Heart Disease	Natural*
13 Years	Gunshot Wound of Back with Injuries of Heart, Liver and Kidney	Homicide
13 Years	Gunshot Wound of Head	Homicide
14 Years	Pannmyocarditis	Natural*
14 Years	Gunshot wound to back	Homicide
14 Years	Blunt Impact of Head, Torso and Upper and Lower Extremities	Accident
14 Years	Brain Death due to Brain Herniation due to Posterior Fossa Mass with Hemorrhage (Newly Diagnosed)	Natural
15 Years	Pulmonary Edema due to Sepsis due to Sickle Cell Disease	Natural
15 Years	Asphyxia due to Neck Compression	Homicide
15 Years	Lung Collapse due to Pneumonia due to Sepsis due to Renal Failure	Natural
15 Years	Lennox-Gastaut Syndrome	Natural
16 Years	Gunshot Wound of Head	Homicide
16 Years	Complications of Cerebral Palsy	Natural*
16 Years	Gunshot wound of Chest Perforating Left Lung	Homicide
16 Years	Gunshot wound of Left Thigh with Perforation of Left Femoral Artery	Homicide
16 Years	Gunshot wound of Head and Torso	Homicide*
17 Years	Gunshot Wounds to Head	Homicide*
17 Years	Multiple Gunshot Wounds	Homicide*
17 Years	Respiratory Failure due to Septic Shock due to Acquired Immune Deficiency Syndrome due to Human Immune Deficiency Virus Infection	Natural
17 Years	Hypoxic Encephalopathy due to Acute Cor Pulmonale due to Pulmonary Artery Hypertension	Natural
17 Years	Gunshot Wound of Right Buttock with Perforations of Right Ilium, Right Common Iliac Artery and Vein, Small Intestine, Large Intestine	Homicide
17 Years	Gunshot Wound of Back	Homicide
17 Years	Gunshot Wound of Torso Perforating Left Lung and Subclavian Artery	Homicide

**APPENDIX C**

17 Years	Gunshot Wound of Head with Injury of Brain	Homicide
17 Years	Gunshot Wound to Shoulder with Perforation of Heart and Lung	Homicide
18 Years	Gunshot Wounds to Head and Chest	Homicide*
18 Years	Intracranial Bleed	Natural
18 Years	Gunshot Wound of Posterior Chest	Homicide
18 Years	Multiple Gunshot Wounds	Homicide
18 Years	Mycobacterium Avium Intracellular due to Cytomegalovirus Ependymitis due to Acquired Immunodeficiency Syndrome	Natural
18 Years	Multiple Gunshot Wounds	Homicide
18 Years	Gunshot Wound of Back	Homicide
19 Years	Gunshot Wounds of Head and Leg	Homicide
19 Years	Multiple Gunshot Wounds	Homicide*
19 Years	Multiple Blunt Impact Injuries	Accident
19 Years	Gunshot Wound of Chest Injuring Right Lung	Homicide
19 Years	Pulmonary Embolus due to Deep Venous Thrombosis of the Lower Extremities due to Paraplegia due to Gunshot Wound of Back	Homicide
19 Years	Arrhythmogenic Right Ventricular Dysplasia	Natural
19 Years	Multiple Gunshot Wounds with Injuries of Heart, Lung, Liver, Aorta, Pancreas, Duodenum, Esophagus and Diaphragm	Homicide
20 Years	Gunshot Wound to Back	Homicide*
20 Years	Gunshot Wound of Head	Homicide
21 Years	Multiple Gunshot Wounds with Perforation of Heart, Lung, Liver and Kidney	Homicide
21 Years	Septicemia due to Cerebral Palsy	Natural*
21 Years	Gunshot Wounds of Torso and Extremities with Perforation of Heart and Liver	Homicide
21 Years	Gunshot wound of Head	Homicide*
21 Years	Gunshot Wound of Chest	Homicide
22 Years	Gunshot Wound of Head and Chest	Homicide
22 Years	Multiple Gunshot Wounds with Injuries of Heart, Subclavian Vein, Lung and Brain	Homicide
23 Years	Multiple Stab Wounds	Homicide

\* Medical Examiner Cases from other jurisdictions

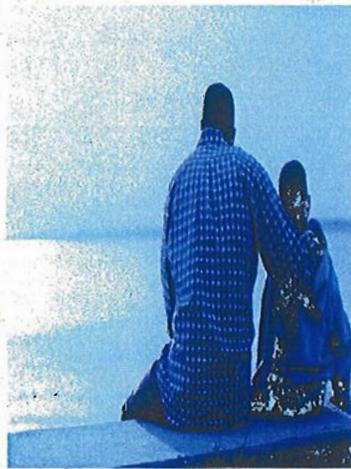


# ACKNOWLEDGEMENTS

*We wish to acknowledge the dedication and unwavering support of the public servants, private agency/program representatives and community volunteers who serve as members of the District of Columbia Child Fatality Review Committee. It is an act of courage to acknowledge that the death of a child is a community problem. The willingness of Committee members to step outside of their traditional professional roles and examine all the circumstances that may have contributed to a child's death and to seriously consider ways to prevent future deaths and improve the quality of children's lives is an admirable and difficult challenge. This challenge speaks to the commitment of members to improving services and truly making life better for the residents of this city. Without this level of dedication the work of the Committee would not be possible.*

*We would like to thank the members of the Committee for volunteering your time, giving of your resources, support and dedication to achieving our common goal. A special thanks is extended to the community volunteers who continue to serve the citizens of the District throughout every aspect of the child fatality review process.*





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