



DISTRICT OF COLUMBIA CHILD FATALITY REVIEW COMMITTEE

2007 ANNUAL REPORT



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**DISTRICT OF COLUMBIA
CHILD FATALITY REVIEW COMMITTEE**

2007 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 M. Fenty, Mayor, District of Columbia
The Council of the District of Columbia

DECEMBER 2008



DISTRICT OF COLUMBIA CHILD FATALITY REVIEW COMMITTEE

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.

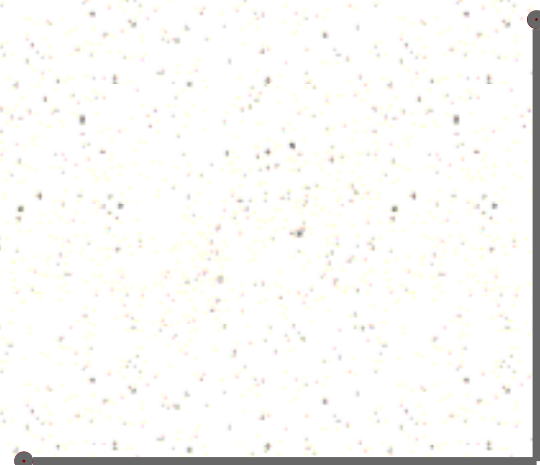


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EXECUTIVE SUMMARY

*“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 from 160 child/youth fatalities identified from calendar year 2007.

KEY CHILD FATALITY REVIEW DATA FINDINGS

DECEDENT DEMOGRAPHICS

- ◆ The ages of the 2007 decedents ranged from birth through 23 years.
- ◆ The majority of the decedents were under the age of one year. Ninety-seven infant deaths were identified from 2007, representing 61% of the overall CFRC child death population.
- ◆ The second leading population of District child deaths was youth over the age of 14 years (N = 40 or 25%).
- ◆ Black/African American children/youth continue to be disproportionately represented in the District's death population. During calendar year 2007, 84% (N = 135) of the deaths involved Black/African American children.
- ◆ Fifty-three percent of the decedents were males (N = 85).
- ◆ The majority of the decedents were residents of Wards Five, Seven and Eight, with the largest number being residents of Ward Eight (N = 36).

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 2007 calendar year. There were a total of 103 Natural deaths. The majority of these deaths involved children under the age of one (N = 86).
- ◆ The majority of Natural infant deaths was associated with prematurity, low gestational age and birth weight.
- ◆ The leading cause of death for the 17 children one year of age or older was infection (N = 7), followed by cancer (N = 3).

Violent Deaths

Thirty-eight child and youth deaths from calendar year 2007 were attributed to acts of violence. Thirty-six of these deaths were determined to be Homicides. The manners of the remaining two deaths include a Suicide and an Undetermined death.

Homicides in 2007 represented a slight decrease (N = 36 in 2007 and 37 in 2006).

- ♦ **Fatal Abuse** - Two of the 2007 fatalities involved fatal abuse and neglect and were directly linked to the caregivers at the times of the deaths. Both of the victims, one male and one female, were Black/African Americans, under the age of three years.
- ♦ **Youth Violence** - Youth violence accounted for 32 or 89% of the 2007 child/youth Homicides. The majority of the deaths were caused by firearms (97%). The ages of the youth ranged from 13 to 23 years of age. Ninety-four percent of the victims were Black/African American; and 81% were males.
- ♦ **Other** - Two child Homicides involved deaths committed by unrelated and/or unknown perpetrators. The victims were under five years of age, Black/African American; one male and one female.

Unintentional Injuries

There were nine unintentional injuries during 2007. The causes of accidental deaths in all age groups were:

- ♦ Transportation Related (N = 5)
- ♦ Fire Related (N = 1)
- ♦ Asphyxia (N = 2)
- ♦ Electrocution (N = 1)

Undetermined Deaths

- ♦ In calendar year 2007, there were 10 deaths where the manner was Undetermined.
- ♦ Nine deaths involved children under the age of one year; one involved an 18 year old.
- ♦ All of the decedents were Black/African American; the majority were females (N = 6).
- ♦ Two thirds of the Undetermined infant deaths involved co-sleeping with one or more adults and/or children at the times of the deaths.

Top CFRC Recommendations from Calendar Years 2007

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. Ten of the most critical 2007 CFRC recommendations are provided as part of the Appendices (see appendix A).

INTRODUCTION

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; and recommending strategies to reduce the number of preventable child deaths and/or improve 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.

The Committee is responsible for reviewing the deaths of District children from birth through 18 years of age and those over 18 who were known to the child welfare and juvenile justice systems. 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 and family service agencies and programs. 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 depending 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 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 160 child/youth fatalities that occurred during the 2007 calendar year (Endnote #1, see page 30). This report contains two major parts. ***Section I: 2007 Case Review Findings***, provides a general description of the decedents' demographics and the causes and manners of death. ***Section 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.

SECTION I: 2007 CASE REVIEW FINDINGS

SUMMARY OF TOTAL CFRC FATALITIES (YEARS 2004 - 2007)

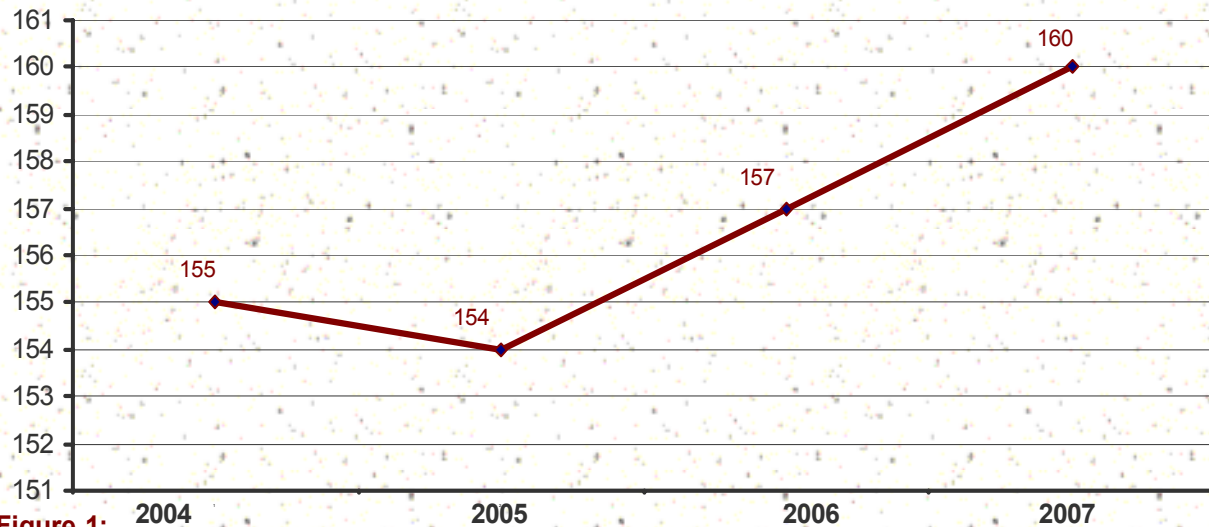


Figure 1:

- ◆ 160 child/youth deaths were identified from the 2007 calendar year as meeting the CFRC criteria for review. Figure 1 illustrates the total child/youth deaths identified by CFRC between calendar years 2004 and 2007.

DESCRIPTION OF DECEDENT POPULATION

AGES OF DECEDENTS

- ◆ The ages of the decedents identified ranged from birth through 23 years. Consistent with previous CFRC data, the two largest age categories continued to be infants (under the age of one year) and youth over 14 years of age.
- ◆ In 2007, 61% of the fatalities involved infants and 25% were youth over the age of 14 years. Combined, these two age categories represent 86% of the 2007 CFRC deaths reviewed.

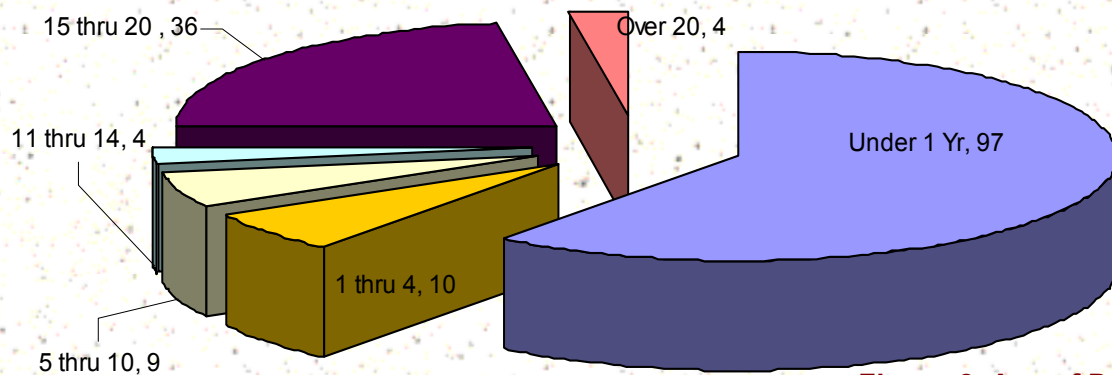


Figure 2: Age of Decedents

RACE AND GENDER OF DECEDENTS

- ◆ Findings from 2007 data highlight a slight change in racial composition and gender of the decedents. Although Black/African American, male decedents continued to be the dominate population, the percentage of decedents in these racial and gender groups reduced.
- ◆ As Figure 3 illustrates, in 2007 Black/African American children/youth represented 84% (N = 135) of the decedent population, representing a nine percent reduction from 2006 data.
- ◆ Deaths among Hispanic and White racial groups increased in calendar year 2007. Hispanic and White children/youth represented the second and third leading child death populations, respectively. Thirteen Hispanic (8%) and 11 White (7%) children/youth died in calendar year 2007; in comparison Hispanic and White children represented 2% and 4% of all child deaths respectively in 2006.

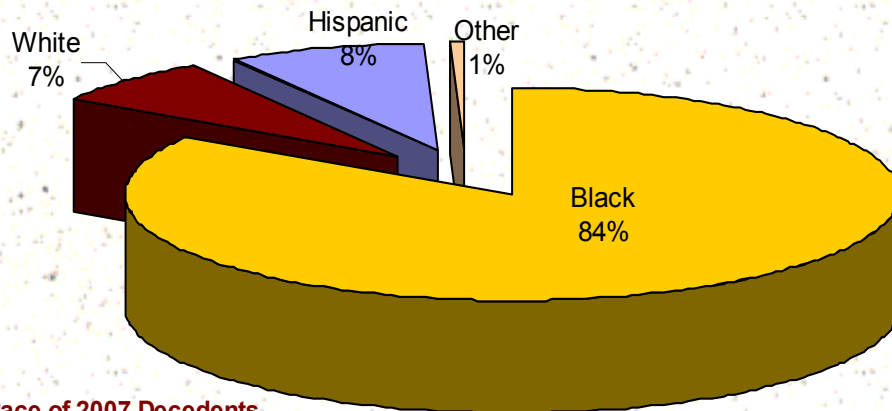


Figure 3: Race of 2007 Decedents

- ◆ While male decedents continued to represent the largest proportion of the child/youth population, 2007 data indicates the percentage of male deaths decreased significantly. As Figure 4 illustrates, 53% (N = 85) of the 160 CFRC deaths from 2007 were males, compared to 69% in 2006. Data from 2007 indicate that males represent 75% (N = 30) of the decedent population over 14 years.

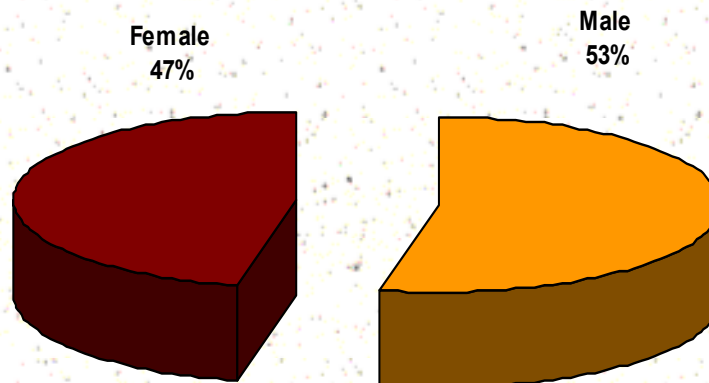


Figure 4: Gender of 2007 Decedents

AGE OF DECEDENTS BY RACE AND GENDER

- ◆ Table 1 illustrates the disparity among 2007 Black/African American decedents in all age and gender categories. In 2007, 52% of the 135 Black/African American decedents were males.
- ◆ The number of Black/African American females increased in all age categories between birth and 14 years. Additionally, in 2007, there was a 150% increase in the number of Black/African American females in the over 15 year age category (four in 2006 and 10 in 2007).
- ◆ Among White and Hispanic decedents, the majority of the deaths continued to include children under the age of one year.

TABLE 1: RACE AND GENDER BY AGE OF DECEDENT						
Race/Gender	<1 Year	1 thru 4	5 thru 10	11 thru 14	Over 15 Yrs	Total
Black Males	33	4	3	3	27	70
Black Females	44	5	5	1	10	65
White Males	6				1	7
White Females	4					4
Hispanic Males	5		1		2	8
Hispanic Females	5					5
Other Females		1				1
Totals	97	10	9	4	40	160

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.).

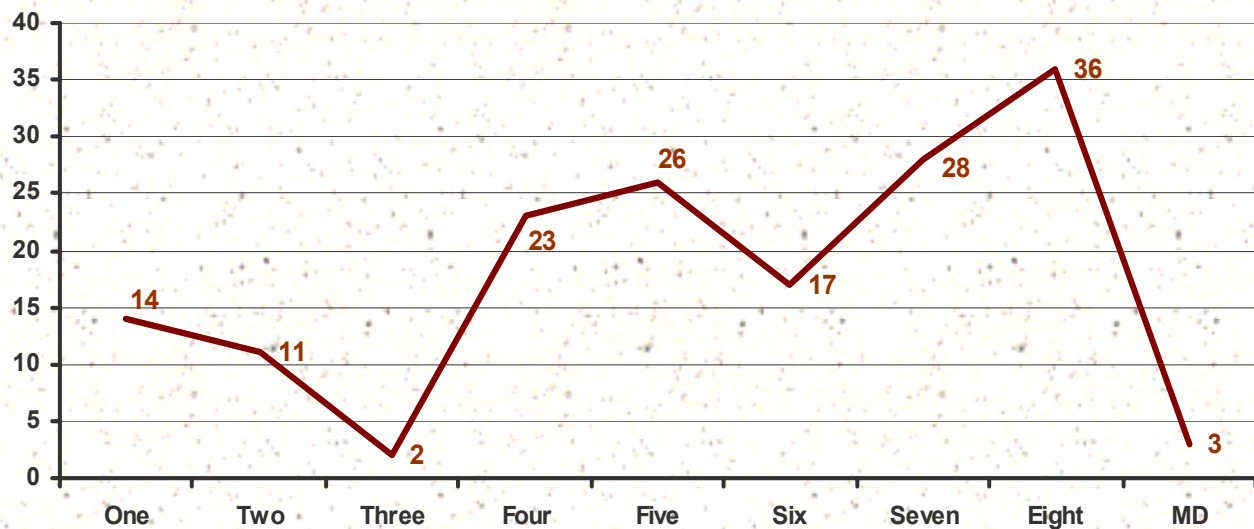
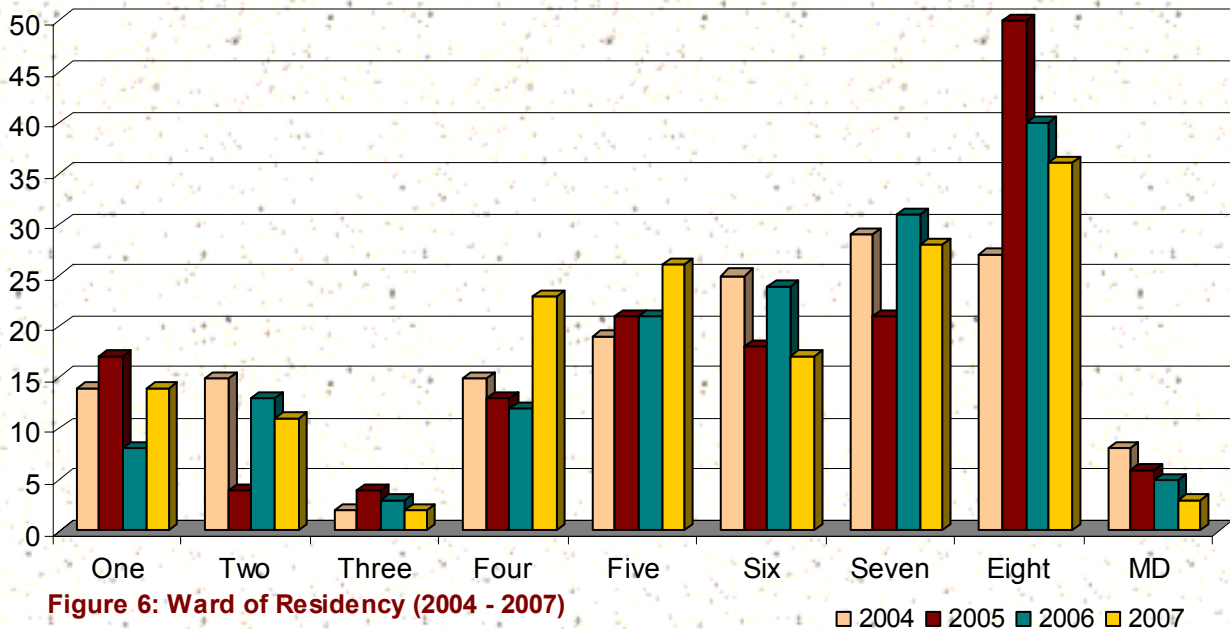


Figure 5: Ward of Residency

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- ◆ As illustrated by Figure 5 (see page 4), most of the District Wards had over 15 child/youth deaths; only one had under five. The majority of the 2007 decedents were residents of Wards Four, Five, Seven and Eight; each of these Wards had over 20 child/youth deaths. Combined, the deaths from these Wards account for 71% of 2007 deaths (N =113). The largest number of decedents continued to reside in Wards Eight (23%) and Seven (18%).
- ◆ Three of the CFRC deaths reviewed were residents of Maryland. These children/youth meet the criteria for review based on their involvement with the child welfare or juvenile systems.
- ◆ Figure 6 below depicts the Wards of residence for CFRC fatalities for a four year period.



MANNER AND CAUSE OF 2007 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 for the cause and/or manner of death. For the 2007 calendar year, causes and manners of death were obtained for 159 (99%) of the 160 fatalities. The one death where the cause and manner were unknown involved a one year old, Black/African American decedent. The death occurred in another state and CFRC was unable to obtain copies of the death certificates.

MANNER OF DEATH

- ◆ Figure 7 illustrates the 159 known manners of death from calendar year 2007.
- ◆ Consistent with historical CFRC data, District children continued to die primarily from Natural causes followed by Homicides. In 2007, there were 103 Natural deaths and 36 Homicides.
- ◆ Similar to 2005 and 2006 data, Undetermined fatalities ranked third with 10 deaths; and Accidents ranked fourth with nine child deaths. There was one Suicide death in 2007.

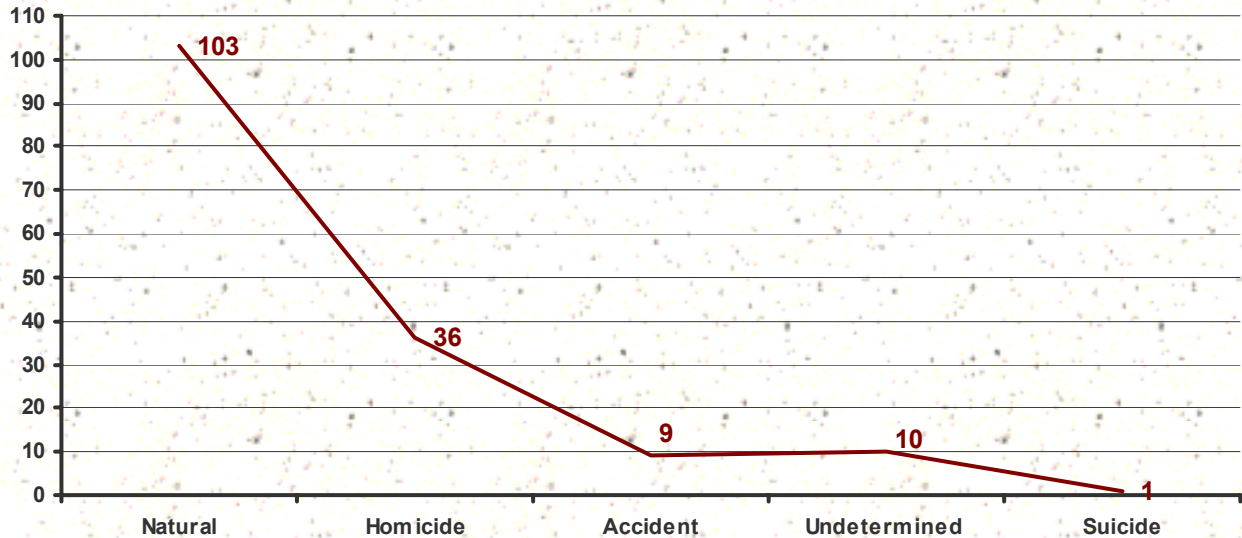


Figure 7: 2007 Manners of Death

Manner By Ward of Residence

Table 2 below illustrates the Wards of decedents' residences by manners of death for the 159 fatalities that occurred in 2007 where death certificates were received.

TABLE 2: MANNER BY WARD						
WARD	Natural	Homicide	Accident	Undetermined	Suicide	Total
Ward One	10	3				13
Ward Two	8	3				11
Ward Three	2					2
Ward Four	20	2	1			23
Ward Five	15	6	2	3		26
Ward Six	8	4	3	2		17
Ward Seven	16	7	2	4		29
Ward Eight	24	9	1	1	1	36
MD		2				2
Totals	103	36	9	10	1	159

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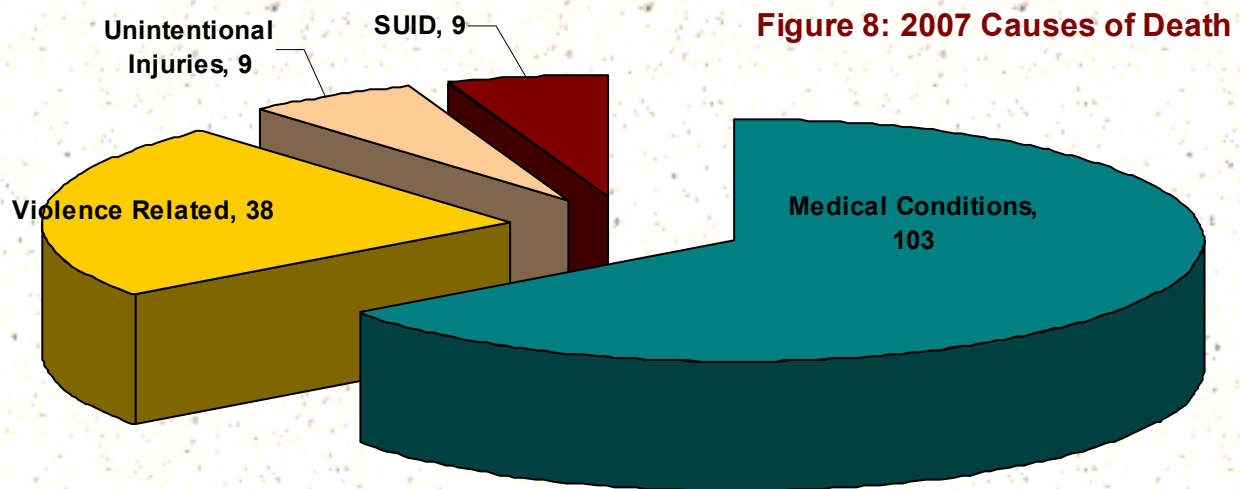
Manner By Age, Race and Gender

Table 3 illustrates the known manners of death by the age, race and gender for the 159 decedents who died in calendar year 2007.

TABLE 3: MANNERS OF DEATH BY RACE AND GENDER						
Age/Race/Gender	Natural	Homicide	Accident	Suicide	Undetermined	Total
Under Age One Year						
Black Male	30				3	33
Black Females	36		2		6	44
White Males	6					6
White Females	4					4
Hispanic Males	5					5
Hispanic Females	5					5
Ages 1 Through 4 Years						
Black Males	1	2				3
Black Females	1	2	2			5
Other Female	1					1
Ages 5 through 10 Years						
Black Male	2		1			3
Black Female	3		2			5
Hispanic Male	1					1
Ages 11 Through 14 Years						
Black Male	1	2				3
Black Female	1					1
Ages 15 Through 23 Years						
Black Male	2	22	1		1	26
Black Female	3	6	1	1		11
White Male	1					1
Hispanic Male		2				2
Totals	103	36	9	1	10	159

CAUSE OF DEATH

For purposes of this Report and to ensure consistency in evaluating Committee data, the causes of death have been grouped in four categories: Medical Conditions, Violence Related, Sudden Unexplained Death of Infant (SUDI)/Undetermined and Unintentional Injuries. These categories do not always reflect the cause as stated on the death certificate. However, specific information on the actual causes of the 160 deaths is provided as each category is discussed throughout this section and the causes as cited on death certificates are provided in Appendix C: 2007 Calendar Year Fatality Listing By Age, Cause and Manner of Death.



MEDICAL CONDITIONS

- ◆ The leading cause of death for District children continued to be associated with medical conditions (see Figure 8). Of the 159 CFRC deaths where causes were known, 65% involved deaths associated with medical conditions (N = 103).
- ◆ The ages of the decedents ranged from birth through 18 years, with an average age of two.

Children Under One Year of Age (Infants) – 2007 data indicates that 83% (N = 86) of the 103 medically related deaths were infants. The majority of these deaths (N = 71, or 83%) occurred within the first 28 days after birth and 73% of these children died in the first day of life (N = 52).

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 conditions was prematurity and associated complications. **Prematurity** as the primary cause of death accounted for 47% (N = 40) of the 86 infant deaths associated with medical causes; and an additional 22 infant death certificates included prematurity as a contributing cause. Of the 62 deaths where prematurity caused or contributed to the death, extremely low birth weight (less than 500 grams) was a factor in over half (N = 36, or 58%) of the infant deaths. Twenty-five additional cases involved infants with birth weights between 500 and 1000 grams.

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- ♦ *Respiratory System Disorder* ranked second with 23 infant deaths attributed to this cause.
- ♦ *Congenital Anomalies and Infections* ranked third with equal numbers of death certificates (N = 6 each) highlighting these problems as the primary causes of deaths. There were 17 additional death certificates that indicated infection was a contributing cause of infant deaths and 11 additional deaths where death certificates attributed congenital anomalies as a contributing cause. Combined, infection and congenital anomalies caused or contributed to 27% and 20% of the 86 medically related infant deaths respectively (N = 23 and 17 respectively).

Children/Youth One Year of Age or Older – In 2007, 17 children and youth, between the ages of one through 21 died from medical conditions. The average age was 11 years.

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

- ♦ Data from calendar year 2007 indicate that *Infection* was the leading cause of medical deaths in this age group; the primary cause of death for seven children was due to infections and three of these children had HIV/AIDS. There were two additional decedents whose death certificates included infection as a contributor to the deaths.
- ♦ *Neoplasms* ranked second with three deaths, followed by *Cardiac* and *Respiratory System Disorders* with equal numbers of deaths in each category (N = 2).
- ♦ Sixty-five percent (N = 11) of the 17 children/youth who died from medically related causes had pre-existing medical conditions. Four of the children were previously diagnosed with asthma; two died from asthma related causes and reviews highlighted social/environmental and medical management factors as risk indicators in these deaths. The remaining two children who had asthma as a pre-existing condition died from cardiac conditions. Cancer and AIDS/HIV were other pre-existing medical conditions. Of the three children/youth who died from AIDS/HIV related causes, records indicate that two had been exposed at birth.

Categorization of Underlying Medical Causes of Death

Based on a review of death certificates, Table 4 depicts the leading causes by age for the 102 decedents who died from causes associated with medical conditions.

TABLE 4: MEDICAL CAUSES OF DEATH—2007 DECEDENTS			
PRIMARY CAUSES OF DEATH	Infants < 1 Yr	1—21 Yrs	Total
Infections	6	7	13
Neoplasms	1	3	4
Respiratory System Disorder	23	2	25
Hemorrhage	2	1	3
Congenital Anomalies	6	0	6
Prematurity	40	0	40
Cardiac Disorder	2	2	4
Metabolic Disorder	3		3
Other	3	2	5
Totals	86	17	103

VIOLENCE RELATED DEATHS

The number of CFRC child/youth deaths attributed to violence has ranked second since 1996. For purposes of this Report, violence related deaths include Homicide, Undetermined and Suicide manners of death. During 2007, 24% (N = 38) of deaths were violence related; 36 were Homicides, one was Undetermined and one Suicide. Firearms accounted for 37 of these deaths.

Suicide and Undetermined

The one Suicide death involved a 16 year old Black/African American male. The events leading to the death involved issues of domestic violence. The decedent had a prior history with the District's child welfare, juvenile justice and mental health systems. He had a previous mental health diagnosis and several psychiatric hospitalizations four years prior to his death; but no record of recent treatment. The cause of death was gunshot wound.

The Undetermined death involved an 18 year old Black/African American male. The events leading to the death involved the decedent fleeing from police after committing a criminal act. He lost control of the vehicle, struck a pole and was found with a gunshot wound to the head.

Homicides

CFRC maintains child/youth Homicide data in three categories: youth violence, fatal child abuse/neglect and other. For purposes of this Report, youth violence refers to Homicides where another juvenile or young adult was the perpetrator; and/or the motive for the death was related to criminal behavior, gang/drug activity/behavior, or retaliation/argument/conflict. Fatal child abuse and neglect Homicides include deaths that 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 an act of violence by either a related, unrelated or unknown adult not in a caretaker role.

- ◆ During calendar year 2007, the number of child/youth Homicides reduced in two major categories, youth violence and fatal abuse. However, Homicides continued to be dominated by acts of violence that involved youth victims.
- ◆ Homicides in the "other" category increased from no deaths in 2006 to two in 2007.
- ◆ Figure 9 illustrates four years of CFRC Homicide data.

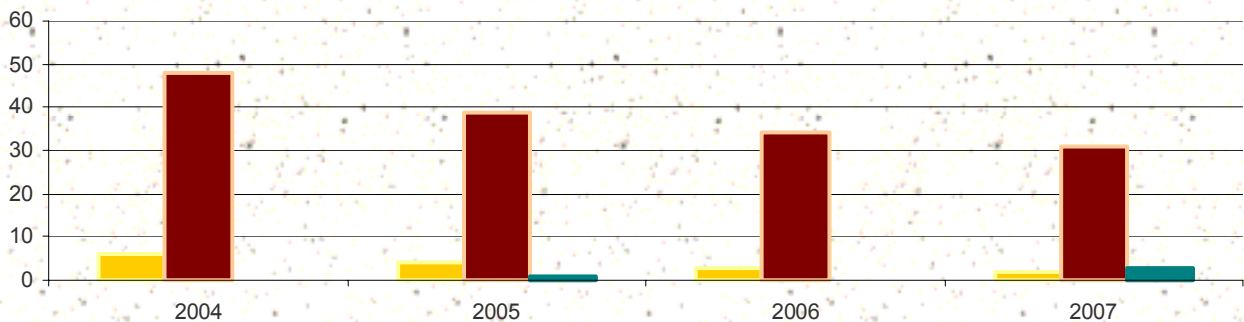


Figure 9: CFRC Homicide Data (2004 - 2007)

■ Child Abuse ■ Youth Violence ■ Other

Fatal Abuse and Neglect Fatalities

- ◆ There were two Homicide fatalities in calendar year 2007 that were associated with fatal child abuse. This represents a 33% reduction from the three 2006 fatal abuse deaths .
- ◆ The causes of death for the two fatal abuse/neglect Homicides was “Blunt Impact Injuries”.
- ◆ The ages of the victims of fatal abuse/neglect were one and two years; both were Black/African Americans; one was male and one female.
- ◆ The decedents resided in Wards Six and Eight and the fatal incidents occurred in the same Wards. One death occurred in the home of the father who lived in a separate household but in the same Ward as the decedent. The second fatal abuse death occurred in the decedent’s home.
- ◆ Both perpetrators were in caregiver roles at the times of the deaths; one was a parent, and one was the mother’s paramour. The ages of the perpetrators were 19 and 21 years; both were Black/African American males. One perpetrator had prior histories of criminal behavior and alcohol use. Both were prosecuted for the calendar year 2007 child murders.

Case Vignettes: 2007 Fatal Abuse Deaths

Case #1: At approximately 3:00 AM, DC medics responded to a report of an unresponsive toddler. The child was transported to a local hospital where life saving efforts failed and he was pronounced dead at 5:00 AM. Physical injuries included multiple lacerations and bruises on the face, arms and abdomen. The investigation revealed the injuries were caused by the parent/caregiver who the child was visiting at the time of the fatal incident.

Cause/Manner of Death: Cardio Pulmonary Arrest; Hemorrhagic Shock; Child Abuse/Sexual Abuse/Homicide

Case #2: At approximately 2:00 PM, DC medics responded to a report of a toddler “having breathing difficulty”. CPR was performed on the scene and in route to the hospital. Once at the hospital life saving measures continued but failed; the child was pronounced dead at 3:35 PM. Investigation revealed the child had been in the care of her mother’s paramour, who eventually admitted to “accidentally killing the child.”

Cause/Manner of Death: Blunt Impact Trauma of Torso with Lacerations of Liver, Spleen, Pancreas, Kidneys and Right Adrenal Gland/Homicide

National Risk Indicators

Based on national risk factors associated with child abuse and neglect deaths, the following applied to the two CFRC fatal abuse deaths that occurred in calendar year 2007:

- | | |
|----------------------------------------------------------------------------------|------------------|
| ◆ Young children under the age of 5 years | Both 2007 Cases |
| ◆ Parents or caregivers under the age of 30 years | Both 2007 Cases |
| ◆ Low income, single parent families experience major stresses | Both 2007 Cases |
| ◆ Children left with male caregivers who lack emotional attachment to the child | Both 2007 Cases |
| ◆ Child with emotional and health problems | Nether 2007 Case |
| ◆ Lack of suitable child care | Both 2007 Cases |
| ◆ Substance abuse among caregivers | One 2007 Case |
| ◆ Parents/caregivers with unrealistic expectations of child development/behavior | Both 2007 Cases |

Youth Violence Homicides

- ◆ Thirty-two, or 89% of the 2007 Homicides were associated with youth violence. This represents a six percent decrease from the 34 youth violence deaths from 2006.
- ◆ **Age, Race and Gender of Decedent** – The ages of the victims from 2007 ranged from 13 to 23 years. As Figure 10 illustrates, the majority (N = 16) were between the ages of 18 through 20 years; the average age was 18 years. Black/African American males represented 75% of the 2007 victims (N = 24); two victims were Hispanic males. There were six female victims representing a 500% increase from the one 2006 female victim and a 20% increase from the five female victims from 2005.

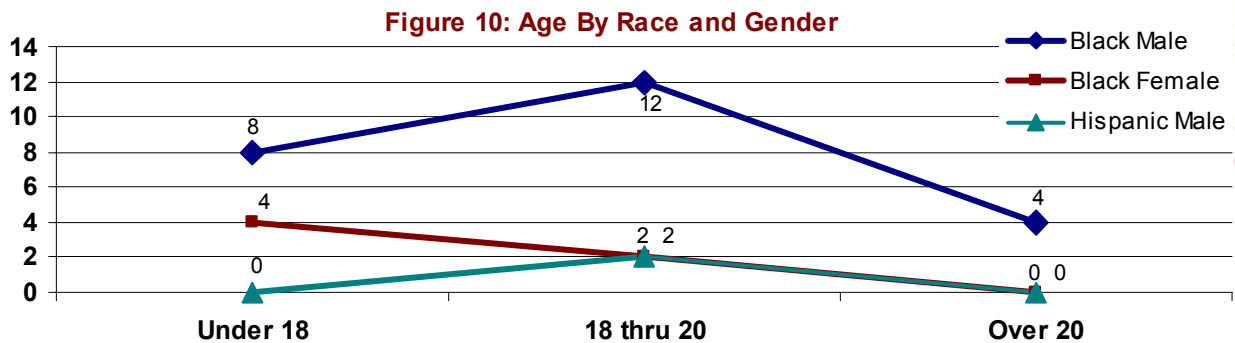
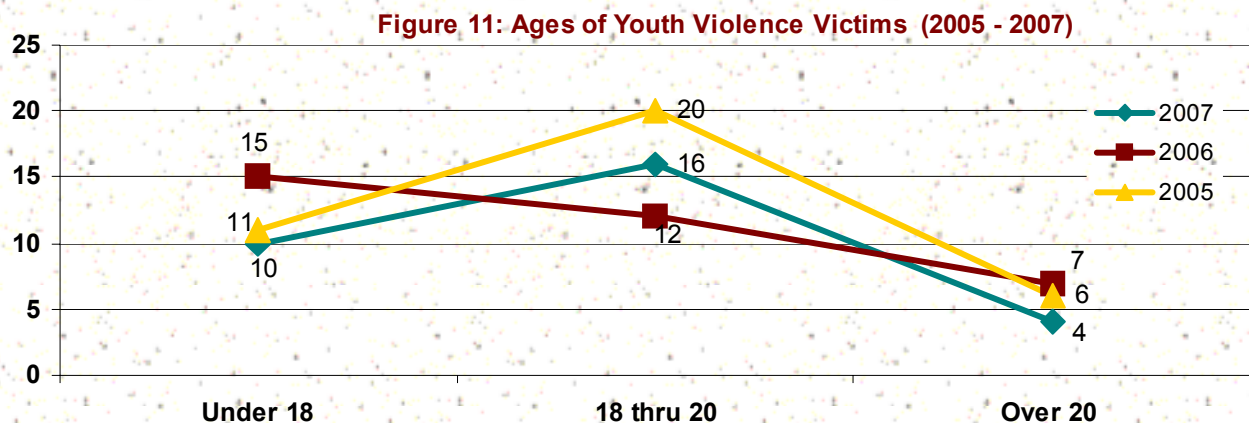
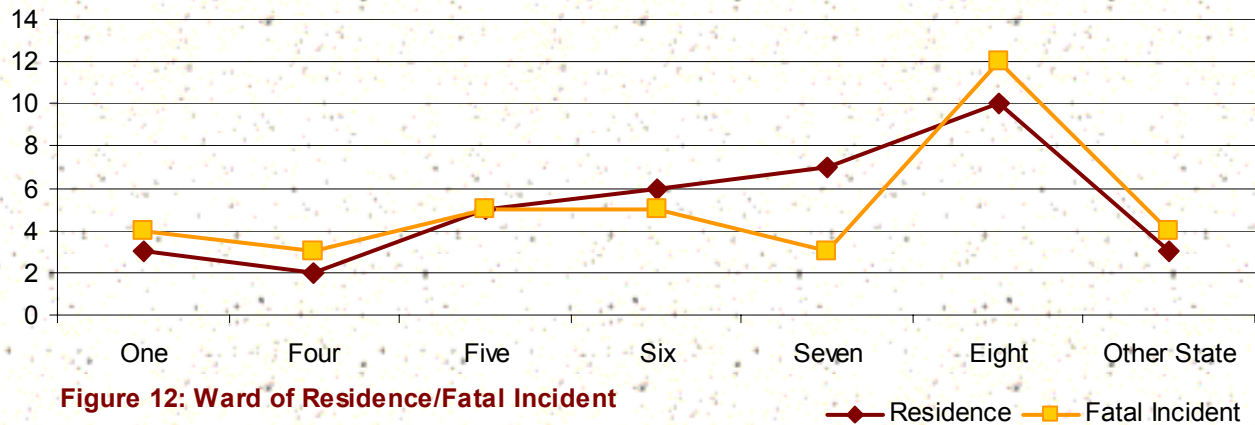


Figure 11 below depicts similarities related to the ages of the youth violence victims over a three year period.



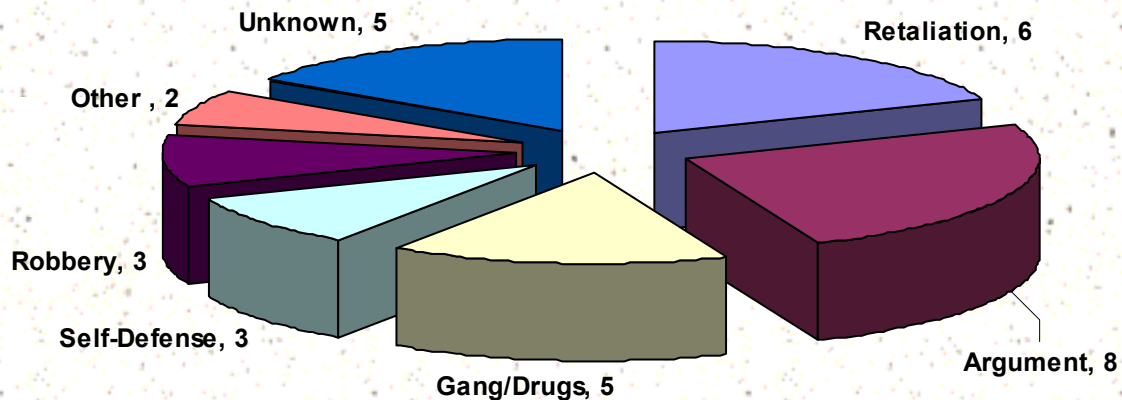
- ◆ **Ward of Residence/Fatal Incident** – The majority of the 32 youth violence decedents were residents of Wards Eight, followed by Wards Seven, Six and Five; each Ward had between five and 10 Homicide victims (see Figure 12 on page 13). Combined, these Wards represent 88% (N = 28) of the total number of youth violence deaths for 2007. Similarly, the majority of the fatal events during 2007 also occurred in Ward Eight (N = 12); followed by Wards Five and Six, with five deaths each. Four District youth died violently in other states including Maryland and Delaware.

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- ♦ **Cause of Death** – Guns continued to be the weapon of choice in youth violence homicides. In 2007, 97% (N = 31) of the 32 youth Homicides were caused by firearms. One victim died from “Blunt Impact Torso Trauma with Liver Lacerations.”
- ♦ **Toxicology Screen** – The majority of the decedents were not using substances at the time of their deaths. Based on the results of toxicology screens conducted at the time of autopsy, 38% (N = 12) of the 32 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 at death was low, records documented drugs and/or alcohol use as a problem for nearly two thirds (N = 20, or 62%) of 2007 youth violence victims.
- ♦ **Motive for the Fatality** - Motives were known for 27 of the 32 youth violence Homicides. Motive was unknown for five of the deaths and three of these deaths occurred in other states and CFRC was unable to obtain copies of police investigation records. Based on MPD and USAO Reports, 2007 data indicates that arguments and retaliation/revenge were the leading known motives among 2007 youth Homicides (25% and 19% respectively). Gang and drug activity were associated with 16% of the Homicides.

Figure 13: Motives - 2007 Homicides



National Risk Indicators - Youth Homicides

Based on national risk indicators established by National Center for Child Death Review and other CFRC risk factors associated with the review of youth homicides, data from the 2007 youth fatalities revealed the following:

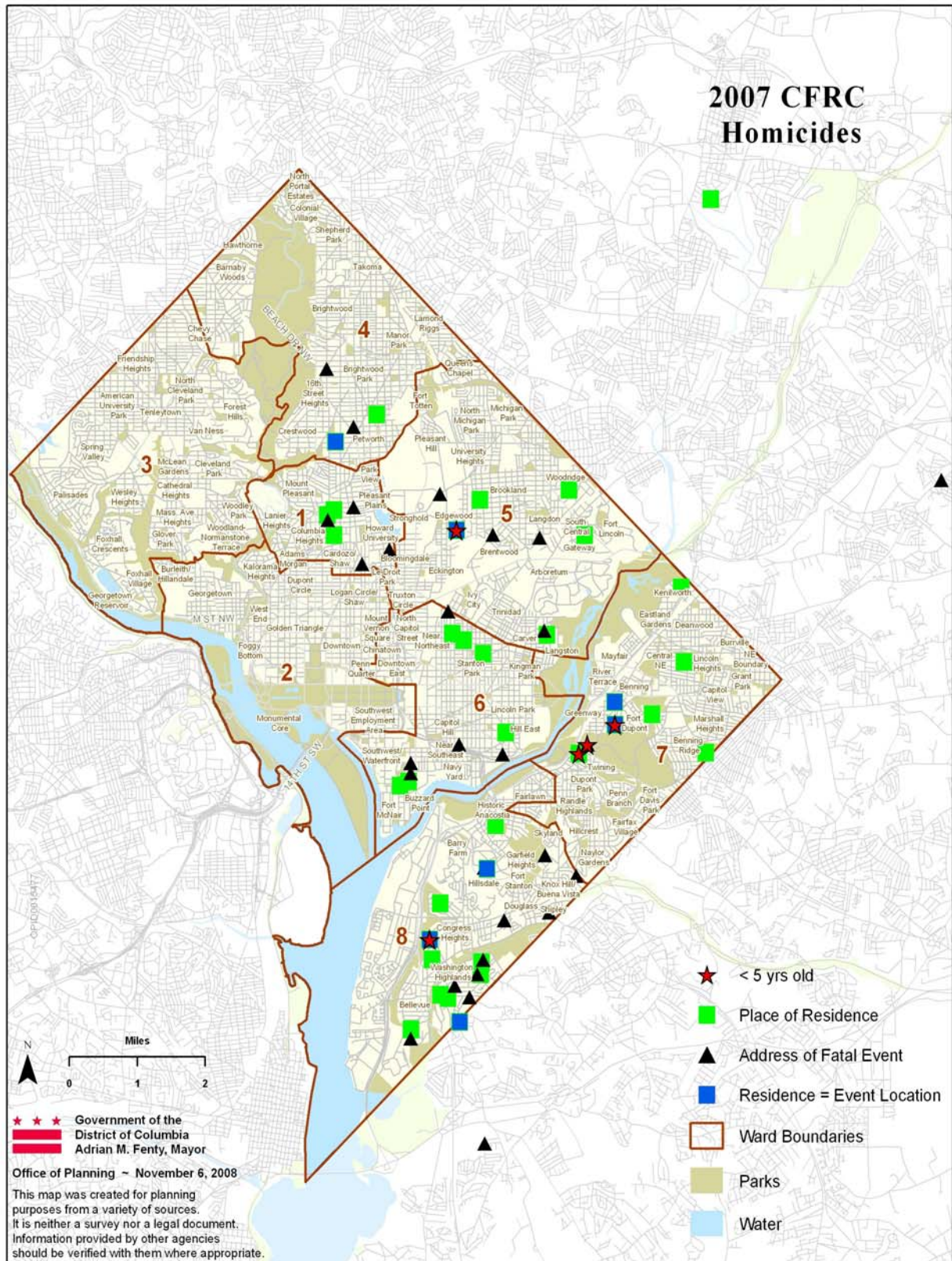
- ♦ *Easy availability and access to firearms* - 97% of the youth fatalities were caused by gunshot wounds. 38% of the 32 decedents had prior arrests associated with possession of firearms or allegedly had firearms at the time of their deaths.
- ♦ *Youth living in neighborhoods with high rates of poverty, social isolation and family violence* - 100% of the 32 youth were known to the District's public assistance program; 38% were receiving services (TANF, Food Stamps and/or medical assistance) at the times of their deaths.
- ♦ *Youth residing/active in drug and gang activity* - 6% of the 32 youth victims resided in and 22% died in areas designated by MPD as "Hot Spots."
- ♦ *Youth dealing with mental health, behavioral and other emotional problems* - Half of youth victims had a diagnosed mental illness and received public mental health services. 71% of victims had behavior problems within their homes, schools and/or communities. 34% of the victims reported dealing with issues of grief associated with the loss 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 21 youth Homicide victims between the ages of 18 and 23 years, two had graduated from high school or obtained a GED; and two were enrolled in the 12th grade at the time of his death. Of the remaining 17 youth, 11 (65%) had withdrawn from school prior to the death. Of the remaining 11 youth victims who were compulsory school age, four had dropped out of school.
- ♦ *Youth with delinquent/criminal justice history* - 53% of the youth 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* - 38% of the youth were known to the District's child welfare system and had histories of neglect/abuse; only 2 of these families had active child welfare cases at the times of their deaths.

OTHER

- ♦ Two Homicides from 2007 involved children whose deaths were the result of violent acts perpetrated by unrelated or unknown individuals.
- ♦ One was a four year old, Black/African American male who was found in his Ward 8 home with his mother. Both the mother and child were victims of gunshot wounds.
- ♦ One was a three year old, Black/African American female who died from injuries associated with a gunshot wound suffered by her mother while pregnant.

The map on page 15 illustrates the Ward of residence and location of the fatal incident for the 36 District child/youth Homicides that occurred in 2007 in all categories (fatal abuse, youth violence and other).

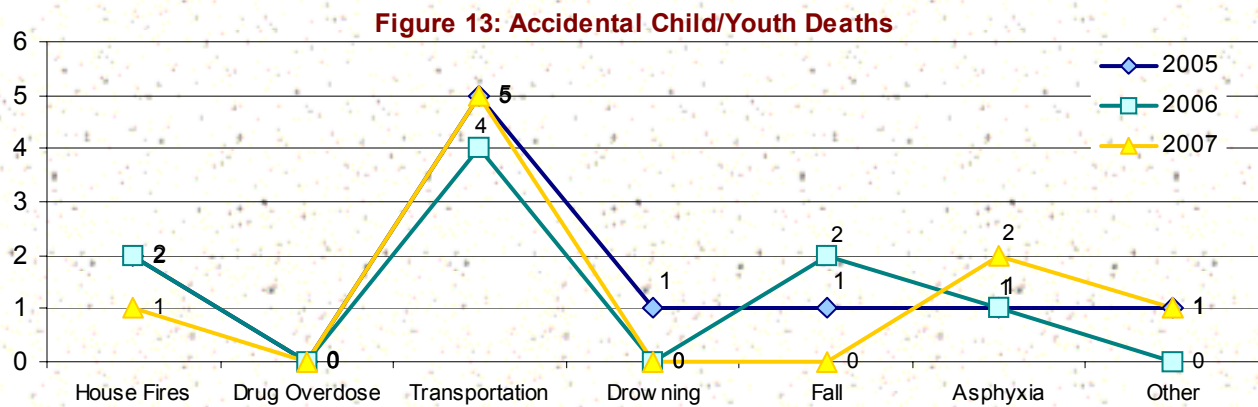
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UNINTENTIONAL INJURIES

Unintentional injuries are incidents where the deaths were not the result of deliberate acts. This may include violent or non-violent acts that were determined by autopsy to be accidental. In 2007, there was an equal number of accidental deaths as those that occurred in calendar year 2006 (N = 9). Since 2005, there has been an average of 10 child/youth accidental deaths annually. The primary causes are depicted in Figure 13 below.

- ◆ As with previous years, most 2007 unintentional injuries were transportation related.
- ◆ The ages of the 2007 victims of unintentional injuries ranged from 1 month to 18 years.
- ◆ One hundred percent of 2007 unintentional deaths involved Black/African American victims.
- ◆ In 2007, there were more female than male victims of accidental deaths (N = 7, or 78% females).



Transportation Related Accidents

- ◆ Transportation related accidents represented 56% (N = 5) of the nine 2007 accidental deaths. Four of these incidents involved motor vehicles; one involved a motorcycle. Of the four incidents that involved motor vehicles, two were pedestrians, and two were passengers in separate two vehicle collisions.

TABLE 5: TRANSPORTATION RELATED ACCIDENTS

<i>AGE/RACE/ GENDER</i>	<i>Month/Day/ Time of Injury</i>	<i>Ward – Residence/ Fatal Incident</i>	<i>Type of Victim</i>	<i>Type of Vehicle</i>	<i>Contributing Factor #1</i>	<i>Contributing Factor #2</i>
6/Black/ Male	Feb/Fri/8:05 AM	5/5	Pedestrian	Automobile	Driver Violation Ped Right of Way	
6/Black/ Female	Apr/Mon/4:15 PM	6/6	Pedestrian	Automobile	Ped Violation/ Not at corner/ crosswalk	Hit & Run
5/Black/ Female	Jun/Tue /3:40 PM	5/MD	Passenger	Automobile	Driver Violation	Alcohol
17/Black/ Male	Jul/Mon/8:30 PM	7/7	Driver	Motorcycle	Speed	No Helmet
2/Black/ Female	Oct/Sun/3:10 AM	4/1	Passenger	Automobile	Red Light Speed	Hit & Run

House Fires/Smoke Inhalation

- ◆ One of the 2007 accidental deaths involved a house fire.
- ◆ The victim, a Black/African American, female, was four years of age.
- ◆ The location of the fire was the decedents' family home in Ward Seven.
- ◆ Based on investigative reports, the fire originated in the living room area; however, the cause was "undetermined". The report also indicated the home was equipped with smoke detectors.
- ◆ The incident occurred during the night when the family was asleep. There were other family members and unrelated occupants in the home. In addition to the fatality, four other occupants were hospitalized for non-fatal injuries.

Asphyxia

- ◆ There were two Asphyxia deaths in 2007; both were Black/African American females, ages one and two months. Both deaths occurred while the infants were co-sleeping with their parents and were found unresponsive. The investigations revealed indications of overlay.

Other

- ◆ *Electrocution* - One 2007 unintentional death involved an 18 year old, Black/African American female who was struck by lightening. The fatal incident occurred while the decedent was talking on a cell phone, standing under a tree in the rain.

Case Vignette: Two 2007 Deaths—Accident and Undetermined

Case 1: A mother of a 2 month old reported to the 911 dispatcher that she discovered her infant unresponsive at approximately 5:00 AM. CPR was performed on the scene and in route to the hospital. Despite aggressive resuscitation efforts at the hospital, the infant remained without vital signs and was pronounced dead 6:17 AM. A retrospective scene investigation revealed that the child was co-sleeping with two adults and a sibling; there was no crib in the home as the family was homeless and had just moved in with a friend. The child was found partially underneath an adult in the bed.

Cause/Manner of Death: Asphyxia/Accident

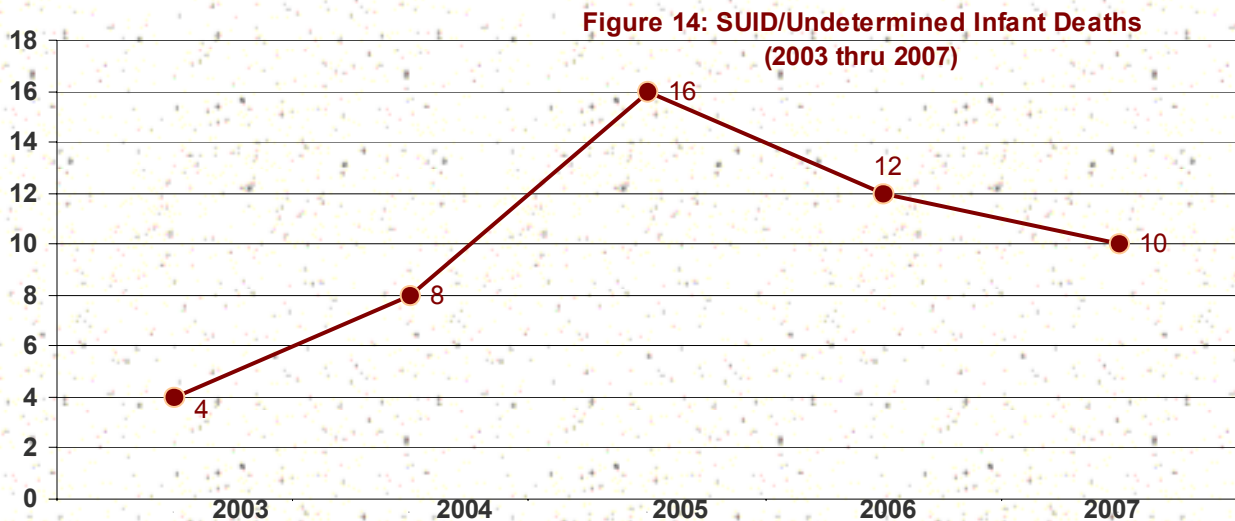
Case #2: The father of a 4 month old infant called 911 and reported that his baby was not breathing. With the assistance of a neighbor, CPR was initiated on the scene; medics continued CPR in route to the hospital. Medical intervention also continued at the hospital but was futile and the child was pronounced dead at 1:50 PM. A retrospective scene investigation revealed the infant was lying on the sofa with an adult relative. She was placed on her back against the rear of the sofa and was found on her back, close to the edge of the sofa. The investigation also revealed that the adult who was sleeping on the sofa with the infant had taken cold medication prior to falling asleep.

Cause/Manner of Death: Sudden Unexplained Infant Death Associated with Co-sleeping/Undetermined

SUDI/UNDETERMINED CAUSES OF DEATH

Both “Sudden Unexplained Death of Infant” and “Undetermined” causes of death fall under the “Undetermined” manner of death. “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/forensic investigation, toxicology screens and any other social, familial, medical and/or other specific events leading to or surrounding the fatal incident.

In 2007, the number of “Undetermined” child fatalities continued to decline. Figure 14 illustrates the pattern of Undetermined child deaths in the District over a five year period. The more stable incline in Undetermined deaths began in 2003, with the most substantial increase occurring in calendar year 2005 (Endnote 2, see page 30). In 2007 there were 10 child/youth fatalities where the manner of death was Undetermined, representing a 17% decrease from 12 similar deaths that occurred in 2006.



Based on a review of the 2007 “Undetermined” deaths, the following findings were identified:

- ◆ The ages of the decedents ranged from one month to 18 years. Nine of the decedents were infants (90%).
- ◆ Consistent with previous years, all 2007 decedents were Black/African American; and the majority were females (N = 6 or 60%).
- ◆ The decedents were residents of Wards Five, Six, Seven and Eight, with Wards Five and Seven having equally higher numbers (N = 3 each).
- ◆ Ninety percent (N = 9) of the Undetermined deaths had causes of SUDI. (For additional information related to SUDI deaths refer to the Infant Mortality Data on page 20)
- ◆ One Undetermined death involved an 18 year old Black/African American male and the cause was related to firearms (gunshot wound).

Educational Fact: Sudden Unexplained Infant Death



Sudden Unexplained Infant Death (SUID) is the unexpected death of a child under one year due to natural or unnatural causes. Sudden Infant Death Syndrome (SIDS) is one cause of SUID deaths. Placing infants on their backs to sleep has been nationally recommended to reduce the risk of 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.

Ten recommended ways to reduce the risk of SUDI/SIDS (National Institute of Child Health and Human Development):

- ◆ *Always place the baby on his/her back to sleep, for naps and at night.* The back sleep position is the safest, and every sleep time counts.
- ◆ *Place the baby on a firm sleep surface, such as on a safety-approved crib mattress, covered by a fitted sheet.* Never place a baby to sleep on soft surfaces (i.e., pillows, quilts, sheepskins).
- ◆ *Keep soft objects, toys, and loose bedding out of the baby's sleep area.* Don't use pillows, blankets, quilts, and pillow-like crib bumpers in baby's sleep area, and keep any other items away from the baby's face.
- ◆ *Do not allow smoking around the baby.* Don't smoke before or after the birth, and don't let others smoke around the baby.
- ◆ *Keep the baby's sleep area close to, but separate from, where you and others sleep.* A 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/her back in a separate sleep area, such as a bassinet, crib, or cradle 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, wait until your child is 1 month old or is used to breastfeeding before using a pacifier.)
- ◆ *Do not let the baby overheat during sleep.* Dress the 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 the baby's head:* provide “Tummy Time” when the baby is awake and someone is watching; change the direction that the baby lies in, in the crib from one week to the next; and avoid too much time in car seats, carriers, and bouncers.

PART II: SUMMARY OF CFRC SUBCATEGORIES

INFANT MORTALITY DATA

Infant mortality is a complex issue that is affected by medical, socioeconomic, psychological, ethical and political factors. As a result, 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 and autopsy findings) to develop a comprehensive account of the factors that contributed to poor pregnancy outcomes 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 2007 Infant Death

A 29-year-old mother with a negative history for serious medical problems reported to the emergency room with complaints of contractions. Records indicate she had received routine prenatal care with a maternal fetal medicine specialist. Pregnancy was complicated by twin gestation, congenital anomalies and symptoms of premature labor. Multiple sonograms and other tests showed multiple anomalies for twin B. After several tests and treatment at the emergency room, contractions subsided and she was discharged and given an appointment for follow-up with her physician. One month later she again reported to the emergency room with complaint of contractions. She was again given medication to stop the contractions but with poor results. She was discharged and instructed to monitor for labor symptoms. She returned to the hospital the next day with complaints of vaginal bleeding and contractions. Pelvic examination revealed the cervix to be 70% effaced and 6 cm. dilated; shoulder presentation was noted for twin B. Mother was informed of the complications for delivery, and consented to a C/section delivery. The twin infants were born one hour later at 31 weeks gestation; twin A weighed 4 pounds and twin B weighed 3 pounds. The mother was discharged home with twin A, three days later and was given an appointment for follow-up with her obstetrician in 6 weeks. Twin B was diagnosed with a neurological tube defect/spinal bifida; once stabilized after birth he was transferred to the Neonatal Intensive Care Unit where he remained until his death 4 days later. Family members were provided grief counseling by the hospital social worker and given referrals for community support groups.

Cause/Manner of Death: Multiple Congenital Anomalies/Natural

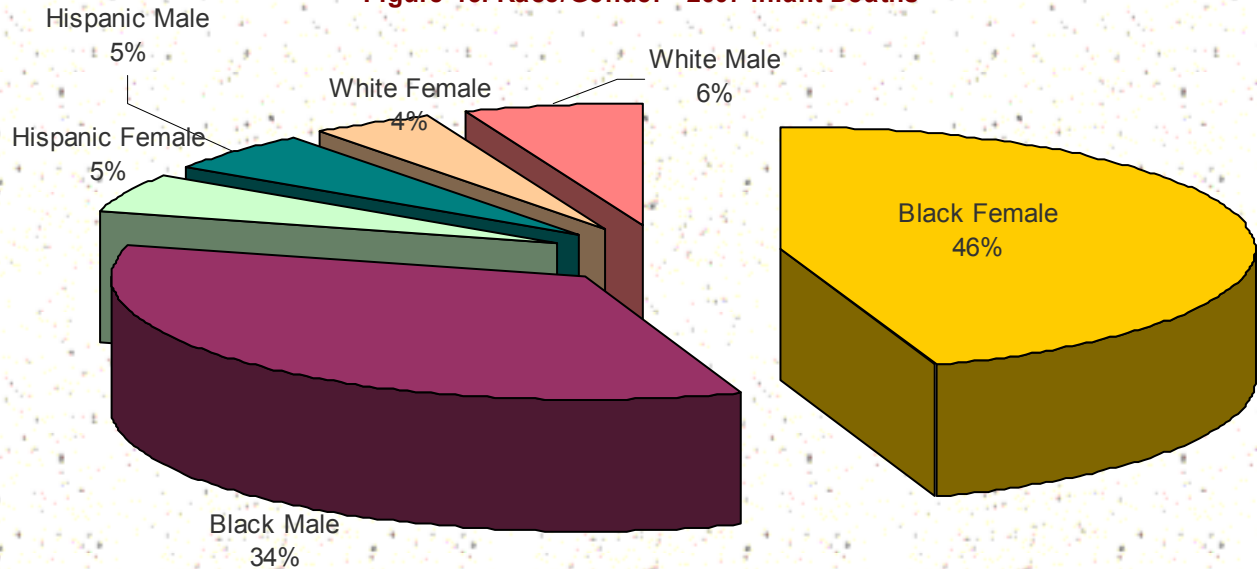
2007 INFANT DECEDENT/FAMILY DEMOGRAPHICS

- ◆ Ninety-seven of the 160 children/youth (61%) identified from calendar year 2007 were under the age of one year (Endnote # 2, see page 30).
- ◆ The ages of the decedents ranged from birth through eight months. Nearly three quarters of the infant population (N = 71, or 73%) died within the first 28 days of life (neonates) and 73% of these infants (N = 52) died within the first day of life.
- ◆ Consistent with the overall population, the majority of the infants were Black/African American (N = 77, or 79%). There were equal numbers of White and Hispanic infant deaths. The White and Hispanic infant decedent populations represent 100% and 91% respectively of the total deaths in these racial groups from the 2007 calendar year.

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- ◆ There were slightly more female than male infant decedents. Females represented 54% (N = 53) of the infant death population from 2007.
- ◆ Figure 15 illustrates the race and gender of the 2007 CFRC infant decedent population.

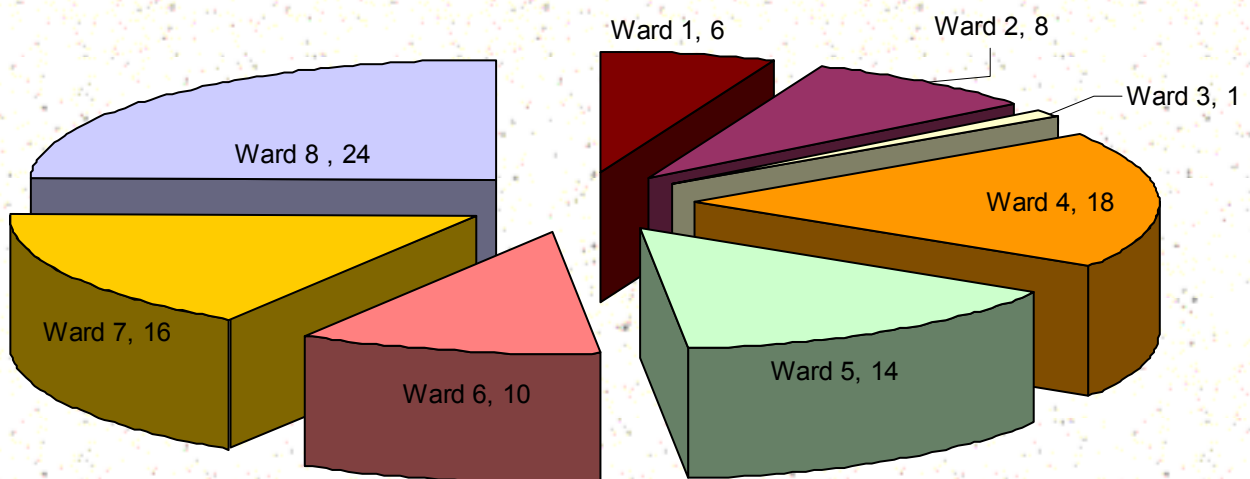
Figure 15: Race/Gender - 2007 Infant Deaths



District Ward of Decedents

- ◆ As Figure 16 illustrates, infant deaths occurred in all Wards of the District during calendar year 2007.
- ◆ Data indicates that the majority of the infant deaths involved residents of Ward Eight (N = 24), followed by Wards Four, Seven and Five. Combined, these Wards represented 74% of the total infant deaths for 2007 (N = 72).

Figure 16: Ward of Residence - 2007 Infant Deaths



Gestational Age/Birth Weight

Infants with low gestational age and birth weight are at much higher risk of mortality. Historically, CFRC data consistently documented these risk factors as contributors to the high number of infant deaths in the District. Data from 2007 continued to support the severity and significance of this problem. Gestational age and birth weight are obtained from the birth certificate and birth records. This information was known for 94 of the 97 infant decedents from 2007.

- ◆ As Table 6 illustrates, 86% of the 97 infant decedents were born prematurely. Nearly half (N = 38 or 44%) of these children were born with gestational ages below 23 weeks.
- ◆ Also consistent with previous years, the majority (N = 74) of the 97 infants had birth weights under 1500 grams and 40 of these infants weighed less than 500 grams. Eleven of the 2007 infant decedents were full term; gestational age was unknown for three infants.

TABLE 6: Gestational Age/Low Birth Weight

Gestational Age	2007
< 38 Weeks	83/86%
< 23 Weeks	38
Low Birth Weight	2007
< 1500 Grams	74/76%
< 500 Grams	40

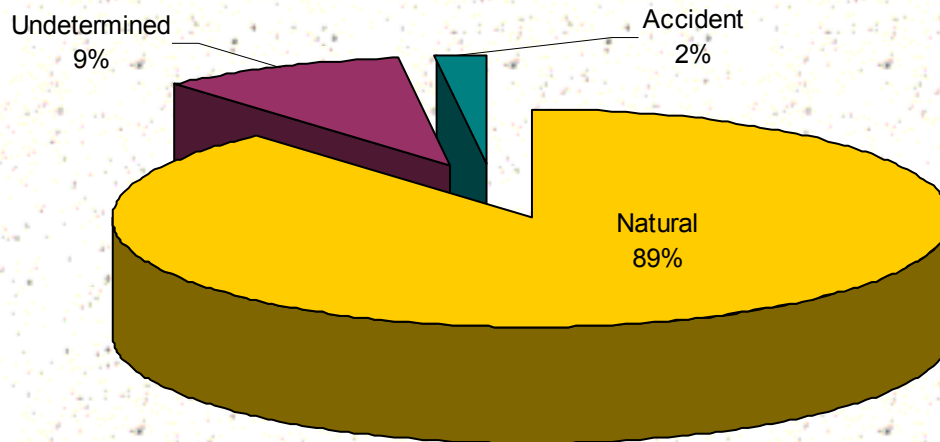


Figure 17: Manner of 2007 Infant Deaths

Manner of Death

- ◆ **Natural** deaths of infants continued to comprise the largest group of deaths in the District. As with previous years, the greater majority of the calendar year 2007 infants died from Natural causes. Eighty-nine percent (N = 86) of children under the age of one year died during 2007 from Natural causes. As previously discussed in the **Medical Conditions** section of this report (see page 8), death certificates for 62 infants (72%) listed premature births as a primary or contributing cause of death. Table 7 (see page 24) depicts the categorization of the primary and contributing causes of death for the 86 infants who died from Natural manners of death based on the death certificates.

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TABLE 7: MEDICAL CAUSES OF DEATH - 2007 INFANTS

<i>PRIMARY CAUSES OF DEATH</i>	<i>Primary Cause</i>	<i>Primary & Contributing Cause</i>
Infections	6	23
Respiratory System Disorder	23	26
Congenital Anomalies	6	17
Prematurity	40	62
Maternal Complications	1	45
Cardiac Disorders	2	
Metabolic Disorder	3	
Other	3	8
Totals	86	

- ◆ **Undetermined** infant deaths has ranked second for the past five years in the District (2003 through 2007). In 2007, there were nine infants who died of “Undetermined” manners of death. Based on reviews of these deaths the following trends were identified:
 - ◇ Ages of the decedents ranged from 1 to 7 months with 56% being one month (N = 5). Females represented 67% of the infants (N = 6); 100% were Black/African American.
 - ◇ Most infants were full term (N = 7 or 78%); all had birth weights over 2040 grams (N = 9). Eight of the infants (89%) had no birth abnormalities or problems.
 - ◇ Most infants had at least one pediatric well child visit prior to their deaths. Investigations revealed only one parent reported the infant being ill immediately prior to the death.
 - ◇ Eight (89%) infants were co-sleeping or sleeping in unsafe sleep environments at the times of their deaths (i.e., sofa, adult beds with excessive blankets, pillows, etc). Four families did not have cribs or bassinets in the home.
 - ◇ The position in which the infant was placed was unknown for six of the nine “Undetermined” infant deaths. Of the three where position placement was known, one each was placed on the back, stomach and side. Of the eight cases where the position of the infant when found at the time of the fatal incident was known, three were found on their backs (supine) and five on their stomachs (prone).
 - ◇ All of the Undetermined infant deaths had causes of Sudden Unexplained Death in Infancy. The official autopsy reports for six (N = 67%) directly linked co-sleeping/ bed sharing and/or inappropriate sleep environments to the cause of death.

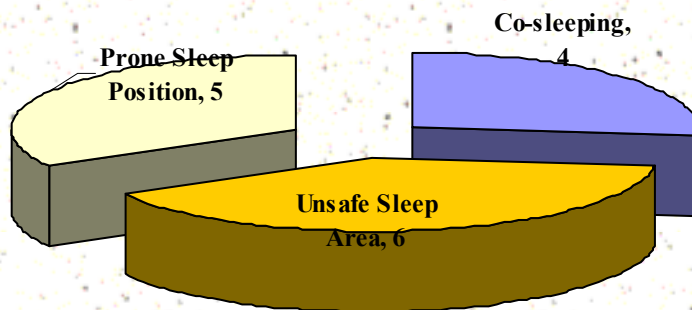
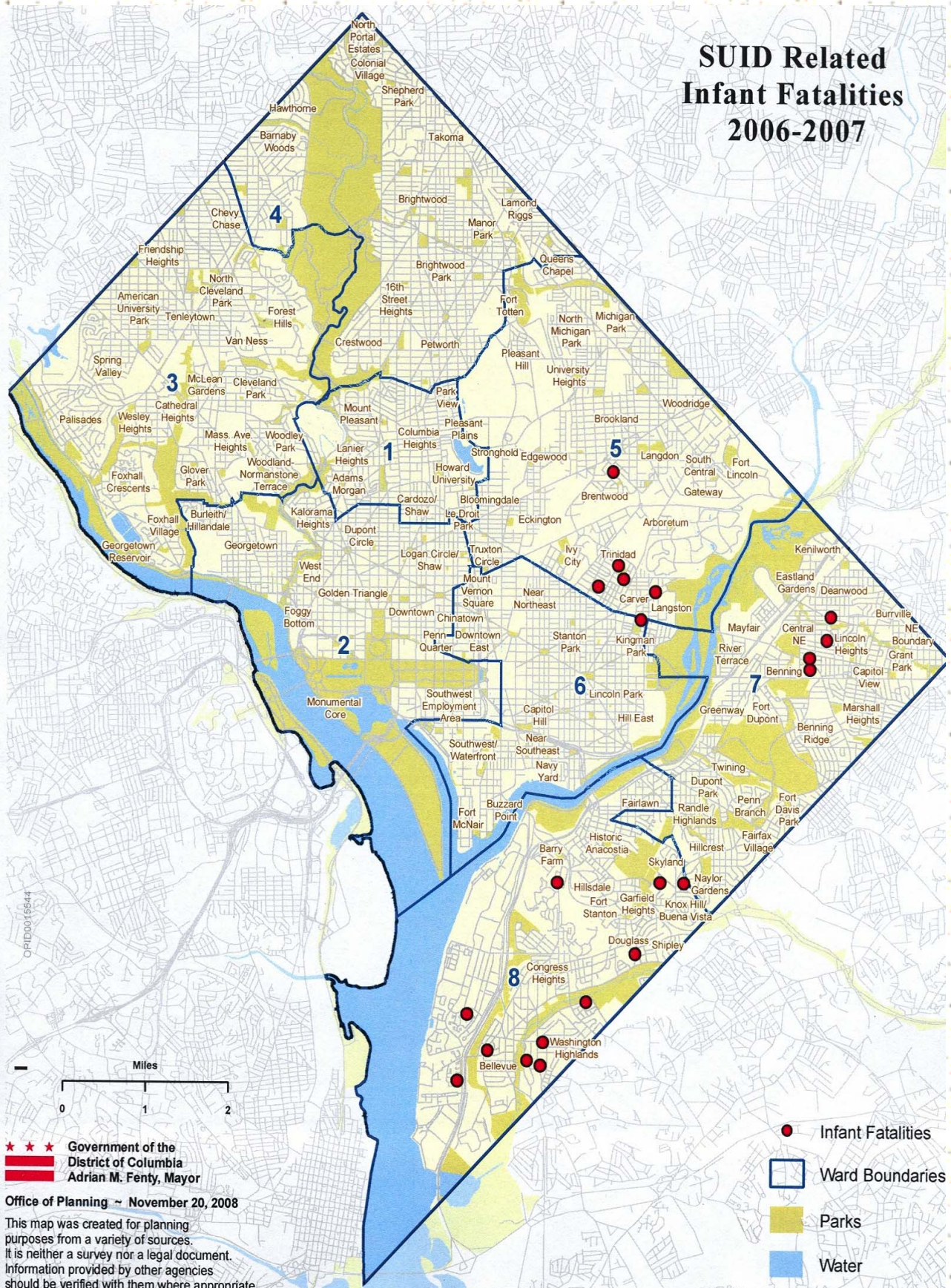


Figure 18: SUID Risk Factors

- ◇ The map on page 24 illustrates the Ward of residence for the infants’ families’ at the time of the calendar years 2006 and 2007 SUDI deaths.

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SUID Related Infant Fatalities 2006-2007



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- ♦ **Accidental** deaths ranked third among 2007 infant deaths (N = 2). Both accidental deaths were caused by Asphyxia and involved co-sleeping with adults; overlay was a primary contributing factor.
- ♦ There were no 2007 infant deaths associated with **Homicide**.

Decedent's Maternal Demographic Data

- ♦ Age of the mother at the time of the 2007 death was known for 94 of the 97 CFRC infant fatalities. Their ages ranged from 17 to 44 years, with an average age of 26. The ages of the mothers at the time of the birth of their first child was known for 85 cases. The ages ranged from 13 to 41, with an average age of 21 years.
- ♦ Race was known for 96 of the 97 mothers; 78% of the mothers (N = 76) were Black/African American; 11 were Hispanic and nine White.
- ♦ The majority of the mothers for calendar year 2007 infant deaths (N = 83) were single and never married. Eleven mothers were married at the time of the death. Marital status was unknown for three mothers.
- ♦ Educational level was known for 74 of the 97 mothers of 2007 infant decedents. Seventy-three percent (N = 54) of the mothers where educational level was known had at least a high school education and 12 of these women had participated in college level educational programs; six of these mothers had completed undergraduate level. Twenty mothers had less than a high school education.
- ♦ Of the 76 mothers where employment history was known, 31 were employed; and 45 unemployed at the time of the death.

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 82 or 84% of the mothers. Seven mothers did not received prenatal care during their pregnancies with the 2007 decedents. Based on the birth medical records and/or the decedents' birth certificates, 75 mothers received at least one prenatal visit; the majority received routine prenatal care (N = 52).
- ♦ **Physical Health** - Of 79 cases where mothers' health status was known, 46% (N = 36) were diagnosed with physical health conditions. Some of the most common health problems included anemia (N = 7), asthma (N = 14), allergies (N = 6), diabetes (N = 3), obesity (N = 9) and thyroid problems (N = 2).
- ♦ **Mental Health/Developmental Problems** - Twelve mothers had documented histories of mental health disorders, including depression, schizophrenia, bipolar and anxiety disorders. Three had known histories of domestic violence and one had a history of sexual assault.
- ♦ **STD/Maternal Infections** - Forty-seven women (48%) had histories of sexually transmitted diseases and/or maternal infections during their pregnancies with the decedent (i.e., pre-eclampsia, urinary tract infections, gonorrhea, HIV, Chorioamnionitis, Chlamydia, etc.)

Case Vignette: Three Infant Deaths Associated with Prematurity

Case #1: A 22 year old mother of 1 living child came to the delivery hospital with a primary complaint of uterine contractions for 3 days. Her medical history was remarkable for asthma, fibroid tumors and marijuana abuse. She also reported that she had received no prenatal care, indicating that she was unaware that she was pregnant. Several hours after arrival at the hospital, she gave birth to a male infant, determined to be 25 weeks gestation and weighing 505 grams. After 29 days of aggressive medical care/treatment in the Neonatal Intensive Care Unit, the infant died in his mother's arms.

Cause/Manner of Death: Extreme Immature Infant, Respiratory Distress Syndrome/Natural

Case #2: A 30 year old female with no living children came to the delivery hospital with primary complaints of leaking fluids and uterine contractions. Her medical history was negative for serious illnesses and she reported receiving prenatal care at a local clinic. Pelvic examine revealed grossly ruptured membranes with fluid pooling; she was determined to be 3 cm. dilated and sonogram findings indicated vertex presentation of both twins. The female was counseled related to the poor pregnancy outcome associated with the status of the fetuses. Labor progressed quickly and within 3 hours, the female delivered twins determined to be 22 weeks gestation and weighing 461 and 501 grams. Both infants were wrapped and placed in warmers; vital signs were monitored until their deaths 7 minutes and 3 hours later.

Causes/Manners of Death: Extreme Prematurity, Premature Rupture of Membranes, Chorioamnionitis/Natural

◇ Substance Abuse/Tobacco Use

- Fourteen mothers (14%) had problems with substance abuse; five reported illicit drug use only; four alcohol and five reported problems with both drugs and alcohol.
- Three mothers had positive toxicology screens for illicit substances at the time of the decedents' birth.
- Nineteen mothers reported tobacco use.

Sibling Data

- ◇ Most calendar year 2007 infant decedents had siblings. Of the 64 (66%) families known to have other children, the number ranged from one to six, with an average of two siblings.
- ◇ Nineteen infants were part of multiple births; 17 were twins; one was a triplet and one was a quadruplet. Five families lost both twins and one family lost two of the quadruplets born in 2007.
- ◇ Three additional mothers also had child deaths prior to 2007.

JUVENILE JUSTICE FATALITY DATA

Twenty-one (13%) of the 160 fatalities from calendar year 2007 were youth known to the juvenile justice system with two years of their deaths. Reviews of these cases revealed the following trends/observations:

DECEDENT DEMOGRAPHIC DATA

- ♦ *Age/Race/Gender* – Ages of the decedents ranged from 15 through 23 years with an average age of 18. Black/African American males dominated the juvenile justice fatality population. (N = 20 Black/African Americans and 19 males).
- ♦ *Ward of Residence* – The majority (50%) of the juvenile justice deaths involved residents of Wards Seven and Eight (N = 5 each).
- ♦ *Substance Abuse/Involvement* – Substance abuse continued to be a major concern in the majority of the juvenile justice fatalities. Ninety percent of the decedents (N = 19) had known histories of substance use (drugs and/or alcohol).
- ♦ *Educational Level* – Based on reviews of public school and other public records, and death certificates, one juvenile justice decedent from 2007 had received a GED. Fifty-seven percent (N = 12) of the decedents, between the ages of 17 and 23 years, had withdrawn prior to the fatal event. Six youth, ages 15 through 18, were enrolled in schools at the times of their deaths. Educational information was unknown for two youth.
- ♦ *Mental Health Problems* - 42% of the youth had known diagnosed mental health disorders/conditions; one committed Suicide during 2007 and had documented prior mental health diagnosis/history including suicide ideation.

MANNER/CAUSE OF DEATH

- ♦ Ninety-five percent of the juvenile justice deaths were violence related. Of the 19 violence related deaths, Homicide continued to be the prevailing manner of death for juvenile justice fatalities. Eighty-one percent of decedents (N = 17) died from Homicides. The three remaining violence related deaths included Suicide, Undetermined and Accident. Ninety-four percent of the violence related deaths were caused by firearms and one was caused by Blunt Impact Trauma.
- ♦ One juvenile justice fatality was a Natural death.
- ♦ Fatal incidents occurred in all Wards of the District except Ward Three. The highest number of fatal incidents occurred in Wards Eight (N = 6) and Five (N = 4).

JUVENILE/COURT HISTORY

- ♦ All 21 decedents from calendar year 2007 had multiple arrests/charges and 71% (N = 15) had violent and/or gun related offenses.
- ♦ Nearly half (N = 10) of the juvenile justice decedents had active cases at the time of deaths; five were committed to the District; four were on probation and one was on a consent decree.

CHILD WELFARE FATALITY DATA

During 2007, 44 or 28% of the 160 deaths identified were children who were known to the child welfare system within four years prior to their deaths. Reviews of calendar year 2007 child welfare fatalities revealed the following trends/observations:

DECEDENT DEMOGRAPHIC

- ♦ *Age/Race/Gender of Decedent* – The ages of the child welfare decedents ranged from birth through 23 years, with an average age of eight years. Seventy-seven percent of the decedents were infants (N = 18) and youth over the age of 14 years (N = 16). Ninety-eight percent of the decedents were Black/African American (N = 43) and 57% were males (N = 25).
- ♦ *Educational Level of Decedents* - Data reflected that of the 10 youth who were 18 years of age or older, two had graduated from high school or obtained a GED and seven had withdrawn from school prior to the deaths. The educational level for one was unknown.

CAUSE/MANNER OF DEATH

Forty-five percent of the child welfare decedents died from Natural causes (N = 20). Homicides ranked second (N = 14). Undetermined and Accidental deaths ranked third and fourth. One child welfare youth also known to the juvenile justice system committed Suicide.

NUMBER AND REASONS FOR CHILD PROTECTION SERVICES REFERRAL AND CASE STATUS

- ♦ At the time of death, 10 (23%) of the 2007 child welfare fatalities were families with active cases. Eighteen cases had closed within two years prior to death.
- ♦ The majority of the 2007 families referred to the child welfare system were reported multiple times (N = 32, or 73%). The number of reports ranged from one to 19. Cases were never opened on eight of the families as, based on the investigations, the allegations included in the reports received were not substantiated.
- ♦ Based on the last child abuse/neglect report received, the primary reason for families being referred was “neglect”, including general, educational and medical neglect. Thirty-five (80%) families were reported for neglect issues.

Case Vignette: A 2007 Juvenile Justice/Child Welfare Suicide

DC Medics arrived on the scene and found a teenage victim lying on the floor, unconscious and unresponsive, suffering from a gunshot wound to the head. Resuscitation efforts were initiated on the scene and continued in route to a local hospital. Life saving measures continued in the hospital emergency room; however, efforts failed and the victim was pronounced dead approximately one hour after arrival. Based on the investigation, the events leading to the death involved a domestic dispute between the victim and his significant other. As the argument began to escalate, the victim began making suicide threats. Based on family members interceding, the argument subsided several times and would then resume shortly afterwards. After approximately an hour, a relative reported hearing a loud noise and then the victim's paramour scream repeatedly, "he shot himself". The investigation revealed the decedent had threatened to take his life numerous times prior to the fatal incident. It was also revealed that friends were aware that the decedent had a gun and on at least one other occasion had placed the gun to his head and threatened to shot himself. The victim had an extensive history with the mental health system but was non-compliant with his treatment and medication during recent years. Based on the autopsy, the victim had experience several significant losses as evident by several tattoos observed during the examination. His toxicology screen at autopsy was positive for methamphetamines.

Causes/Manners of Death: Gunshot Wound of Head/Suicide

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 18)	As prior CFRC Annual Reports have documented, the steady increase in “Undetermined” fatalities was directly associated with a change in autopsy practice for deaths where the investigations revealed 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 # 3 (page 20)	Increases in CFRC infant deaths can be more directly associated with several changes in CFRC practices and may not be reflective of an increase in the overall number of 2007 infant deaths in the District. 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.

APPENDICES

2007 CFRC Recommendations

POLICY AND PRACTICE STANDARDS

- ◆ Department of Health (DOH) should collaborate with Children's National medical Center (CNMC) and DC Public Schools (DCPS) to improve the school health program by:
 - ◇ Reassessing current protocols and amend/clarify procedures related to activating the 911 emergency medical services system by appropriate DCPS personnel.
 - ◇ Developing and implementing a formal in-service training program for school nurse and other appropriate staff on the identification signs and symptoms requiring emergency treatment and activating the 911 EMS system. Training should include contracted RN's and other clinical DCPS staff covering school clinics.
 - ◇ Establishing protocols to formalize the communication process between the nursing/clinical staff and pediatrician to determine disposition for treatment.
 - ◇ Providing copies of relevant guidelines and policies to school nurses and other appropriate DCPS personnel.
- ◆ In an effort to better identify genetic disorders, DOH, in collaboration with prenatal providers should promote early genetic screening for mothers with increased risk of genetic disorders based on abnormal laboratory findings and family history. Screenings should be offered during the first and second trimester of pregnancies.
- ◆ DOH should work with representatives from local hospitals (acute care and convalescent) and Managed Care Organizations (MCO) to improve discharge planning for medically high risk infants to include a home visit to ensure that the child and family have support needed and that the home environment is appropriate in view of the needs of the child.
- ◆ Child and Family Services Agency should re-assess guidelines for monitoring a child born to a substance abusing mother who refuses treatment and continues to abuse drugs and be neglectful and/or abuse. Criteria and procedures for removal of a child in this situation should be clearly delineated.
- ◆ Department of Mental Health (DMH) should modify mental health contracts to ensure the following as minimum standards of practice:
 - ◇ Ensure that full medical histories are obtained on all children entering mental health services (including in and out patient services) that include previous hospitalizations, mental health evaluations, diagnosis and treatment.
 - ◇ Ensure that appropriate mental health client information is shared among mental health providers, in accordance with HIPPA regulations, when multiple care providers are involved in the treatment of clients. This will ensure smooth transition among service providers and continuity and consistency in care and treatment planning.
 - ◇ When a child has three or more hospitalizations within one year, establish a mechanism to ensure that the client is monitored related to discharge recommendations for outpatient mental health services and other appropriate follow-up. When a child/youth does not follow-up with outpatient mental health services after hospitalization, a referral should be made to CFSA for potential medical neglect.

RESOURCE DEVELOPMENT/EXPANSION

- ◆ DOH, in collaboration with DMH should strengthen and/or expand substance abuse treatment services/resources to women 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.
- (Note: This is a longstanding CFRC recommendation. It was reissued by the Committee in 2006 and again in 2007 because of the number of fatalities reviewed where maternal substance abuse and the shortage of substance abuse services in the District were documented problems.)*
- ◆ DMH should review the availability of residential treatment programs for children, and expand resources to prevent excessive length of stays for children in acute care settings.

PUBLIC EDUCATION/TRAINING

- DOH should ensure that all MCO's receive mandated reporter training to increase their understanding of DC Law 2-22, their responsibilities as professional mandated reporters and the method of reporting. Collaboration with CFSA could assist in outlining the training content and conducting training.
- DOH should develop and implement aggressive public health education campaigns to address the following:
 - ◇ To increase awareness of risk factors associated with substance use during pregnancy and potential links to premature births of infants and congenital anomalies.
 - ◇ To increase awareness of symptoms of premature labor, when to seek assistance and the importance/need for early prenatal care.
- In light of the recent Court of Appeals decision striking down a portion of District law that banned guns and the problem of easy access to guns, the District should incorporate education on gun safety into health programs in the DC Public Schools system. The education should emphasize the dangers of possessing guns as well as the need to utilize safety devices and practices when handling or exposed to firearms. *(This recommendation was issued to DC Public Schools jointly by CFRC and the Domestic Violence Fatality Review Board prior to the Supreme Court decision to rescind the District's gun ban)*

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).

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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.

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(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.

2007 CALENDAR YEAR CFRC CAUSE/MANNER OF DEATH LISTING

APPENDIX C

2007 Calendar Year Fatality Listing

<i>Age Years/Months/Days</i>	<i>Cause of Death</i>	<i>Manner of Death</i>
0/0/0	Extreme Prematurity, due to Complications of Planned Therapeutic Termination	Natural
0/0/0	Extreme Prematurity @ 21 4/7 Weeks Gestation due to Premature Labor of Unknown Etiology	Natural
0/0/0	Extreme Premature Infant with Cardiorespiratory Failure due to Preterm Labor and Delivery of Unknown Etiology	Natural
0/0/0	Prematurity @ 21 Weeks due to Maternal Incompetent Cervix	Natural
0/0/0	Extreme Prematurity due to Oligohydramnios of Unknown Etiology	Natural
0/0/0	Respiratory Failure due to Sepsis due to Extreme Prematurity due to Spontaneous Rupture of Membranes of Unknown Etiology	Natural
0/0/0	Maternal Placental Abruption	Natural
0/0/0	Cardio-Respiratory Failure and Arrest due to Multisystem Failure due to Prematurity @ 22 Weeks Gestation	Natural
0/0/0	Preivable Infant Delivery due to Preterm Labor due to Advanced Dilation of Unknown Etiology	Natural
0/0/0	Nonviability @ 20 Weeks Gestation due to Unknown Etiology	Natural
0/0/0	Pulmonary Hypoplasia due to Oligohydramnios (Maternal) due to Severe Preeclampsia (Maternal)	Natural
0/0/0	Preterm Birth @ 18 Weeks due to Maternal Cervical Incompetence	Natural
0/0/0	Prematurity due to Chorioamnionitis with Preterm Labor	Natural
0/0/0	Preivable @ 22 Weeks Gestation due to Unknown Etiology	Natural
0/0/0	Preivable @ 21 Weeks due to Preterm Premature Rupture of Membranes; Other Significant Conditions: Chorioamnionitis, Rescue Cerclage Placed Last Week	Natural
0/0/0	Pulmonary Hypoplasia due to Bilateral Renal Agenesis; Other Significant Conditions: Multiple Congenital Anomalies	Natural
0/0/0	Respiratory Failure due to Prematurity of Unknown Etiology	Natural
0/0/0	Prematurity of Unknown Etiology	Natural
0/0/0	Immaturity of Unknown Etiology	Natural
0/0/0	Severe Premature Non-Viable @ 20 Weeks Gestational Age due to Maternal Chorioamnionitis	Natural
0/0/0	Respiratory Failure due to Pulmonary Hypoplasia	Natural
0/0/0	Extreme Prematurity due to Premature Delivery due to Maternal Incompetent Cervix; Other Significant Conditions: Preterm Rupture of Membranes	Natural
0/0/0	Multiple Congenital Anomalies due to Unknown Etiology	Natural
0/0/0	Extreme Prematurity due to Preterm Delivery due to Incompetent Cervix	Natural
0/0/0	Preivable Fetus @ 18 Weeks Gestation due to Incompetent Cervix	Natural
0/0/0	Prematurity due to Chorioamnionitis with Preterm Labor	Natural
0/0/0	Extreme Prematurity due to Incompetent Cervix, Maternal	Natural
0/0/0	Multiple Fetal Anomalies due to Amniotic Band Syndrome	Natural
0/0/0	Preterm Delivery @ 22 Weeks Gestation due to Complications of Maternal Abruption Placentae	Natural
0/0/0	Cardiorespiratory Failure and Arrest due to Multisystem Failure due to Maternal Chorioamnionitis	Natural
0/0/0	Prematurity due to Elective Termination of Pregnancy due to Fetal Skeletal Dysplasia; Other Significant Conditions: Fetal Malformations	Natural
0/0/0	Trisomy 13	Natural
0/0/0	Preivable Fetus due to Premature Delivery of Unknown Etiology	Natural
0/0/0	Extreme Prematurity @ 21 4/7 Weeks Gestation	Natural
0/0/0	Extreme Prematurity due to Premature Rupture of Membranes due to Unknown Etiology	Natural
0/0/0	Prematurity due to Anencephaly	Natural
0/0/0	Extreme Prematurity due to Premature Rupture of Membranes due to Chorioamnionitis	Natural
0/0/0	Respiratory Distress Syndrome and Shock due to 24 Weeks Gestation due to Abruption Placentae	Natural
0/0/0	Extreme Prematurity due to Premature Rupture of Membranes due to	Natural

	Chorioamnionitis	
0/0/0	Respiratory Failure due to Prematurity of Unknown Etiology	Natural
0/0/0	Extreme Prematurity due to Preterm Delivery due to Chorioamnionitis with Acute Funisitis	Natural
0/0/0	Extreme Prematurity due to Preterm Delivery due to Chorioamnionitis	Natural
0/0/0	Extreme Prematurity due to Preterm Delivery due to Maternal Cervical Incompetence	Natural
0/0/0	Cardiorespiratory Failure and Arrest due to Multisystem Failure due to Extreme Prematurity @ 20 Weeks due to Incompetent Cervix	Natural
0/0/0	Previable Fetus of Unknown Etiology	Natural
0/0/0	Perinatal Asphyxia due to Placental Abruptio	Natural
0/0/0	Extreme Prematurity @ 22 Weeks due to Maternal Chorioamnionitis	Natural
1 Day	Respiratory Distress due to Extreme Prematurity of Unknown Etiology	Natural
1 Day	Previable, Non-Viable Fetus due to Prematurity @ 20-21 Weeks	Natural
1 Day	Respiratory Failure due to Extreme Prematurity of Unknown Etiology	Natural
2 Days	Extreme Prematurity of Unknown Etiology; Other Significant Conditions: Hyperkalemia, Disseminated Intravascular Coagulation	Natural
2 Days	Metabolic Acidosis due to Pulmonary Hypoplasia, Bilateral due to Extreme Prematurity due to Undetermined Etiology	Natural
2 Days	Metabolic Acidosis due to Group B Streptococcal Septic Shock due to Maternally Acquired Group B Streptococcus	Natural
2 Days	Extreme Prematurity due to Intra-Uterine Growth Retardation due to Severe Preeclampsia	Natural
2 Days	Respiratory Failure due to Brain Stem Dysfunction due to Trisomy 13	Natural
2 Days	Respiratory Arrest due to Anencephaly; Other Significant Conditions: Gastroschisis	Natural
2 Days	Pulmonary Hemorrhage and Respiratory Distress Syndrome due to Prematurity @ 26 Weeks Gestation due to Maternal Incompetent Cervix	Natural
2 Days	Severe Respiratory Distress Syndrome due to Extreme Prematurity @ 23 Weeks due to Chorioamnionitis; Other Significant Conditions: Premature Rupture of Membranes	Natural
2 Days	Extreme Prematurity due to Respiratory Distress Syndrome due to Hypotensive Possible Intraventricular Hemorrhage	Natural
2 Days	Pulmonary Hemorrhage due to Extreme Prematurity due to Preterm Labor of Unknown Etiology	Natural
2 Days	Severe Perinatal Asphyxia due to Cord Entanglement and Strangulation due to Monozygotic, Monoamnionic, Monochorionic Twin Gestation; Other Significant Conditions: Extreme Prematurity, Profound Lactic Acidemia, Subdural Hemorrhage, Neonatal Seizures	Natural
2 Days	Extreme Prematurity due to Preterm Labor of Unknown Etiology	Natural
4 Days	Respiratory Failure Due to Early Neonatal Sepsis due to Extreme Prematurity due to Chorioamnionitis	Natural
5 Days	Cardiopulmonary Failure due to Extreme Prematurity due to Undetermined Etiology	Natural
6 Days	Respiratory Failure due to Pulmonary Insufficiency due to Extreme Prematurity due to Chorioamnionitis	Natural
7 Days	Acute Bronchopneumonia	Natural
8 Days	Respiratory Failure due to Sepsis due to Extreme Prematurity due to Abruptio Placentae	Natural
10 Days	Extreme Prematurity due to Premature Rupture of Membranes due to Chorioamnionitis	Natural
17 Days	Cardiopulmonary Failure due to Severe Capillary Leak Syndrome due to Down's Syndrome with Congenital Lymphactasis; Other Significant Conditions: Severe Pulmonary Hypertension/Severe Systemic Hypotension	Natural
26 Days	Sudden Infant Death Associated with Metabolic Abnormality	Natural
1 Month	Necrotizing Enterocolitis Bowel Perforation due to Extreme Prematurity due to Maternal HELLP Syndrome; Other Significant Conditions: Patent Ductus Ateriosus, Pneumothorax, Pulmonary Hemorrhage	Natural
1 Month 2 Days	Sudden Unexpected Death in Infancy Associated with Cleft Palate and Sleeping in Prone Position	Undetermined
1 Month 5 Days	Sudden Unexpected Infant Death Associated with Co-sleeping	Undetermined
1 Month 6 Days	Necrotizing Enterocolitis Totalis due to Extreme Prematurity due to Preterm Labor	Natural
1 Month 7 Days	Persistent Pulmonary Hypertension Newborn due to Congenital Diaphragmatic Hernia	Natural
1 Month 11 Days	Sudden Unexpected Death in Infancy Associated with Co-sleeping	Undetermined
1 Month 13 Days	Sudden Unexplained Death in Infancy	Undetermined

1 Month 15 Days	Sudden Unexpected Death in Infancy Associated with Co-sleeping with Both Parents	Undetermined
1 Month 19 Days	Asphyxia	Accident
2 months 1 Day	Fungemia and Staphylococcus Aureus Sepsis due to Omphalocele; Other Significant Conditions: Omphalocele	Natural
2 Months 1 Day	Cardiopulmonary Failure due to Pneumonia due to Chronic Lung Disease due to Extreme Prematurity	Natural
2 Months 3 Days	Complications of Preterm Birth @ 24 Weeks Gestation due to Preterm Labor and Delivery of Undetermined Etiology	Natural
2 Months 6 Days	Asphyxia	Accident
2 Months 14 Days	Coagulopathy due to Liver Failure due to Enteroviral Infection of Undetermined Origin; Other Significant Conditions: Myocarditis	Natural
2 Months 24 Days	Sudden Unexpected Death in Infancy Associated with Soft Bedding	Undetermined
2 Months 25 Days	Cardiac Fibroma	Natural
4 Months 3 Days	Pulmonary Insufficiency due to Extreme Prematurity and Severe Intrauterine Growth Restriction of Unknown Etiology	Natural
4 Months 17 Days	Complications of Extreme Prematurity of Unknown Etiology	Natural
4 Months 19 Days	Necrotizing Enterocolitis Totalis	Natural
4 Months 21 Days	Sudden Unexpected Death in Infancy Associated with Streptococcus Agalactiae (Group B) due to Septicemia and Eczema	Natural
4 Months 27 Days	Multiorgan Failure due to Sepsis due to Extreme Prematurity of Undetermined Etiology	Natural
5 Months 23 Days	Sudden Unexpected Death in Infancy Associated with Inappropriate Bedding	Undetermined
6 Months 26 Days	Sudden Unexpected Infant Death with Pulmonary and Gastrointestinal Eosinophilia of Unknown Etiology	Undetermined
7 Months 19 Days	Sudden Unexplained Infant Death	Undetermined
8 Months 2 Days	Congenital Heart Disease due to Sepsis	Natural
8 Months 19 Days	Pulmonary Vascular Disease due to Pulmonary Vein Hypoplasia and Agenesis due to Vacterl; Other Significant Conditions: Ventricular Septal, Failure to Thrive, Absent Right Kidney	Natural
1 Year	Blunt Impact Head and Torso Trauma	Homicide
1 Year	Unknown (MD Death)	Unknown
2 Years	Blunt Impact Trauma of Torso with Lacerations of Liver, Spleen, Pancreas, Kidneys and Right Adrenal Gland	Homicide
2 Years	Blunt Impact Head Trauma	Accident
3 Years	Cardiac Arrest due to Hemorrhage due to Septic Shock	Natural
3 Years	Complications of Anoxic Encephalopathy Following Maternal Gunshot Wound of Chest	Homicide
4 Years	Soot and Smoke Inhalation with Thermal Injuries	Accident
4 Years	Asphyxiating Asthma due to Anoxic Brain Injury	Natural
4 Years	Sepsis due to Hemophagocytic Lympha Histiocytosis due to Partial Monosomy	Natural
4 Years	Gunshot Wound of Head	Homicide
5 Years	Fulminant Viral Myocarditis	Natural
5 Years	Multiple Injuries	Accident
5 Years	Sudden Death due to Anomalous Origin of Right Coronary Artery	Natural
6 Years	Blunt Impact Head Trauma	Accident
6 Years	Blunt Impact Injuries of Head, Torso and Extremities	Accident
8 Years	Acute Exacerbation of Asthma	Natural
8 Years	Cardiopulmonary Arrest due to Sepsis	Natural
9 Years	Cardiorespiratory Failure due to Irreversible Septic Shock	Natural
10 Years	Acute Purulent Peritonitis due to Ruptured Acute Appendicitis	Natural
12 Years	Metastatic Rhabdomyosarcoma	Natural
13 Years	Anomalous Origin of Left Coronary Artery from Right Sinus	Natural
13 Years	Gunshot Wound of Chest Perforating Lung and Aorta	Homicide
14 Years	Gunshot Wound of Head	Homicide
15 Years	Gunshot Wound of Torso	Homicide
15 Years	Klebsiella Pneumonia Sepsis due to Human Immunodeficiency Virus; Other Significant Conditions: HIV Nephropathy, HIV Enteropathy, Human Disseminated Myobacterium Avium	Natural
15 Years	Gunshot Wound of Head	Homicide
16 Years	Gunshot Wound of Head with Perforation of Brain	Homicide
16 Years	Gunshot Wound of Head	Homicide
16 Years	Gunshot Wound to Chest and Leg	Homicide

17 Years	Gunshot Wound Through Chest and Right Arm	Homicide
17 Years	Hypoxic Ischemic due to Status Epilepticus due to Encephalitis due to AIDS	Natural
17 Years	Uncontrolled Coagulopathy due to Antiphospholipid Syndrome; Other Significant Conditions: Left Ventricular Rupture, Aortic Rupture	Natural
17 Years	Gunshot Wounds of Head, Left Arm and Chest	Homicide
17 Years	Multiple Gunshot Wounds	Homicide
17 Years	Gunshot Wound of Chest with Injury of Heart and Lung	Homicide
17 Years	Blunt Trauma to Head and Torso	Accident
17 Years	Gunshot Wound of Neck with Injury of Spinal Cord	Homicide
17 Years	Seizure Disorder of Unknown Etiology	Natural
17 Years	Ewing's Sarcoma	Natural
17 Years	Gunshot Wound	Homicide *
18 Years	Multiple Gunshot Wounds	Homicide
18 Years	Human Immunodeficiency Virus	Natural
18 Years	Electrocution	Accident
18 Years	Blunt Impact Torso Trauma with Liver Lacerations	Homicide
18 Years	Gunshot Wound of Head with Injury of Brain	Homicide
18 Years	Gunshot Wound of Chest Penetrating Left Lung and Aorta	Homicide
18 Years	Multiple Gunshot Wounds of Head and Torso	Homicide
18 Years	Gunshot Wound of Head	Homicide
18 Years	Gunshot Wounds of Head, Torso and Extremities	Homicide
18 Years	Gunshot Wound of Head with Perforation of Brain	Homicide
18 Years	Multiple Gunshot Wounds with Injuries to Heart, Right Lung, Liver and Right Leg	Homicide
18 Years	Gunshot Wound of Head	Homicide
19 Years	Multiple Gunshot Wounds	Homicide
19 Years	Gunshot Wound of Head with Perforation of Brain	Homicide
20 Years	Gunshot Wound of Torso	Homicide
20 Years	Gunshot Wound of Head	Homicide
20 Years	Gunshot Wound of Head	Homicide
20 Years	Gunshot Wounds (2) of Head and Hand	Homicide
20 Years	Gunshot Wound of Neck with Fractures of Cervical Spine, Contusion of Spinal Cord, Laceration of Major Blood Vessels	Homicide
21 Years	Gunshot Wound of Torso	Homicide
23 Years	Gunshot Wounds of Head and Torso	Homicide
23 Years	Gunshot Wound of Chest Injuring Heart and Lungs	Homicide
23 Years	Multiple Gunshot Wounds of Torso and Extremity	Homicide

* Medical Examiner Cases from other jurisdictions



Acknowledgement

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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