District of Columbia
Child Fatality Review Committee

2008 Annual Report

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District of Columbia Government

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District of Columbia
Child Fatality Reviw Committee

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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

JUNE 2010

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

The District of Columbia Child Fatality Review Committee is pleased to present its 14th Annual Report. This Report covers data from 178 child/youth fatalities identified in 2008.

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: 1) to identify risk reduction, prevention and system improvement factors, and (2) to recommend strategies to reduce the number of preventable child deaths and/or improve the quality of life of District residents.

KEY CHILD FATALITY REVIEW DATA FINDINGS

DECEDENT DEMOGRAPHICS

- The age range of the 2008 decedents reveiwed by the CFRC was birth through 22 years.
- The majority of the decedents were under the age of one year. Ninety-three infant deaths were identified in 2008, representing 52% of the overall CFRC child death population.
- During calendar year 2008, 152 or 84% of the deaths involved Black children.
- Sixty-one percent of the decedents were males.
- Most of the decedents were residents of Wards Five, Seven and Eight, with the largest number being residents of Ward Eight.

MANNERS OF DEATH

Natural Deaths

A review of death certificates indicates most District children/youth died from natural causes during the 2008 calendar year. There were 114 Natural deaths. The majority of these deaths involved children under the age of one. The greatest number of these infant deaths is associated with prematurity or its complications.

Violent Deaths—Homicide and Suicide

In 2008, a total of 47 child/youth fatalities were the result of violent acts. Forty-five of the child/youth fatalities were Homicides, of which nine were victims of "Fatal Abuse" with the suspected perpetrator being the parent or caregiver of the child, and the remaining two fatalities were Suicides.

Accidental Deaths

There were eight accidental deaths involving children and youth in 2008. The circumstances leading to the accidental deaths were as follows:

- Motor vehicle (4)
- Motorcycle (1)
- Asphyxia (1)
- Accidental Overdose/Intoxication (2)

Undetermined Deaths

In 2008, nine infant deaths were attributed to Sudden Unexpected Infant Death (SUID), with an "Undetermined" manner of death. SUID is the term recommended by the CDC to describe what was formerly known as SIDS or crib deaths.

CFRC 2008 Recommendations

The following are recommendations developed by CFRC and presented to the Executive Office of the Mayor, the Office of the City Administrator, and the Interagency Collaboration Services Integration Committee.

Description	Area of Focus	Recommendations	Response received
Natural Deaths -Infant Mortality- (52% of CFRC Cases)	Agency Policy	1. The Department of Health should develop standard discharge planning protocols to be utilized by hospitals in the District of Columbia.	**Yes.** Agency agreed with the recommendation and Implemented a process to address the issue. (See page 9 for details)
	Agency Policy	2. The Department of Health should develop a standard risk assessment tool to be used by medical providers to monitor high risk pregnant women and infants born in the District of Columbia.	**Yes.** Agency agreed with the recommendation and Implemented a process to address the issue. (See page 9 for details)
Homicides Including Fatal Abuse (25% of CFRC Cases)	Agency Policy and Practice	1. The District of Columbia should develop a unified case management system to address the systemic and program needs of vulnerable families participating in government funded public welfare/child and youth programs.	**Yes**. Agency agreed with the recommendation and Implemented a process to address the issue. (See page 14 for details)
	Agency Policy and Practice	2. The District of Columbia should develop consistent reporting of truancy and improve response to educational neglect.	**Yes**. Agency agreed with the recommendation and Implemented a process to address the issue. (See page 14 for details)
	Agency Policy and Practice	3. The District of Columbia should develop standard protocols for end of life planning.	**Yes**. Agency agreed with the recommendation and Implemented a process to address the issue. (See page 14 for details)
	Agency Policy and Practice	4. The Child and Family Services Agency (CFSA) should improve the quality and consistency in practices related to conducting safety and risk assessments of children that include routine supervisory oversight and approval, and compliance.	**Yes**. Agency agreed with the recommendation and Implemented a process to address the issue. (See page 14 for details)
	Agency Policy and Practice	5. The District of Columbia should explore child care for children under 6 years of age as a prevention measure.	**Yes**. Agency agreed with the recommendation and Implemented a process to address the issue. (See page 15 for details)

CFRC 2008 Recommendations Cont'd.

Description	Area of Focus	Recommendations	Response received
Suicide Deaths (1% of CFRC Cases)	Agency Policy, Practice and Budget	1. The Department of Mental Health (DMH) in collaboration with other health care providers should develop city-wide guidelines to support a practice of educating parents/caregivers of children who have attempted or talked about Suicide. Education should include related risk factors, signs of plans/intent to commit Suicide and how to respond.	**Yes**. Agency agreed with the recommendation and Implemented a process to address the issue. (See pages 18-19 for details)
	Agency Policy, Practice and Budget	2. DMH should take the lead in developing and implementing an evidence based general public education campaign related to child/youth suicide (i.e., risk factors, signs/symptoms; when and how to seek help - Suicide Hotline numbers), in collaboration with key stakeholders (families, systems partners and community organizations).	**Yes**. Agency agreed with the recommendation and Implemented a process to address the issue. (See pages 18-19 for details)
	Agency Policy, Practice and Budget	3. In an effort to ensure continuity of care and improved community-based services to patients being discharged from area hospitals after attempting suicide, DMH in collaboration with DC Hospital Association should improve psychiatric discharge protocols and practices by ensuring the following: a. Patients are appropriately linked to community based services that provide intensive follow-up and treatment; b. Appropriate information, including diagnoses at discharge, is provided to the referral source prior to discharge; and c. A discharge planning meeting is held that minimally includes parents/caregivers, the patient and a representative from the community based program.	**Yes**. Agency agreed with the recommendation and Implemented a process to address the issue. (See page 19-20 for details)
	Agency Policy, Practice and Budget	4. The District of Columbia should provide training and education opportunities to school employees and parent with regards to the signs of depression which manifest in youth in different ways. Unrecognized depression is a risk factor for suicide and youth homicide.	**Yes**. Agency agreed with the recommendation and Implemented a process to address the issue. (See page 20 for details)

INTRODUCTION

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 reviews 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 up to age 22. 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 and death certificates, copies of records from the medical examiner, police, hospitals and other major child and family-serving agencies. Records are reviewed and a summary is developed for presentation during case review meetings that are held twice monthly.

Committee membership is multidisciplinary, representing public and private child and family service agencies and programs, and includes, by law, a community member for each of the eight District Wards. ***All fatality review meetings are confidential.*** Committee members seek to identify shortfalls related to the services and interventions provided to the child and/or family. More importantly, the Committee also identifies potential system improvements and makes recommendations for the prevention of deaths.

This Annual Report summarizes data collected from 178 child/youth fatalities that occurred during the 2008 calendar year. This report contains two major sections, which are as follows:

Section I: Summary of Case Findings: This section summarizes decedents' demographics and the causes and manners of death.

Section II: Summary of CFRC Subcategories: This section provides information on the interaction between some of the decedents and the government agencies serving them. This includes CFRC decedents known to the child welfare and juvenile justice systems.

SECTION I: SUMMARY OF CASE FINDINGS

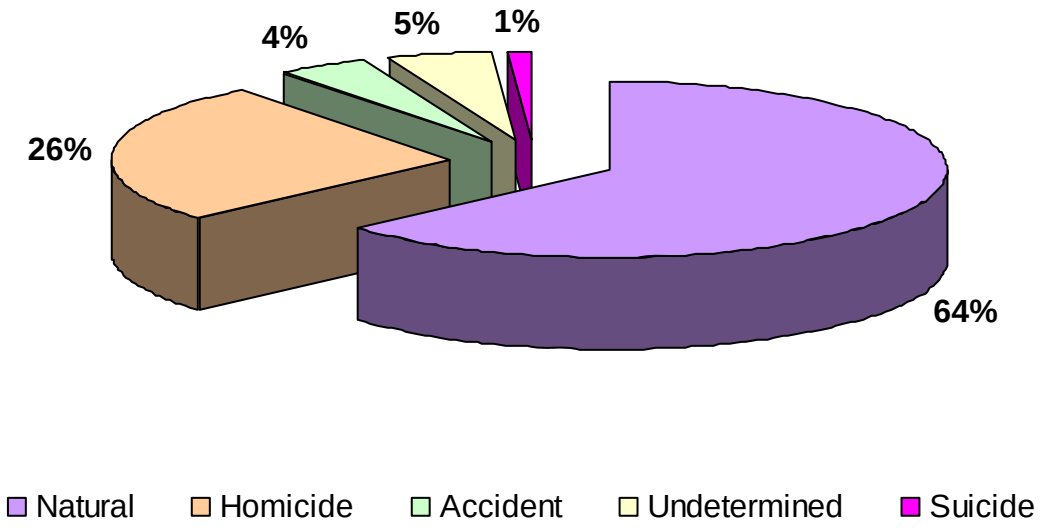
CAUSE AND MANNER OF 2008 FATALITIES

The cause of death refers to the underlying pathologic 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 surrounding the death. Manners of death are categorized as Natural, Accidental, Homicide, Suicide or Undetermined. The manner is determined based on information provided by investigative bodies and by examination of the decedent. The causes and manners of death are obtained from the review of death certificates.

In 2008, the leading manner of death for children/youth in the District of Columbia was Natural at 114, followed by Homicides at 45, and Undetermined with 8 child deaths . In 2008, the cause of all Undetermined deaths reviewed by the CFRC had a Cause of Death certified as Sudden Unexpected Infant Death (SUID), which is explained further in the Natural Death section.

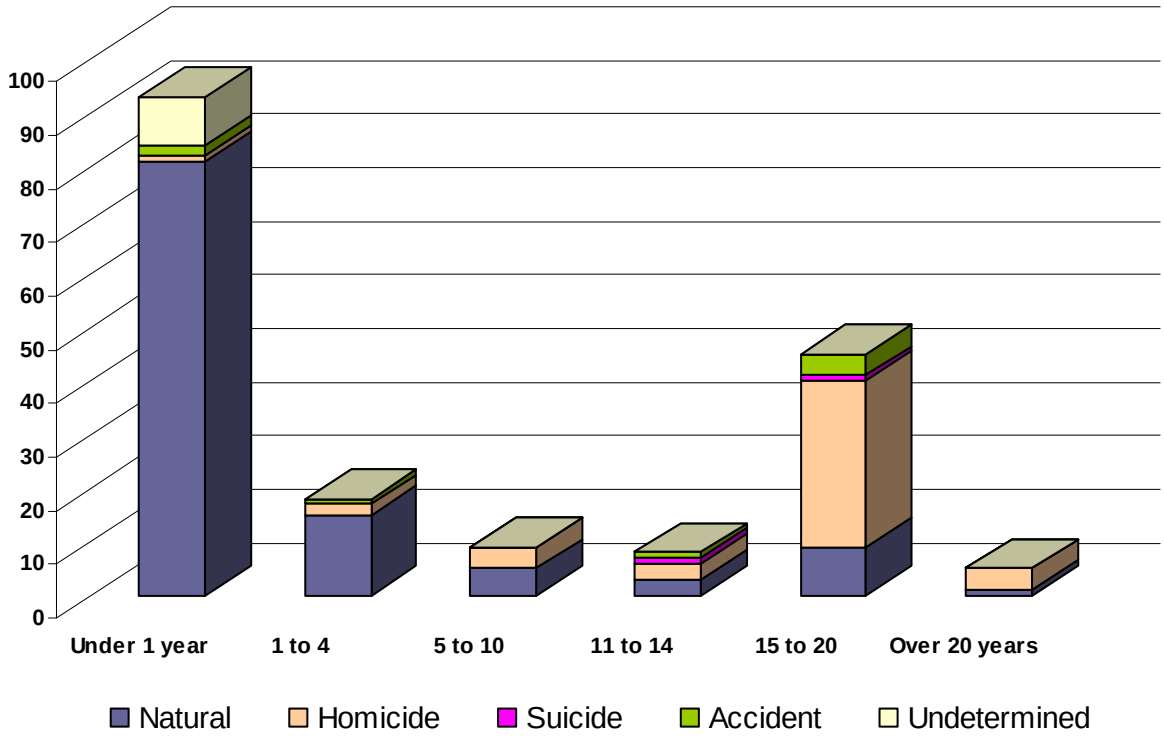
CHART—2008 Manner of Death



DECEDENT DEMOGRAPHICS BY MANNER OF DEATH

The CFRC reviewed 178 child/youth deaths in 2008. The decedents ages ranged from birth through 22 years. The age categories with the greatest number of deaths were infants (under the age of 1 year) and youth 15 to 20 years.

Age of Decedents by Manner of Death

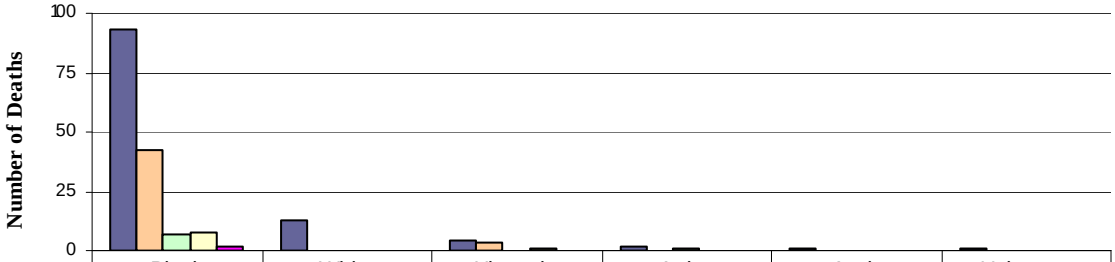


Race and Gender by Manner of Death

Figure 3 illustrates that in 2008 Black children/youth represented 152 deaths or 85% of the CFRC decedent population.

Also, deaths among White, and Asian racial groups increased in calendar year 2008, when compared to 2007, while Hispanic racial groups experienced a slight decline. White and Hispanic children/youth represented the second and third leading child death populations, respectively. One infant was of Arab ethnicity, and the race of one decedent was unknown.

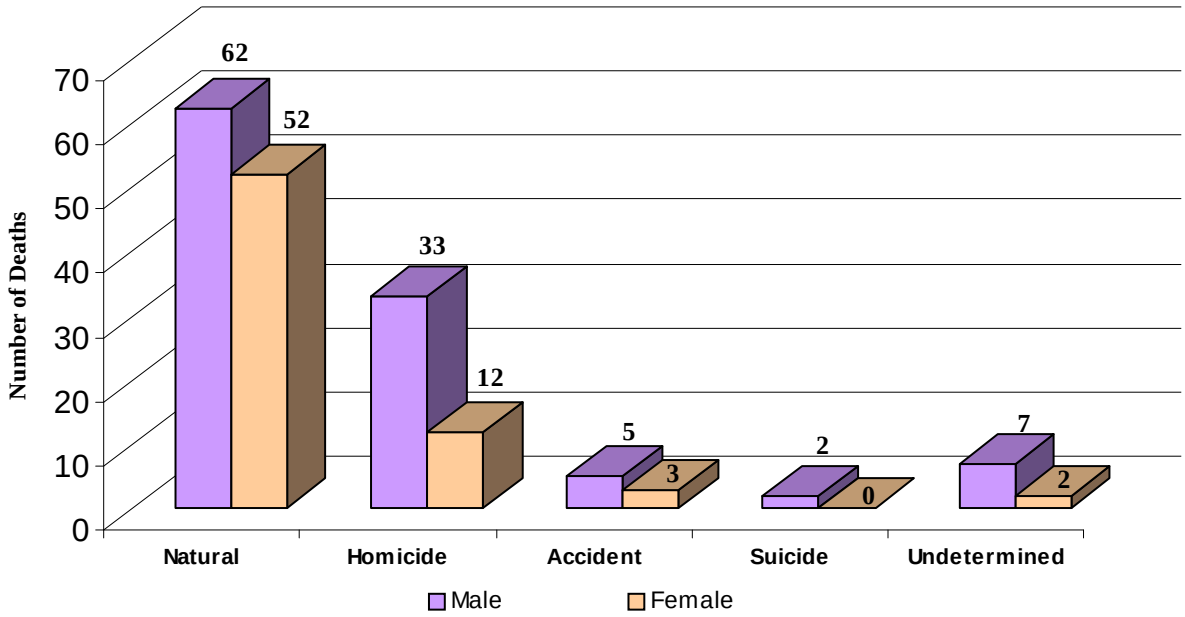
Figure 3: Race of 2008 CFRC Decedents by Manner of Death



	Black	White	Hispanic	Asian	Arab	Unknown
Natural	93	13	4	2	1	1
Homicide	42	0	3	0	0	0
Accident	7	0	0	1	0	0
Undetermined	8	0	1	0	0	0
Suicide	2	0	0	0	0	0

Figure 4 illustrates that male decedents represent the largest proportion of the child/youth population, and 2008 data indicates that the percentage of male deaths increased significantly. As illustrated below, 109 which represents 61% of the 178 CFRC deaths from 2008 were males, compared to 53% in 2007. Data from 2008 indicate males represent the largest proportion of child/youth fatalities in all manners of death.

Figure 4: Gender of 2008 CFRC Decedents by Manner of Death



Decedents' Ward of Residency by Manner of Death

The CFRC decedents' Ward of Residency is primarily determined by 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.). Ward 8 experienced the greatest number of child/youth fatalities in 2008. Ward 7 and Ward 5 had the second and third largest number of child/youth fatalities with 21%, and 12%, respectively. Four of the child/youth decedents were residents of Maryland at the time of their death; however, CFRC records reviewed indicate these children met the criteria for CFRC review due to previous or current involvement with the District Government's human services delivery systems.

Figure 5: 2008 Decedents by Ward of Residency

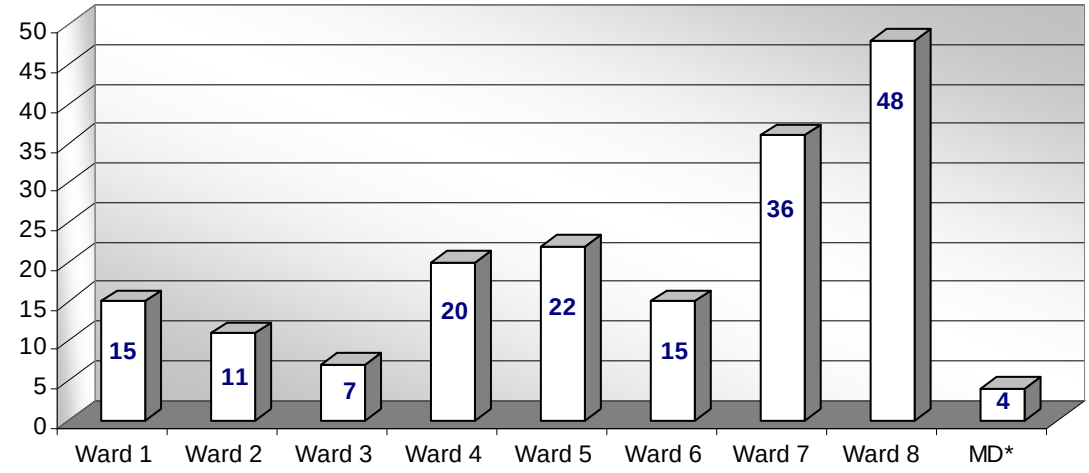
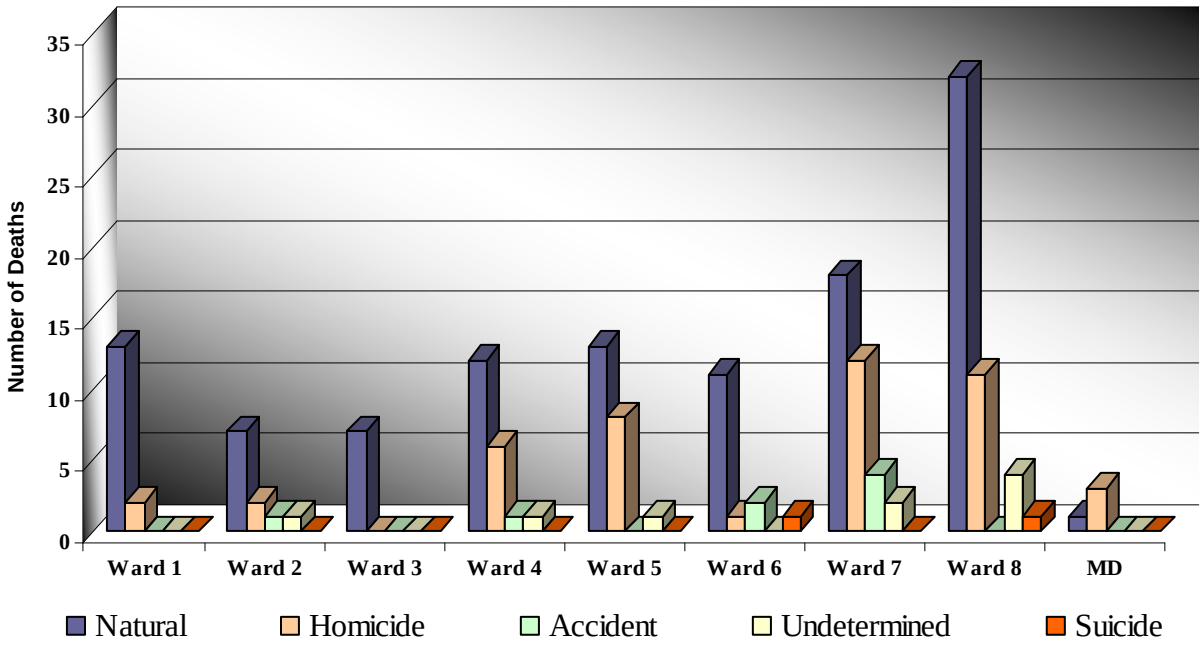
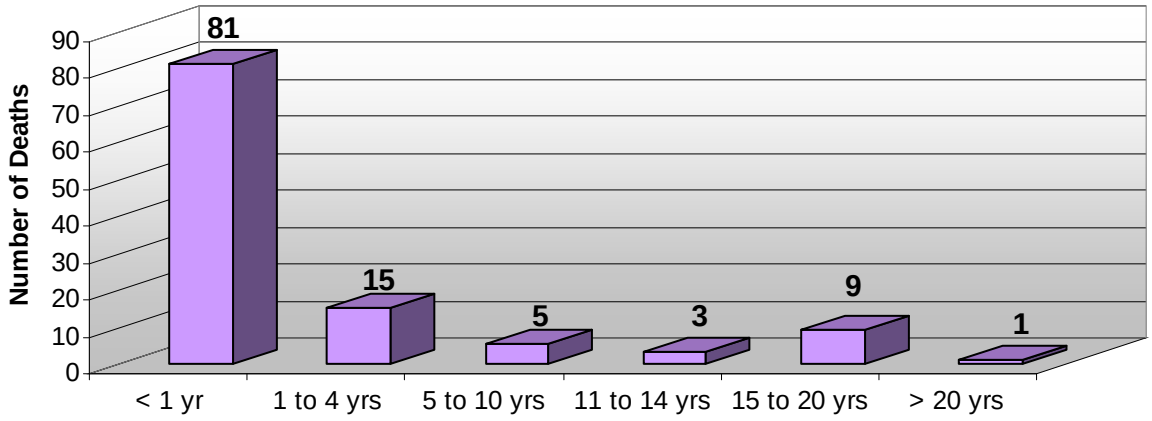


Figure 6: Manner of Death by Ward of Residency



Natural Deaths

In 2008, 114 of the 178 children/youth fatalities resulted from pre-existing or underlying medical conditions. Seventy-one percent of CFRC natural deaths involve infants under 1 year of age whose deaths were reviewed by the Infant Mortality Review Team.



Premature Deaths

Eighty percent of the infant fatalities reviewed by the Infant Mortality Review Team were due to prematurity or complications thereof. The causes of prematurity identified in the review process are summarized in Table #1.

TABLE 1

Causes of Prematurity (Infants up to 1 yr)

Cause of Death	Number of deaths
Preterm Parturition	50
Chorioamnionitis	5
Placental Abruption	4
Maternal Diseases	3
Induction of Labor	3
Sepsis	2
Oligohydramnios	2
Twin Pregnancy	1
Total	**70**

Other Natural Causes of Death in Infants

Among the other infant deaths reviews by the Infant Mortality Review Team, Congenital Anomalies (4%) and Congenital Heart Disease (3%) are the second and third leading causes of infant deaths, respectively (see Table #2).

TABLE 2
Other Natural Causes of Death (Infants up to 1 yr)

Cause of Death	Number of Deaths
Congenital Anomalies	5
Congenital Heart Disease	4
Infectious Disease	3
Genetic Disorder	2
Inborn error of Metabolism	1
Cancer	1
Neuromuscular Disorder	1
Total	**17**

Natural Causes of Death in Children over 1 year

As presented in Table 3, diseases of the Central Nervous System were the leading cause of natural death in children over 1 year of age. Cancer and Cardiovascular diseases were the second and third leading causes of natural death in this age category.

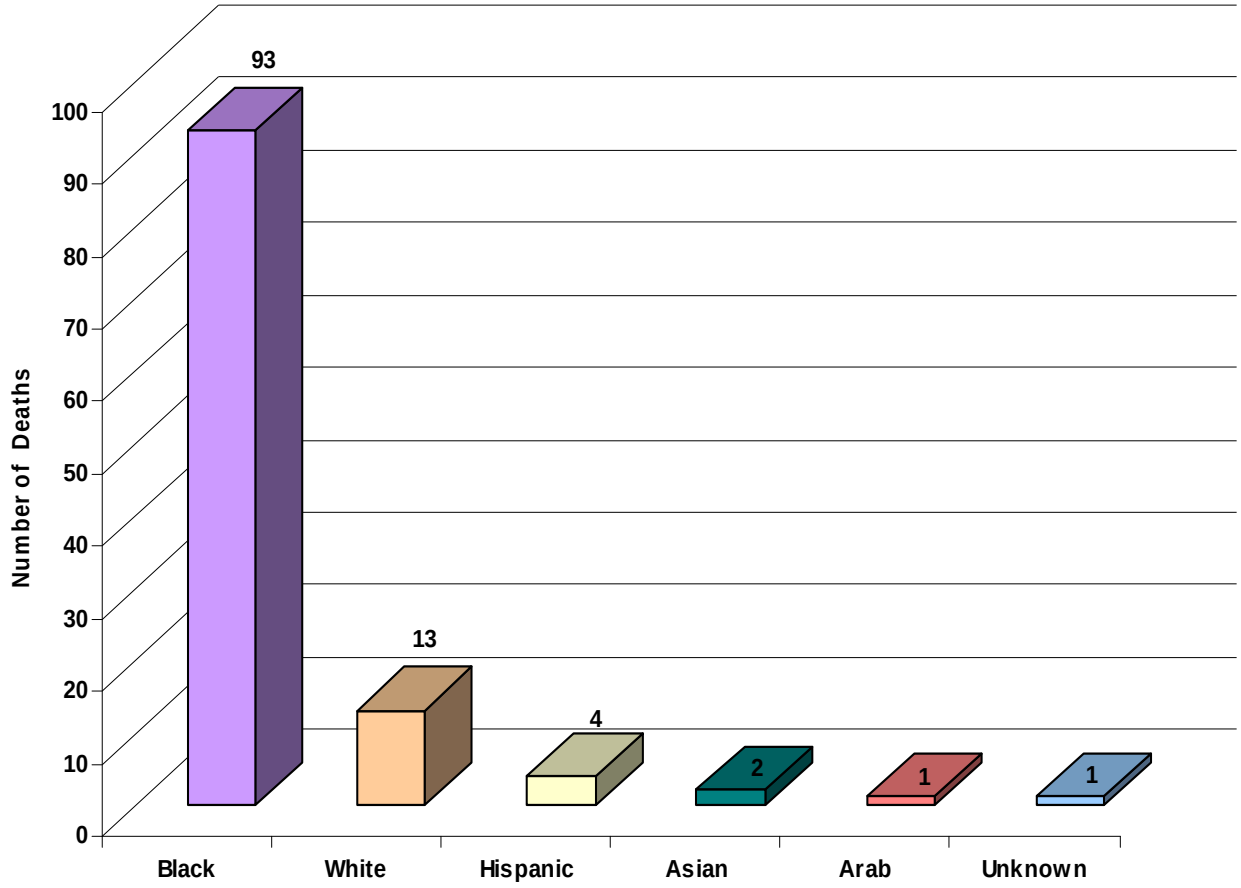
TABLE 3
Natural Causes of Death—Children > 1 year and Youth

Cause of Death	Number of deaths
Central Nervous System (CNS)	6
Cancer (CA)	5
Cardiovascular (CV)	5
Non-neoplastic Hematologic Disease (NNH)	4
Infectious Diseases (INFD)	3
Gastrointestinal (GI)	2
Respiratory (Rep)	1
Neuromuscular (NM)	1
Total	**27**

Overall Natural Deaths in Children of all Ages

Of the 2008 Natural death cases reviewed by CFRC, 81% involved Black children, followed by White children (11%) and Hispanic children (3%).

Figure 8: Race of CFRC Natural Decedents



CFRC Recommendations pertaining to Natural Deaths:

The prevailing risk factor associated with fatalities of infants and medically fragile children was poor discharge planning. Records (72%) documented inconsistency in practices among hospitals to educating women on infant care and safety, as well as patient specific medical services for health maintenance.

High risk pregnancies include pre-existing medical conditions (e.g.. Diabetes, obesity, sickle cell disease), social–economic issues (uninsured, inconsistent prenatal care), nutritional and psychiatric problems. Comprehensive risk assessments are a nationally recognized tool to examine a woman's risk factors and assist in providing appropriate interventions and treatment. Risk assessments will also help ensure that women and infants are provided case management, home visitation and other services to sustain the health of the mother and infant while decreasing poor outcomes in future pregnancies. As such the Committee issued the following recommendations:

Recommendation #1: DOH should develop standard discharge planning protocols to be utilized by hospitals in the District of Columbia.

Recommendation #2: DOH should develop a standard risk assessment tool to be used by medical providers to monitor high risk pregnant women and infants born in the District of Columbia.

Response for Both: There is a revision underway that will make the electronic birth certificate a more robust data collection tool allowing for risk determinations for individual women and infants.

Also, the Department of Health will work with the Health Care Financing Agency to assure that a more robust risk assessment tool is being utilized, and that protocols will be developed based on risk determination, which will be conducted in collaboration with the Department of Health Perinatal Advisory Committee.

Homicides

In 2008, 45 of the 178 CFRC reviews were child/youth homicides. The information was categorized as follows; ***Youth Violence Homicide***, ***Fatal Child Abuse***, *and* ***Other***. Youth violence homicides are those deaths that are the result of an act of violence by a perpetrator not in a caretaker role and is usually associated with criminal activity, arguments or retaliation*****. Fatal child abuse and neglect Homicides are those that occurred at the hands of a parent, legal custodian or other person responsible for the child's care at the time of the fatal incident.

Youth Violence

- Homicides continue to be the leading cause of death for youth ages 15 to 20 years (69%).
- Seventy-three percent of the CFRC Homicide victims were male.
- Ninety-three percent of the CFRC Homicide victims were Black.
- Youth violence related homicides account for 80% of the 2008 CFRC Homicides.

Figure 9: Age of 2008 CFRC Homicide Victims

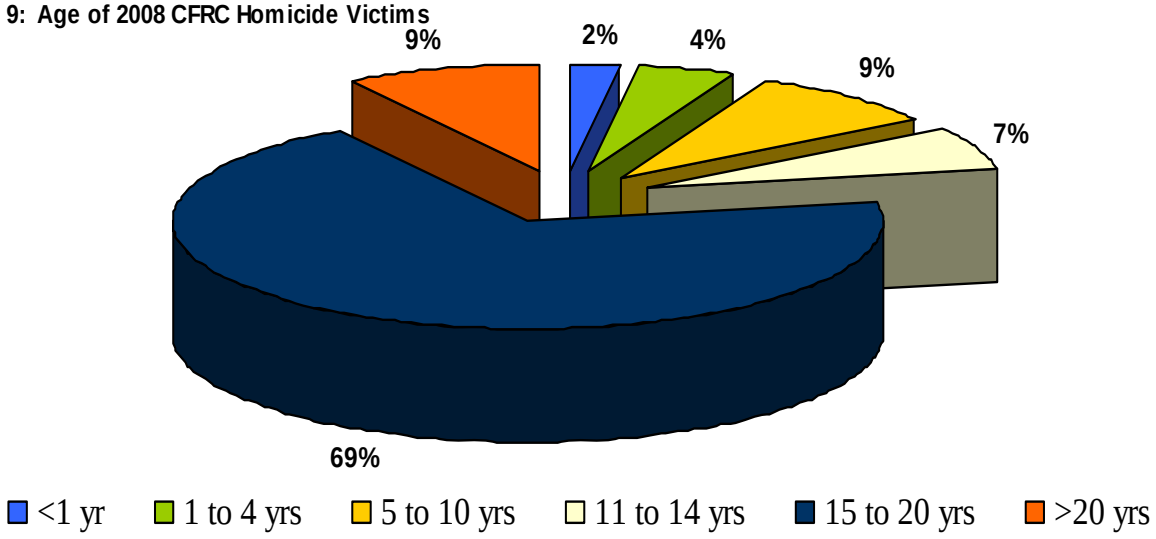


Figure 10: Gender of 2008 Homicide Victims

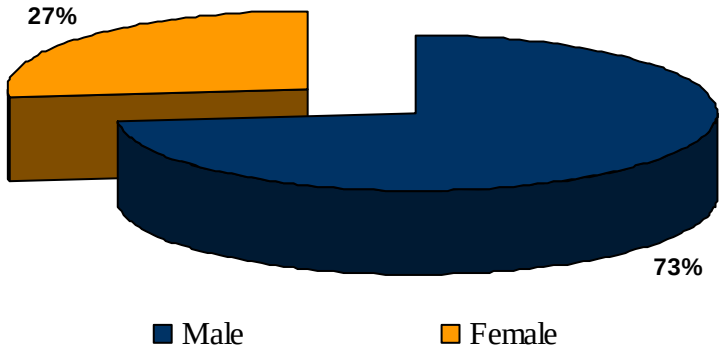
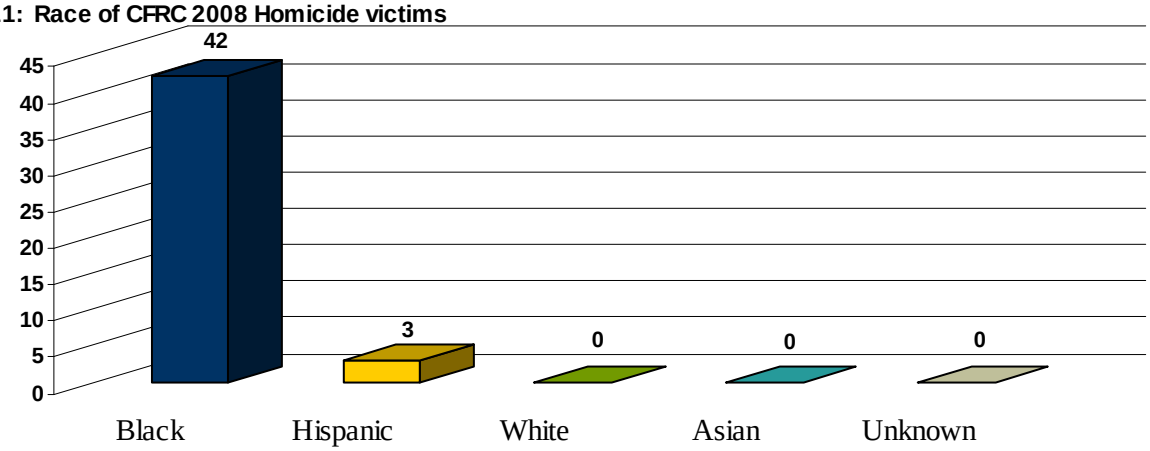


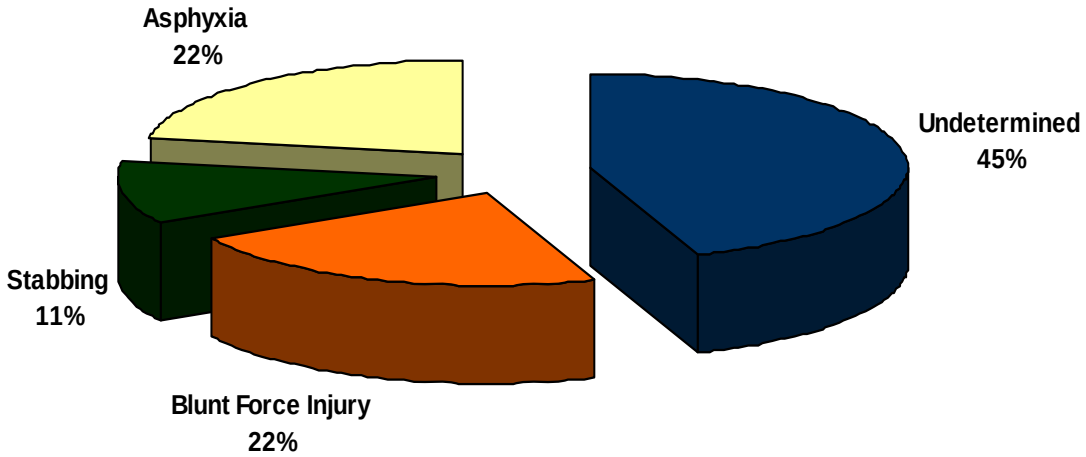
Figure 11: Race of CFRC 2008 Homicide victims



Fatal Child Abuse

- In 2008, nine of the 45 Homicide fatalities were the result of fatal child abuse. In 77% of these cases, the biological or adoptive parent was the perpetrator of the abuse which led to the death of the child/youth.
- Eight of the fatal child abuse victims were known to the District's child welfare program preceding their deaths.
- Eight of the victims were Black, which includes seven females and one male.
- The remaining one fatal abuse victim was a Hispanic female.

Figure 12: Causes of Fatal Child Abuse Deaths



Other Homicides

One Black male infant was killed by an unknown perpetrator in 2008.

Cause of Death and Motives of CFRC Homicides

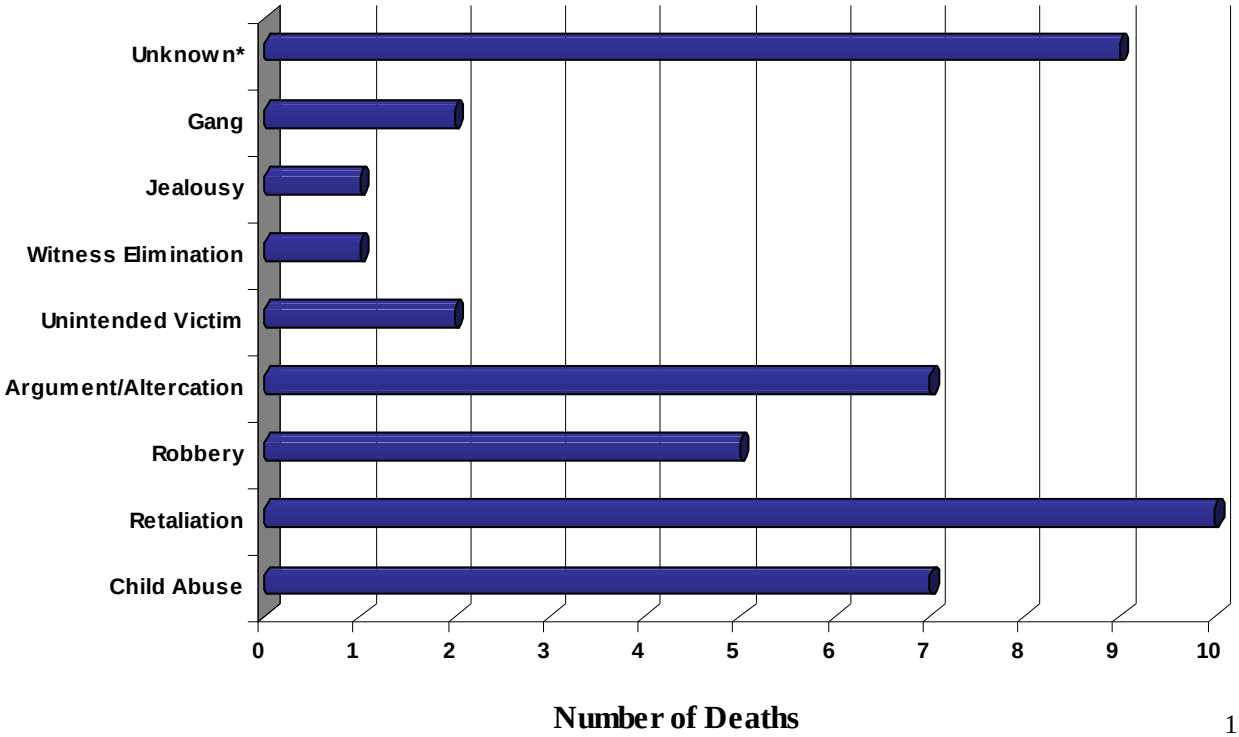
Gun violence continues to be the leading method of homicide among CFRC decedents. Seventy-eight percent of the CFRC decedents died as a result of gun violence. Metropolitan Police Department (MPD) data (See Figure 13) indicates 22% of these homicides were the result of Retaliation. Arguments/Altercations and Child Abuse were contributing factors in 15% of the CFRC homicide case reviews.

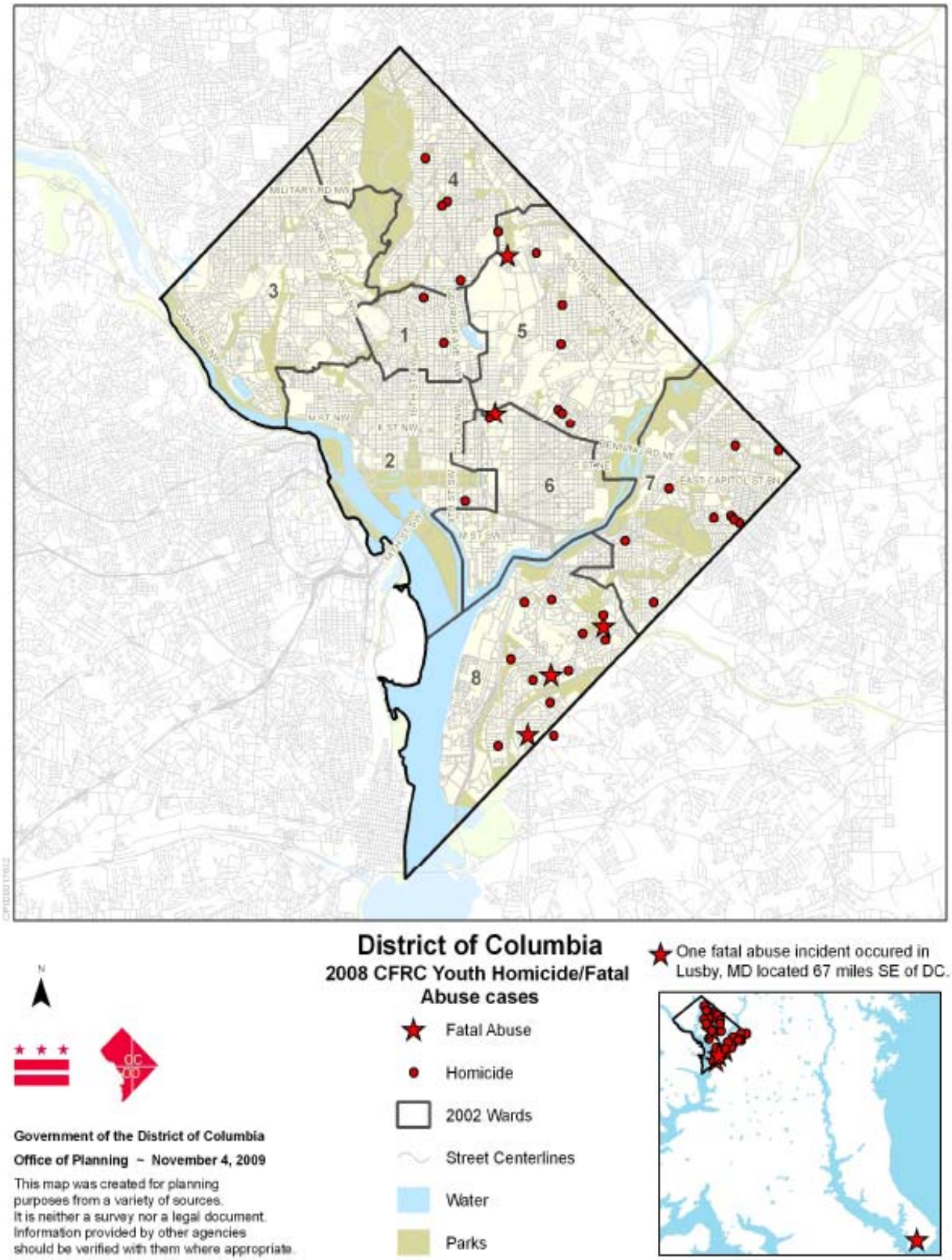
TABLE 4

CAUSES OF DEATH BY CFRC HOMICIDE CATEGORY

Method	Fatal Child Abuse	Youth Violence	Other Homicides
Gunshot Wounds	0	31	1
Stab Wounds	1	4	0
Blunt Force	2	0	0
Asphyxiation	1	0	0
Undetermined	5	0	0
Total	**9**	**35**	**1**

Figure 13: Motives of Homicides based on MPD data





District of Columbia

2008 CFRC Youth Homicide/Fatal Abuse cases

★ One fatal abuse incident occured in Lusby, MD located 67 miles SE of DC.

Fatal Abuse

Homicide

2002 Wards

Street Centerlines

Water

Parks

N

Government of the District of Columbia

Office of Planning ~ November 4, 2009

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

CFRC Recommendations for Homicide Fatalities

The Committee developed the following recommendations, which address five major areas of concern associated with Homicide fatalities: 1) District Agency collaboration and communication; 2) school truancy; 3) grief counseling/end of life planning; 4) safety and risk assessments; and 5) child care for children under the age of five.

Recommendation #1: The District of Columbia should develop a unified case management system to address the systemic and program needs of vulnerable families participating in government funded public welfare/child and youth programs.

Response: The Office of the City Administrator is currently working with the Department of Human Services to create a unified case management system. This project is ongoing.

Recommendation #2: The District of Columbia should develop consistent reporting of truancy and improve response to educational neglect.

Response: The Office of the State Superintendent for Education (OSSE) has established new truancy regulations that were adapted and vetted by the District of Columbia Truancy Taskforce. The District of Columbia truancy regulations went into effect for the 2008-2009 school year.

Recommendation #3: The District of Columbia should develop standard protocols for end of life planning.

Response: The Department of Mental Health (DMH) will provide information to families that reference expert providers in the area of grief counseling, and services for surviving children and families.

Recommendation #4: The Child and Family Services Agency (CFSA) should improve the quality and consistency of practices related to conducting safety and risk assessments of children. Protocols developed should include routine requirements for supervisory oversight and approval, as well as the social worker's compliance.

Response: CFSA has integrated the Structures Decision Making tool (SDM) to assist investigative staff with assessing risk of abuse or neglect to determine if additional services are needed at the close of an investigation. The tool also assists staff serving children in foster care and at home with assessing needs and strengths at three-month intervals over the life of a case and with assessing safety when a crisis or change in circumstances occurs in a family. The domains in the SDM will be the basis for conducting regular safety assessments for children who remain at home. In addition, SDM has a supervisory case reading tool that assists supervisors with reviewing a small number of completed assessments per worker, per month for quality assurance and compliance

Recommendation #5: The District of Columbia should explore child care for children under 6 years of age as a prevention measure.

Response: The Office of the State Superintendent for Education (OSSE) has taken the lead in implementing this recommendation. Providing child care to District Superior Court and Child and Family Services Agency referrals is an eligibility priority. To ensure that all agencies partnering with OSSE are informed about policy and protocols, the following will be implemented:

- Establish OSSE/ECEA communication policy to inform partner agency staff on obtaining child care;
- Establish an OSSE Memorandum of Understanding with CFSA, DHS, and Head Start programs to ensure priority child care placement in programs with family support;
- Expand partner agencies' knowledge of resources and protocols through Intergovernmental Roundtable meetings; and
- Inclusion of multi-level agency staff in the Biennial CCDF Community Input Survey (on child care) as a method of training partner agencies about District of Columbia Child Care options every two years.

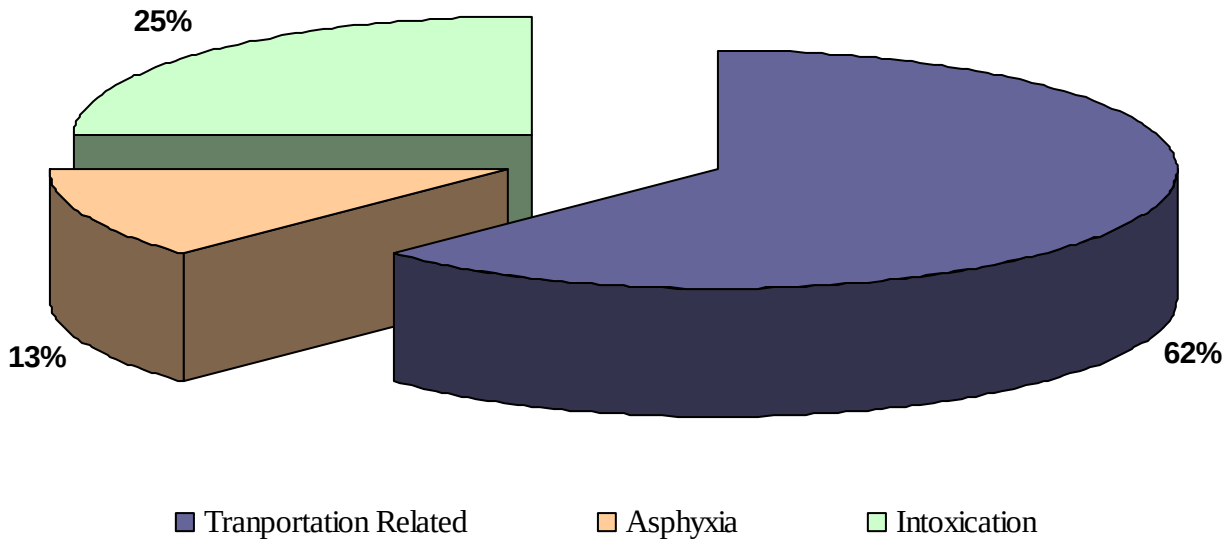
Accidental Deaths

In 2008, there were 8 accidental deaths. Accidental deaths are incidents in which the deaths were not the result of deliberate acts at the hand of another as determined by the forensic investigation and autopsy.

- Transportation related deaths continue to be the leading cause of accidental deaths in CFRC case reviews (See Table 5).
- The ages of the 2008 accidental death victims ranged from 1 month to 20 years.
- Seven of the eight decedents in this category were Black. The other decedent was Indonesian.
- Of the accidental deaths five decedents were male and three were female.

TABLE 5	
CFRC ACCIDENTAL DEATHS	
Motor Vehicle/Transportation	**4**
Accidental Overdose/ Intoxication	**2**
Motorcycle/Transportation	**1**
Asphyxia	**1**
Total	**8**

Figure 14: CFRC 2008 Accidental Death Categories



Transportation Related Deaths

The following table provides details regarding the 2008 transportation related child fatalities reviewed by CFRC.

TABLE 6: TRANSPORTATION RELATED ACCIDENTS

AGE/RACE/ GENDER	*Time of Injury*	*Ward – Residence/ Fatal Incident*	*Type of Victim*	*Type of Vehicle*	*Contributing Factor #1*	*Contributing Factor #2*
14/Black/ Male	9:00 PM	7/7	Passenger	Automobile	Driver Violation/ Collision	Stolen Vehicle/ Police Intervention
17/Black/ Male	9:30 PM	6/MD	Passenger	Automobile	Driver Violation/ Collision	Late evening collision
18/Black/ Male	9:30 PM	6/MD	Driver	Automobile	Driver Violation/ Collision	Late Evening collision
1/ Indonesian/ Male	11:00 AM	2/2	Pedestrian	Automobile	Unattended Child	N/A
20/Black/ Female	1:10 AM	7/8	Passenger	Motorcycle	Driver Violation High Rate of Speed	Late Evening Collision

Asphyxia Fatalities

- In 2008, CFRC reviewed one infant death due to asphyxia. The infant was a Black female who choked on a makeshift pacifier.

Intoxication/Overdose

- Two child fatalities, a 6 year old Black female, and a newborn Black male, were attributed to intoxication of illicit drugs.

SUICIDE DEATHS

In 2008, CFRC reviewed the cases of two Suicide deaths. The table below provides information pertaining to and including the identified CFRC risk factors associated with each case.

TABLE 7: 2008 CFRC SUICIDE DATA

Age/Race/ Gender/	Method	Ward Residence/ Fatal Incident	Contributing Mental Health And Social Factors
18 yr/Black Male	Hanging	8/8	• Poor School Performance • Unresolved Depression • Substance Abuse • Prior Suicide Attempt
12 yr/Black Male	Hanging	6/6	• Abrupt Change in Lifestyle • Recent Traumatic Experience • History of Bullying in School and Community

CFRC Recommendations Pertaining to Suicide fatalities

The need to improve parental and community awareness of the risk factors associated with suicide was evident during these case reviews. As a result, the following recommendations were developed by the CFRC:

Recommendation #1: The Department of Mental Health (DMH) in collaboration with other health care providers should develop city-wide guidelines to support a practice of educating parents/caregivers of children who have attempted or talked about Suicide. Education should include related risk factors, signs of plans/intent to commit Suicide and how to respond.

Recommendation #2: DMH should take the lead in developing and implementing an evidence based general public education campaign related to child/youth suicide (i.e., risk factors, signs/ symptoms; when and how to seek help - Suicide Hotline numbers), in collaboration with key stakeholders (families, systems partners and community organizations).

Response: Agreed and Implemented as follows
DMH has contracted with MEE Productions with funding from the Suicide Prevention Grant Capital Cares to address the above recommendation. A social marketing plan is being developed for the purpose of reducing stigma associated with mental health services and raising awareness about suicide behaviors and related risk factors as a public health problem in D.C. Outreach messages, strategies and activities will be developed to target all youth with a special emphasis on African American and Latino communities. Focus groups will be used to inform how the message should be tailored. The message is expected to be delivered through radio, print and TV. Outreach strategies will be employed to build partnerships with grassroots organizations such as churches, barber shops, social organizations and multi-lingual radio stations with the purpose of furthering campaign goals.

Through the focus group DMH will identify the message content ("what to say") and media strategies ("how to say it") that will help DC youth and the primary influencers and their lives understand that: (1) they may already possess some protective factors (resiliency, spirituality, social fabric, etc.) that may be leveraged to prevent suicidal thoughts/behaviors and/or blunt the impact of adverse events in their lives; (2) it is both OK and sometimes necessary to access mental health services, based on their daily lives and experiences; and (3) there are various options and resources available to support the mental wellness of DC Youth. DMH wants D.C. residents to know about a local crisis line to call (1800 273 TALK) and how to access mental health services. The goal of this campaign is to help the DC residents understand that mental wellness is as important as physical wellness and dental wellness.

Recommendation #3: In an effort to ensure continuity of care and improved community-based services to patients being discharged from area hospitals after attempting suicide, DMH in collaboration with DC Hospital Association should improve psychiatric discharge protocols and practices by ensuring the following:

- Patients are appropriately linked to community based services that provide intensive follow-up and treatment;
- Appropriate information, including diagnoses at discharge, is provided to the referral source prior to discharge; and
- A discharge planning meeting is held that minimally includes parents/caregivers, the patient and a representative from the community based program.

Response: Agreed and Implemented as follows
DMH has worked closely with Psychiatric Institute of Washington (PIW) and Children's National Medical Center's Psychiatric Unit to ensure that intensive follow up is occurring within the community following hospitalization. The following steps have been taken:

- DMH developed a tracking data base to track if children/youth have made their 7 days follow up appointments.
- Develop a mechanism for providers to attend discharge planning meetings at the hospital to engage youth and families in post hospitalization treatment.
- The Child/ youth are connected to a Core Service Agency when appropriate.
- Parents and youth are given information about the Child and Adolescent Mobile. Psychiatric Services (ChAMPS) upon discharge to access community based 24hrs crisis intervention for their child/youth.

- Psychiatric Services (ChAMPS) upon discharge to access community based 24hrs crisis intervention for their child/youth.

Recommendation #4: The District of Columbia should provide training and education opportunities to school employees and parents with regards to the signs of depression which manifest in youth in different ways. Unrecognized depression is a risk factor for suicide and youth homicide.

Response: Agreed and Implemented as follows
The Department of Mental Health has taken the lead in implementing this recommendation. The Children's Department of DMH received a Suicide Prevention grant from The Substance Abuse and Mental Health Services Administration (SAMHSA) that will help address this recommendation. In partnership with the Children Trust, several small grants will be awarded to a citywide representation of community providers, some of which will work with schools, to implement high quality activities that will help improve outcomes for youth. These activities will educate the community and schools about the signs of depression and disseminate suicide prevention materials that include access to services within the mental health system.

The DMH suicide prevention grant known as the Capital CARES Initiative seeks to:
- Promote awareness that suicide is a public health problem that is preventable.
- Develop broad-based support for suicide prevention.
- Develop and implement strategies to reduce the stigma associated with being a consumer of mental health, substance abuse and suicide prevention services
- Promote and support research on suicide and suicide prevention
- Improve and expand surveillance systems

Undetermined Deaths

In 2008, CFRC conducted case reviews of nine infants whose deaths were attributed to Sudden Unexpected Infant Death. The following table summarizes these findings:

TABLE 8: FINDINGS OF SUID CASE REVIEWS

Age/Race/ Gender	*Ward of Residence*	*Medical History*	*Sleep Environment*	*Other Risk Factors*
1month/Black/ Male	8	Premature 35 weeks	Infant placed on pillow on adult bed with father	• Prone sleep position
2month/Black/ Female	8	Healthy Full Term	Infant placed in adult bed with three older siblings	• Prone sleep position • History of previous infant death
6month/ Hispanic/Male	6	Healthy Full Term	Infant placed on pillow in playpen cluttered with plastic bags and laundry	• Left unsupervised in the home
1month/Black Female	7	Healthy Full Term	Infant placed in adult bed with grandparent away from home	• Prone sleep position • Recent heat stress • Change in sleep condition (location)
2months/ Black/Male	2	Perinatal Merconium Aspiration/ Full Term	Infant placed in adult bed	• Parental observation of cough the day preceding the death.
3months/ Black/Male	4	Premature 34 weeks/History of reflux	Infant placed in bassinet with "bulky" bedding in daycare setting	• Complaints of stuffy nose • Left unsupervised in daycare setting
3months/ Black/Male	8	Healthy Full Term	Infant placed in adult bed	• Prone sleep position
4months/ Black/Male	7	Premature/31 weeks	Infant placed on sofa with mother	• Prone sleep position
2months/ Black/Male	8	Healthy Full Term/History of Reflux	Infant placed in adult bed with grandparent	• Prone sleep position

As indicated, the leading risk factors observed by CFRC regarding SUID fatalities are:

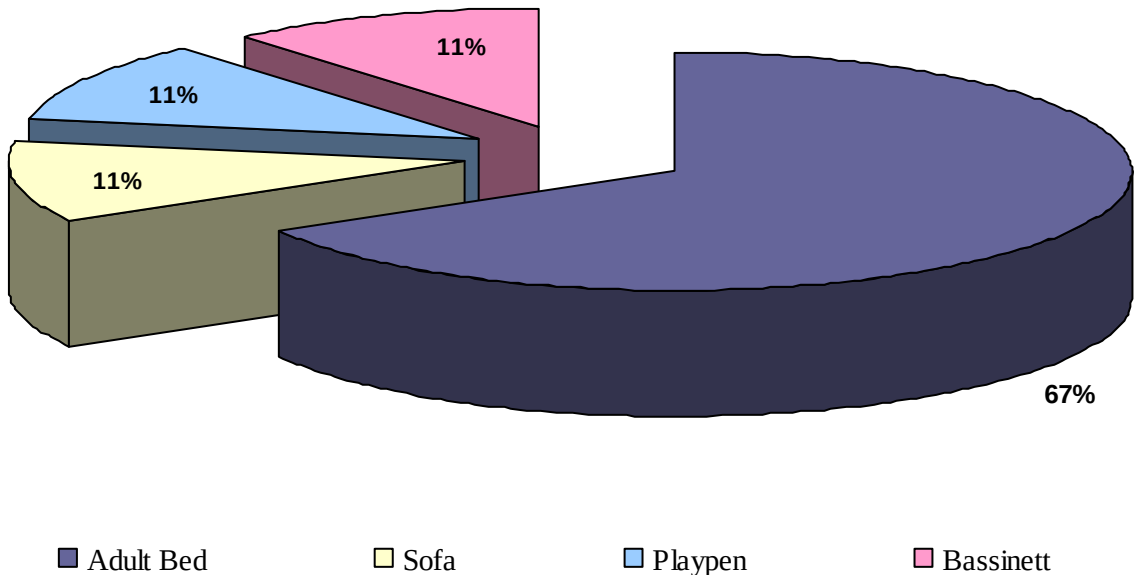
- Infant in a Prone Sleep Position
- Placing the infant in an adult bed
- Infant bed sharing with siblings, parents or grandparents.

All three risk factors were present in 67% of 2008 CFRC SUID cases.

CFRC SUID Infant Sleep Surface

Information obtained during CFRC case reviews indicate 67% of these infants had cribs/bassinets readily available for use, however in 89% of these cases, the infant was not placed in the crib to sleep. Figure 15 indicates the sleep surface by percent for the children represented in this category of death.

Figure 15: CFRC SUID Infant Sleep Surface



SECTION II: SUMMARY OF CFRC SUBCATEGORIES

The Child Fatality Review Committee is charged with reviewing the deaths of children and youth who are involved with the District of Columbia's child welfare and juvenile justice programs. The following depicts data obtained through the fatality review process.

JUVENILE JUSTICE FATALITY DATA

Twenty-two, which represents 12% of the 178 fatalities from calendar year 2008, were youth known to the District of Columbia's juvenile justice system within two years of their death.

- The majority (55%) of the CFRC juvenile justice decedents were school-aged youth between the ages of 15 and 18 years of age.
- All of the juvenile justice decedents were males; twenty-one were Black and the remaining decedent was Hispanic.

Figure 16: Age of Juvenile Justice Decedents

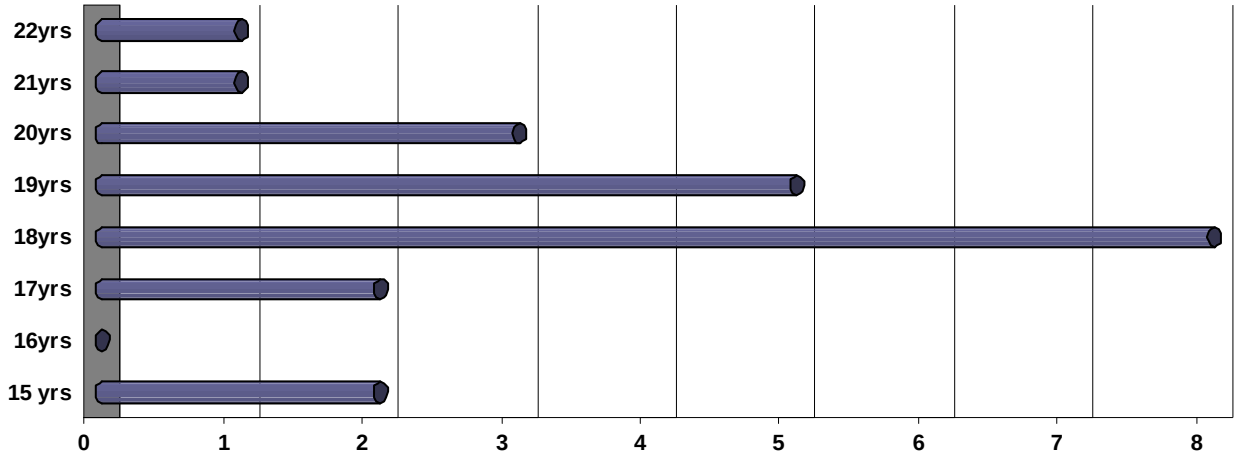


Figure 17: CFRC Juvenile Justice Decedents Ward of Residency

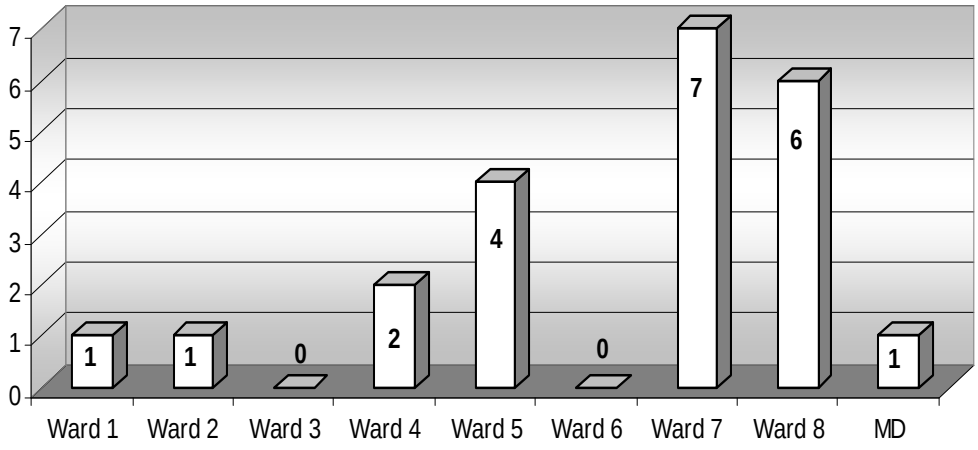
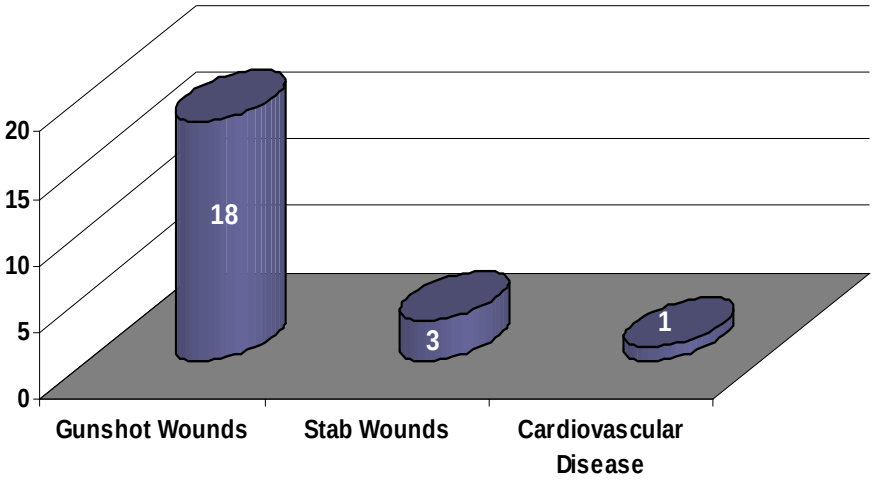


Figure 18: CFRC Juvenile Justice Decedent Causes of Death



Cause and Manner of Death

- Twenty-one of the twenty-two CFRC Juvenile Justice decedents were victims of Homicide (95%). The remaining decedent died due to natural causes.
- Eighty-two percent of the CFRC juvenile justice decedents died as a result of gun violence. As a result, access to guns is the leading risk factor of CFRC juvenile justice related fatalities.

TABLE 9	
SOCIAL RISK FACTORS ASSOCIATED WITH YOUTH HOMICIDES	
Pre-teen/Teen Substance Abuse	**18**
Poor School Performance/Truancy	**18**
Diagnosed Mental Illness	**13**

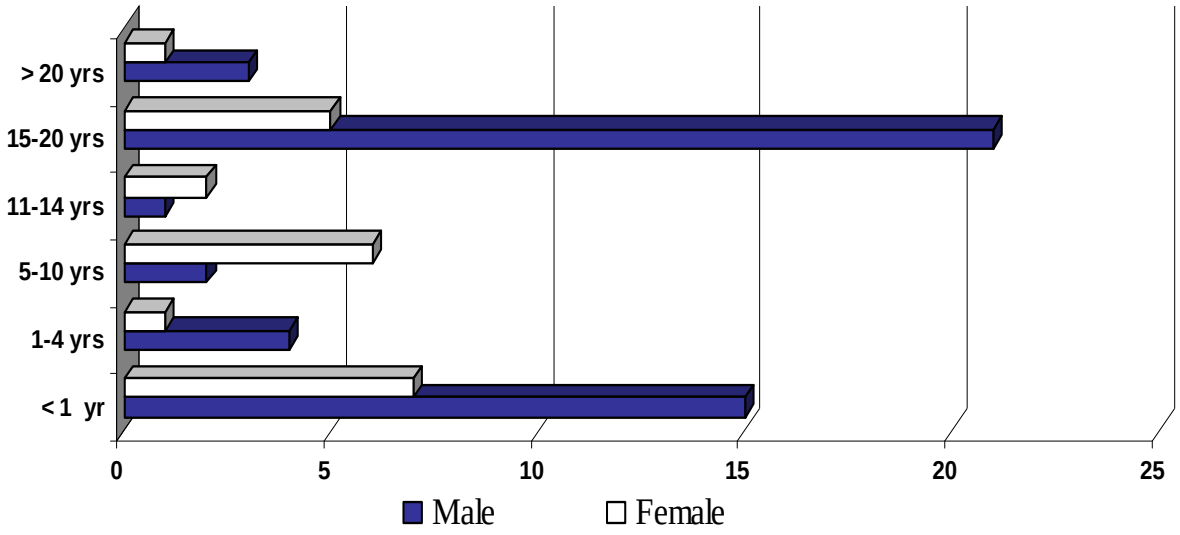
Social/Economic Issues Observed Among Juvenile Justice Decedents

- Eighty-two percent of the CFRC Juvenile Justice case records indicate an early onset of substance abuse among the decedents. Use of marijuana has been reported in 100% of these cases.
- The same number of youth exhibited poor school performance and truancy.
- Only one of the twenty-two decedents in this category successfully graduated from High School.
- Sixty-two percent of the youth had mental health diagnosis, including dual diagnoses such as Depression and Cannabis Dependency.

Child Welfare Fatality Data

During 2008, 68 of the 178 CFRC deaths identified were children and youth who were known to the child welfare system within four years prior to their deaths. History of involvement with child welfare is a nationally recognized risk factor in child death reviews. Reviews of calendar year 2008 child welfare fatalities revealed the following trends/observations.

Figure 19: CFRC Child Welfare Age and Gender



Decedent Demographics

- Sixty-eight percent of the CFRC child welfare decedents were males, and 32% were females.
- Ninety-four percent were Black, and the remaining 6% were Hispanic.
- Children/youth between the ages of 15-20 years composed the majority of child welfare decedents with 38% in this category, followed by infants under the age of one (32%).

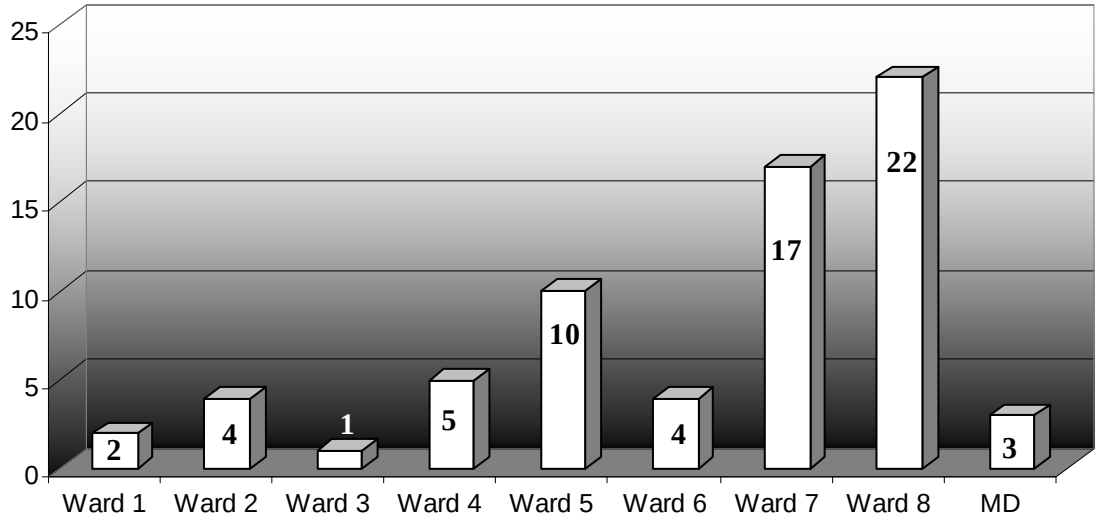
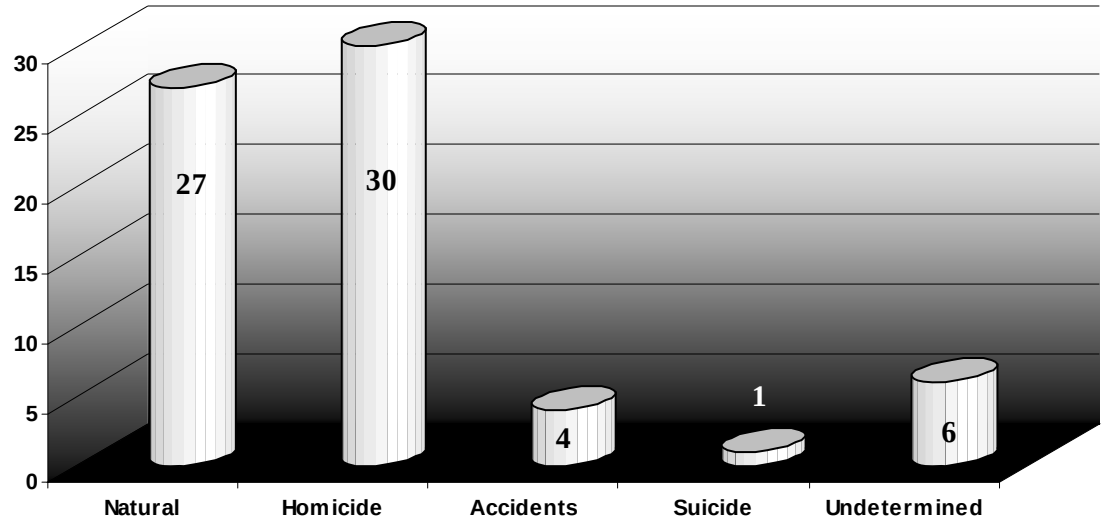


Figure 21: CFRC Child Welfare Manner of Death



Manner of Death for Children known to Child Welfare:

- Forty-four percent of the CFRC child welfare decedents were victims of Homicide. Of the Homicide cases, 27% were victims of fatal abuse.
- Forty percent of the CFRC child welfare decedents died of natural deaths. Of these, 56% were infants under the age of one.
- Fifty-seven percent of the CFRC child welfare case reviews indicated that parents/ caretakers were investigated as a result of allegations of neglect within the year of the child/youth's death.

Dual District Agency Involvement

Of the 53 youth between the ages of 15-21 known to child welfare and juvenile justice agencies, 13 were known to both systems simultaneously. Twelve of the 13 youth were victims of Homicide, and all of these youth were Black males.

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APPENDICES

APPENDIX A: 2008 Calendar Year CFRC Cause and Manner of Death Listing

APPENDIX B: CFRC, DC Law 14-28, codified at DC Official Code §4-1371.01 et seq. (2001)

2008 Calendar Year CFRC Cause/Manner of Death Listing

Age	Cause	Manner
00/00/00	**Prematurity due to Placental Abruption due to Maternal Acute Cocaine Intoxication**	**Accident**
3 Months 6 Days	Asphyxia, Choking	Accident
1 Year 5 Months	Blunt Impact Head Trauma	Accident
6 Years	Acute Bupropion Intoxication	Accident
14 Years	Head Injuries	Accident
17 Years	Unknown	Accident
18 Years	Unknown	Accident
20 Years	Blunt Impact Injuries of Head, Chest, Abdomen and Pelvis	Accident
8 Months 8 Days	**Gunshot Wound**	**Homicide**
1 Year 7 Months	Blunt Head Trauma	Homicide
1 Year 8 Months	Multiple Blunt Impact Trauma including Fractures of Skull, Contusions and Lacerations of Internal Organs with Internal Hemorrhage.	Homicide
5 Years	Undetermined	Homicide
7 Years	Undetermined	Homicide
7 Years	Stab Wound of Chest	Homicide
10 Years	Unknown/Maryland Death	Homicide
11 Years	Undetermined	Homicide
13 Years	Asphyxia due to Pressure on Neck (Strangulation)	Homicide
14 Years	Multiple Stab Wounds	Homicide
15 Years	Gunshot Wound of Right Posterior Chest with Perforations of Right Lung, Heart and Aorta	Homicide
15 Years	Gunshot Wound of Torso	Homicide
15 Years	Gunshot Wound of Head	Homicide
15 Years	Gunshot Wounds of Head	Homicide
15 Years	Gunshot Wounds of Chest and Extremities	Homicide
16 Years	Gunshot Wound of Head	Homicide
16 Years	Gunshot Wounds of Head and Upper Extremities	Homicide
17 Years	Gunshot Wounds of Chest and Buttock	Homicide
17 Years	Undetermined	Homicide
17 Years	Gunshot Wound of Chest with Injury of Heart and Lung	Homicide
17 Years	Gunshot Wound of Torso and Left Upper Extremity	Homicide
17 Years	Multiple Gunshot Wounds	Homicide
17 Years	Gunshot Wound of Torso with Injury of Lung and Spinal Cord	Homicide
17 Years	Gunshot Wound	Homicide
17 Years	Gunshot Wound of Torso	Homicide

Age	Cause	Manner
18 Years	Gunshot Wound of Head with Injury of Vertebral Artery	Homicide
18 Years	Multiple Gunshot Wounds	Homicide
18 Years	Gunshot Wounds and Shotgun Wounds of Head and Torso	Homicide
18 Years	Gunshot Wound of Head	Homicide
18 Years	Gunshot Wounds of Torso and Left Thigh	Homicide
18 Years	Stab and Incised Wounds with Injury to Head, Neck, Torso and Right and Left Extremities	Homicide
18 Years	Gunshot Wound	Homicide
18 Years	Multiple Gunshot Wounds	Homicide
18 Years	Gunshot Wounds of Head, Neck, Right Shoulder and Right Hand	Homicide
19 Years	Sharp Force Injuries	Homicide
19 Years	Gunshot Wound	Homicide
19 Years	Gunshot Wound of Torso and Extremities	Homicide
19 Years	Multiple Gunshot Wounds with Injury to Heart, Right and Left Lungs, Liver, Spleen and Left Kidney	Homicide
20 Years	Gunshot Wound	Homicide
20 Years	Stab Wounds of Chest Injuring Heart and Lungs	Homicide
20 Years	Gunshot Wound of Chest	Homicide
21 Years	Gunshot Wound of Head with Injury of Brain	Homicide
21 Years	Multiple Gunshot Wounds	Homicide
22 Years	Multiple Gunshot Wounds	Homicide
22 Years	Gunshot Wound of Head	Homicide
00/00/00	**Severe Prematurity, Premature Rupture of Membranes of Unknown Etiology**	**Natural**
00/00/00	Preterm Premature Rupture of Membranes @ 23 Weeks, Od Unknown Etiology	Natural
00/00/00	Prematurity @ 19 Weeks Gestation, Chorioamnionitis	Natural
00/00/00	Preamturity, Severe Fetal Growth Retardation, Maternal Auto immune Disorder of Unknown Etiology	Natural
00/00/00	Multiple Congenital Anomalies	Natural
00/00/00	Cardiorespiratory Failure, Extreme Prematurity 23 Weeks of Unknown Etiology	Natural
00/00/00	Previable Fetus, Unknown Etiology	Natural
00/00/00	Preterm 21 Weeks Gestation, Premature Labor, Prolonged Premature Rupture of Membranes of Unknown Etiology	Natural

Age	Cause	Manner
00/00/00	Prematurrity, Induction of Labor, Trisomy 21 (Down Syndrome)	Natural
00/00/00	Prematurity, Preterm Premature Rupture of Membranes, Chorioamnionitis	Natural
00/00/00	Preterm Labor and Delivery of Undetermined Etiology	Natural
00/00/00	Previable Delivery, Preterm Premature Rupture of Membranes, Unknown Etiology	Natural
00/00/00	Prematurity, Induction of Labor, Hydrocephalus of Undetermined Etiology	Natural
00/00/00	Prematurity, Preterm Labor and Delivery, Unknown Etiology	Natural
00/00/00	Prematurity, Induction of Labor, Hydrocephalus of Undetermined Etiology	Natural
00/00/ 00	Previable delivery, Severe Prematurity, Sponntaneous Rupture of Membranes of Unknown Etiology	Natural
00/00/00	Respiratory Failure, Extreme Prematurity, Incompetent Cervix	Natural
00/00/00	Multiple Congenital Anomalies Incompatible with Life	Natural
00/00/00	Immaturity, Abruptio Placenta	Natural
00/00/00	Prematurity, Preterm Delivery, Previable Fetus, Preterm Prematuer Rupture of Membranes/Previable Delivery, of Undetermined Et	Natural
00/00/00	Previable Fetus @ 20 Weeks, Premature Rupture of Membranes of Unknown Etiology	Natural
00/00/00	Extreme Prematurity, Preterm Delivery of Unknown Etiology	Natural
00/00/00	Previable Birth, Extreme Prematurity of Unknown Etiology	Natural
00/00/00	Previable Infant @ 23 Weeks Gestation, Undetermined Etiology	Natural
00/00/00	Extreme Prematurity, Cervical Incompetence	Natural
00/00/00	Severe Prematurity, Respiratory Failure	Natural
00/00/00	Nonviable Fetus, Premature Labor of Unknown Etiology	Natural
00/00/00	Premature Rupture of Membranes, Extreme Prematurity of Unknown Etiology	Natural
00/00/00	Second Trimester Miscarriage, Subchorionic Bleeding of Unknown Etiology	Natural
00/00/00	Extreme Prematurity, Twin Gestation @ 24 Weeks	Natural
00/00/00	Extreme Prematurity, Twin Gestation @ 24 Weeks of Unknown Etiology	Natural

Age	Cause	Manner
00/00/00	Multiple Fetal Anomalies, Genetic Abnormalities	Natural
00/00/00	Extreme Prematurity, Cardiopulmonary Insuffu-ciency of Unknown Etiology	Natural
00/00/00	Extreme Prematurity, Preterm Labor of Unknown Etiology	Natural
00/00/00	Multisystem Failure, Gross Prematurity, Unknown Etiology	Natural
00/00/00	Multi System Failure, Gross Prematurity, Prema-ture Rupture of Membranes	Natural
00/00/00	Pulmonary Hypoplasia, Prematurity, Preterm La-bor of Unknown Etiology	Natural
00/00/00	Extreme Prematuer Previable Infant, Preterm La-bor and Delivery	Natural
00/00/00	Extreme Prematurity, Respiratory Insufficiency, Presumed Sepsis	Natural
00/00/00	Premature Rupture of Membranes of Unknown Etiology	Natural
00/00/00	Preterm Delivery, Immature Fetus @ 22 Weeks Gestation	Natural
00/00/00	Premature Rupture of Membranes, Premature Delivery	Natural
00/00/00	Extreme Prematurity 23 3/7 Weeks, Premature Rupture of Membranes Unknown Etiology	Natural
00/00/00	Perinatal Asphyxia, Prematurity, Chorioamnionitis, Oligohydramnios	Natural
00/00/00	Previable Infant @ 22 Weeks Gestation, Undeter-mined	Natural
00/00/00	Severe Immaturity, Miscarriage, Miscarriage of Unknown Etiology	Natural
00/00/00	Preterm Delivery at 22 Weeks, Premature Rupture of Membranes of Unknown Etiology	Natural
00/00/00	Multisystem Failure, Previable Fetus	Natural
00/00/00	Previable Fetus at 22 Weeks Gestation, Unknown Etiology	Natural
00/00/00	Previable fetus at 22 weeks gestation due to unknown etiology	Natural
00/00/00	Previable fetus at 20 weeks gestation due to unknown etiology	Natural
1 Day	Tremination @ 20 Weeks, Maternal Lups and Liver Disease	Natural
1 Day	Cardio-Respiratory Failure Arrest, Respiratory Distress, Pulmonary Hypoplasia and Prematurity (24 Weeks) Prolonged Rupture of	Natural
2 Days	Extreme Prematurity and Extremely Low Bitrh Weight, Severe Maternal Pre-eclampsia and Essen-tial Hypertension	Natural
3 Days	Hypoxic-Ischemic Encephalopathy, Severe Perina-tal Asphyxia, Placental Abruption	Natural
3 Days	Grade IV Intraventricular Hemorrhage, Prematur-ity, Preterm Labor of Unknown Etiology	Natural

Age	Cause	Manner
5 Days	Severe Respiratory Distress Syndrome, Extreme Prematurity @ 27 Weeks, Severe Intrauterine Growth Retardation, Pregnancy Induc	Natural
6 Days	Intraabdominal Hemorrhage, Lacerartion of Liver During Repair of Congenital Cardiac Anomalies	Natural
6 Days	Cardio Respiratory Failure, Prematurity of Unknown Etiology	Natural
8 Days	Respiratory Failure, Complex Congenital Heart Disease, Conjoint Twin with Shared Heart and Liver	Natural
8 Days	Respiratory Failure, Complex Congenital Heart Disease, Conjoint Twin with Shared Heart and Liver	Natural
10 Days	Septic Shock, Prematurity	Natural
14 Days	Cardio-Respiratory Failure and Arrest, Respiratory Distress and Intracranial Bleeding, Extreme Prematurity 25 Week Gestation,	Natural
17 Days	Gram Negative Sepsis, Necrotizing Enterocolitis, Prematurity, Preterm Labor and Bleeding of Undetermined Etiology	Natural
17 Days	Cardiorespiratory Failure, Hypertrophic Cardiomyopathy, Lactic Acidosis, Inborn Error of Metabolism of Unknown Etiology	Natural
19 Days	Multi Organ Failure, Sepsis (MSSA Bacteremia) Necrotizing Enterocolitis, Extreme Prematurity of Unknown Etiology	Natural
19 Days	Congenital Heart Disease, Sepsis	Natural
24 Days	Hypoxemia, Extreme Prematurity, Chorioamnionitis	Natural
1 Month 4 Days	Respiratory Failure, Sepsis, Extreme Prematurity of Undetermined Origin	Natural
1 Month 11 Days	Respiratory Failure, Necrotizing Enterocolitis Totalis of Unknown Etiology	Natural
1 Month 13 Days	Respiratory Failure, Necrotizing Enterocolitis, Extreme Prematurity	Natural
1 Month 16 Days	Necrotizing Enterocolitis (Necrotizing Totalis), Prematrutiy of Unknown Etiology	Natural
2 Months 4 Days	Bronchopulmonary Dysplasia, Chronic Lung Disaese of Prematurity	Natural
3 Months 6 Days	Extreme Prematurity, Sepsis	Natural
4 Months 6 Days	Plum Vein Stenosis	Natural
4 Months 8 Days	Acute Bronchopneumonia Complicating Viral Bronchiolotis	Natural
4 Months 8 Days	Respiratory Distress, Chronic Lung Disease of Prematurity, Of Unknown Etiology	Natural

Age	Cause	Manner
5 months	Hemorrhagic shock due to MRSA pneumonia	Natural
5 Months 4 Days	Cardiorespiratory Failure, Bronchopulmonary Dysplasia, Prematurity, Unknown Etiology	Natural
5 Months 7 Days	Hemorrhagic Shock, MRSA Pneumonia	Natural
6 Months 3 Days	Bronchopulmonary Dysplasia, Idiopathic Prematurity	Natural
11 Months 16 Days	Pneumonia, Sepsis, Right Heart, Pulmonary Hypertension, Down Syndrome	Natural
11 Months 8 Days	Spinal Muscular Atrpohy, Progressive Respiratory Failure, Bradycardia Asystole	Natural
1 Year 6 Months	Respiratory Distress, Congenital Heart Disease, Trisomy 18	Natural
1 Year 17 Days	Fetal Death in Utero at 39 Weeks of Unknown Etiology	Natural
1 Year 4 Months	Complications from Viral Illness and Prematurity of Undetermined Etiology with Complex Medical Background	Natural
1 Year 6 Months	Community Acquired Methicilin Resistant Staph, Aureus Pneumonia	Natural
1 Year 10 Months	Pending	Natural
1 Year 11 Months	Pulmonary Hypertension, Pneumonia	Natural
2 Years	Cardiac Arrest due to Myocarditis of Undetermined Etiology	Natural
2 Years 8 Months	Metastatic Hepatoblastoma	Natural
2 Years 9 Months	Compliocations of Hypoxic Ischemic Encephalopathy due to Placental Abruption of Unknown Etiology at Birth	Natural
3 Years	Stroke, Cerebral Edema, Sickle Cell Disease	Natural
4 Years	Severe Cerebral Palsy	Natural
4 Years	Respiratory Failure, Respiratory Syncytial Virus Pneumonia	Natural
4 Years	Choroid Plexus Carcinoma	Natural
4 Years	Epilepsy of Unknown Etiology	Natural
4 Years 2 Months	Complications of Dandy walker Syndrome	Natural
6 Years	Complications of Complex Congeintal Heart Disease (Tetralogy of Fallout): Operated, Remote	Natural
6 Years	Pneumonia, Bilateral due to Cerebral Palsy with Mental Retardation	Natural
10 Years	Septic Shock	Natural
11 Years	Intestinal Obstruction, Volvulus of Small Bowel and Fecal Impaction	Natural
12 Years	Glioblastoma	Natural
14 Years	Meningitis	Natural

Age	Cause	Manner
15 Years	Sepsis,Acquired Immunodeficiency Syndrome, Vertical Transmission	Natural
15 Years	Cerebral Palsy, Asystole	Natural
15 Years	Strepoccocus Pneumoniae Sepsis due to Sickle Cell Anemia	Natural
16 Years	Focal Colonic Ischemic due to Intestinal Volvulus	Natural
16 Years	Cardiac Arrhythmia due to Non-Ischemic Cardiomyopathy Involving Roght Ventricle	Natural
18 Years	Complications of Bone Marrow Embolization following Spinal Fusion for the Treatment of Neuromuscular Scoliosis	Natural
18 Years	Acute Exacerbation of Asthma	Natural
19 Years	Occlusive Coronary Artery Thrombus	Natural
22 Years	Complications of Congenital Heart Disease/ Tetralogy of Fallot with Absent Pulmonic Valve	Natural
22 Years	Pulmoanry Thromboembolism due to Deep Venous Thrombosis due to Decreased Mobility	Natural
12 Years	**Hanging**	**Suicide**
18 Years	Hanging	Suicide
1 Month 15 Days	**Sudden Unexpected Death in Infancy Associated with Co-sleeping (bed sharing) and sleeping in prone position**	**Undetermined**
1 Month 20 Days	Sudden Unexpected Infant Death Associated with Co-sleeping and Recent Heat Stress	Undetermined
1 Month 29 Days	Sudden Unexplained Infant Death Associtaed with Bedsharing and Prone Position	Undetermined
2 Months 1 Day	Sudden Unexpected Infant Death Associated with Cosleeping and History of Perinatal Meconium Aspiration	Undetermined
2 Months 3 Days	Sudden Unexpected Infant Death While Co-sleeping with Three Siblings in a Full Size Bed	Undetermined
3 Months 4 Days	Sudden Unexpected Infant Death Associated with Soft Bedding, Prone Position and Thymic Hypertrophy	Undetermined
3 Months 7 Days	Sudden Unexpected Death in Infancy with Generalized Organomegaly	Undetermined
4 Months 7 Days	Sudden Unexpected Infant Death While Co-sleeping with Adult on Inappropriate Bedding (Sofa)	Undetermined
6 Months 7 Days	Sudden Unexpected Infant Death Associated with Sleeping in Prone Position and Inappropriate Bedding	Undetermined

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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).

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 Establishment 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.

(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.

(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 Establishment 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 Establishment 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 Establishment 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.

(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 Establishment 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 Establishment 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 Establishment 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.

(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 Establishment 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 Establishment 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 Establishment 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.

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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 live 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.

Government of the District of Columbia
Office of the Chief Medical Examiner,
Fatality Review Unit, Child Fatality Review Committee