

DISTRICT OF COLUMBIA CHILD FATALITY REVIEW COMMITTEE

2009 ANNUAL REPORT



Vincent Gray, Mayor
District of Columbia Government

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**DISTRICT OF COLUMBIA
CHILD FATALITY REVIEW COMMITTEE**

2009 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 Vincent Gray, Mayor, District of Columbia
The Council of the District of Columbia

APRIL 2012



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.

TABLE OF CONTENTS

EXECUTIVE SUMMARY

INTRODUCTION

Page 1

SECTION I: 2009 SUMMARY OF CASE FINDINGS

Page 2

Description of Decedent Population

Cause and Manner of 2009 Fatalities

Page 2

Decedent Demographics by Manner of Death

Page 3

Race and Gender of Decedents

Page 4

Decedents' Ward of Residency

Page 5

Manner of Death by Ward

Page 5

Natural Deaths

Page 6

Homicide Deaths

Page 9

CFRC Child/Youth Homicide Map

Page 13

CFRC Recommendations for Homicide Deaths and Responses

Page 14

Accidental Deaths

Page 16

CFRC Recommendations for Accidental Deaths and Response

Page 19

Suicide Deaths

Page 20

Undetermined Deaths

Page 20

CFRC Recommendations for SUID Position Statement

Page 23

CFRC SUDI Map

Page 26

SECTION II: SUMMARY OF CFRC SUBCATEGORIES

Page 27

Juvenile Justice Fatality Data

Page 27

Child Welfare Fatality Data

Page 29

APPENDICES

Appendix A: DC Code Title 4, Subchapter V. Child Fatality Review Committee

EXECUTIVE SUMMARY

The District of Columbia Child Fatality Review Committee (CFRC) is pleased to present its 14th Annual Report. This Report covers data from 133 child/youth fatalities that occurred in 2009 and were reported to or identified by the committee during a 3-year span (2009-2011).

The CFRC is a citywide collaborative effort 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 reviews of the circumstances contributing 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) identify risk reduction, prevention and system improvement factors, and (2) 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 of the 2009 decedents reviewed by the CFRC ranges from birth through 23 years, with sixty-four percent (n =85) of the decedents under the age of one.
- ♦ Eighty-four percent (112) of the decedents were Black .
- ♦ Seventy percent (93) of the decedents were males.

CASE IDENTIFICATION

The primary sources that report child deaths to the committee are: the Department of Health (DOH), the Office of the Chief Medical Examiner (OCME); Child and Family Service Administration (CFSA); Department of Youth Rehabilitation Services (DYRS), and the Metropolitan Police Department (MPD). The majority of these cases were reported and reviewed in 2009. Twenty of the 133 cases were reported in 2010, and another 16 cases were reported in 2011. All of the 2009 child deaths have been reviewed, with the exception of three cases, which will be reviewed in January 2012.

MANNERS OF DEATH

Natural Deaths

There were 81 deaths from natural causes during the 2009 calendar year. The majority of these deaths involved children under the age of one. The greatest number of these infant deaths was associated with premature birth or its complications.

Violent Deaths—Homicide and Suicide

In 2009, a total of 32 child/youth fatalities were the result of violent acts. Of these, four children were victims of "Fatal Abuse". The suspected perpetrator in these cases was either a parent or a caregiver of the child. One death resulted from an act of Suicide.

Accidental Deaths

There were 11 accidental deaths involving children and youth in 2009. The circumstances leading to the accidental deaths were as follows: Motor vehicle accidents (3); Fire deaths (6); Asphyxia (1); and Aspiration (1)

Undetermined Deaths

Nine infant deaths were classified as Undetermined manner of death; eight of these deaths were attributed to Sudden Unexpected Infant Death (SUID). SUID is the term recommended by the Center for Disease Control to describe what was formerly known as SIDS or crib deaths. The remaining infant's cause and manner of death was undetermined.

**2009 Child Fatality Review Committee Annual Report
Executive Summary**

CFRC 2009 Recommendations

The following were recommendations developed by the Child Fatality Review Committee to address the need for improvements in systems and/or program initiatives to ameliorate outcomes for children and families in the District of Columbia.

Manner of Death	Area of Focus	Recommendation	Response
Homicides, Fatal Abuse, and Suicide Fatalities (23% of CFRC Cases)	Agency Policy and Practice	The Office of the State Superintendent for Education should ensure that Subsidized Day Care Programs provide as part of the mandated annual training/staff development program the following to all employees: (1) Training on understanding the dynamics of abusive relationships and recognizing the signs of child abuse and domestic violence. (2) Training on reporting suspected child abuse, including appropriate procedures to be followed, timeframes for reporting and agency to receive reports (3) Training on requirements of the DC Law related to responsibilities of mandated reporters, definitions of abuse, and penalties for not reporting.	Agreed with Modifications See Page 14 and 15 for details
		The Office of the State Superintendent for Education should modify the Subsidized Day Care Program transfer process to facilitate a more effective transfer of an enrolled child moving from one facility/center to another. The process should include the following: The requirement that certain records from the transferring school follow the children (eg. Immunizations/health records, history of unusual incidents, developmental milestones, and family/emergency contact information) A standardized transfer checklist providing minimum information needed on the child/family and specifies the documents that will follow the child; A transitional meeting with the parent/caregivers, a representative from both the transfer and receiving day care facility and OSSE. This process will serve as an opportunity for OSSE to evaluate providers, track complaints, and monitor outcomes for children.	
Homicides, Fatal Abuse, and Suicide Fatalities (23% of CFRC Cases)	Agency Policy and Practice	District government agencies that serve children and families should collaborate to develop and implement a comprehensive public education campaign to heighten awareness of the general public of the problem of child abuse/neglect in the District's communities and how to seek assistance. The campaign should include at a minimum the following: (1) Education/outreach that specifically focused on recognizing the signs of abuse, the importance of reporting, and the potential outcome of choosing not to report allegations of child abuse. (2) Education/outreach providing information on available community resources that supporting positive parenting and child rearing practices (i.e., respite and day care services, Collaborative, and the District's child welfare agencies.) (Child and Family Services Agency Designated as Lead Agency)	No Response
Homicides, Fatal Abuse, and Suicide Fatalities (23% of CFRC Cases)	Agency Policy and Practice	The Executive Office of the Mayor should educate District Government employees to encourage better understanding of their specific role as mandated reporters as provided by DC §4-1231.02, which can be implemented through government wide emails, the Mayor's monthly newsletter, pay stub notification and the District Government web site. This will ensure District Government employees have a more clear understanding of the District's stance on child abuse and neglect as well as their responsibilities as mandated reporters and penalties associated with not reporting.	

**2009 Child Fatality Review Committee Annual Report
Executive Summary**

CFRC 2009 Recommendations Cont'd.

Manner of Death	Area of Focus	Recommendation	Response
Homicide/ Fatal Abuse and Suicide Fatalities (23% of CFRC cases)	Agency Policy and Practice	Child and Family Services Agency should review current policies and practice related to domestic violence intervention to determine the level of compliance among social workers, and the need for improvement. CFRC recognizes that areas of improvement should include : (1) Improved routine training of all direct service employees regarding domestic violence awareness, and; (2) Strengthen supervision of social workers to ensure social work practice is in compliance with established domestic violence policy and procedures.	Agreed withModifi- cationsSee page 17 for details
Accidents (8% of CFRC cases)	Agency Policy / Practice/Budget	DC Fire and Emergency Medical Services should provide ongoing fire safety training/literature to District residents within their communities, particularly in the following high risk communities: • Communities with multiple wood-framed homes • Communities with a high concentration of low income residents • Communities with a high concentration of multi-family residences Fire safety information should be regularly disseminated prior to the winter season when families are more likely to use alternative heating sources.	Agreed See page 21 for details
Undetermined (7% of CFRC cases)	Agency Policy/ Practice	Child Fatality Review Committee Position Statement: Safe Sleep for Infants	See page 26 for details

INTRODUCTION

The District's child death review process is the only formally established mechanism within the District Government 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 Child Fatality Review 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 23. When a child dies in the District, the Committee is notified through several established sources. Once notified, the Committee staff 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 133 child/youth fatalities that occurred during the 2009 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

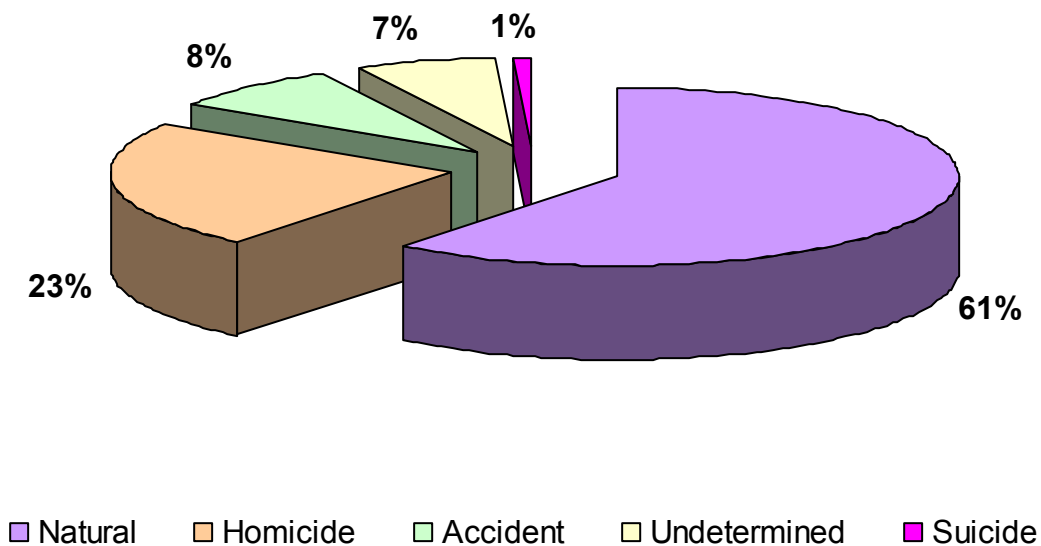
CAUSE AND MANNER OF 2009 FATALITIES

The cause of death refers to the underlying disease 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 2009, 81 children and youth died of natural causes, which was the leading manner of death for children/youth in the District of Columbia. The second leading manner of death was Homicides with 31 deaths. Eleven children/youth died due to Accidents. Eight of the nine Undetermined deaths reviewed by the CFRC had a Cause of Death certified as Sudden Unexpected Infant Death (SUID). There was one Suicide fatality.

Figure 1: 2009 CFRC Decedents Manner of Death



DECEDENT DEMOGRAPHICS BY MANNER OF DEATH

The CFRC reviewed 94 child/youth deaths in 2009. The decedents ages ranged from birth through 23 years. The age categories with the greatest number of deaths were infants (under the age of 1 year) 64% (N=85) and youth 15 to 20 years 18% (N=20) of all CFRC fatalities. This represents a significant decrease in the overall number of child/youth fatalities in the District of Columbia, and the lowest number of child/youth fatalities since 2003. CFRC observed a 29% (N=33) decrease in the number of Natural Deaths of District residents in 2009, as well as a 31% (N=14) decrease in the number of Homicides.

Figure 2: Two Year Comparison of CFRC Decedents (2008 and 2009)

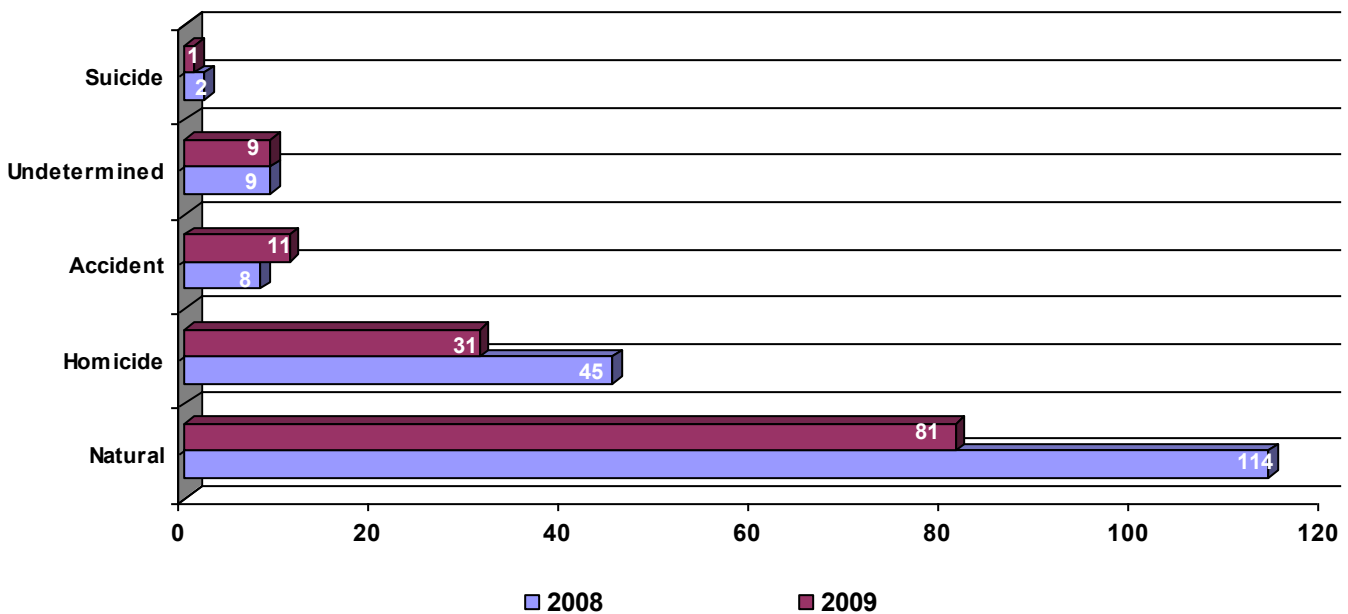
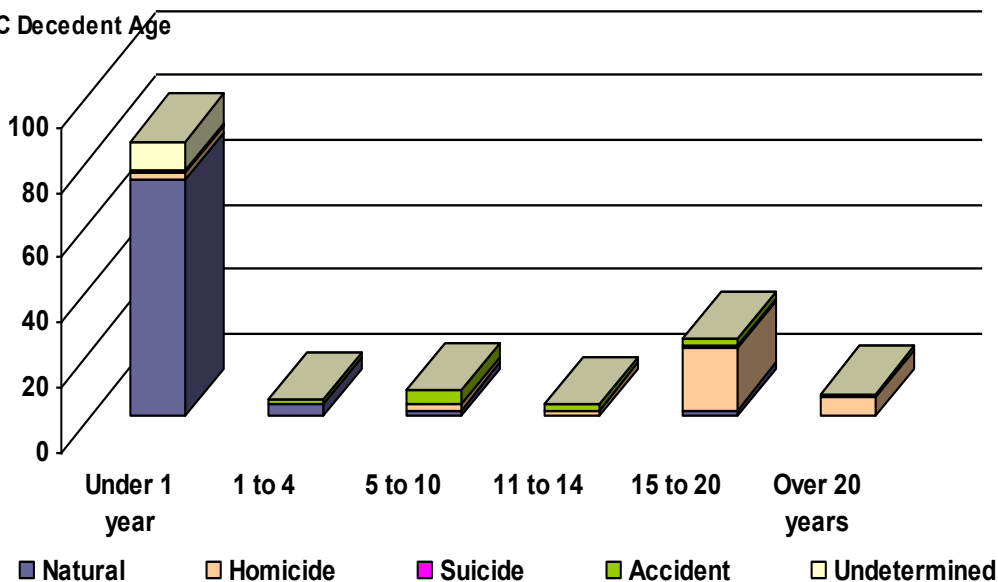


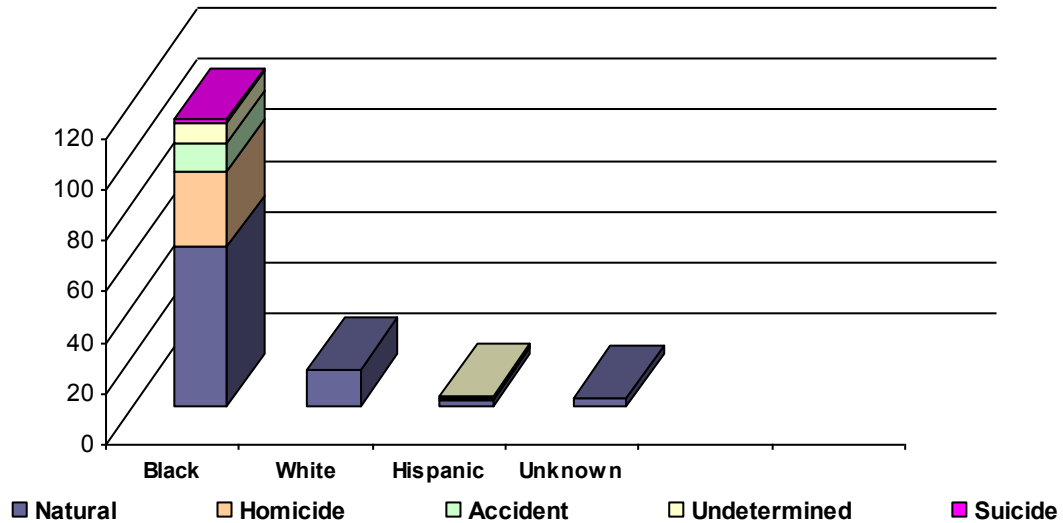
Figure 3: 2009 CFRC Decedent Age



RACE AND GENDER BY MANNER OF DEATH

As Figure 3 illustrates, Black children/youth represented 84% (N=112) of the total CFRC decedent population, with leading representation in all manners of death.

Figure 4: Race of 2009 CFRC Decedents



As illustrated in Figure 4, male decedents represented the largest proportion of the children/youth population in all manners of death totaling 70% (N=93) of the 133 decedents.

Figure 5: Gender of 2009 CFRC Decedents



DECEDENTS' WARD OF RESIDENCY BY MANNER OF DEATH

The CFRC decedents' Ward of Residency is primarily determined by information contained on the death certificates. However, based on additional supporting documentation, other forms of verification may be used (i.e., child welfare, public assistance records/databases, etc.). Ward 8 had the greatest number of child/youth fatalities in 2009 with 29% (N=39). Ward 4 had the second largest number with 17% (N=23), followed by Ward 5 with 15% (N=20). Two 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 review due to current involvement with the District Government's child welfare programs.

Figure 6: 2009 CFRC Decedent Ward of Residency

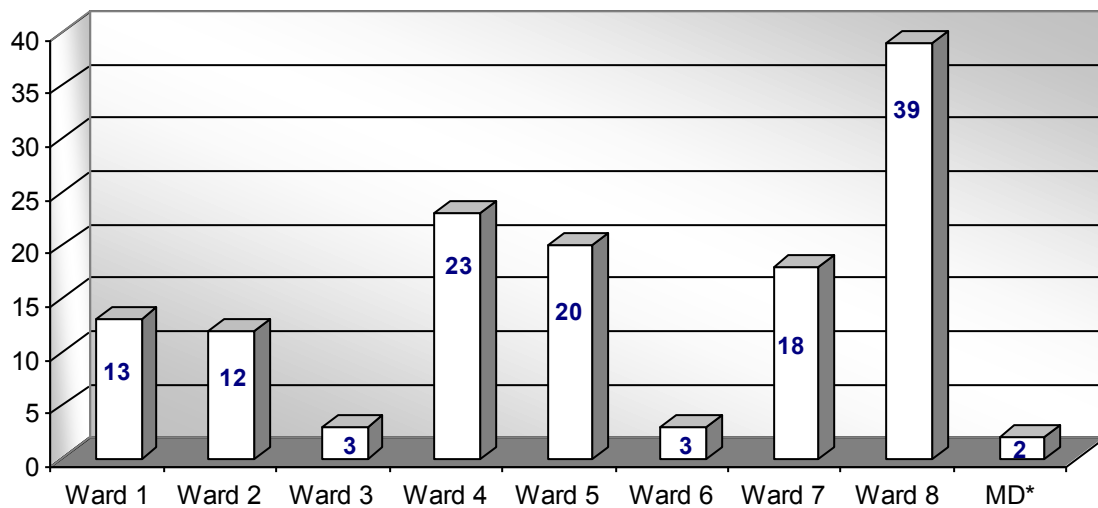
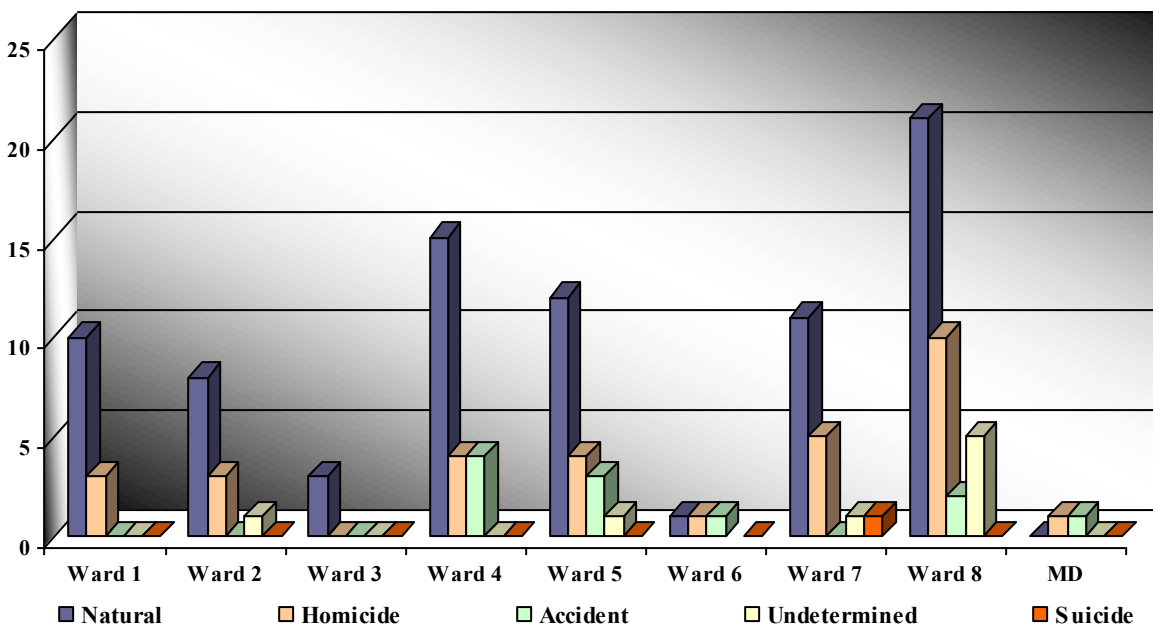


Figure 7: Manner of Death by Ward



Natural Deaths

Eighty-one (61%) of the 133 CFRC children/youth fatalities were non-violent in nature. Of these cases, 54 (66%) involved infants whose deaths were reviewed by the Infant Mortality Review Team.

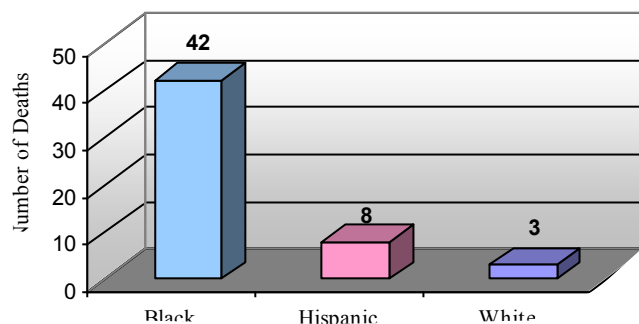
Infant Mortality Review (IMR)

The challenge to reduce child infant mortality related to prematurity has been a persistent goal for the Child Fatality/Infant Mortality Program. In the year 2009 and previous years infant mortality due to premature birth has accounted for more than half of the infant death rate. In 2009 of the 81 natural deaths 71 were infants, and of these decedents 57 were born prematurely.

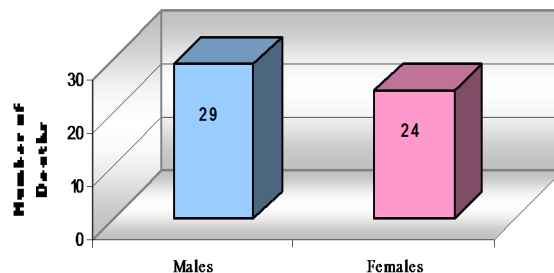
The IMR Committee through the review of individual cases identified several risk factors associated with prematurity and mortality. For this report the committee will outline some maternal and infant risk factors seen with consistency in the cases reviewed. Significant maternal risk factors have been: insufficient prenatal care, obesity, premature rupture of membranes, incompetent cervix, and Chorioamnionitis (Infection). Pertinent infant risk factors included: Immaturity, low birth weight and congenital anomalies. This report presents an assessment of these risk factors for 53 cases as they relate to infant risk factors and 52 cases as they relate to maternal risk factors. Overall, the five cases not included are: Two cases in which the mother received her medical care in Maryland; two cases were reviewed by the Child Fatality Review Committee (CFRC) because they are cases involved an extensive child welfare history; and although one case was not reviewed by the IMR due to insufficient medical history there was enough information available to include the demographics and Infant Risk factor data.

Race and Gender

Natural Deaths by Race



Natural Deaths by Gender



Risk Factors

Risk Factors associated with Prematurity can originate either from the infant himself or from the mother.

Infant Risk Factors

The factors evaluated by the committee were Immaturity including gestational age, birth weight, and Congenital Anomalies.

Gestational age and birth weight

The American Academy of Pediatrics defines a preterm birth as "any delivery, regardless of birth weight" that occurs before 37 completed weeks from the first day of the last menstrual period". It further divides and classifies preterm birth as:

- Extreme prematurity, birth before 24 weeks
- Moderate prematurity, birth between 24 to 33 weeks,
- Late prematurity, birth between 34 to 36 weeks.

Birth weight is also an important factor in survival of premature infants especially when the weight is below the range 700 to 1000g (1.9 to 2.32 lbs).

Twenty-nine of the infants whose deaths were reviewed fell in the category of extreme prematurity (gestational age: 17 to 24 weeks) and Twenty-four were in the category of moderate to late prematurity (gestational age: 24 to 36 weeks).

Level of Prematurity	Number
Extreme	29
Moderate to Late	24

The birth weights were found to be in the following ranges:

- Twenty-one infants were between 100 to 500g (3.52oz to 1lb 1.63oz);
- Twenty were 501 to 1000g, (1lb 1.67oz to 2lbs 3.2 oz); and
- Twelve were 1001 to 4000g (2lbs 3.30oz to 8lbs 13.09oz).

Weight	Number of infants
100-500g	21
501-1000g	20
1001-4000g	12

Note: Resuscitative efforts were made for 21 presumed viable infants.

Congenital Anomalies

Congenital anomalies including genetic/chromosomal disorders such as Patau Syndrome (aka trisomy 13), and other anomalies were present in 5 infants. Developmental anomalies such as Potter Syndrome were present in 6 infants. One infant had an intracranial teratoma (neoplasm/brain tumor).

Infant Risk Factors	Number of infants
Congenital Anomalies	11
Neoplasm/Brain Tumor	1
Complications of Prematurity	42

Maternal Risk Factors*

It is to be noted that several of these factors may be present in the same case.

Prenatal Care

Adequate prenatal care is associated with lower risks of maternal as well as infant deaths. The American Academy of Pediatrics and the American College of Obstetricians and Gynecologists defines optimal prenatal care as: "A comprehensive ante partum care program involves a coordinated approach to medical care and psychological support that optimally begins before conception and extends throughout the ante partum period."

The committee did not review preconception data but focused on timeliness of the initial prenatal visit and subsequent routine visits. Based on these two parameters, the committee concluded that in 28 of the 52 cases reviewed, prenatal care was adequate. In the other 24 cases, prenatal care was insufficient due to late entry, missed appointments or lack of compliance with medical care.

Premature Rupture of Membranes

Premature rupture of fetal membranes before 37 completed weeks of gestational age and prior to the onset of labor are an important cause of prematurity. A specific cause for this anomaly has not been established though infection is thought to be the underlying factor. Of the 52 cases reviewed, 29 presented with premature rupture of fetal membranes.

Chorioamnionitis

Chorioamnionitis is defined as an inflammation of the chorion and amnion, membranes that surround the fetus. Chorioamnionitis is usually associated with bacterial infection which may be passed on to the fetus causing sepsis.

A diagnosis of Chorioamnionitis was made in 28 of the 52 premature births reviewed. Of these cases, 11 had either a history of or a current diagnosis of sexually transmitted diseases.

Incompetent Cervix

This term refers to a painless, spontaneous dilatation of the uterine cervix, usually in the second trimester with resultant expulsion of the fetus. This condition was present in 32 of the 52 cases reviewed.

Obesity

Several studies report a negative impact of excessive maternal weight on the outcome of a pregnancy. Maternal Obesity was a recognized risk factor in 12 of the 52 cases.

Maternal Risk Factors	Number of cases
Insufficient Prenatal Care	23
Premature Rupture of Membranes	29
Chorioamnionitis	28
Incompetent cervix	32
Obesity	12

*Although there are 53 cases noted in the Infant Risk Factors and demographic information, one was not reviewed by the IMR due to insufficient access to appropriate medical records and therefore no Maternal Risk Factor data is available for this one case. So only 52 are considered..

Other Natural Causes of Deaths in Infants

Thirteen infants succumbed to different natural diseases as outlined in Table 2. Two of these infants died at an early age from complications of prematurity.

TABLE 2	
Other Natural Causes of Death in Infants	
Cause of Death	Number of Deaths
Congenital Anomalies	6
Infectious Disease	3
*Sudden Infant Death (SIDS)	1
Hematologic Disorders	1
Genetic/Chromosomal Disorders	2
Total	13

As presented in Table 3, Of the 10 children whose deaths were due to natural diseases, two had cancer, 3 had complex cardiac ailments and two had diseases of the blood.

Natural Causes of Death in Children

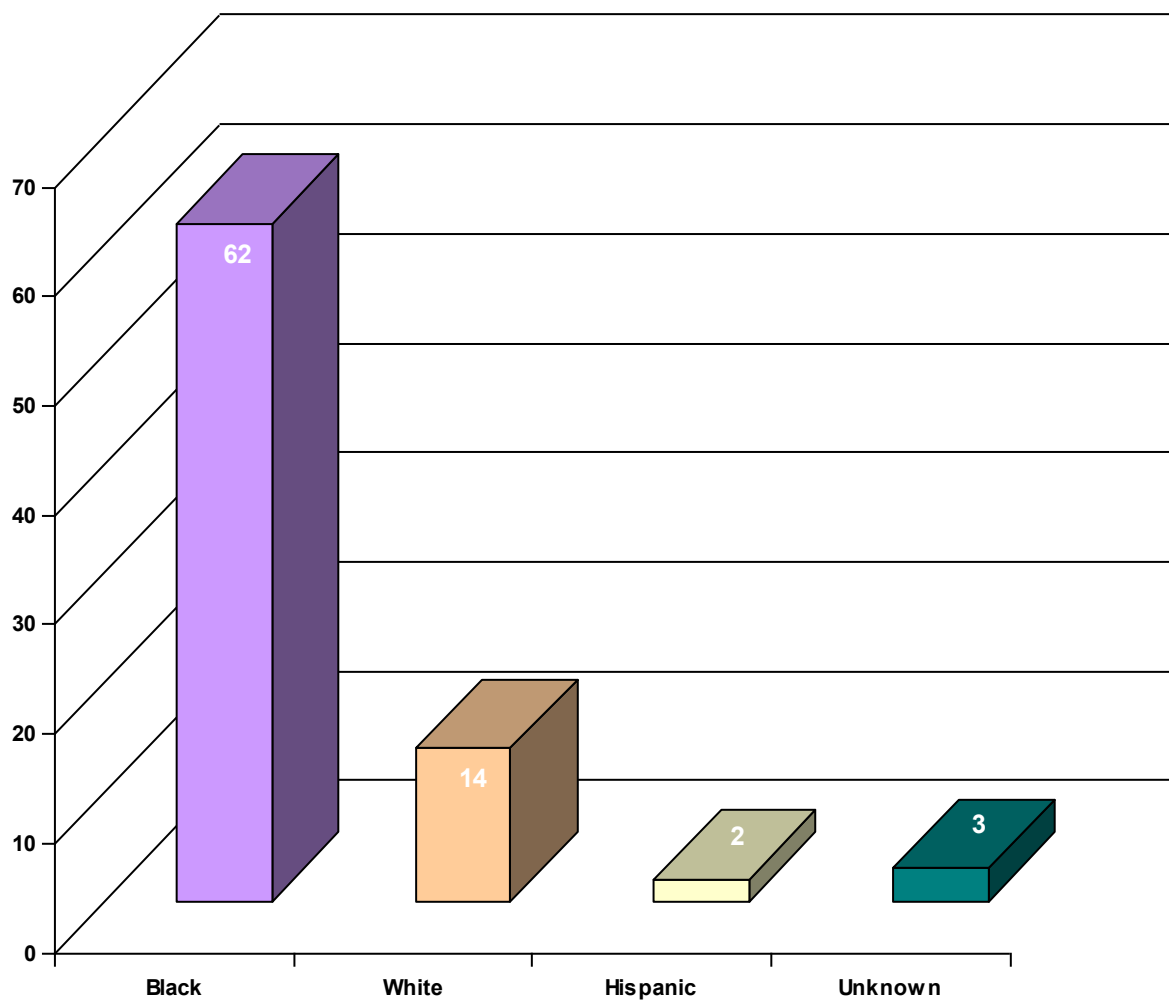
TABLE 3	
Natural Causes of Death—Children > 1 year and Youth	
Cause of Death	Number of deaths
Congenital Anomalies	1
Hematological Diseases	2
Cardiovascular Diseases	3
Neurologic Disorders	1
Infectious Diseases	1
Cancer	2
Total	10

* This case of Sudden Infant Death occurred in Maryland and was verified by the Maryland Office of the Chief Medical Examiner

Race of Decedents

Of the 2009 Natural death cases reviewed by CFRC, 77% involved Black children, followed by White children (17%) and Hispanic children (2%). In 4% of these cases the race of the decedent is unknown.

Figure 8: Race of CFRC Natural Decedents



Homicides

In 2009, 31 of the 133 CFRC reviews were 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.

Summary Review

- ♦ Ninety-four percent (n=29) of all CFRC Homicide victims were male.
- ♦ Sixty-two percent of all CFRC Homicide victims were between the ages 15 to 20 years.
- ♦ Ninety-seven (30) percent of all CFRC Homicide victims were Black, and the remaining homicide victim was an Hispanic male.

Figure 9: 2009 CFRC Homicides by Age

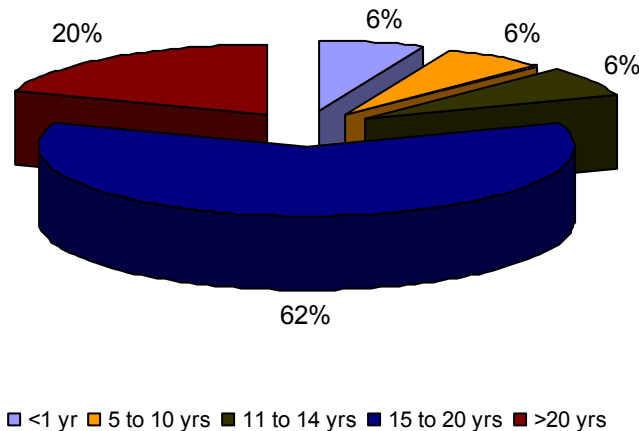
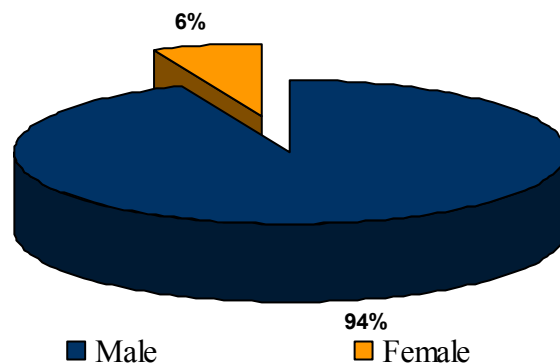
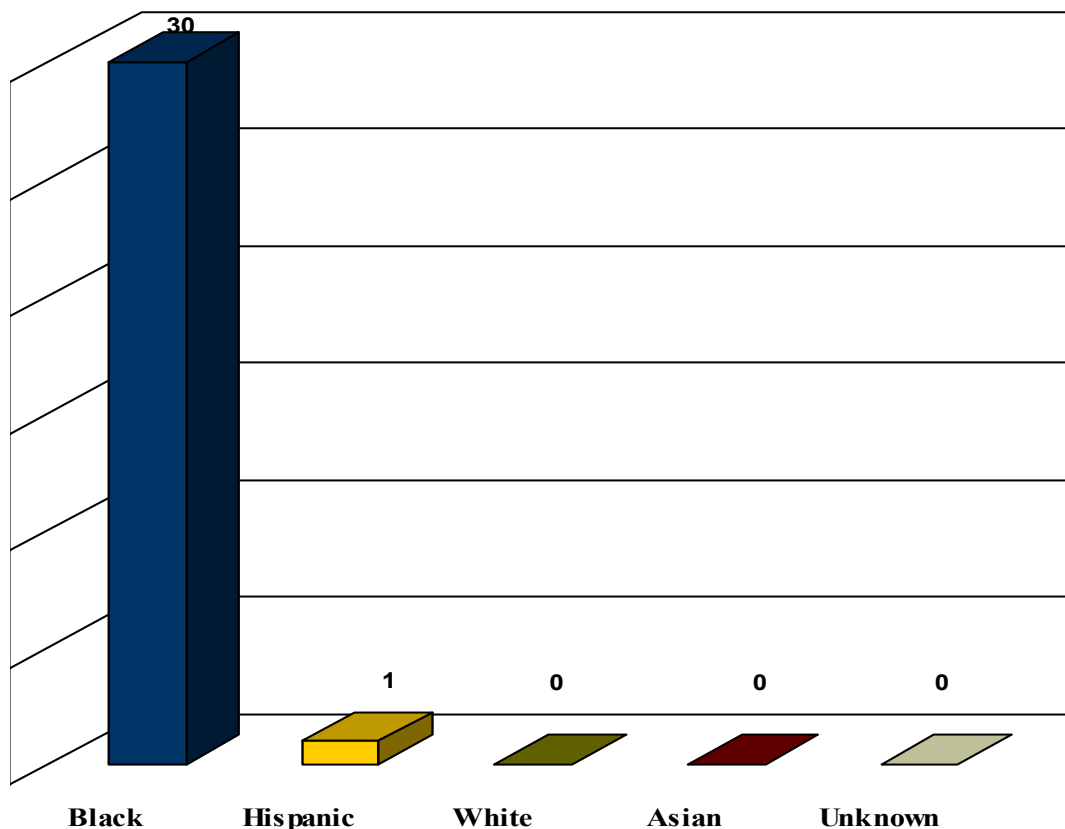


Figure 10: Gender of 2009 Homicide Victims



* Source is the Metropolitan Police Department. There were no homicides of children between the ages of 1-4 in the District of Columbia.

Figure 11: Race of CFRC 2009 Homicide victims



Youth Violence

- ♦ In 2009, 27 (87%) of the 32 Homicide fatalities were the result of youth violence.
- ♦ Homicides continue to be the leading cause of death for youths ages 15 to 20 years (N=19) .
- ♦ All of the youth violence homicide victims were Black males.

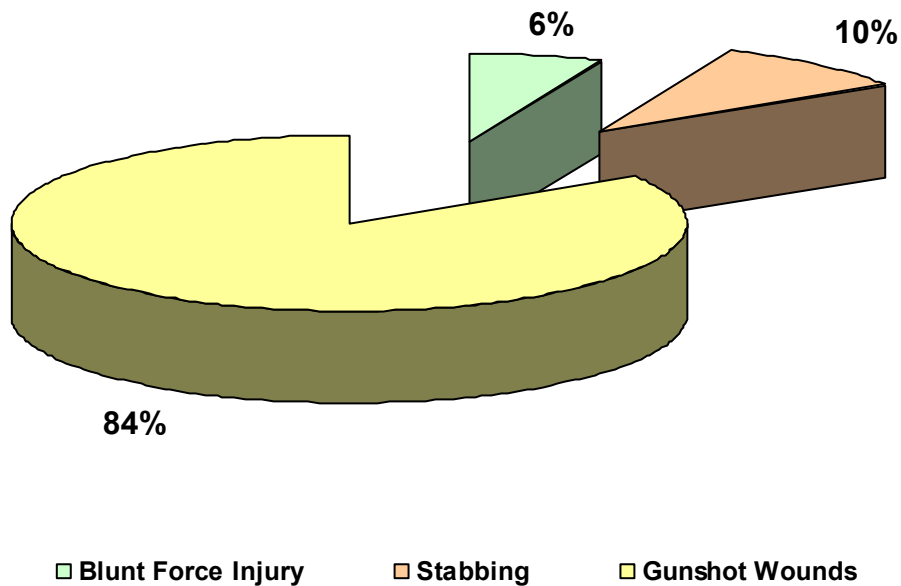
Fatal Child Abuse

- ♦ In 2009, four of the 31 Homicide fatalities were the result of fatal child abuse. In one case, the biological father was the perpetrator of the abuse; in the other three cases the mother's paramour was the perpetrator of the abuse.
- ♦ All of the fatal child abuse victims were known to the District's child welfare program preceding their deaths.
- ♦ All of the fatal abuse victims were Black males.

Cause of Death and Motives for CFRC Homicides

Gun violence continues to be the leading method of homicide deaths among CFRC decedents. Eighty-four percent of the CFRC decedents died as a result of gun violence. Metropolitan Police Department (MPD) data indicates the motives for 29% of these homicides are unknown; 16% were due to arguments/altercations; and 16% were due to retaliation. These were the three leading contributing factors identified through CFRC Case Reviews. (See Figure 13)

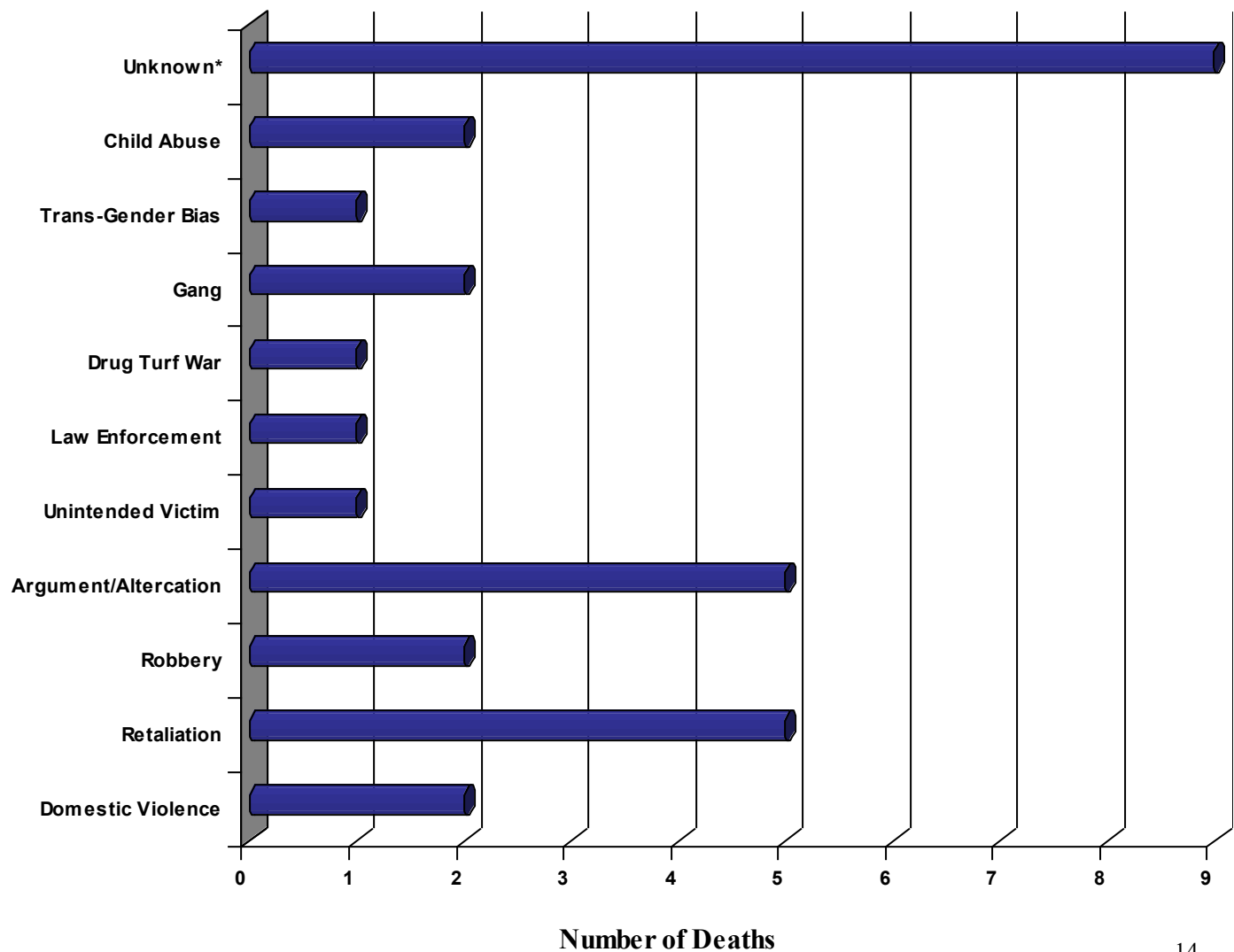
Figure 12: Causes of CFRC Homicides



2009 Child Fatality Review Committee Annual Report
Homicides

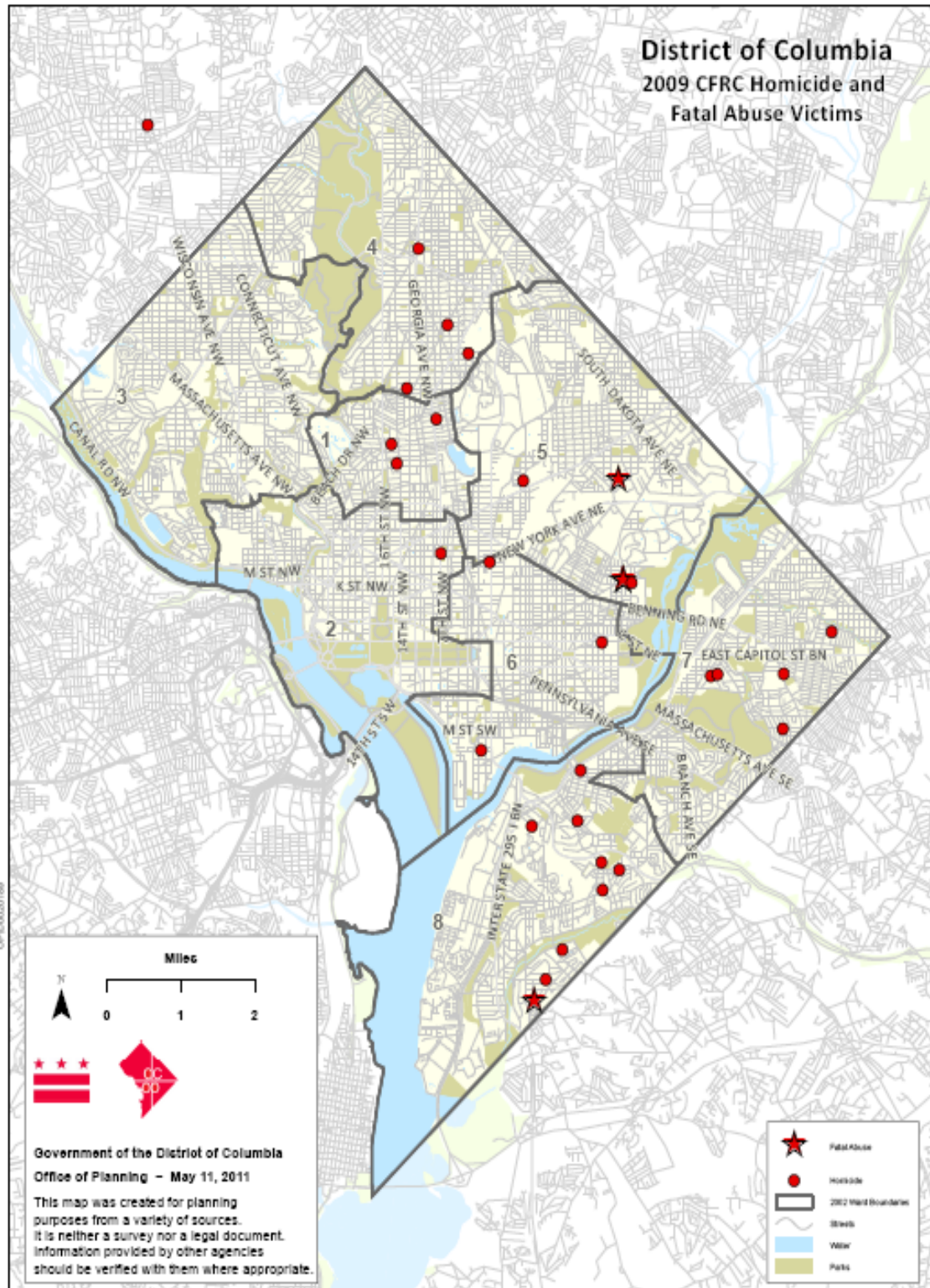
TABLE 4		
Method	Fatal Child Abuse	Youth Violence
Gunshot Wounds	0	26
Stab Wounds	2	1
Blunt Force	2	0
Total	4	27

Figure 13: Motives of CFRC Homicides



2009 Child Fatality Review Committee Annual Report

Homicides



CFRC Recommendations for Homicide Fatalities

The Committee developed the following recommendations, which address the following major areas of concern regarding children/youth Homicides: 1) *Mandated Reporter* training for District government employees and contractors working on behalf of children, (2) the continuum of care for infants and children participating in subsidized day care, (3) educating the public of the problem of child abuse and neglect, and (4) review of child welfare policies and training of employees on issues related to Domestic Violence.

Recommendation #1 : The Office of the State Superintendent for Education should ensure that Subsidized Day Care Programs provide as part of the mandated annual training/staff development program the following to all employees:

- ◆ Training on understanding the dynamics of abusive relationships and recognizing the signs of child abuse and domestic violence.
- ◆ Training on reporting suspected child abuse, including appropriate procedures to be followed, timeframes for reporting and agency to receive reports
- ◆ Training on requirements of the DC Law related to responsibilities of mandated reporters, definitions of abuse, and penalties for not reporting.

Response: OSSE requires employees working in licensed and Subsidy Child Care Programs to complete trainings that encompass the CFRC recommended mandates. The Child Care Licensing Unit and the Subsidized Program will continue to monitor compliance with the training requirements on an annual basis. The OSSE/ECE Professional Development Unit will provide grantee sponsored training that encompasses the regulatory requirements and CFRC recommended mandates. OSSE Grantee conducts training that includes components consistent with regulatory requirements and the CFRC recommended mandates. OSSE Grantee Training (CANTI) components satisfy the requirements of the DC Law related to responsibilities of mandated reporters, definitions of abuse, and penalties for not reporting. By January 2012, OSSE expects to have the following in place: (1) monthly CANTI training opportunities (2) data and reports on OSSE/ECE Child Abuse and Neglect Allegations referrals to CFSA, and (3) data and reports on facility compliance rates pursuant to training mandates

Recommendation#2: The Office of the State Superintendent for Education should modify the Subsidized Day Care Program transfer process to facilitate a more effective transfer of an enrolled child moving from one facility/center to another. The process should include the following:

- ◆ The requirement that certain records from the transferring school follow the children (eg. Immunizations/health records, history of unusual incidents, developmental milestones, and family/emergency contact information);
- ◆ A standardized transfer checklist providing minimum information needed on the child/family and specifies the documents that will follow the child;
- ◆ A transitional meeting with the parent/caregiver's, a representative from both the transfer and receiving day care facility and OSSE. This process will serve as an opportunity for OSSE to evaluate providers, track complaints, and monitor outcomes for children.

CFRC Recommendations for Homicide Fatalities

Response: Pursuant to current Child Development Facilities Regulations, the parent or guardian must provide a receiving facility, prior to enrollment and on an annual basis, a complete, current health certificate with up-to-date immunizations records and family/emergency contact information.

1. Although not stipulated in the current regulations, non-accredited facilities will be encouraged to provide parents or guardians with a written developmental progress report of their child when that child is moved from one facility to another, with a copy for the receiving facility.
2. A transitional meeting with the parent/caregiver(s), a representative from both the transfer and receiving child development facility and the OSSE is not feasible. OSSE therefore recommends that in cases where abuse, neglect and domestic violence is a factor, CFSA (who would have jurisdiction over the investigation) should be involved and provide the OSSE with a written investigative report which addresses allegations made against the transferring facility. Furthermore pursuant to current regulations, each child development facility is required to maintain a log of all complaints and Unusual Incident Reports, including any interaction with the Metropolitan Police Department. Annually, these documents are requested during routine licensure inspections by the OSSE Child Care Licensing Unit and by the Education Services Monitoring Unit during the renewal of the Subsidy Provider Agreement, and failure to maintain and provide a log of all complaints and Unusual Incidents, including any interaction with the Metropolitan Police Department may result in a denial of an annual license, denial of initial approval or renewal of subsidy agreement and/or the implementation of enforcement action.
3. OSSE proposes a Memorandum of Agreement (MOA) be developed between CFSA, DHS Child Care Services Division (CCSD) and OSSE wherein at-risk children can be identified and subsequently tracked in the current Early Childhood Education Information Management System (EIMS) data base. Specific actions planned towards implementation include the following:

(1) Current regulations mandate that receiving facilities are responsible for obtaining a complete, current health certificate containing up-to-date immunization records and family/emergency contact information for each child prior to enrollment and subsequently annually thereafter. The OSSE Child Care Licensing Unit will continue to regulate and monitor facility compliance in this area. (Note: This is a regulatory requirement for all facilities; additional actions are not planned to specifically address children being transferred to other licensed and/or subsidy child care programs.)

(2) The OSSE/ECE Professional Development Unit will expand the availability of training in this area for both facility staff and Subsidy Program Monitoring Staff.

(3) OSSE to seek a Memorandum of Agreement (MOA) between the DHS/CFSA and DHS/CCSD wherein at-risk children are protected, identified, and subsequently tracked in the enhanced Early Childhood Education Information Management System (EIMS) data base.

CFRC Recommendations for Homicide Fatalities

By January 2012, OSSE Expects the following outcomes:

- 1.) Increase in OSSE/ECE sponsored curriculum training opportunities, which include a component on the observation and preparation of children's developmental milestones and progress reports.
- 2.) Increase evidence of facility prepared children's developmental milestones and progress reports.
- 3.) Establish a Memorandum of Agreement (MOA) be developed between CFSA , DHS Child Care Services Division (CCSD) and OSSE wherein at-risk children can be protected, identified and subsequently tracked in the Current Early Childhood Education Information Management System (EIMS) data base.

Recommendation#3: District government agencies servicing children and families should collaborate to develop and implement a comprehensive public education campaign to heighten awareness of the general public of the problem of child abuse/neglect in the District's communities and how to seek assistance. The campaign should include at a minimum the following:

- ♦ Education/outreach specifically focusing on recognizing the signs of abuse, the importance of reporting, and the potential outcome of choosing not to report allegations of child abuse.
- ♦ Education/outreach providing information on available community resources supporting positive parenting and child rearing practices (i.e., respite and day care services, Collaborative, and the District's child welfare agencies.

Response: This recommendation was submitted to the Executive Office of the Mayor during the 2009 case review period with the indication the Child and Family Services Agency should take the lead in the implementation of this recommendation. The Child Fatality Review Committee did not receive a response.

Recommendation#4: The Executive Office of the Mayor should educate District Government employees to encourage better understanding of their specific role as mandated reporters as provided by DC §4-1231.02, which can be implemented through government wide emails, the Mayor's monthly newsletter, pay stub notification and the District Government web site. This will ensure that District Government employees have a more clear understanding of the District's stance on child abuse and neglect as well as their responsibilities as mandated reporters and penalties associated with not reporting.

Response: This recommendation was submitted to the Executive Office of the Mayor during the 2009 case review period. The Child Fatality Review Committee did not receive a response.

**2009 Child Fatality Review Committee Annual Report
Recommendations for Homicides**

Recommendation #5: CFSA should review current policies and practice related to domestic violence intervention to determine the level of compliance among social workers, and the need for improvement. CFRC recognizes that areas of improvement should include:

- ♦ Improve routine training of all direct service employees regarding domestic violence awareness, and ;
- ♦ Strengthen supervision of social workers to ensure that social work practice is in compliance with established domestic violence policy and procedures.

CFSA modified the recommendation as follows: CFSA should assess current training regarding domestic violence awareness to strengthen practice and supervision of social workers. CFSA agreed to (1) review the need to mandate a two-day domestic violence training for CFSA and contracted provider staff (2) work with contracted provider agencies to develop means of delivering training to staff, and (3) annually include domestic violence training in all-staff held in the month of October. A review and revision of the CFSA policies and procedures related to domestic violence is underway. In November 2009, CFSA completed an administrative issuance for social workers whose clients have histories of domestic violence. The assessment for domestic violence was included in the April 2009 structured decision-making tool.

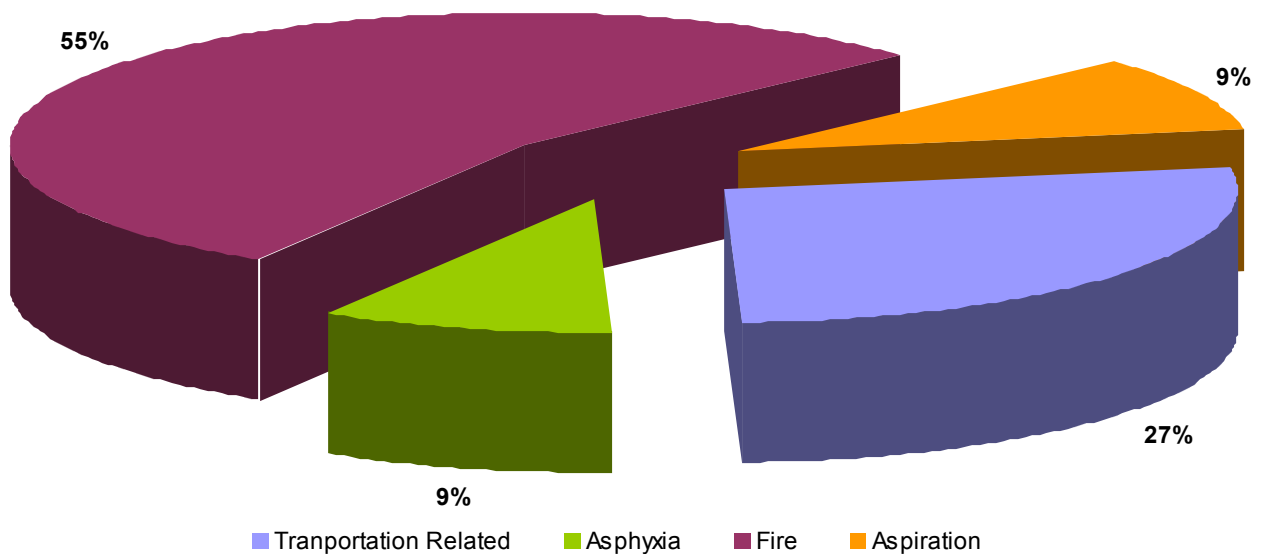
ACCIDENTAL DEATHS

In 2009, there were 11 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.

- ♦ Fire related deaths were the leading cause of accidental deaths in CFRC case reviews (See Table 5).
- ♦ The ages of the 2009 accidental death victims ranged from 5 months to 22 years.
- ♦ All of the 11 decedents in this category were Black.
- ♦ Of the accidental deaths 10 decedents were male and one was female.

TABLE 5	
CFRC ACCIDENTAL DEATHS	
Fire	6
Motor Vehicle/Transportation	3
Asphyxia	1
Aspiration	1
Total	11

Figure 14 : CFRC Accidental Deaths



2009 Child Fatality Review Committee Annual Report Accidents

2009 Accidental Deaths Continued

The following tables provides details regarding the 2009 accident related child fatalities reviewed by CFRC.

TABLE 6: TRANSPORTATION RELATED ACCIDENTS						
<i>AGE/RACE/ GENDER</i>	<i>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>
17/Black/ Male	1:30 AM	4/4	Driver	Automobile	Driver Violation/ Collision	Stolen Vehicle
22/Black/ Male	1:11 AM	6/8	Passenger	Automobile	Driver Violation/ Collision	Driver Intoxicated
14/Black/ Male	9:30 PM	8/8	Pedestrian	Automobile	Driver Violation/ Collision	None

TABLE 7: ASPHYXIA FATALITY				
<i>AGE/RACE/ GENDER</i>	<i>Place of Injury</i>	<i>Ward Residence/ Fatal Incident</i>	<i>Contributing Factor #1</i>	<i>Contributing Factor #2</i>
5 month Black/Male	Family home	8/8	Inappropriate Sleep Environment	Extreme Clutter

TABLE 8: ASPIRATION FATALITY				
<i>AGE/RACE/ GENDER</i>	<i>Place of Injury</i>	<i>Ward Residence/Fatal Incident</i>	<i>Contributing Factors #1</i>	<i>Contributing Factor #2</i>
15/Black/Male	Foster Home	MD	Medically Fragile	Unsupervised

2009 Child Fatality Review Committee Annual Report
Accidents

Fire Related Fatalities

The following table provides details regarding the six 2009 fire related child fatalities reviewed by CFRC.

TABLE 9: Fire Related Fatalities					
<i>AGE/RACE/ GENDER</i>	<i>Time of Injury</i>	<i>Ward Residence/ Fatal Incident</i>	<i>Place of Incident</i>	<i>Contributing Factors#1</i>	<i>Risk Factors</i>
11/Black/ Male	7:20 AM	5/5	Family Home	Overload of Electrical Appliances	Failure to use Smoke Detectors
11/Black/Male	7:00 AM	5/5	Family Home	Electrical Malfunction	Failure to use Smoke Detectors
10/Black/Male	7:00 AM	5/5	Family Home	Electrical Malfunction	Failure to use Smoke Detectors
4/Black/ Female	7:00 AM	5/5	Family Home	Electrical Malfunction	Failure to use Smoke Detectors
7/Black/Male	6:00 PM	4/MD	Relatives Home	Cooked food left unattended	Child left unsupervised
6/Black Male	6:00 PM	4/MD	Relatives Home	Cooked food left unattended	Child left unsupervised

CFRC Recommendation for Accident Fatalities

CFRC developed the following recommendation to address the need for public education regarding fire safety and prevention.

Recommendation: DC Fire and Emergency Medical Services should provide ongoing fire safety training and literature to District residents within their communities, particularly in the following high risk communities:

- ♦ Communities with multiple wood-framed homes
- ♦ Communities with a high concentration of low-income residents
- ♦ Communities with a high concentration of multi-family residences

Fire safety information should be regularly disseminated prior to the winter season when families are more likely to use alternative heating sources (eg. Electric heaters, gas stoves)

Response: DC Fire and Emergency Medical Services agreed with this recommendation. Fire safety and literature is presented to residents in communities when a fire occurs. However, current budgetary restraints prohibit the implementation of this recommendation citywide.

SUICIDE DEATHS

In 2009, CFRC reviewed the case of one Suicide death. Suicide rates among the children and youth in the District of Columbia remain low. These CFRC reviews provide insight on the delivery of mental health services to youth with histories of mental illness. The table below provides information pertaining to and including the identified CFRC risk factors associated with this case.

TABLE 10: 2009 CFRC SUICIDE DATA

<i>Age/Race/ Gender/</i>	<i>Method</i>	<i>Ward Residence/ Fatal Incident</i>	<i>Contributing Mental Health And Social Factors</i>
15 yr/Black Male	Jumped in front of moving vehicle	7/1	<ul style="list-style-type: none">• History of Mental Illness• Noncompliance with mental health treatment• Poor medication management• Excessive school absences• Involved with child welfare services

UNDETERMINED DEATHS

In 2009, CFRC conducted case reviews of nine infants whose manner of death was Undetermined. In eight of these cases, the immediate cause of death was Sudden Unexpected Death in Infancy (SUDI). Although the manner of death in these cases is undetermined, scene investigations provide further information into the contributing factors associated with the infant's death.

As indicated in Table 11, 6 of the 9 SUDI related fatalities were born healthy at full term. The infants ranged in age from 1 month to 6 months of age. Six of these infants were placed in the prone position to sleep. In all but one case, the scene investigation revealed the infant was placed to sleep in an unsafe sleep environment.

Undetermined Deaths and Associated Risk Factors

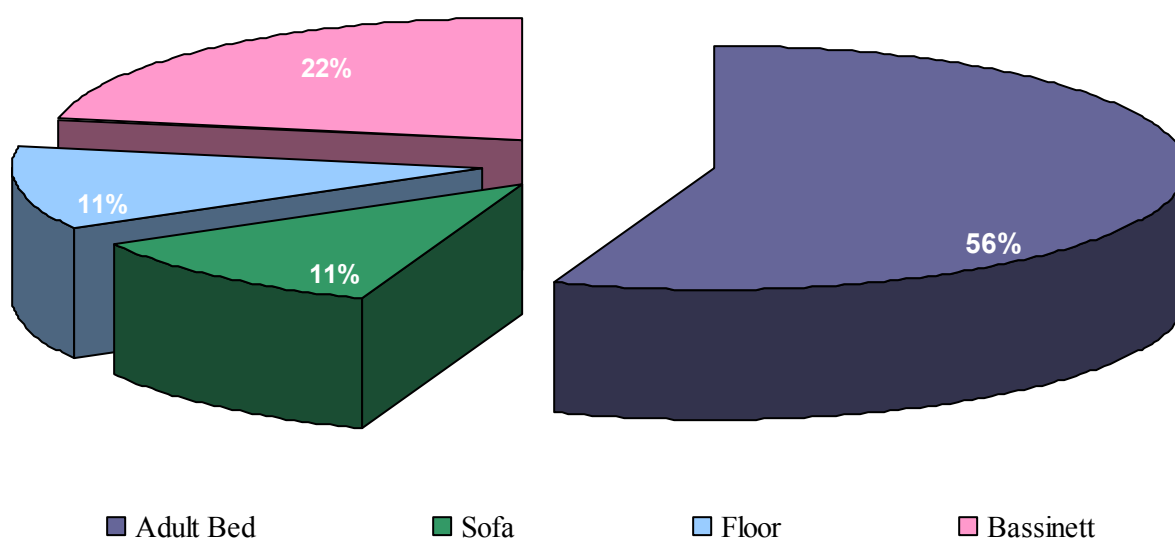
TABLE 11: FINDINGS OF UNDETERMINED CASE REVIEWS

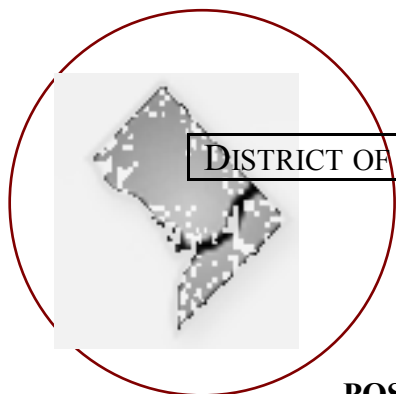
<i>Age/Race/ Gender</i>	<i>Ward of Residence</i>	<i>Medical History</i>	<i>Sleep Environment</i>	<i>Other Risk Factors</i>
6month/Black/ Female	7	Healthy Full Term	Infant placed on back in adult bed with bottle	<ul style="list-style-type: none"> • Infant left unsupervised
3month/Black/ Male	8	Healthy Full Term	Infant placed in adult bed to sleep with parents	<ul style="list-style-type: none"> • Teen parent
2month/Black/ Female	4	Healthy Full Term	Infant placed on sofa to sleep	<ul style="list-style-type: none"> • Exposure to cigarette smoke • Adult alcohol use
1month/Black Male	1	Healthy Full Term	Infant placed in prone position on adult bed/soft bedding	<ul style="list-style-type: none"> • Adult alcohol use
3months/ Black/Male	8	Premature 36 weeks/History of Apnea at birth	Infant placed in prone position in bassinet with inappropriate bedding (pillow and blanket)	<ul style="list-style-type: none"> • Exposure to cigarette smoke
1months/ Black/Male	8	Full Term G6PD Deficiency	Infant placed in prone position in bassinet	<ul style="list-style-type: none"> • Exposure to cigarette smoke • Excessive clutter in home
2months/ Black/Male	6	Healthy Full Term	Infant placed in prone position in adult bed on a pillow with parent	<ul style="list-style-type: none"> • Exposure to cigarette smoke
3months/ Black/Female	8	Healthy Full Term	Infant placed in prone position on pillow on floor	<ul style="list-style-type: none"> • Adult alcohol use • Inappropriate caretaker (siblings)
2 months/ Black Male	2	Healthy Preterm 36 weeks	Infant placed in prone position in adult bed with parent	<ul style="list-style-type: none"> • Teen parent (1st child) • No history of safe sleep training in prenatal records

CFRC Undetermined Infant Sleep Surface

Information obtained during CFRC case reviews indicate 3 of these infants had bassinets readily available for use; of these cases 2 used the bassinet as the infant's sleep environment. Figure 15 indicates the sleep surface by percent for the children represented in this category of death. In response to the SUDI case reviews, the **CFRC issued the Position Statement: Safe Sleep for Infants.**

Figure 15: Undetermined Infant Sleep Surface





DISTRICT OF COLUMBIA CHILD FATALITY REVIEW COMMITTEE

POSITION STATEMENT: SAFE SLEEP FOR INFANTS

The District's Child Fatality Review Committee in collaboration with other District child/family serving agencies is charged with the responsibility of reducing the number of preventable child/infant deaths and improving the quality of life for District residents. This goal is accomplished through conducting retrospective reviews of child deaths, assessing services and systems involved with these families and making recommendations for systemic improvements and improved public education. The DC CFRC initiated a Prevention Subcommittee to assess trends and risk factors associated with infant who died due to Sudden Unexpected Death in Infants (SUDI) and other related causes; and to develop prevention strategies and recommendations to reduce the number of related deaths. As a result of the work of the Prevention Subcommittee, the DC CFRC has developed a position statement on infant and child safe sleep environments. It is the hope of the DC CFRC that this statement will be adopted by the District government agencies that serve children, youth and families; or may be used as a guide to address the prevalence of SUDI in the District by promoting improved policies, practices, resources and education.

Consistent with other states, the Center for Disease Control, American Academy of Pediatrics, and other national organizations, the DC CFRC supports promoting safe sleep practices and safe sleep environments as a primary means of reducing the number of preventable infant deaths from SUDI. The DC CFRC makes the following recommendations on sleep environments and practices as well as general health practices to help reduce the number of preventable infant deaths and to reinforce researched best practices for safe sleep of infants.

Bed Sharing and Co-Sleeping

The DC CFRC accepts the following distinctions in the definitions of bed-sharing and co-sleeping and encourages all public and private child/family servicing agencies to incorporate these definitions in relevant policies and practices:

- Bed-sharing refers to a sleeping arrangement in which the infant shares the same sleep surface with the parent, caregiver or sibling.
- Co-sleeping refers to a sleeping arrangement in which the infant is sleeping in the same room, however not sleeping in the same bed as the parent, caregiver, or sibling. Placing the infant's bassinet or crib within arm's reach of the parent's bed promotes bonding and breast feeding.

Sleep Position:

- Infants should be placed in a supine position (on their backs) to sleep for naps or at night. Side sleeping is not as safe as supine and is not advised.
- Infants should be given time on their tummies when awake and supervised by a responsible adult or caregiver.
- Parents should reinforce with relatives and other temporary caregivers the importance of always placing infants on their backs when sleep.

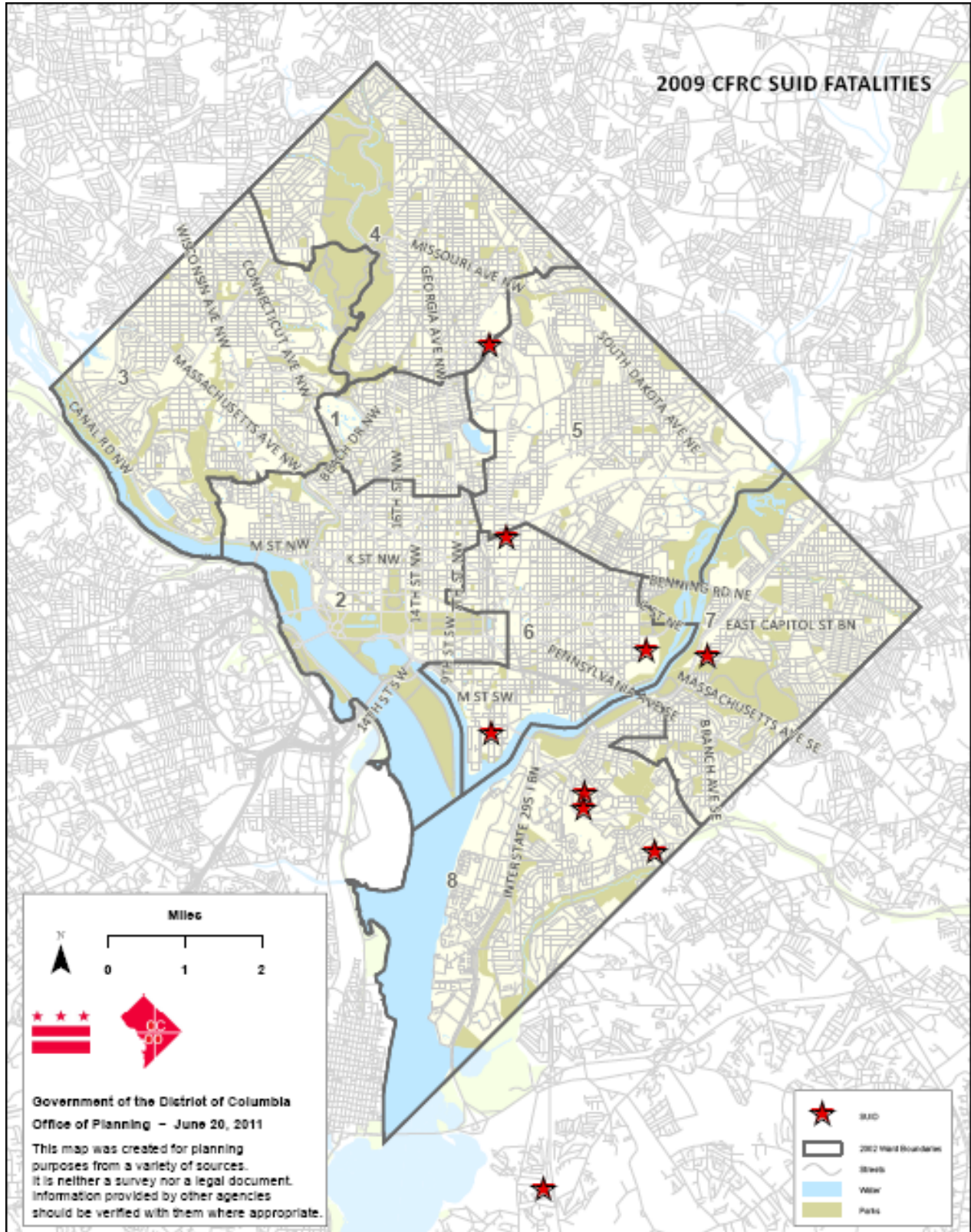
Sleep Environment

- Infants should be placed to sleep preferably in a safety-approved crib or bassinet with a firm mattress, using a well fitting sheet made for the crib/bassinet.
- Parents should maintain the home and especially the infant's sleep area free of cigarette smoke.
- Infants should not be placed on adult beds to sleep as they are more at risk of suffocation from several hidden hazards, such as entrapment between the bed and wall, bed frame, headboard or footboard, and falls from adult beds onto piles of clothing, plastic bags or other soft materials; and adults may roll over onto the infant while sleeping. Securing an infant on an adult bed with pillows also places the infant at risk for suffocation.
- Infants should never be placed to sleep on soft surfaces or objects, such as foam, cushions, pillows, sheepskins, sofas, chairs, waterbeds or air mattresses.
- Infants sleep environment should be free of toys or other soft bedding and loose objects, such as blankets or comforters, stuffed animals and bumper pads, since they could cover the infant's head or face.
- The infants sleep environment should be free of unsafe items, such as plastic sheets, plastic bags, strings, cords or ropes.
- The safest place for an infant to sleep is in the same room with a parent or caregiver but on a separate sleep surface (crib, or bassinet), not sharing space with another child/infant or adult. The same room allows the parent to be able supervise and bond with the infant, and also makes breastfeeding more convenient.
- Infants should sleep in a room that is kept between 68 and 72 degrees.
- Infants should not be over bundled and should be placed in a garment such as a sleeper or sleep sack to ensure the infant's head and face do not get covered by a blanket.

Scholarly research, as well as DC CFRC data confirm that bed-sharing can be unsafe for infants. Adults and siblings can accidentally roll onto an infant while sleeping. However, in the event that parents choose to bed-share based on their own personal decision and cultural beliefs, the DC CFRC recommends that the following information be provided to parents, in addition to the above recommendations on health practices, sleep position and sleep environment:

- An infant should not be allowed to sleep with another infant or child on the same sleep surface (crib, mattress, etc)
- An infant should never sleep with an adult if:
 1. The adult/caregiver sleeps on soft bedding, such as sofas, waterbeds, bean bag, air mattresses etc.
 2. The adult/caregiver or others in the household smoke
 3. The adult/caregiver is under the influence of drugs, alcohol or other medications that can cause drowsiness or incoherent thinking
 4. The adult/caregiver is excessively tired or sick
 5. The adult/caregiver is angry or upset
 6. The caregiver is obese

The DC CFRC supports the concept of educating parents and prospective infant caregivers on safe sleep environments and position. Education should be provided through the course of routine pre-conceptual and prenatal health care, and should continue through the first year of the infant's life. Physicians, discharge planners, social workers, and other direct service providers serving women of child bearing years, relatives and caregivers, should maximize their efforts and opportunities to offer education and support to encourage right decision making to reduce the risk of SUDI. Public education is essential, and should be designed to target not only parents, but infant caregivers (fathers, paramours, and extended family members).



SECTION II: SUMMARY OF CFRC SUBCATEGORIES

The CFRC 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

Thirteen CFRC decedents, which represents 10% of the 133 fatalities from calendar year 2009, were youth known to the District of Columbia's juvenile justice system within two years of their death. Eight (62%) of the CFRC juvenile justice decedents were young adults between the ages of 19 and 22 years of age. All of the juvenile justice decedents were Black males.

Figure 16: Age of Juvenile Justice Decedents

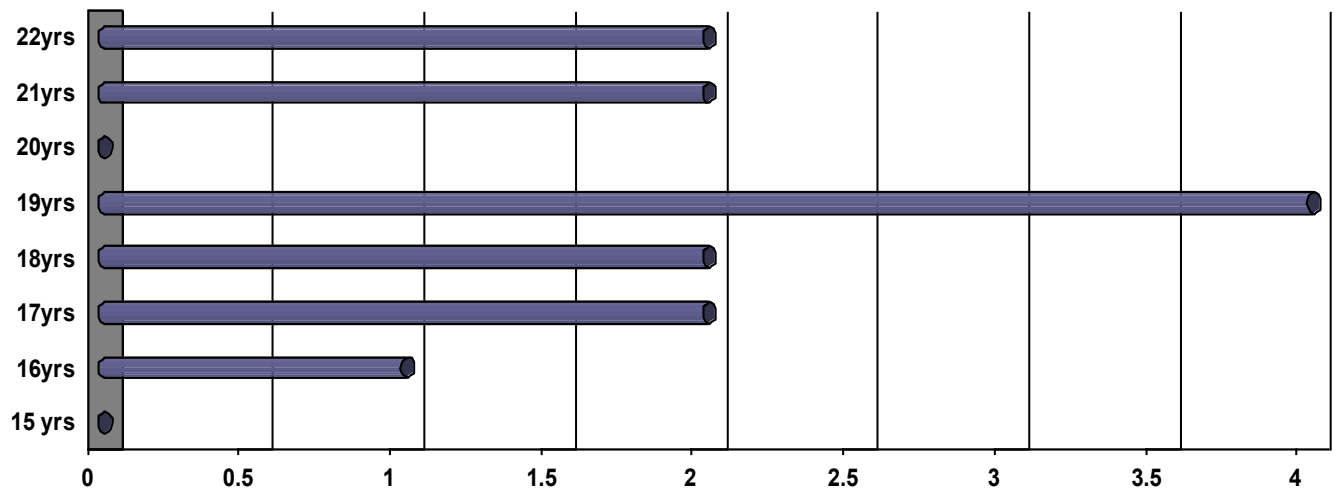
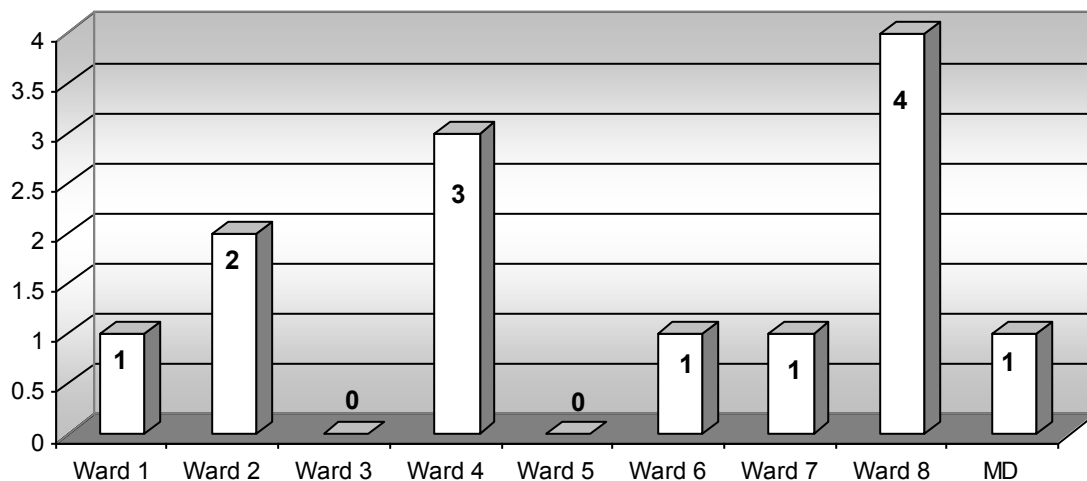


Figure 17: CFRC Juvenile Justice Decedents Ward of Residency



**2009 Child Fatality Review Committee Annual Report
Juvenile Justice Fatality Data**

Cause and Manner of Death

- ♦ All of the 2009 CFRC Juvenile Justice decedents were victims of Homicide.
- ♦ All of the CFRC juvenile justice decedents died as a result of gun violence. Access to guns continues to be the leading risk factor of CFRC juvenile justice related fatalities.

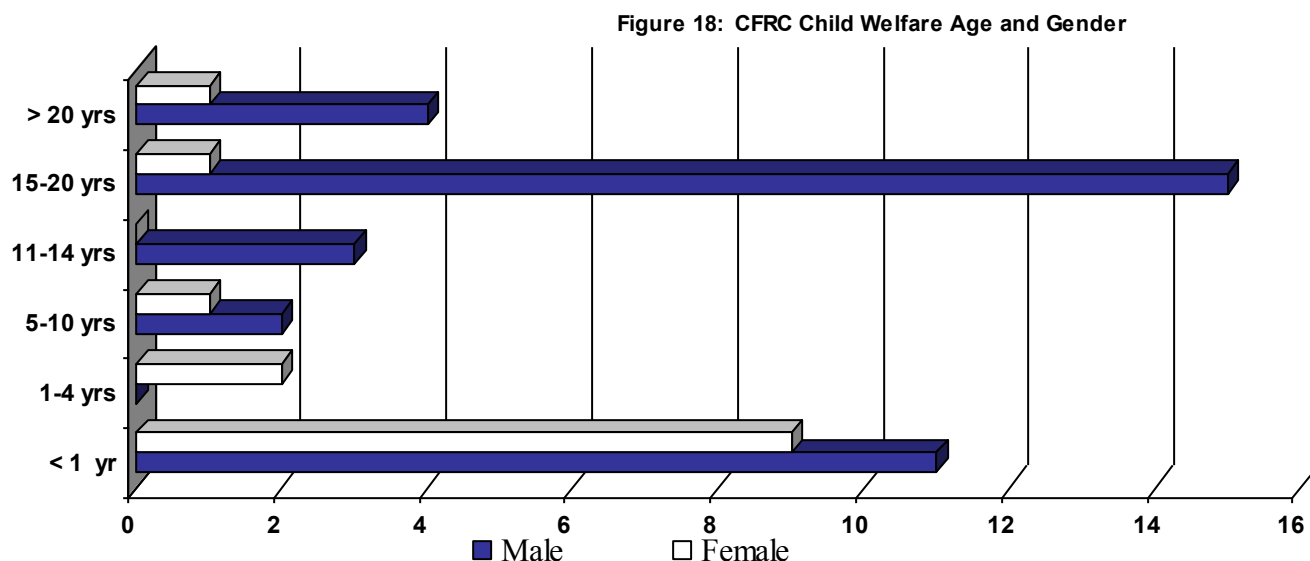
Social/Economic Issues Observed Among Juvenile Justice Decedents

- ♦ Ten 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.
- ♦ Eight of youth exhibited poor school performance and truancy.
- ♦ Six of the youth had mental health diagnosis, including dual diagnoses such as depression and cannabis dependency.
- ♦ Seven of the youth were co-involved with child welfare and juvenile justice programs prior to their death.

TABLE 12	
SOCIAL RISK FACTORS ASSOCIATED WITH YOUTH HOMICIDES	
Pre-teen/Teen Substance Abuse	10
Poor School Performance/Truancy	8
Diagnosed Mental Illness	6
Family History of Involvement with Child Welfare Services	7

CHILD WELFARE FATALITY DATA

During 2009, 49 (37%) of the 133 CFRC deaths identified were children and youth known to the District of Columbia's child welfare system within four years prior to their deaths. History of involvement with child welfare is recognized by the National Center for Child Death Review as a risk factor for child death fatalities.



DECEDENT DEMOGRAPHICS

- ◆ Thirty-five of the CFRC child welfare decedents were males, and 14 were females.
- ◆ All of the CFRC child welfare decedents were Black.
- ◆ Infants under age 1 (N=20) and youth between the ages of 15-20 years (N=16) composed the majority of child welfare decedents.
- ◆ Ward 8 had the highest number of CFRC child welfare decedents (N=12), followed by Ward 7 (N=9).

Figure 19: 2009 CFRC Child Welfare Place of Residence

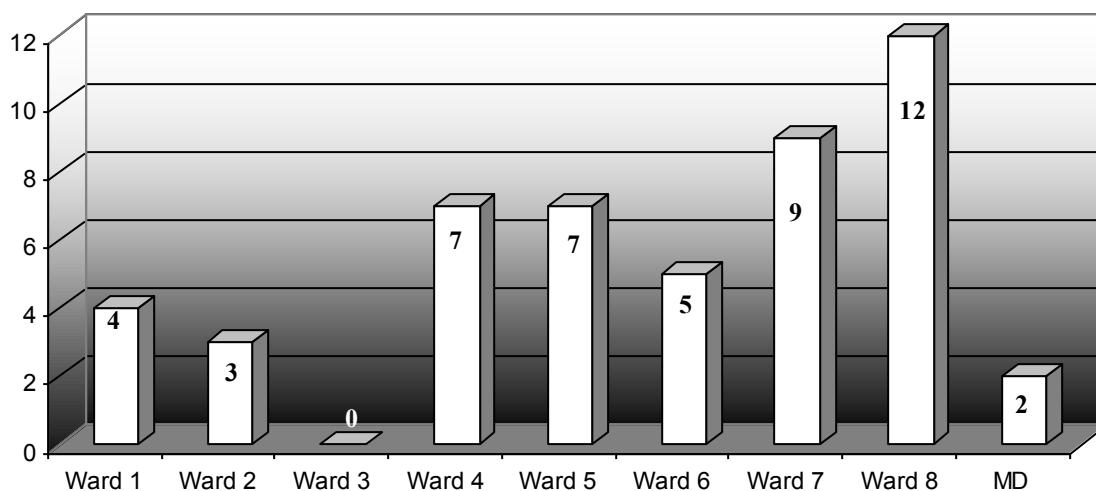
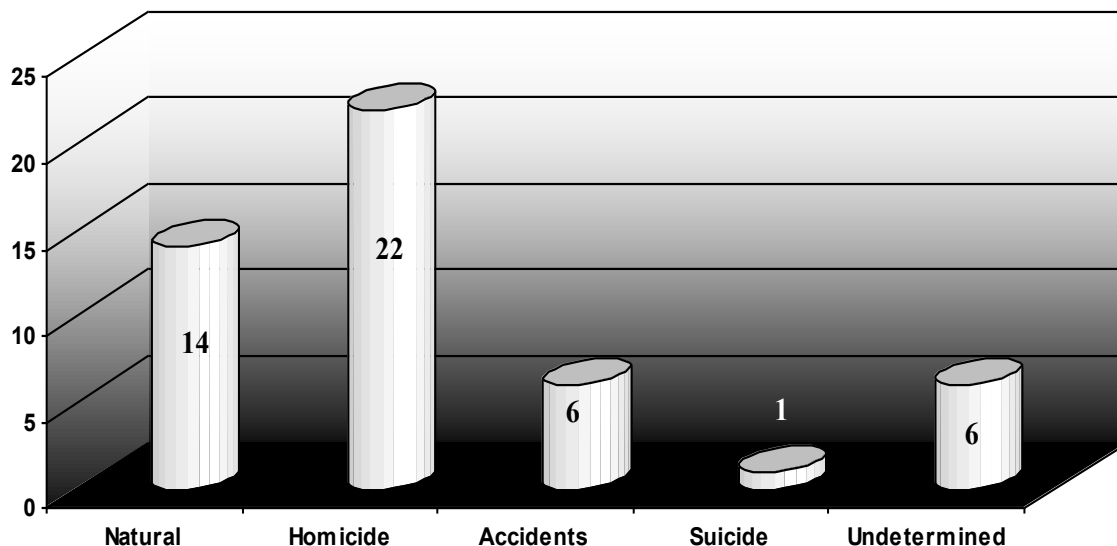


Figure 21: CFRC Child Welfare Manner of Death



Manner of Death for Children known to Child Welfare:

- ◆ Twenty-two of the CFRC child welfare decedents were victims of Homicide. Of the Homicide cases, 4 were victims of fatal abuse.
- ◆ Fourteen of the CFRC child welfare decedents died of natural deaths.
- ◆ Twenty of the CFRC child welfare decedents were infants under the age of one. Among these child welfare cases, Sudden Unexpected Death in Infancy* was the cause of death in 6 decedents.

Dual District Agency Involvement

Of the 21 youth between the ages of 15-23 known to child welfare, 7 (33%) were simultaneously known to the District's juvenile justice system. These youth were victims of Homicide, and all were Black males.

* One infant's cause of death was identified as SIDS by the Maryland Chief Medical Examiner.

APPENDICES

XLVI. CHILD FATALITY REVIEW COMMITTEE

Sec. 4601. Short title.

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

Sec. 4602. Definitions.

For the purposes of this title, 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.

Sec. 4603. Establishment and Purpose.

(a) There is established, as part of the District of Columbia government, a Child Fatality Review Committee. Facilities and other administrative support may be provided in a specific department or through the Committee, as determined by the Mayor.

(b) The Committee shall:

Identify and characterize the scope and nature of child deaths in the jurisdiction, particularly those that are violent, accidental, unexpected or unexplained;

(2) Examine past events and circumstances surrounding child deaths by reviewing the records and other pertinent documents of public and private agencies responsible for serving families and children, investigating deaths, or treating children in an effort to reduce the number of preventable child fatalities and shall give special attention to child deaths that may have been caused by abuse, negligence, or other form of maltreatment;

(3) Develop and revise as necessary operating rules and procedures for the review of child deaths, including identification of cases to be reviewed, coordination among the agencies and professionals involved, and improvement of the identification, data collection, and record keeping of the causes of child death;

(4) Recommend systemic improvements to promote improved and integrated public and private systems serving families and children;

(5) Recommend components for prevention and education programs; and

(6) Recommend training to improve the investigation of child deaths.

Sec. 4604. Composition of the Child Fatality Review Committee.

(a) The Mayor shall appoint a minimum of one representative from appropriate programs providing services to children within the following public agencies:

(1) Department of Human Services;

(2) Department of Health;

(3) Office of the Chief Medical Examiner;

(4) Child and Family Services Agency;

(5) Metropolitan Police Department;

(6) Fire and Emergency Medical Services Department;

(7) D.C. Public Schools;

(8) Department of Housing and Community Development; and

(9) Office of Corporation Counsel

(b) The Mayor shall appoint, or request the designation of, members from federal, judicial, and private agencies and the general public who are knowledgeable in child development, maternal and child health, child abuse and neglect, prevention, intervention, treatment or 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 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.

Sec. 4605. 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, 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.

(b) The Committee may review the deaths of nonresidents if the death is determined to be accidental or unexpected and occur 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 section 4604.

(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.

Sec. 4606. 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 section 20 of the Vital Records Act of 1981, effective October 8, 1981 (D.C. Law 4-34; D.C. Official Code § 7-219); section 512 of the Mentally Retarded Citizens Constitutional Rights and Dignity Act of 1978, effective March 3, 1979 (D.C. Law 2-137; D.C. Official Code § 7-1305.12); section 302 of the District of Columbia Mental Health Information Act of 1978, effective March 3, 1979 (D.C. Law 2-136; D.C. Official Code § 7-1203.02); section 203 of the Prevention of Child Abuse and Neglect Act of 1977, effective September 23, 1977 (D.C. Law 2-22; D.C. Official Code § 4-1302.03); section 306 of the Prevention of Child Abuse and Neglect Act of 1977, effective October 18, 1979 (DC Law 3-29; D.C. Official Code § 4-1303.06); section 28 of the Health Maintenance Organization Act of 1996, effective April 9, 1997 (D.C. Law 11-235; D.C. Official Code § 31-3426); and D.C. Official Code §§ 16-2331, 16-2332, 16-2333, and 16-2335.

(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, as 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.

Sec. 4607. 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.

Sec. 4608. Confidentiality of Proceedings.

(a) Proceedings of the Committee shall be closed to the public and shall not be subject to section 742 of the District of Columbia Home Rule Act, approved December 24, 1973 (87 Stat. 831; D.C. Official Code § 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 provider 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.

Sec. 4609. 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 Title II of the District of Columbia Administrative Procedure Act, effective March 29, 1977 (D.C. Law 1-96; D.C. Official Code § 2-531 et seq.), 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 title.

(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 section 4605(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 sections 4607 and 4608. 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 Title XIV A of the District of Columbia Government Comprehensive Merit Personnel Act of 1978, effective May 16, 1995 (D.C. Law 11-16; D.C. Official Code § 1-614.11 et seq.).

Sec.4610. 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 act shall have immunity from liability, administrative, civil, or of the information.

Sec. 4611. 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 act shall be subject to a fine of not more than \$1,000. Violations of this act 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.

Sec. 4612. Persons Required to Make Reports; Procedure.

(a) Notwithstanding, but in addition to, the provisions of any law, including D.C. Official Code § 14-307 and the District of Columbia Mental Health Information Act of 1978, effective March 3, 1979 (D.C. Law 2-136; D.C. Official Code § 7-1201.01 et seq.), 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 the District of Columbia Health Occupations Revision Act of 1985, effective March 25, 1986 (D.C. Law'6-99; D.C. Official Code § 3-1201.01 et seq.), 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.

Sec.4613. Immunity from Liability for Making Reports.

Any person, hospital, or institution participating in good faith in the making of a report pursuant to this act 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.

Sec. 4614. Failure to Make Report.

Any person required to make a report under section 4612 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 section 4612 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.

Sec.4615. Section 20 of the Vital Records Act of 1981, effective October 8, 1981 (D.C. Law 4-34; D.C. Official Code § 7-219), is amended by adding a new subsection (d) to read as follows:

"(d) Notwithstanding the provisions of this section, the Registrar shall provide reports of deaths of children 18 years of age or younger who either received or were eligible to receive certificates of live birth, as defined by section 2(9), to the Child Fatality Review Committee pursuant to section 4612 of the Child Fatality Review Committee Establishment Act of 2001, passed on 2nd reading on June 5, 2001 (Enrolled version of Bill 14-144)". .

Sec. 4616. Section 302 of the District of Columbia Mental Health Information Act of 1978, effective March 3, 1979 (D.C. Law 2-136; D.C. Official Code § 7-1203.02), is amended by striking the period at the end and inserting the phrase ", including section 4612 of the Child Fatality Review Committee Establishment Act of 2001, passed on 2nd reading on June 5, 2001 (Enrolled version of Bill 14-144)." in its place.

Sec. 4617. Section 203 (a) of the Prevention of Child Abuse and Neglect Act of 1971, effective September 23, 1977 (D.C. Law 2-22; D.C. Official Code § 4-1302.03(a)), is amended as follows:

(a) Paragraph (6) is amended by striking the word "and" at the end.

(b) Paragraph (7) is amended by striking the period at the end and inserting the phrase "; and" in its place.

(c) A new paragraph (8) is added to read as follows:

"(8) The Child Fatality Review Committee, for the purpose of examining past events and circumstances surrounding child deaths in the District of Columbia and deaths of children who were either residents or wards of the District of Columbia in an effort to reduce the number of preventable child deaths, especially those deaths attributable to child abuse and neglect and other forms of maltreatment. The Child Fatality Review Committee shall be granted, upon request, access to information contained in the files maintained on any deceased child or on the parent, guardian, custodian, kinship caregiver, day-to-day caregiver, relative/godparent caregiver, or sibling of a deceased child."

Sec. 4618. Section 306(a) of the Prevention of Child Abuse and Neglect Act of 1977, effective October 18, 1979 (D.C. Law 3-29; D.C. Official Code § 4-1203.06 (a)), is amended by striking the period at the end and inserting the phrase, ", or the investigation or review of child fatalities by representatives of the Child Fatality Review Committee, established pursuant to section 4603 of the Child Fatality Review Committee Establishment Act of 2001, passed on 2nd reading on June 5, 2001 (Enrolled version of Bill 14-144)." in its place.

Sec. 4619. The Fiscal Year 2001 Budget Support Act of 2000, effective October 19, 2000 (D.C. Law 13-172; 47 OCR 6308), is amended as follows:

(a) Section 2905 is amended by adding new subsections (c) and (d) to read as follows:

"(c) The CME shall inform the Registrar of Vital Records of all deaths of children 18 years of age or younger as soon as practicable, but in any event within 5 business days.

"(d) The CME or his or her designee, shall attend all reviews of child deaths by the Child Fatality Review Committee. The CME shall coordinate with the Child Fatality Review Committee in its investigations of child deaths."

(b) Section 2906(b X2) is amended by adding the phrase "for infants one year of age and younger" before the semicolon.

(c) Section 29J3(b) is amended by striking the word "official" and inserting the phrase "official, and the Child Fatality Review Committee when necessary for the discharge of its official duties" in its place.

Sec. 4620. Title 16 of the District of Columbia Official Code is amended as follows:

(a) Section 16-311 is amended by adding after the phrase "promoted and protected." the sentence "Such records and papers shall, upon written application to the court, be unsealed and provided to the child fatality review committee for inspection if the adoptee is deceased and inspection of the records and papers is necessary for the discharge of the Committee's official duties."

(b) Section 16-2331(b) is amended as follows:

(1) Paragraph (8) is amended by striking the word "and" at the end.

(2) Paragraph (9) is amended by striking the period and inserting the phrase " and" in its place.

(3) A new paragraph (10) is added to read as follows:

"(10) The Child Fatality Review Committee for the purposes of examining past events and circumstances surrounding deaths of children in the District of Columbia or of children who are either residents or wards of the District of Columbia, or for the discharge of its official duties".

(c) Section 16-2332(b) is amended as follows:

(1) Paragraph (4) is amended by striking the word "and" at the end.

(2) Paragraph (5) is amended by striking the period at the end and inserting a semicolon in its place.

(3) Paragraph (6) is amended by striking the period at the end and inserting the phrase "; and" in its place.

(4) A new paragraph (7) is added to read as follows:

"(7) The Child Fatality Review Committee for the purposes of examining past events and circumstances surrounding deaths of children in the District of Columbia or of, children who are either residents or wards of the District of Columbia, or for the discharge of its official duties."

(d) Section 16-2333(b) is amended as follows:

(1) Paragraph (6) is amended by striking the word "and" at the end.

(2) Paragraph (7) is amended by striking the word "and" at the end.

(3) Paragraph (8) is amended by striking the period at the end and inserting the phrase "; and" in its place.

(4) A new paragraph (9) is added to read as follows:

"(9) The Child Fatality Review Committee when necessary for the discharge of its official duties."

(e) Section 16-2335(d) is amended by adding after the phrase "in the records to" the phrase "the Child Fatality Review Committee, where necessary for the discharge of its official duties, and".

Sec. 4621. Fiscal Impact Statement.

The Fiscal Year 2002 Budget and Financial Plan provides \$296,000 in local funds to support the Child Fatality Review Committee.



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.





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