

# DISTRICT OF COLUMBIA CHILD FATALITY REVIEW COMMITTEE

## 2010 ANNUAL REPORT



Vincent Gray, Mayor  
District of Columbia Government

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**DISTRICT OF COLUMBIA  
CHILD FATALITY REVIEW COMMITTEE**

**2010 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

MAY 2013



# 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 a better quality of life for all residents.

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# EXECUTIVE SUMMARY

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The District of Columbia Child Fatality Review Committee (CFRC) is pleased to present its 15th Annual Report. This Report covers data from the 122 child/youth fatalities that qualified for review by the Committee in 2010.

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 examinations of the circumstances contributing to the deaths of infants, children and youth who were residents or committed to the District of Columbia. The primary goals of the District's child death review process are to: 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. The primary agencies that report child deaths to the Committee are: the Department of Health (DOH), the Office of the Chief Medical Examiner (OCME), Child and Family Services Agency (CFSA), Department of Youth Rehabilitative Services (DYRS), and the Metropolitan Police Department (MPD).

## KEY CHILD FATALITY REVIEW DATA FINDINGS

### DECEDENT DEMOGRAPHICS

- ◆ The age of the 2010 decedents reviewed by the CFRC ranges from birth through 24 years. Seventy of the 122 decedents reviewed were infants.
- ◆ Ninety percent of the decedents were of the Black race.
- ◆ Fifty-three percent of the decedents were males.
- ◆ Ward 8 and Ward 4 had the highest percentages of CFRC child fatalities with 24% from Ward 8 and 21% from Ward 4.

### MANNERS OF DEATH

#### Natural Deaths

There were 77 deaths resulting from natural causes during the 2010 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 2010, a total of 33 child/youth fatalities were the result of violent acts. Of these, six children were victims of "Fatal Abuse". In these cases, the suspected perpetrator was either a parent or a caregiver of the child. One death resulted from an act of suicide.

#### Accidental Deaths

There were three accidental deaths involving children and youth in 2010. The circumstances leading to the accidental deaths were as follows:

- ◆ Asphyxia (1)
- ◆ Motor Vehicle Accident(1)
- ◆ Drowning (1)

#### Undetermined Deaths

In 2010, the deaths of seven infants and one child were deemed Undetermined; five of these deaths were attributed to Sudden Unexplained Death in Infancy (SUDI).

**2010 Child Fatality Review Committee Annual Report**  
**Executive Summary**

## CFRC 2010 Recommendations

The following are recommendations developed by the Child Fatality Review Committee and adopted by the CFRC Recommendations Subcommittee to address improvements in systems and/or program initiatives with the purpose of improving outcomes for the District's children, youth and families.

Manner of Death	Area of Focus	Recommendation	Response
<b>Natural Fatalities/ Infant Mortality</b> (57% of CFRC Cases)	<b>Agency Policy and Practice</b>	The Department of Health Care Finance should require that the Psycho-social Evaluation section of the Maternal and Infant Assessment of Need screening tool be completed by hospital/clinic staff during the initial prenatal visit. This will ensure that the mother will receive the appropriate social/community based services to allow the best possible home environment for the newborn infant.	<b>The Agency Agreed with Modifications</b> <b>See Page 10</b>
		The Department of Health Care Finance should utilize an approved instrument such as the Edinburgh Depression Assessment Tool to evaluate prenatal/postpartum depression as a part of the Maternal and Infant Assessment of Need.	
<b>Suicide Fatalities</b> (1% of CFRC Cases)	<b>Agency Policy and Practice</b>	The Department of Mental Health should provide mandated reporter training to the agency's contractors that provide community based mental health services to children and incorporate mandated reporter training to all new employees that provide mental health services.	<b>The Agency Agreed with Modifications</b> <b>See Page 18</b>
<b>Homicides</b> (27% of CFRC Cases)	<b>Agency Policy and Practice</b>	<p>The Department of Youth Rehabilitative Services should develop protocols for transitioning youth with significant criminal histories and mental health needs to the community. The transition plan should include intensive monitoring and cooperative parental supervision. This may include the following:</p> <p>(1)Require the completion of the Community Release Contract with the DYRS representative, community based monitor and parents/caretakers, prior to the youth's return to the community.</p> <p>(2)Train direct service staff to conduct internal Quality Service Reviews which will serve to improve the quality of services provided to youth involved with DYRS</p>	<b>The Agency Agreed with Modifications</b> <b>See Page 15</b>

### INTRODUCTION

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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 is divided into two teams; the Infant Mortality Review (IMR) Team and the Child Fatality Review Team. The IMR team reviews the deaths of District infants from birth through age 12 months. The Child Fatality Review Team reviews the deaths of District children from ages 1 through 18 years, and youth older than 18 who were known to the child welfare and juvenile justice programs. 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.

In accordance with DC Official Code §4-1371.04 et. seq, 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 122 child/youth fatalities that occurred during the 2010 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 decedents known to the child welfare and juvenile justice systems.

## SECTION I: SUMMARY OF CASE FINDINGS

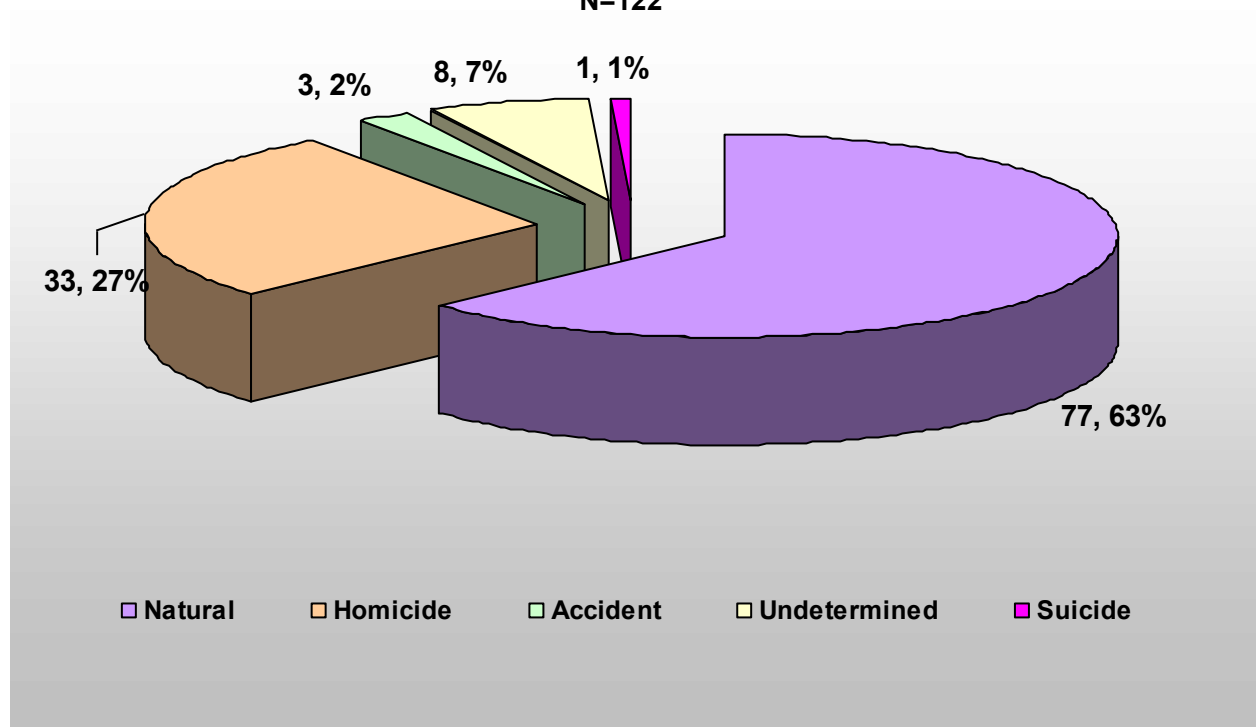
### CAUSE AND MANNER OF 2010 FATALITIES

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 2010, the leading manner of death for children/youth in the District of Columbia was Natural at 77, followed by Homicides at 33 fatalities. Five of the eight Undetermined deaths reviewed by the CFRC had a Cause of Death certified as Sudden Unexpected Death in Infancy (SUDI). There were three Accidental deaths and one Suicide of a District youth.

**Figure 1: 2010 CFRC Decedents Manner of Death**  
N=122



## DECEDENT DEMOGRAPHICS BY MANNER OF DEATH

The CFRC reviewed 122 child/youth deaths in 2010. The decedents ages ranged from birth through 24 years. Although there was a 5% decrease in the number of natural deaths reviewed between 2009 and 2010, the natural death of infants and the homicide of school age children/youth continue to be the majority of child/youth fatalities by the Child Fatality Review Commit-

Figure 2: Two Year Comparison of CFRC Decedent's Manners of Death

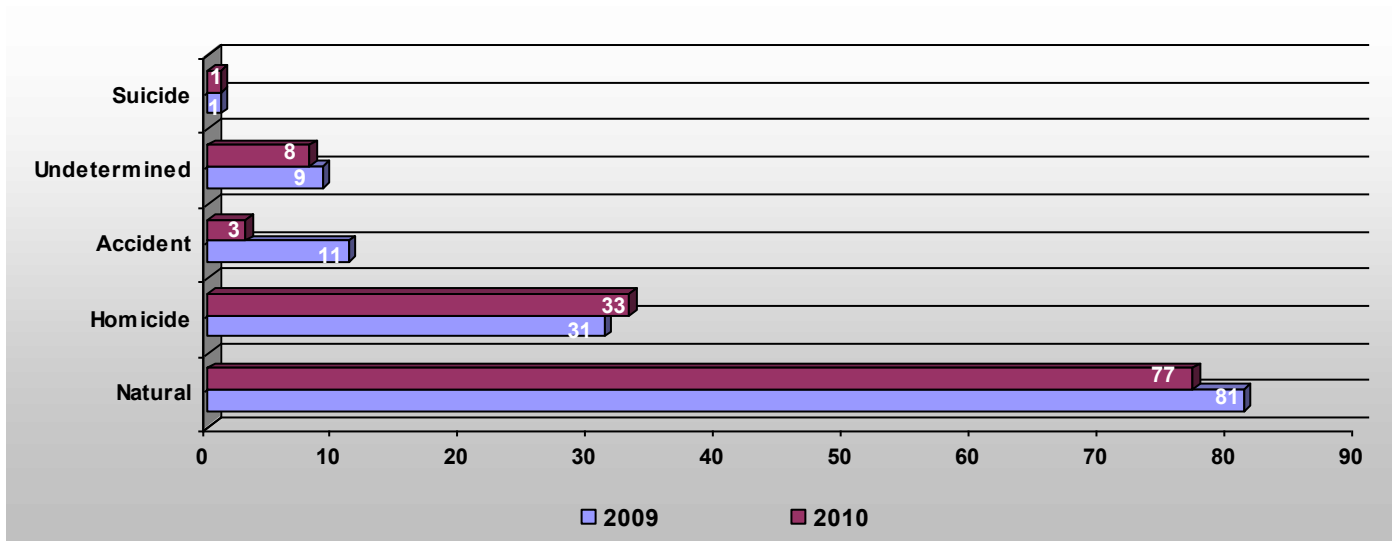
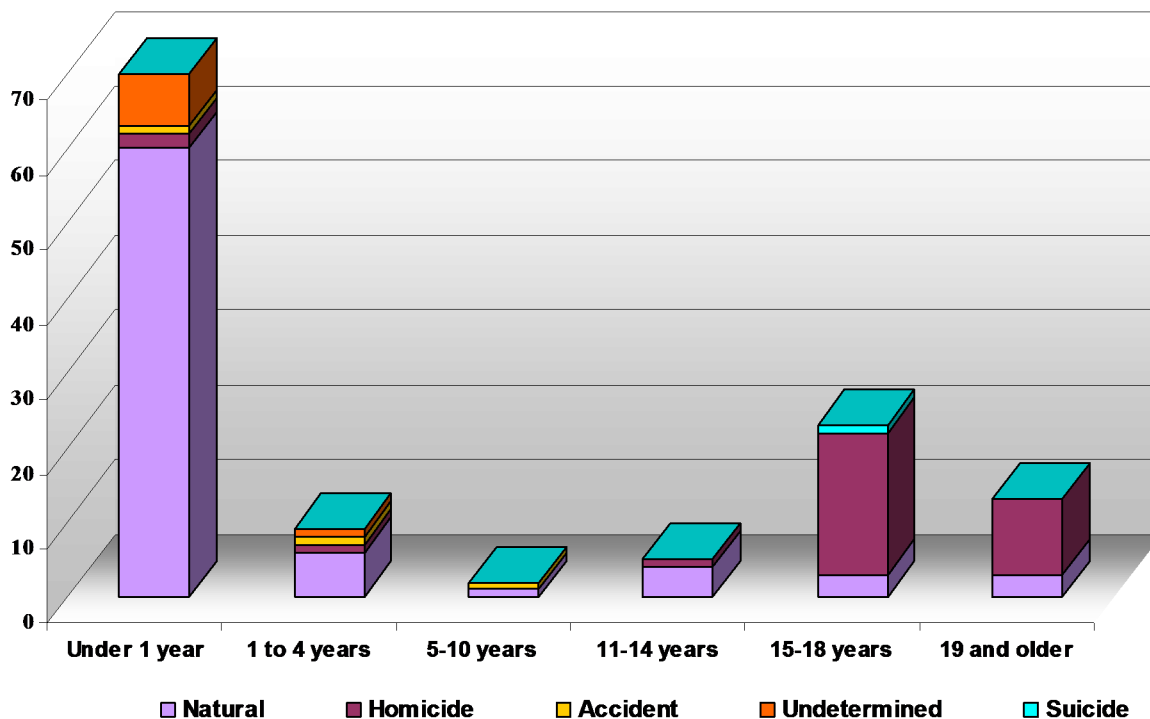


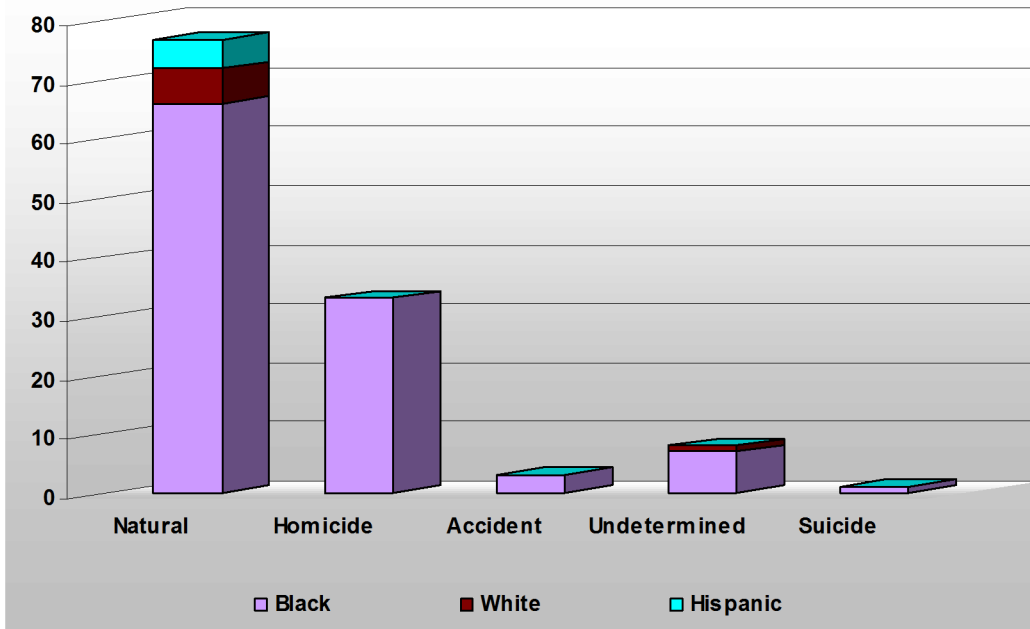
Figure 3: 2010 Age of Decedent by Manner of Death  
N=122



## RACE AND GENDER BY MANNER OF DEATH

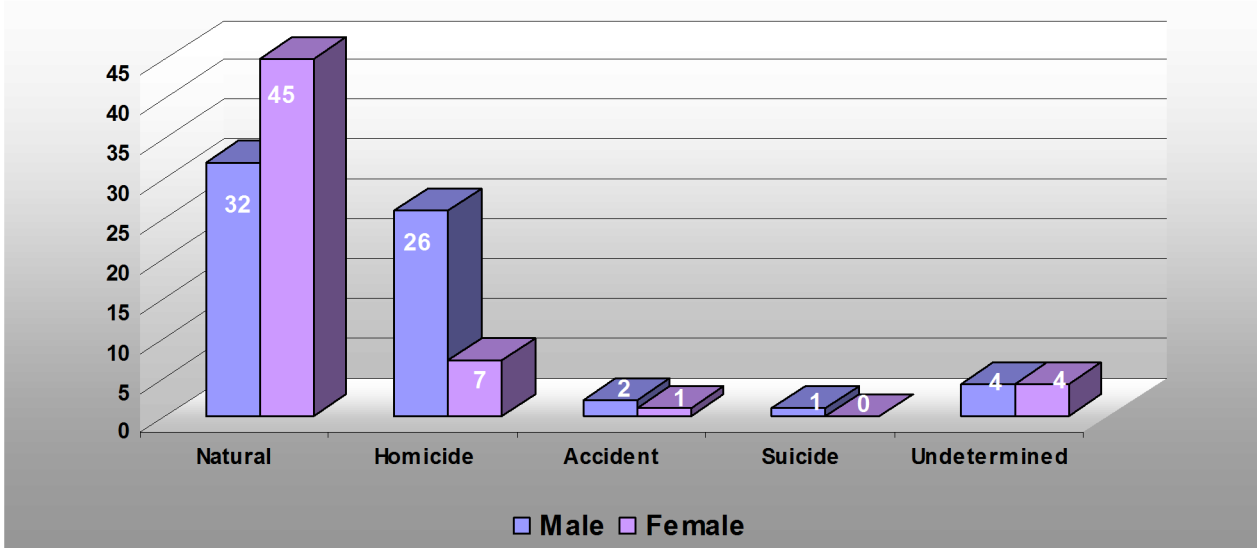
As Figure 4 illustrates, Black children/youth represented 90% of the total CFRC decedent population, with leading representation in all manners of death.

Figure 4: 2010 Race by Manner of Death  
N=122



As illustrated in Figure 5, male decedents represented the largest proportion of the children/youth population in all manners of death totaling 53% of the 122 decedents.

Figure 5: Gender by Manner of Death  
N=122



## 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, 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 of cases reviewed in 2010 with 24% followed by Ward 4 with 21%. Ward 3 had the least, with only one fatality meeting the criteria for CFRC review. Two decedents, both wards of the District's child welfare system, died outside of the District of Columbia.

Figure 6: Decedent Ward of Residency  
N=122

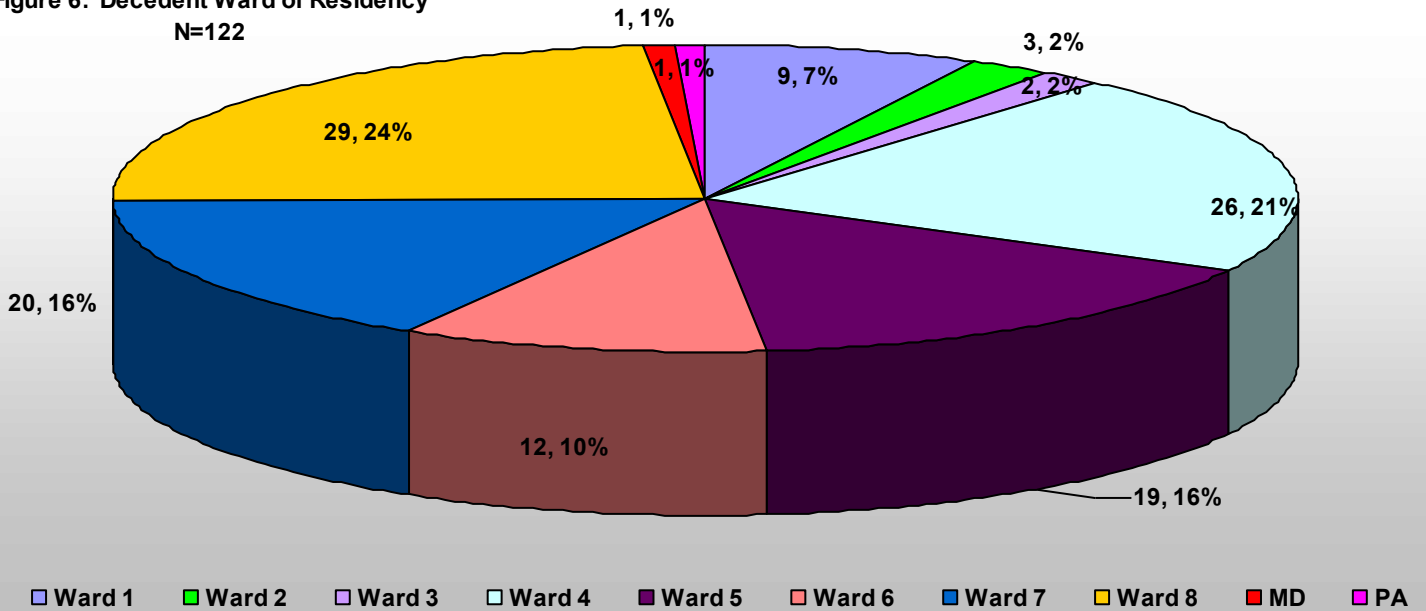
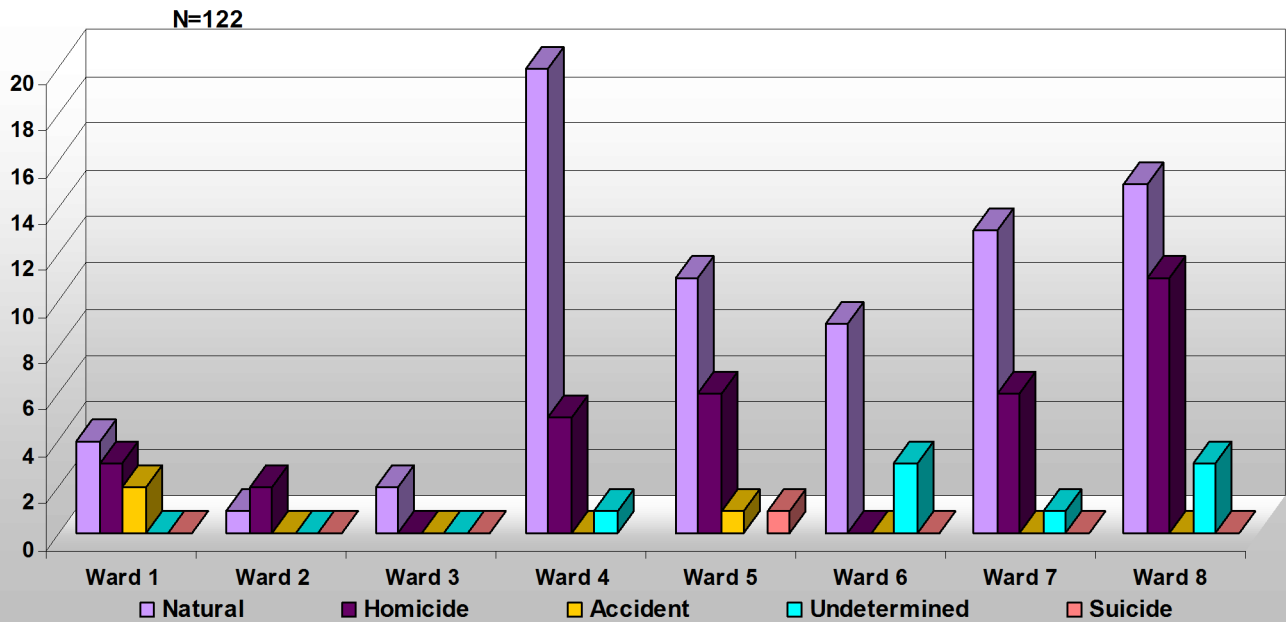


Figure 7: Decedent Ward of Residence by Manner of Death  
N=122



## Natural Deaths of Infants and Children

In 2010, 77 (63%) of the 122 CFRC children/youth fatalities resulted from pre-existing or underlying medical conditions. Of these cases, 78% (N=60) involved infants whose deaths were reviewed by the Infant Mortality Review Team.

### Deaths Related to Premature Births

TABLE 1	
Deaths related to Premature Birth	
Cause of Death	Number of deaths
Unknown Etiology	20
Chorioamnionitis	6
Premature Rupture of Membrane	5
Incompetent Cervix	2
Placental Abruption	2
Pre-Term Labor	5
Maternal Hypertension	1
Fetal Anomaly	1
<b>Total</b>	<b>42</b>

## Natural Deaths of Infant and Children

TABLE 2	
Infant Deaths Unrelated to Prematurity	
Cause of Death	Number of Deaths
Congenital Anomalies	13
Infection	3
Peripartum Complications	1
Cardiovascular	1
<b>Total</b>	<b>18</b>

## Natural Causes of Death in Children

As indicated in Table 3, seventeen of the Natural deaths were of children and youth between the ages of 1 and 24. The leading causes of death among these decedents was Congenital Anomaly and Respiratory Infection.

TABLE 3	
Natural Causes of Death—Children Age 1 year and Older	
Cause of Death	Number of Deaths
Cancer	2
Respiratory Infection	5
Sepsis	1
Congenital Anomaly	5
Hematological Disorder	3
AIDS	1
<b>Total</b>	<b>17</b>

## **Maternal Risk Factors**

The Infant Mortality Review (IMR) team reviewed a total of 60 cases involving infant fatalities in 2010. The following are maternal risk factors observed by the IMR team that are associated with the infant fatality.

### **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 IMR Team did not review preconception data but focused on timeliness of the initial prenatal visit and subsequent routine visits. Based on these two parameters, the IMR Team concluded that inadequate prenatal care was a factor in 21 of the 60 infant cases reviewed.

### **Premature Rupture of Membranes**

Premature rupture of fetal membranes before 28 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 60 cases reviewed, 28 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 29 of the 60 cases reviewed.

### **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 30 of the 60 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 17 of the 60 cases.

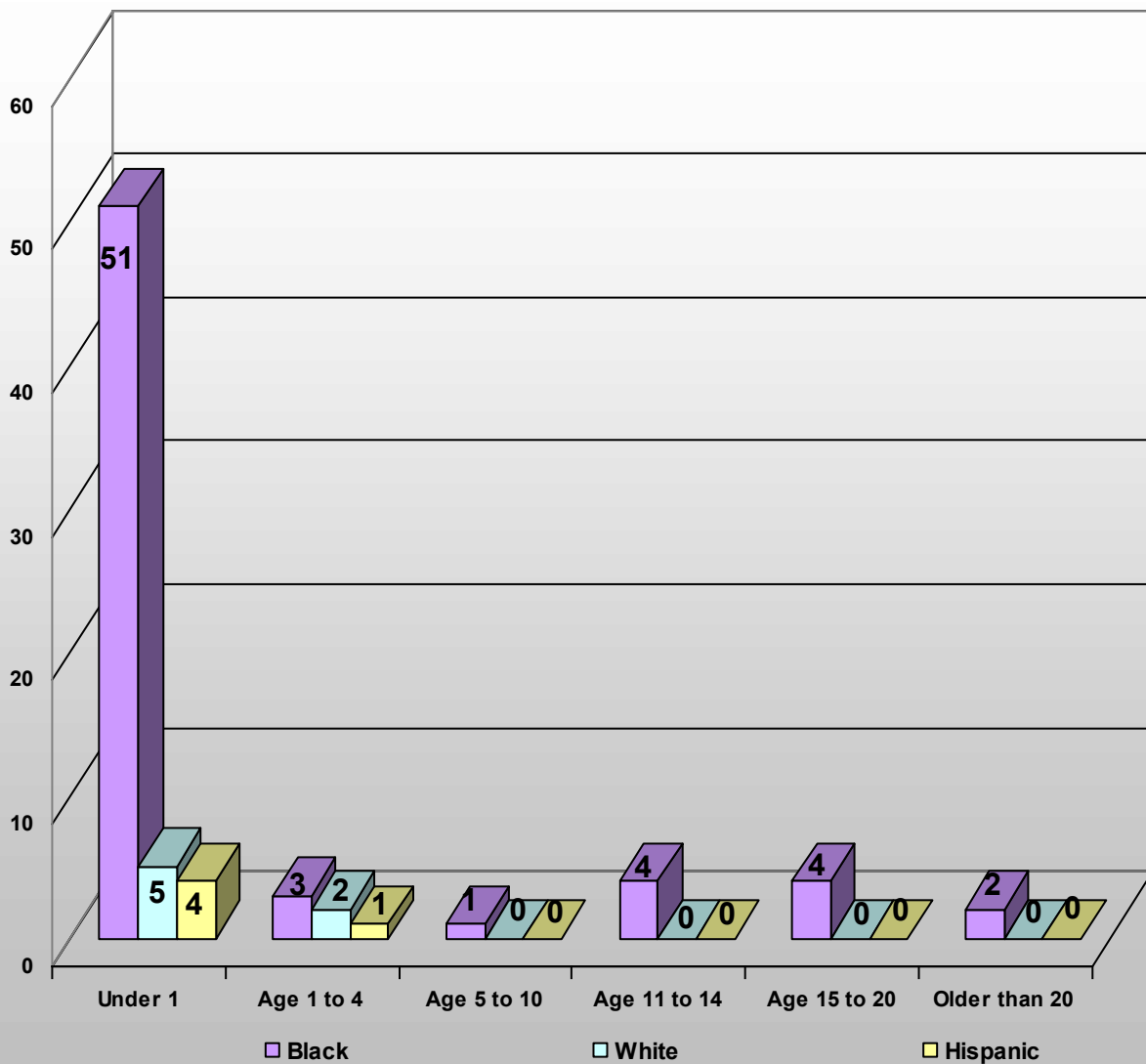
### **Social Risk Factors**

Maternal history of sexually transmitted diseases, illicit substance and alcohol abuse, and cigarette Smoking are social risk factors that can contribute to the premature birth of the infant. These social risk factors were present in 30 of the 60 infant cases reviewed.

## Race and Age of Natural CFRC Decedents

Of the 77 Natural death cases reviewed by the CFRC, 51 were Black infants. Black children had the highest number of natural deaths of CFRC decedents in all age categories (65), followed by White children (7) and Hispanic children (5).

Figure 8: Race and Age of Natural Decedents  
N=77



## CFRC Recommendations for Natural Fatalities

The Committee developed the following recommendation to address the hospital discharge planning process and the physician's identification of post-partum depression in women.

**Recommendation:** The Department of Health Care Finance should require that the Psychosocial Evaluation section of the Maternal and Infant Assessment of Need screening tool be completed by hospital/clinic staff during the initial prenatal visit. This will ensure that the mother will receive the appropriate social/community based services to allow the best possible home environment for the newborn infant.

**Response:** "The Department of Health Care Finance (DHCF) agreed with the recommendation. DHCF will require Managed Care Organizations (MCOs) to require perinatal providers to complete and submit the Psychosocial Evaluation section of the Maternal and Infant Assessment of Need screening tool during the initial prenatal visit. January 1, 2011 is targeted implementation date. DHCF has solicited recommendations for improved formatting and use of the form to make it easier for providers to use and to use at different trimesters. DHCF has completed an analysis of the use of the forms to determine the extent to which forms are fully completed and whether the second page was completed. Results were presented at the September Collaborative meeting. At this meeting, DHCF stated its intent to mandate the use of the second page. Use of Psychosocial Evaluation section will be routinely used beginning on January 1, 2011. Expectation is that MCOs will follow-up on identified risk factors. It is the expectation that this will lead to a reduction in adverse perinatal outcomes defined by Perinatal Collaborative measures."

**Recommendation:** "The Department of Health Care Finance should utilize an approved instrument such as the Edinburgh Depression Assessment Tool to evaluate prenatal/postpartum depression as a part of the Maternal and Infant Assessment of Need."

**Response:** "The Department of Health Care Finance agreed with this recommendation, however, no further is needed. The screening for depression is already incorporated into the Maternal and Infant Assessment of Need."

## Homicides

In 2010, 33 of the 122 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.

Figure 9: 2010 Age of Homicide Decedents  
N=33

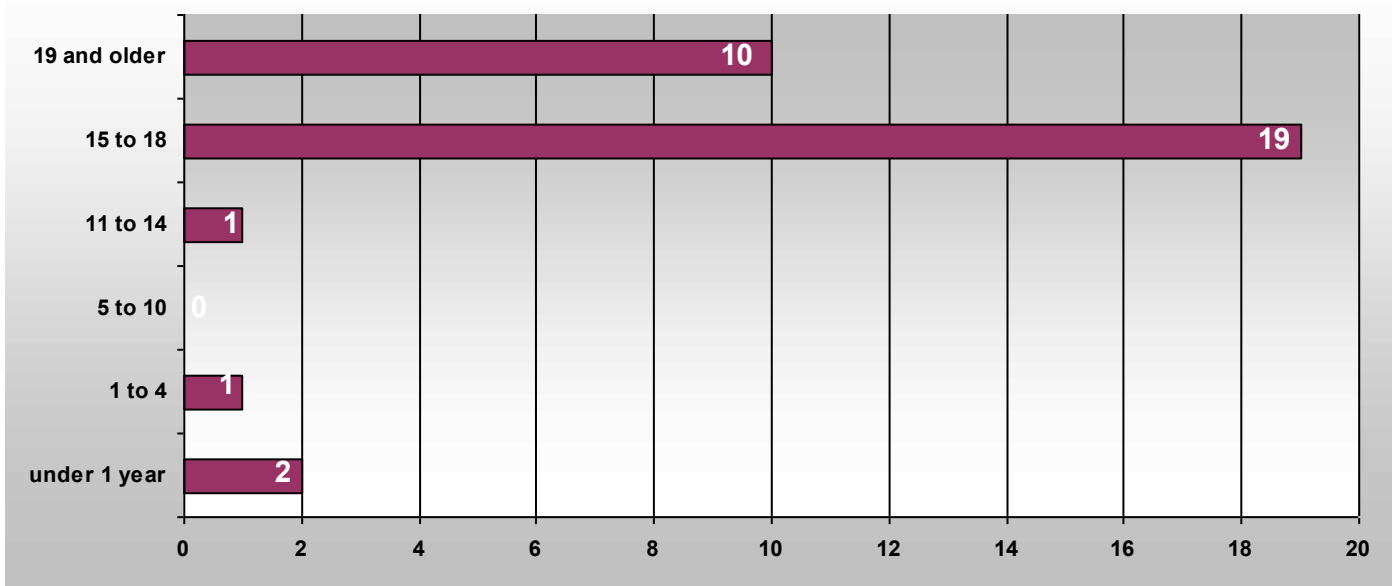
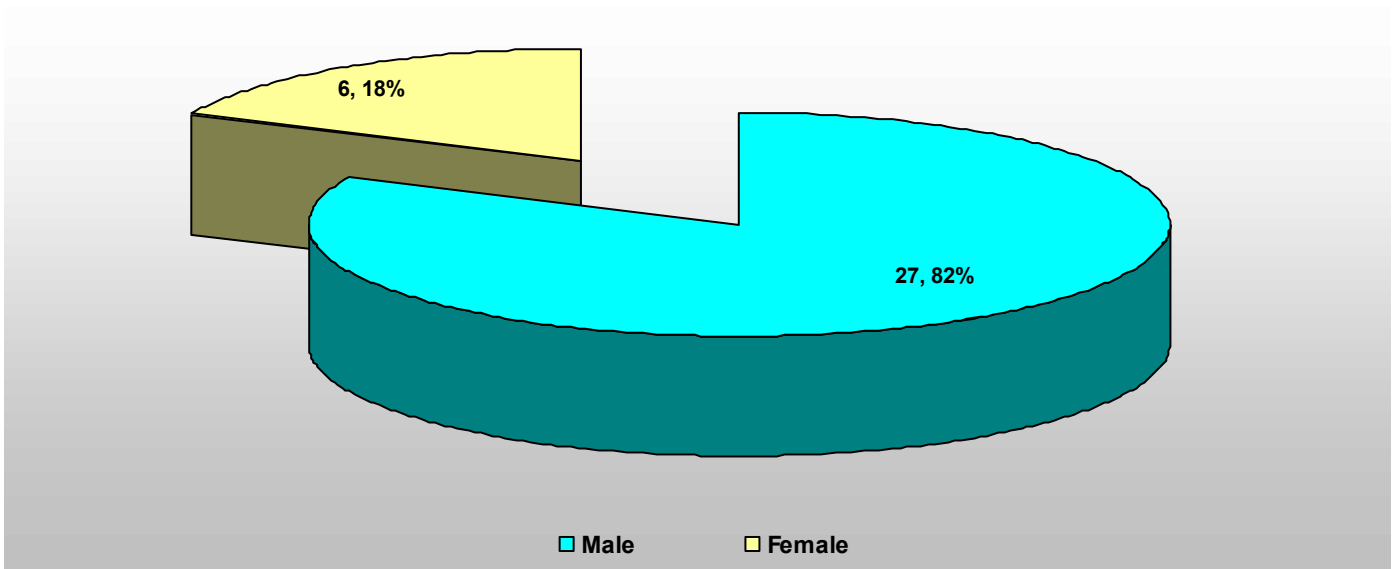


Figure 10: Gender of CFRC Homicide Victims N=33

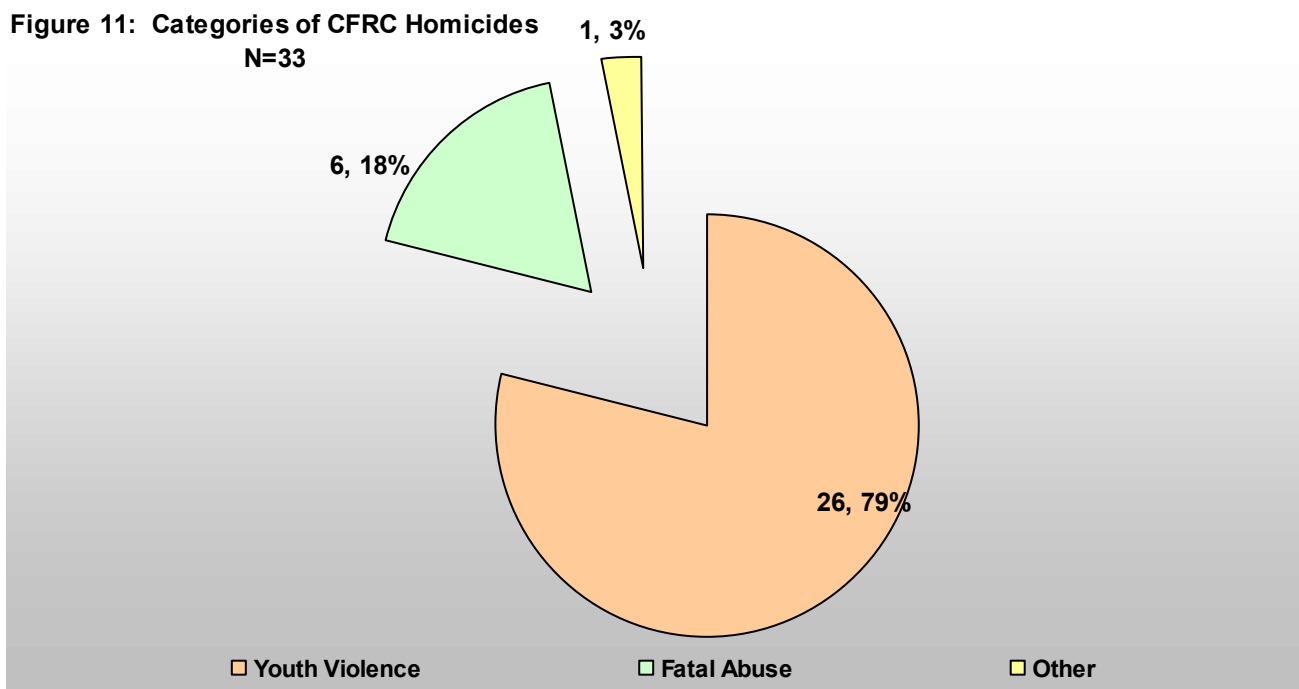


## Homicides

- ♦ In 2010, Homicides were the leading cause of death for youth ages 15 and older.
- ♦ Twenty-seven of the 33 CFRC Homicide victims were male.
- ♦ All of the CFRC Homicide victims were Black.
- ♦ Youth violence related homicides account for 27 of the 2010 CFRC Homicides

Figure 11: Categories of CFRC Homicides

N=33



## Fatal Abuse

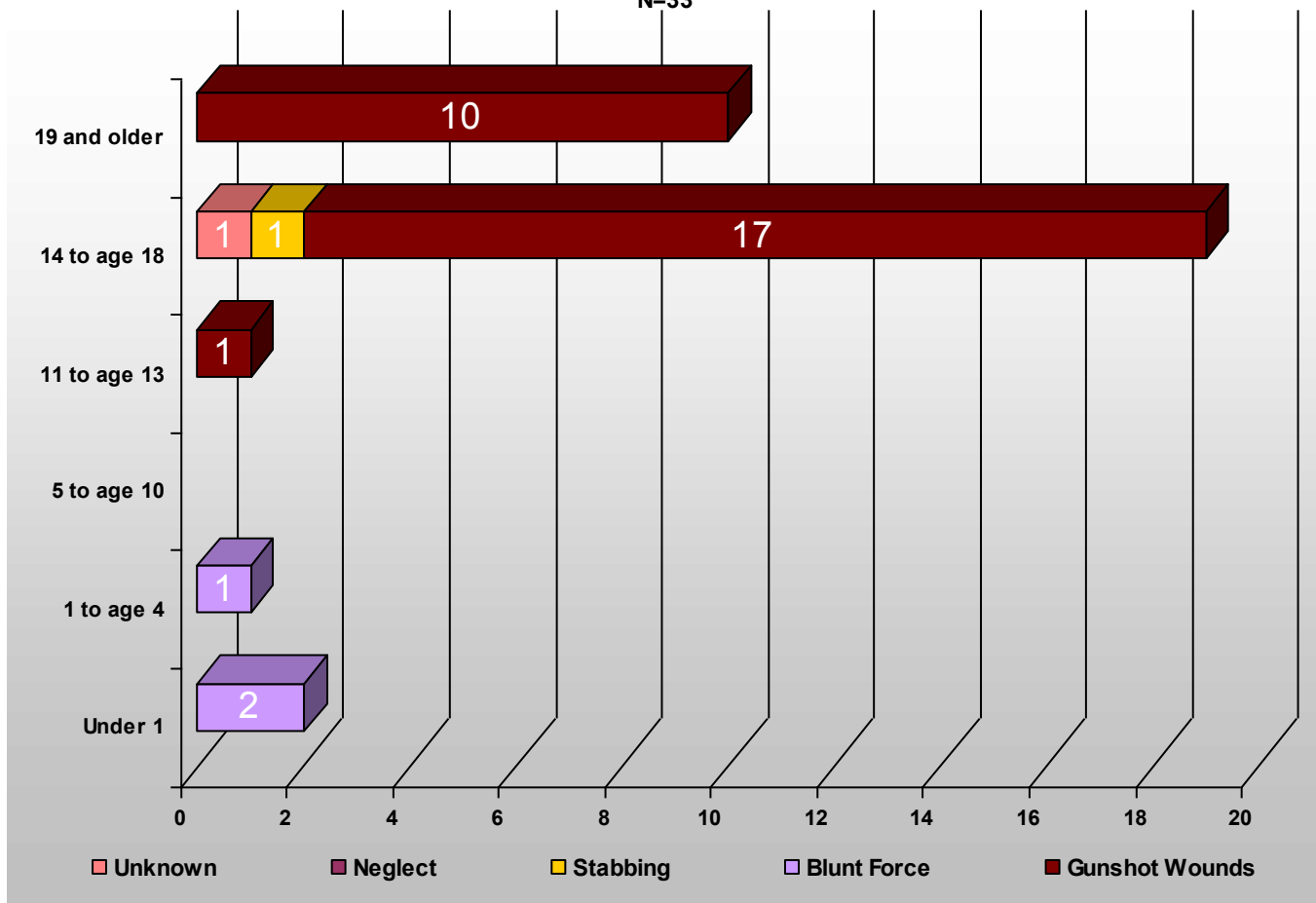
- ♦ In 2010, six of the thirty-three Homicide fatalities were the result of fatal abuse. In two of these cases, the family history of domestic violence was a risk factor associated with the death.
- ♦ Five of the six fatal abuse victims were known to the District's child welfare agency preceding their deaths.
- ♦ All of the fatal abuse victims were Black. Four of the six fatal abuse victims were female.

## Methods and Motives of CFRC Homicide Cases

Gun violence continues to be the leading method of homicide among CFRC decedents. Eighty-five percent of the CFRC decedents, all youth between the ages 11 and older, died as a result of gun violence. Of the young homicide victims ages 4 and younger, the leading cause of homicide was blunt force. Access to guns is the leading risk factor associated with child/youth related homicides of the CFRC decedents. Retaliation is the leading motive for homicides. Domestic issues and Disputes both are the second leading motives for homicides as confirmed in eight of the cases.

Figure 12: Method of Homicide by Age of Decedent

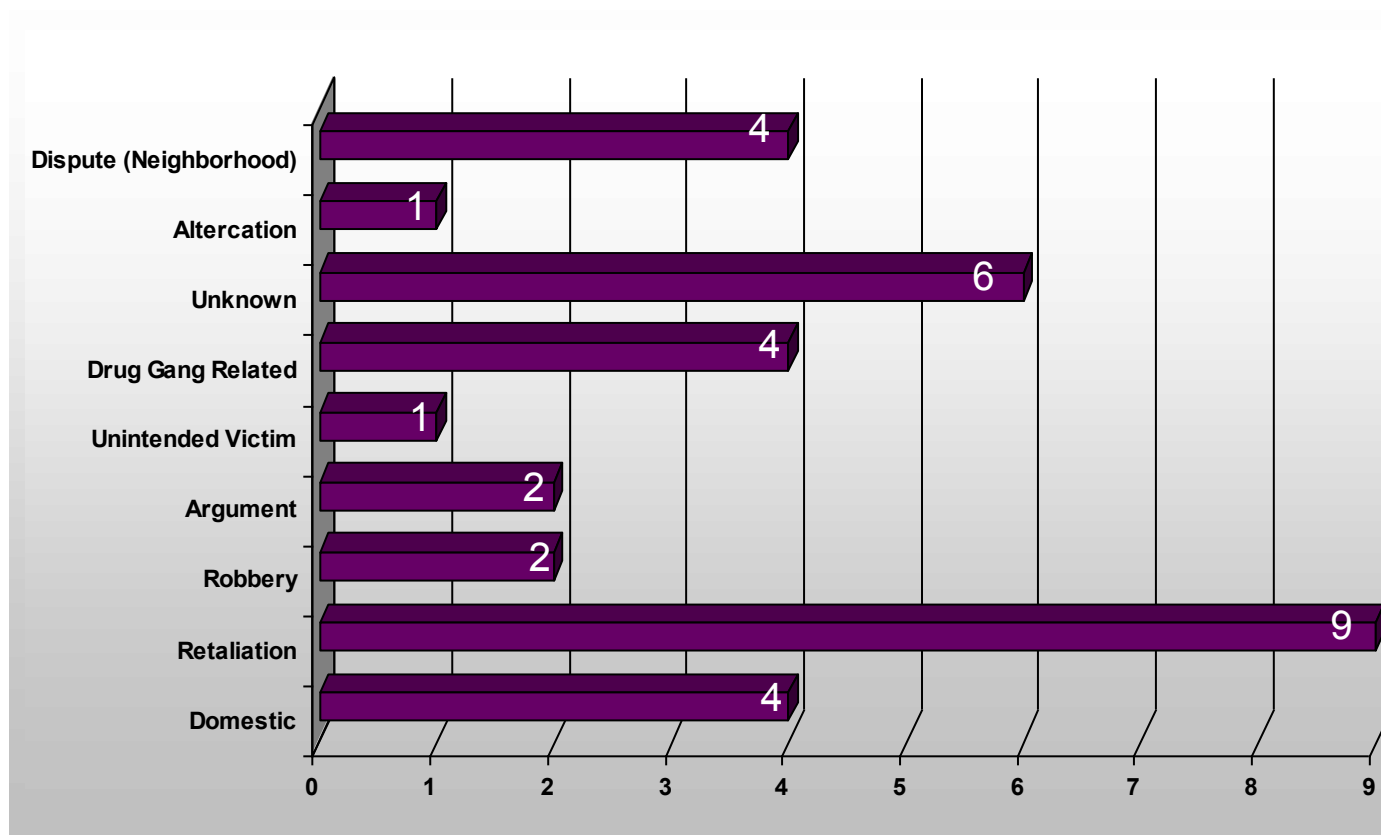
N=33



**2010 Child Fatality Review Committee Annual Report**  
Homicides

<b>TABLE 4: Method of Fatal Abuse and Youth Violence Homicides</b>		
<b>Method</b>	<b>Fatal Abuse</b>	<b>Youth Violence</b>
<b>Gunshot Wounds</b>	<b>1</b>	<b>27</b>
<b>Stab Wounds</b>	<b>1</b>	<b>0</b>
<b>Blunt Force</b>	<b>3</b>	<b>0</b>
<b>Neglect</b>	<b>1</b>	
<b>Total</b>	<b>6</b>	<b>27</b>

**Figure 13: Motives for Child/Youth Homicides**  
N=33



## CFRC Recommendations for Homicide Fatalities

The Committee developed the following recommendation, which address the transition of youth with significant juvenile criminal histories and co-occurring mental health needs to the community.

**Recommendation:** The Department of Youth Rehabilitative Services should develop protocols for transitioning youth with significant criminal histories and mental health needs to the community. The transition plan should include intensive monitoring and cooperative parental supervision. This may include the following:

- (1)Require the completion of the Community Release Contract with the Department of Youth Rehabilitative Services representative, community based monitor and parents/caretakers, prior to the youth's return to the community.
- (2)Train direct service staff to conduct internal Quality Service Reviews which will serve to improve the quality of services provided to youth involved with DYRS

**Response: The Agency Agreed with Modification to the Recommendation.** "The Department of Youth Rehabilitative Services (DYRS) currently have protocols in place that require the completion of the Community Placement Agreement by DYRS representatives, parents/caretakers, and the youth prior to the youth's return to the community. The Quality Assurance Unit has staff that has been trained by the Department of Mental Health as to how to complete Quality Service Reviews; this unit will continue to audit youth's files therefore DYRS will not train direct care staff to conduct quality service reviews. With regards to best practices, recent trends emphasizing client empowerment, self determination and person centered care strategies that shift the decision making balance in favor of the client and his/her family take center stage. DYRS uses this ideology when planning for youth by including their parents or guardians in the planning process which includes returning to the community. These systems are currently in place at DYRS; in addition, Unit Supervisors conduct audits every 45 days. DYRS is currently in the process of implementing a system to monitor the audits electronically. The DYRS IT department is researching how to configure a program which will be compatible with our reporting system. It is the expectation that DYRS will have the capability to measure the effectiveness of audits, and identify services needed."

## ACCIDENTAL DEATHS

In 2010, there were three accidental infant and child deaths that met the criteria for review. 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.

- ◆ The ages of the 2010 accidental death victims ranged from 1month to 6 years.
- ◆ All of the three decedents in this category were Black.
- ◆ Of the accidental deaths, two decedents were male and one was female.

<b>TABLE 5</b>	
<b>CFRC ACCIDENTAL DEATHS</b>	
<b>Motor Vehicle</b>	<b>1</b>
<b>Asphyxia</b>	<b>1</b>
<b>Drowning</b>	<b>1</b>
<b>Total</b>	<b>3</b>

### 2010 Accidental Deaths Continued

The following tables provides details of the 2010 accident related child fatalities reviewed.

<b>TABLE 6: TRANSPORTATION RELATED ACCIDENT</b>						
<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>
6/Black/ Male	7:00 pm	5/5	Pedestrian	Automobile	Driver Collision	Unsupervised Child

**2010 Child Fatality Review Committee Annual Report**  
**Accidental and Suicide Deaths**

**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>
1month Black/Male	Family home	1/1	Bed sharing with an adult	Parental Intoxication

**TABLE 8: DROWNING 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>
6/Black/Female	Public Pool	5/5	Child unable to swim	Unsupervised while at pool

## SUICIDE DEATHS

In 2010, CFRC reviewed the case of one Suicide death. Suicide rates among the children and youth in the District of Columbia remain low. The 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 the fatality.

**TABLE 9: 2010 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>
16 yr/Black Male	Hanging	5/5	<ul style="list-style-type: none"> <li>• History of Mental Illness</li> <li>• Noncompliance with mental health treatment</li> <li>• Poor medication management</li> <li>• Involved with child welfare services</li> </ul>

## **CFRC Recommendation Related to Suicide Fatality**

The Committee developed the following recommendation related to the suicide death to address to ensure that all contracted providers of the Department of Mental Health are made aware of the District of Columbia's law that addresses mandated reporters of child abuse and neglect.

**Recommendation:** The Department of Mental Health should provide mandated reporter training to the agency's contractors that provide community based mental health services to children and incorporate mandated reporter training to all new employees that provide mental health services.

**Response:** "The Department of Mental Health agreed with the recommendation with modifications. The Core Service Agency (CSA) Network shall provide mandated reporter training to all staff upon hiring and a refresher course on a regular basis. DMH has published mandated reporting policies and they have been distributed and published on the DMH website. The Children Services and Youth Division (CYSD) in partnership with the Policy Department will review the mandated reporting policy and update the policy by March 2012. In partnership with the Training Department and the Child and Family Services Administration (CFSA) will provide quarterly mandated reporter training for the CSA provider network. DMH has published mandated reporting policies and they have been distributed and published on the DMH website. During DMH audits, there will be evidence of mandated training certificates in personnel files."

## **Undetermined Deaths**

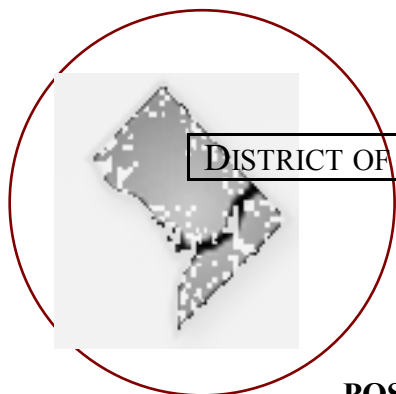
In 2010, eight fatalities met the criteria for CFRC case review in which the Manner of death could not be determined. In five of these cases, the cause of death was Sudden Unexplained Death in Infancy (SUDI). In two cases, Sudden Unexplained death in Childhood, and Asphyxia due to Ligature Strangulation were the causes of death. In the remaining case, the cause of death could not be determined. In the cases where the cause of death was Sudden Unexplained Death in Infancy/Childhood scene investigations provide further information into the contributing factors associated with the infant's death.

## Undetermined Deaths and Associated Risk Factors

As indicated in Table 11, seven of the eight Undetermined related fatalities were healthy, full term infants. The infants ranged in age from 20 days to 19 months. Four of the eight infants were placed to sleep in adult beds. Environmental factors, including excessive clutter and bedding were also observed in these cases. Seven of the eight decedents were Black, the remaining decedent was White.

**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>Risk Factors</i>
20 days/ Black/Male	8	Healthy Full Term	Infant placed in adult bed with parent in supine posi- tion	<ul style="list-style-type: none"> <li>Exposure to cigarette smoke</li> </ul>
21 days/ Black/Male	6	Healthy Full Term	Infant placed to sleep in prone sleep position in bassinet	<ul style="list-style-type: none"> <li>Bassinet mattress wrapped in plastic</li> </ul>
1 month, 6 days/Black/ Female	6	Healthy Full Term	Infant placed to sleep on left side over pillow in bassinet and found in prone sleep position in bassinet	<ul style="list-style-type: none"> <li>Excessive bedding in bassi- nette</li> </ul>
2 months/ Black Male	8	Healthy Full Term	Infant placed in adult bed with siblings in supine position with pillow under head	<ul style="list-style-type: none"> <li>Parental alcohol use</li> </ul>
4months/ Black/ Female	7	Healthy Full Term	Infant placed in adult bed in supine position to sleep with parents.	<ul style="list-style-type: none"> <li>Parental alcohol use</li> </ul>
4months/ Black/ Female	6	Healthy Full Term	Infant placed supine in crib in supine sleep posi- tion with blanket and toys.	<ul style="list-style-type: none"> <li>Excessive clutter in home</li> </ul>
10months/ White/ Female	3	Premature and small for gestational age	Infant placed in crib in supine sleep position.	<ul style="list-style-type: none"> <li>Infant monitor with cord placed inside of crib with infant</li> </ul>
19 months/ Black/Male	8	Healthy Full Term	Infant placed in in adult bed in supine sleep posi- tion.	<ul style="list-style-type: none"> <li>None Known</li> </ul>



## 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/bassinette
- Parents should maintain the home and especially the infant's sleep area free of cigarette smoke.
- Infants should not be placed on adults 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. 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 bassinette), 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 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; falls from adult beds onto piles of clothing, plastic bags or other soft materials; and adults may roll over onto the infant while sleeping. Infants should never sleep with soft bedding or loose objects, such as blankets, pillows, comforters, bumper pads, since they could cover the infant's head or face
- 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:
  - The adult/caregiver sleeps on soft bedding, such as sofas, waterbeds, bean bag, air mattresses, Etc
  - The adult/caregiver or others in the household smoke
  - The adult/caregiver is under the influence of drugs, alcohol or other medications that can cause drowsiness or incoherent thinking
  - The adult/caregiver is excessively tired or sick
  - The adult/caregiver is angry or upset
  - 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 preconceptual 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

Seventeen of the CFRC decedents, which represent 14% of the 122 fatalities from 2010, were youth known to the District of Columbia's juvenile justice system within two years of their death. All of the juvenile justice decedents, whose ages ranged from 16 to 22 years, were Black males. The majority of these decedents were residents of Ward 8.

Figure 15: Age of CFRC Juvenile Justice Decedents

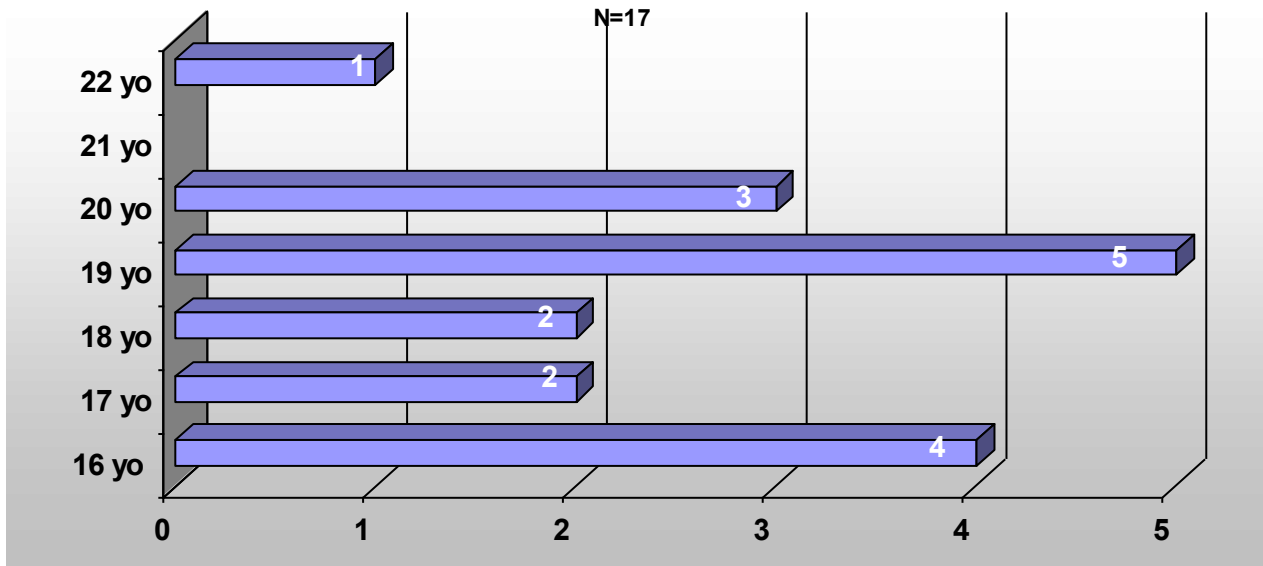
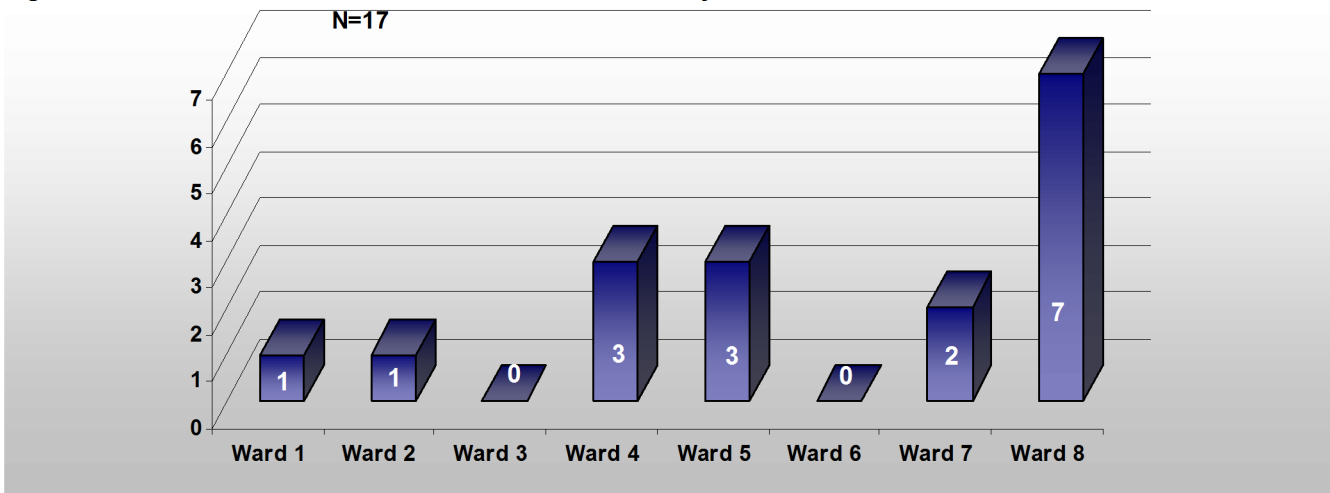


Figure 16: CFRC Juvenile Justice Decedent Ward of Residency



**2010 Child Fatality Review Committee Annual Report  
Juvenile Justice Fatality Data**

**Cause and Manner of Death**

- ♦ All of the 2010 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**

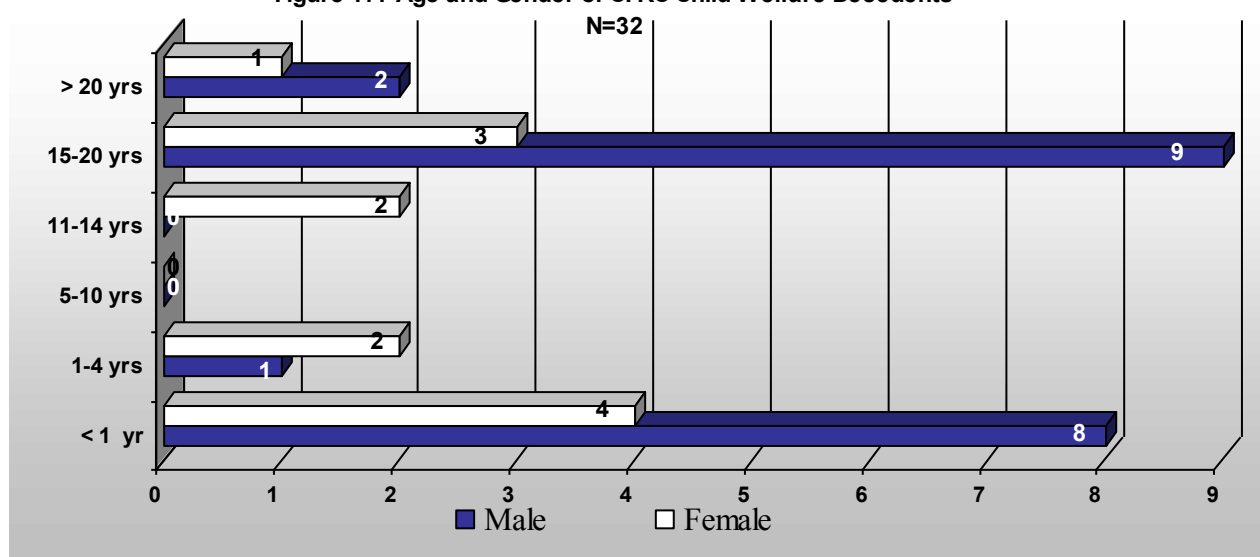
- ♦ Eight of the CFRC Juvenile Justice case records indicate an early onset of substance abuse among the decedents. Use of marijuana has been reported in 100% of these cases.
- ♦ Seven of the youth exhibited poor school performance and truancy.
- ♦ Eight of the youth were co-involved with child welfare and juvenile justice programs prior to their death.

<b>TABLE 12</b>	
<b>SOCIAL RISK FACTORS ASSOCIATED WITH YOUTH HOMICIDES</b>	
<b>Pre-teen/Teen Substance Abuse</b>	<b>8</b>
<b>Poor School Performance/Truancy</b>	<b>7</b>
<b>Family History of Involvement with Child Welfare Services</b>	<b>8</b>

## CHILD WELFARE FATALITY DATA

During 2010, 32 of the 122 CFRC deaths identified were children and youth known to the District of Columbia's child welfare system. A child is considered "known" to CFSA if the Child and Family Services Agency had contact with the child or the child's family at any time in the current year or previous four years. History of involvement with child welfare is recognized by the National Center for Child Death Review as a risk factor for child death fatalities.

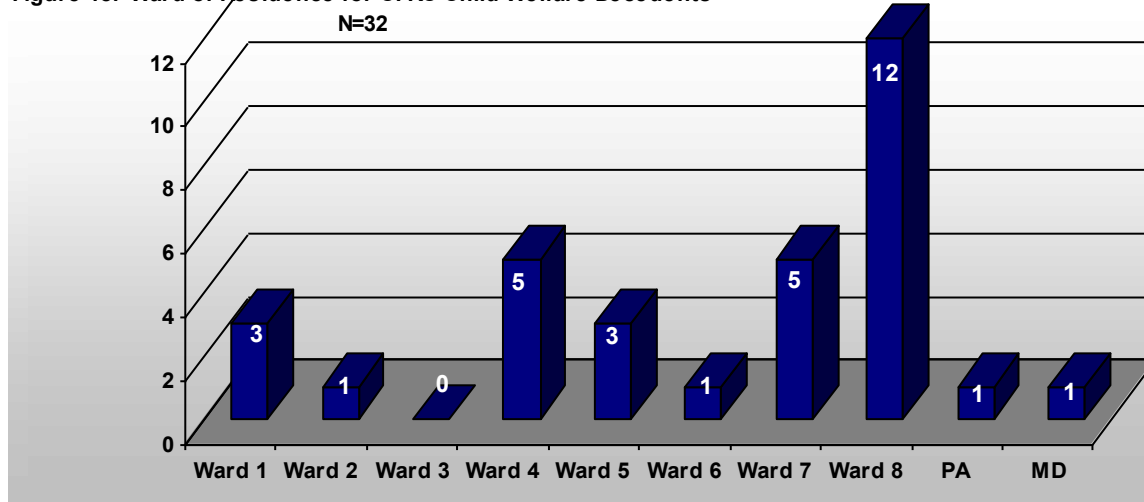
Figure 17: Age and Gender of CFRC Child Welfare Decedents

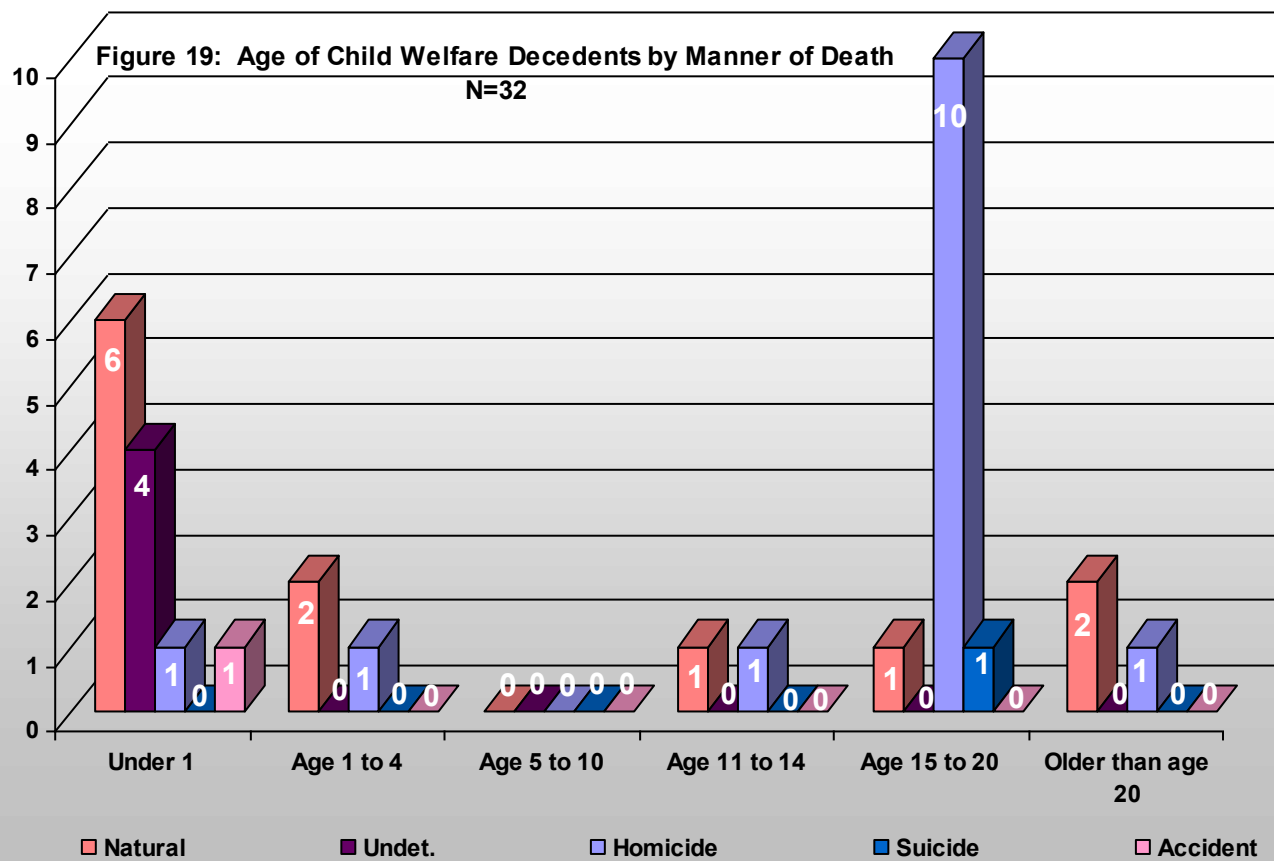


## DECEDENT DEMOGRAPHICS

- ◆ Twenty of the child welfare decedents were males, and 12 were females.
- ◆ All of the child welfare decedents were Black.
- ◆ Infants under age one and youth between the ages of 15 and 20 years composed the majority of child welfare decedents.
- ◆ Ward 8 had the highest number of child welfare decedents.

Figure 18: Ward of Residence for CFRC Child Welfare Decedents





### Manner of Death for Children known to Child Welfare:

- ◆ Fourteen of the CFRC child welfare decedents were victims of Homicide. The majority of these decedents were 15 years of age and older. Of the 32 child welfare CFRC Homicide cases, 5 were victims of fatal abuse.
- ◆ Twelve of the CFRC child welfare decedents died of natural deaths.
- ◆ Twelve of the CFRC child welfare decedents were infants under the age of one. Among these, Natural death was the leading cause of death (N=6). The cause of death in four of the CFRC child welfare cases were Undetermined.

### Dual District Agency Involvement

Eight youth were simultaneously known to both the District's child welfare and juvenile justice system programs prior to their death. These youth, all of whom were Black males, were victims of homicide.

# 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 residences 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

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

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





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