

DISTRICT OF COLUMBIA
CHILD FATALITY REVIEW COMMITTEE

2011 ANNUAL REPORT



Vincent Gray, Mayor
District of Columbia Government

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**DISTRICT OF COLUMBIA
CHILD FATALITY REVIEW COMMITTEE**

2011 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 and youth who continue to lose their lives to medical problems, senseless acts of violence, accidents and suicide.

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

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EXECUTIVE SUMMARY

The District of Columbia Child Fatality Review Committee (CFRC) is pleased to present its 16th Annual Report. This Report covers data from 119 child/youth fatality cases reviewed by the Child Fatality Review Committee in 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 committed to the District. 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); the Child and Family Service Agency (CFSA); the Department of Youth Rehabilitation Services (DYRS), and the Metropolitan Police Department (MPD).

KEY CHILD FATALITY REVIEW DATA FINDINGS

DECEDENT DEMOGRAPHICS

- ◆ The age of the decedents reviewed by the CFRC ranges from birth to 20 years of age, with 56% (67) of the decedents being under the age one.
- ◆ 87 % (104) of the decedents were Black
- ◆ 60% (71) of the decedents were males

MANNERS OF DEATH

Natural Deaths

In 2011, the Committee reviewed 77 natural cases involving infants, children and youth. The majority of these cases, 79% (61) were infants.

Violent Deaths—Homicide and Suicide

In 2011, The Committee reviewed 31 child and youth fatalities whose deaths were the result of violent acts. Of these, four children were victims of "Fatal Abuse". The suspected perpetrator in the four cases was either a parent or a caregiver of the child. One death resulted from a suicidal act.

Accidental Deaths

The Committee reviewed 5 accidental deaths involving infants and children. The circumstances leading to these accidental deaths were as follows: Motor vehicle accidents (1); Fire (2); Asphyxia (1); and Drowning (1).

Undetermined Deaths

The Committee reviewed 6 child fatalities in which the manner of death was classified as Undetermined.

CFRC 2011 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 improve outcomes for children and families in the District of Columbia.

Manner of Death	Area of Focus	Recommendation	Response
<p>Homicides 25% of Cases Reviewed</p>	<p>District Government Policy and Practice</p>	<p>The Child Fatality Review Committee recommends that the District of Columbia continue to advocate for the funding of the middleware for the HIPPA Compliant Database System (also known as the Unified Case Management System resulting from the Jacks-Fogle legislation). This database system will allow the Health and Human Services cluster agencies to share information regarding the District’s most vulnerable residents, and improve outcomes for children and families.</p>	<p>Agreed with Modifications See Page 15</p>
	<p>Agency Policy and Practice</p>	<p>The Child Fatality Review Committee Recommends that all youth committed to the Department of Youth and Rehabilitative Services must receive and participate in educational programs which address their specific academic levels to prepare the youth for his/her eventual return to the community.</p>	<p>Agreed with Modifications See page 16</p>
	<p>Agency Policy and Practice</p>	<p>The Child Fatality Review Committee recommends the Child and Family Services Agency should mandate annual domestic violence training for all staff social workers, contracted social workers, and para-professionals who provide direct services to children and their families who come into contact with the agency as a result of abuse and neglect. This will ensure that all direct service providers within the agency will be trained to appropriately assess the family’s needs and risk factors associated with domestic violence.</p>	<p>Agreed with Modifications See Page 17</p>

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 and youth's lives.

The Child Fatality Review Committee (CFRC) is divided into two teams; the Infant Mortality Review Team reviews the deaths of District infants from birth through 12 months. The Child Fatality Review Team reviews the death of District children ages 1 through 18 years, and youth older than 18 who were known to 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, 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 indicates potential system improvements and makes recommendations for the prevention of deaths.

This Annual Report differs from preceding reports because it is consistent with the CFRC Statute. This report summarizes data collected from 119 child and youth fatalities reported to and reviewed by the Committee during calendar year 2011. These fatalities spanned the years of 2009, 2010, and 2011 but were reported to the Committee in 2011. The statute mandates an Annual Report be published reflecting the work of the Committee during the year of review.

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

Section II: Summary of Child Welfare and Juvenile Justice Decedents: This section summarizes decedent's demographics and the causes of death for CFRC decedents known to child welfare and the juvenile justice system.

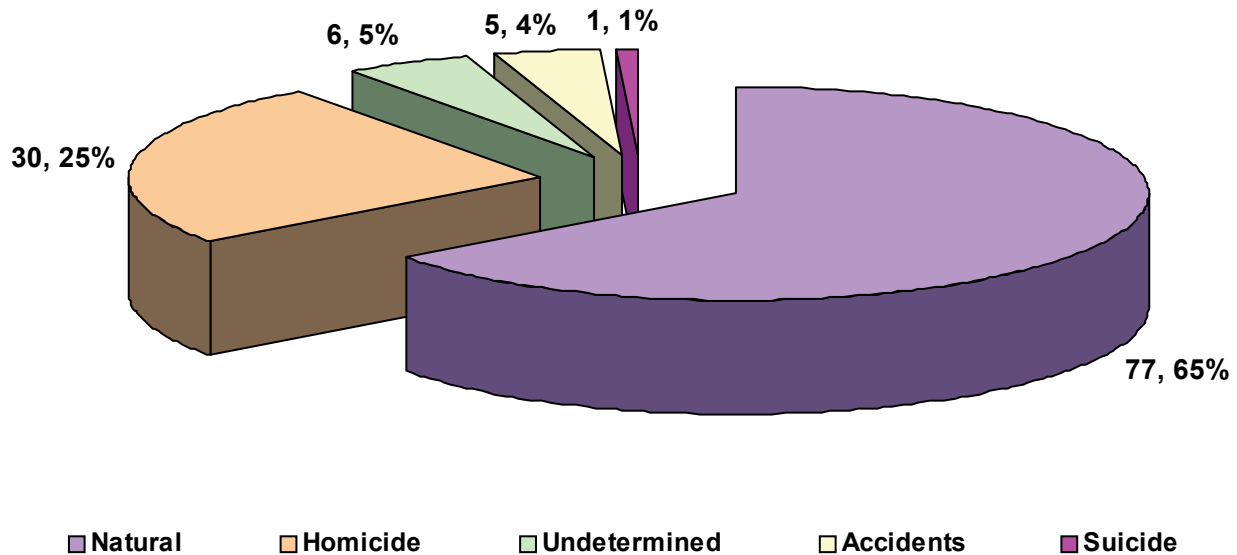
SECTION I: SUMMARY OF CASE FINDINGS

MANNER OF DEATH OF CASES REVIEWED BY THE CFRC IN 2011

Manners of death are categorized as Natural, Accidental, Homicide, Suicide or Undetermined. The manner of death is determined based on information provided by investigative bodies and by examination of the decedent.

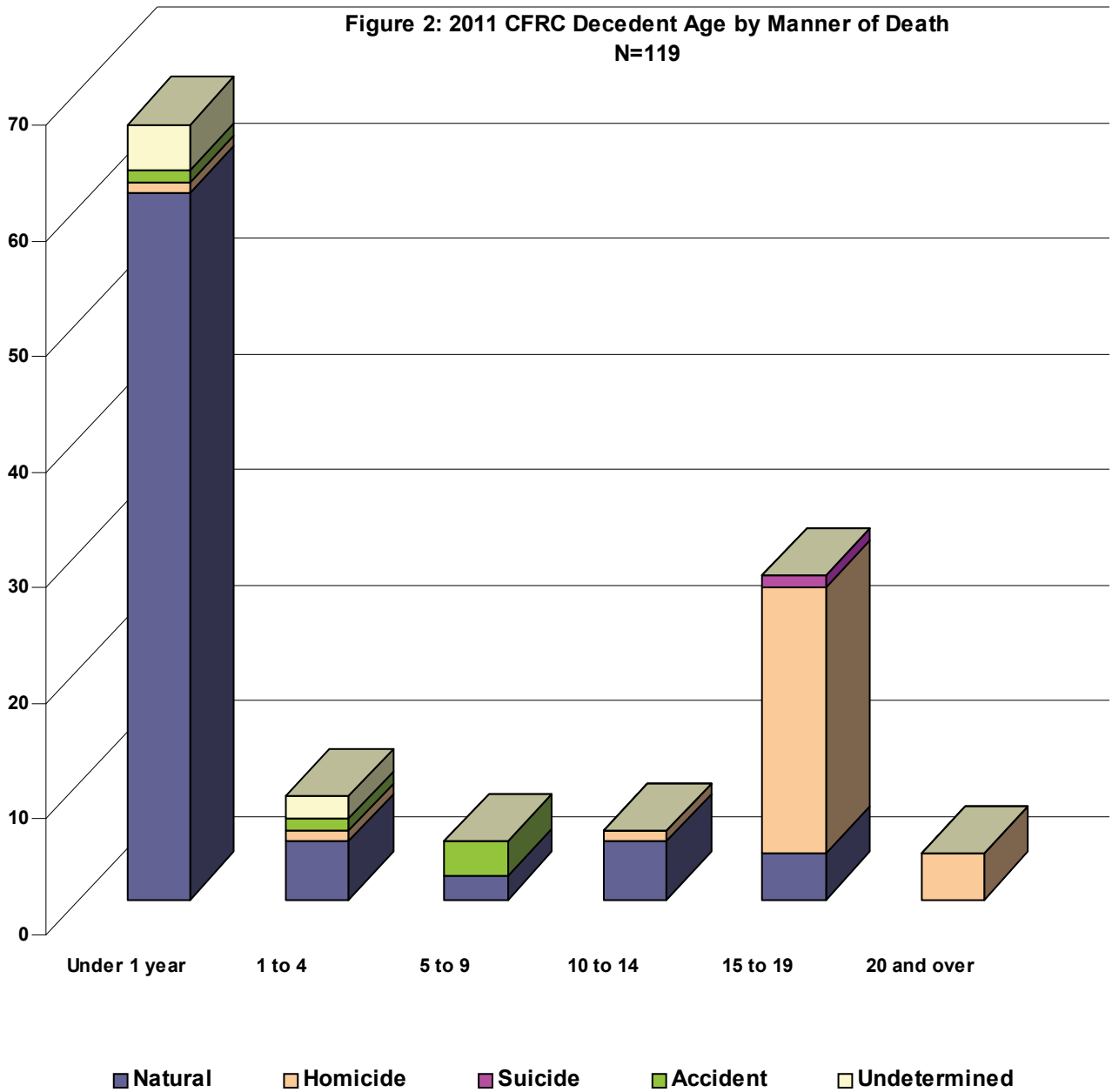
In 2011, the Committee reviewed data associated with 119 infants, children, and youth deaths. Seventy-seven of these deaths (65%) involved infants, children and youth who died of natural causes and thirty (25%) were infants, children and youth whose deaths were the result of a homicidal act. Of the remaining fatalities reviewed, six deaths were classified as Undetermined, and five as Accidents. One fatality was due to an act of suicide.

Figure 1: 2011 CFRC Decedents Manner of Death
N=119



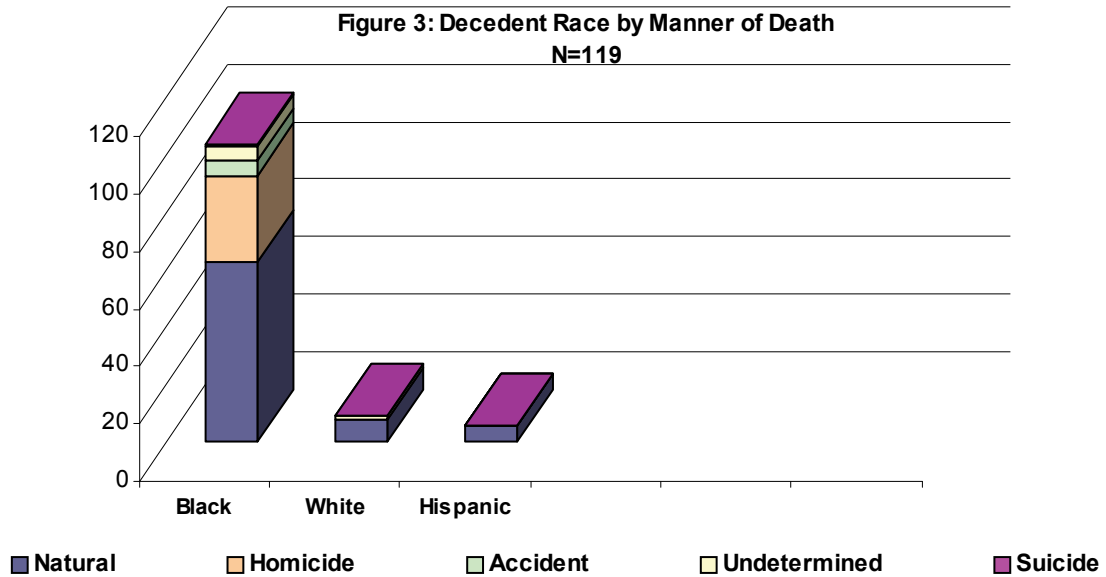
DECEDENT DEMOGRAPHICS BY MANNER OF DEATH

The age of the decedents ranged from birth to 20 years. The age categories with the greatest number of deaths were infants (56%, 67) and youth between the ages of 15 to 20 years (27%, 32).

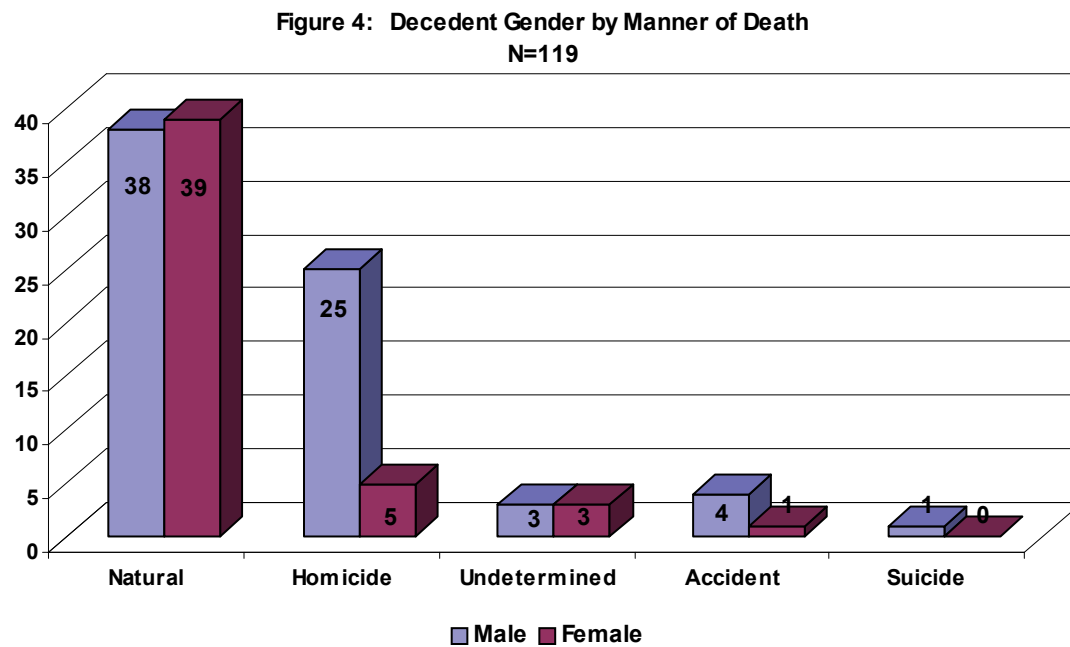


RACE AND GENDER BY MANNER OF DEATH

As Figure 3 illustrates, Black children and youth represented 87% (104) of the total CFRC decedent cases reviewed in 2011. Black children and youth had the highest percentage of representation in all manners of death.



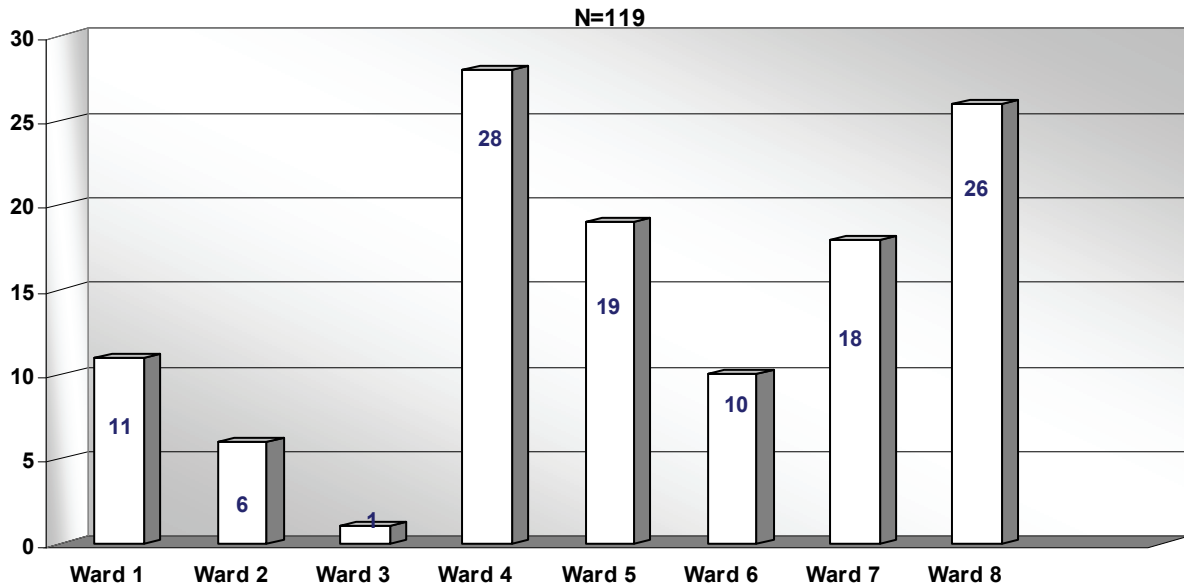
Males predominated in all categories except for a small difference in favor of females in the Natural deaths.



DECEDENTS' WARD OF RESIDENCY BY MANNER OF DEATH

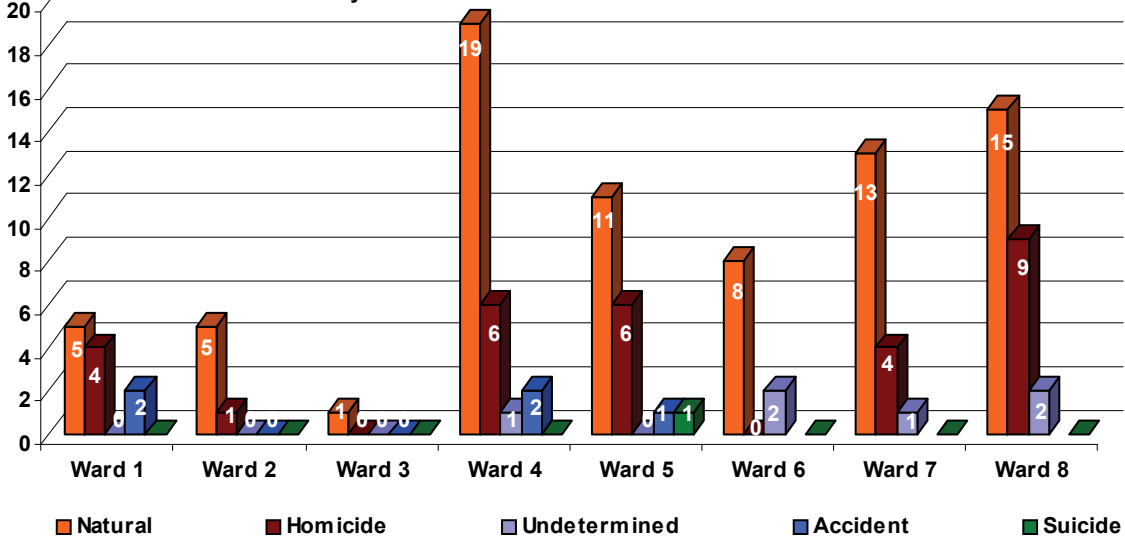
The Ward of residency is primarily determined by information contained on the death certificates and other supporting documentation (i.e., child welfare, public assistance records/databases, etc.). Of the cases reviewed in 2011, Ward 4 had the greatest number of child and youth fatalities with 24% (28), Ward 8 had the second largest number with 22% (26), and Ward 5 was third with 16% (19).

Figure 5: 2011 CFRC Decedent Ward of Residency



As shown in Figure 6, the greatest number of children and youth who died as a result of homicides resided in Ward 8, and the greatest number of children and youth who died of natural causes resided in Ward 4.

Figure 6: 2011 CFRC Decedent Ward by Manner of Death



Natural Deaths

In 2011, the Committee reviewed 77 cases involving infants, children and youth whose death resulted from pre-existing conditions or underlying medical conditions. The majority of these cases, 79% (61) involved infants whose cases were reviewed by the Infant Mortality Review Team (IMR). The majority of the infants in this category were Black males.

Figure 7: Age of Natural Decedents (N=77)

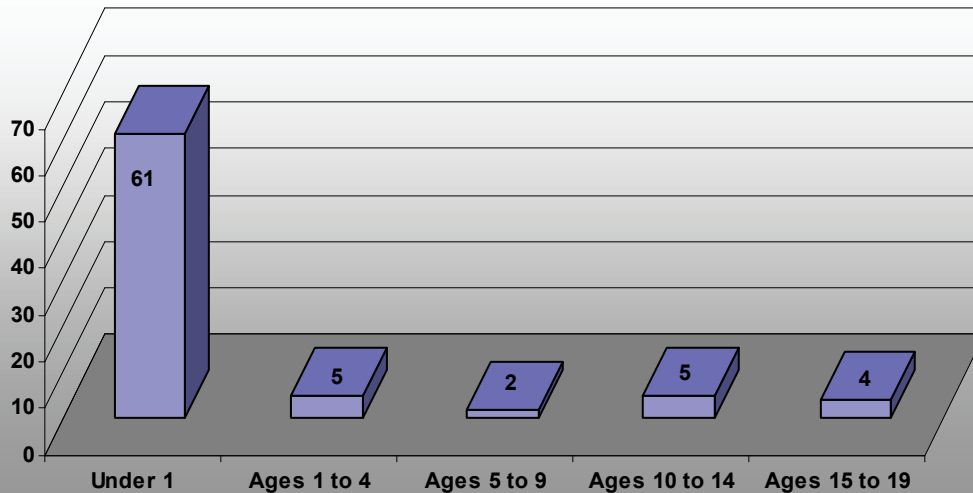


Figure 8: Race of IMR Decedents
 N=61

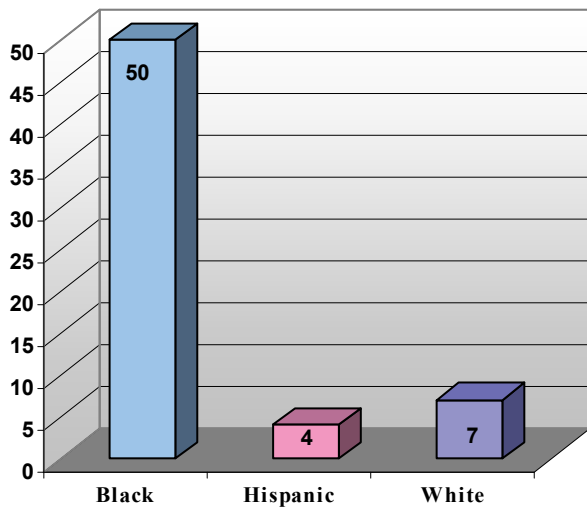
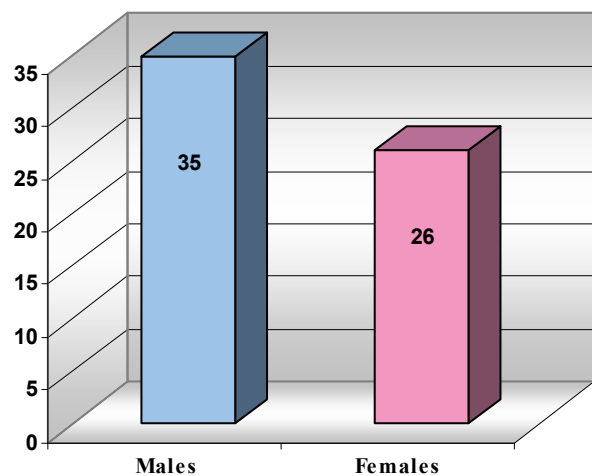


Figure 9: Gender of IMR Decedents
 N=61



Deaths Related to Premature Births

The Infant Mortality Review Team (IMR) reviewed the fatalities of 61 infants. Fifty-three (87%) of these infants died as a result of premature birth. Table 1 presents the risk factors associated with the premature births as outlined on the infant’s death certificates. In the majority of cases, the etiology of the cause of prematurity is unknown.

TABLE 1	
Risk Factors Associated with Prematurity per Death Certificate Review	
Causes	Number of Deaths
Unknown Etiology	22
Chorioamnionitis	10
Premature Rupture of Membrane	5
Placental Abruption	1
Pre-Term Labor	4
Maternal Hypertension	1
Brain Tumor	1
Fetal Anomaly	7
Infection/Sepsis	2
Total	53

Infant Mortality Review Team Findings

The IMR team gathered pertinent information to assess the infant risk factors associated with prematurity and mortality in 44 of the 53 premature cases reviewed. Through the review of individual cases, several risk factors were identified. For this report, the Committee outlined some maternal and infant risk factors observed with consistency in the cases reviewed.

Maternal Risk Factors

Prenatal Care

Adequate prenatal care is associated with lower risks of maternal as well as infant deaths. According to the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists "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 risk factor in 13 of the 61 total infant deaths reviewed.

Premature Rupture of Membranes

Premature rupture of fetal membranes before 37 completed weeks of gestational age and prior to the onset of labor is a cause of prematurity. A specific cause for this anomaly has not been established though infection is thought to be the underlying factor. Of the 61 total infant cases reviewed, 25 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 36 of the 53 premature birth cases reviewed. Of these cases, 10 had either a history or a current diagnosis of sexually transmitted disease.

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 61 total infant 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 15 of the 61 total infant cases.

Social Risk Factors

Maternal history of sexually transmitted disease, 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 23 of the 61 infant cases reviewed

Infant Risk Factors

The risk factors evaluated by the IMR Team were gestational age and birth weight, and congenital anomalies. The following information was gathered from medical records provided in 44 of the cases reviewed by the IMR team.

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 the 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 16 were in the category of moderate to late prematurity (gestational age: 24 to 36 weeks). Twenty-three infants weighed between 100 to 500g (3.52oz to 1lb 1.63oz); 14 weighed 501 to 1000g, (1lb 1.67oz to 2lbs 3.2 oz); and 6 weighed 1001 to 4000g (2lbs 3.30oz to 8lbs 13.09oz).

Table 2	
IMR Prematurity Levels	
Level of Prematurity	Number of Infants
Extreme	29
Moderate to Late	15
Total	44

Table 3	
IMR Decedent Weight	
Weight	Number of infants
100-500g	23
501-1000g	15
1001-4000g	6
Total	44

Congenital Anomalies

Congenital anomalies including genetic/chromosomal disorders, such as Edwards Syndrome and Congenital Heart Disease, were present in 6 infants of the infant cases reviewed.

Natural Deaths

Other Causes of Death in Infancy

Eight of the infants whose case was reviewed by the IMR Team in 2011 died of natural causes not associated with premature birth. The leading cause of death among these infants was Congenital Anomaly (N=6).

TABLE 4	
Other Natural Causes of Death in CFRC Infants	
Cause of Death	Number of Deaths
Congenital Anomaly	6
Infectious Disease	2
Total	8

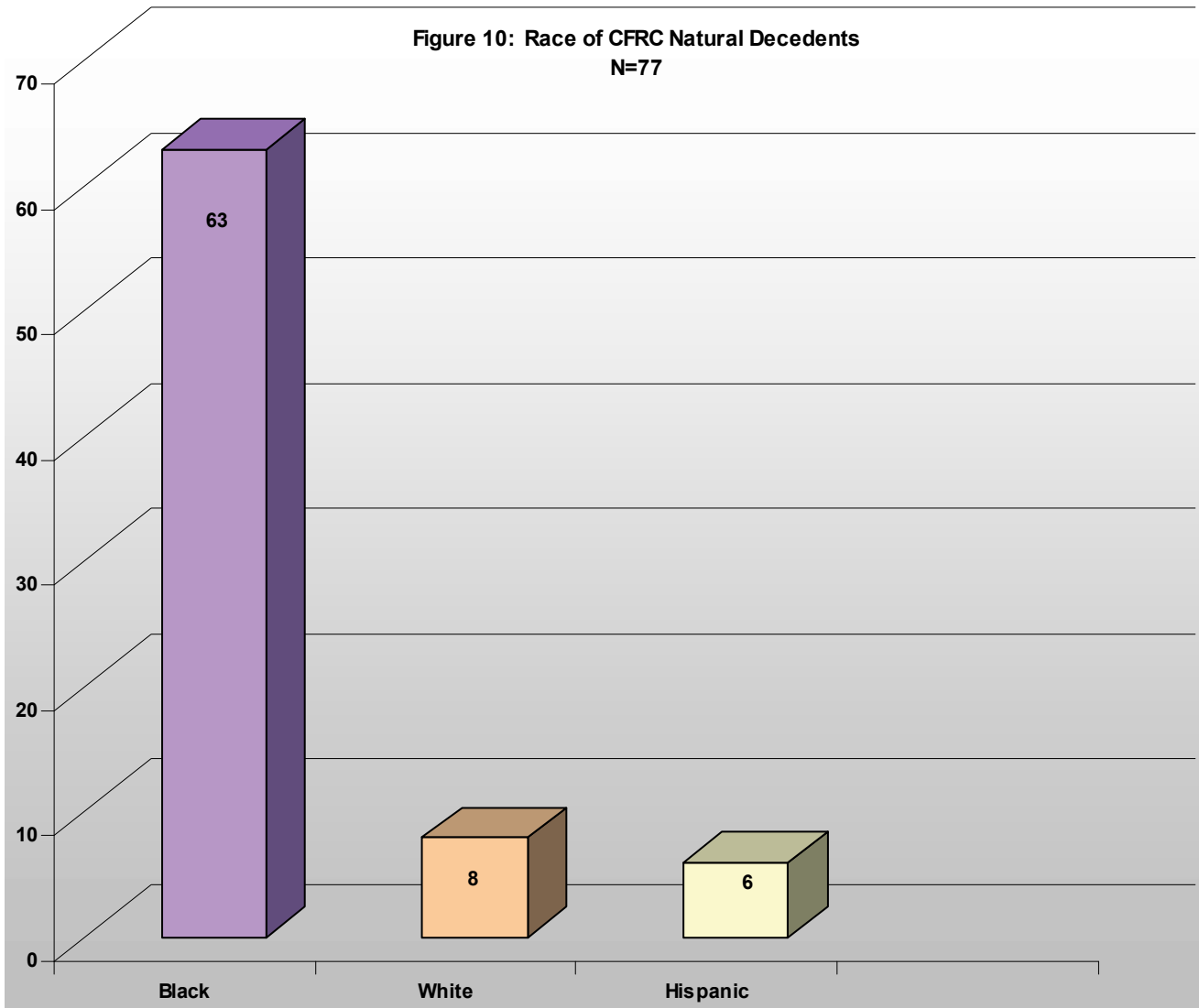
Natural Causes of Death in Children

As indicated in Table 5, 21% (16) of the Natural death cases reviewed by the Committee were of children and youth between the ages of 1 and 19. The leading cause of death among these decedents was Congenital Anomalies (5) followed by Hematological Disease (4).

TABLE 5	
Natural Causes of Death in Children	
Cause of Death	Number of Deaths
Cancer	3
Respiratory Disease	3
Congenital Anomaly	5
Hematological Disease	4
Complication of Peripartum Injury	1
Total	16

Age and Race of Decedents—Natural Child Fatalities

Of the 77 Natural deaths reviewed by the Committee in 2011, 82% (63) of the deaths involved Black children, 10% (8) White children, and 8% (6) Hispanic.

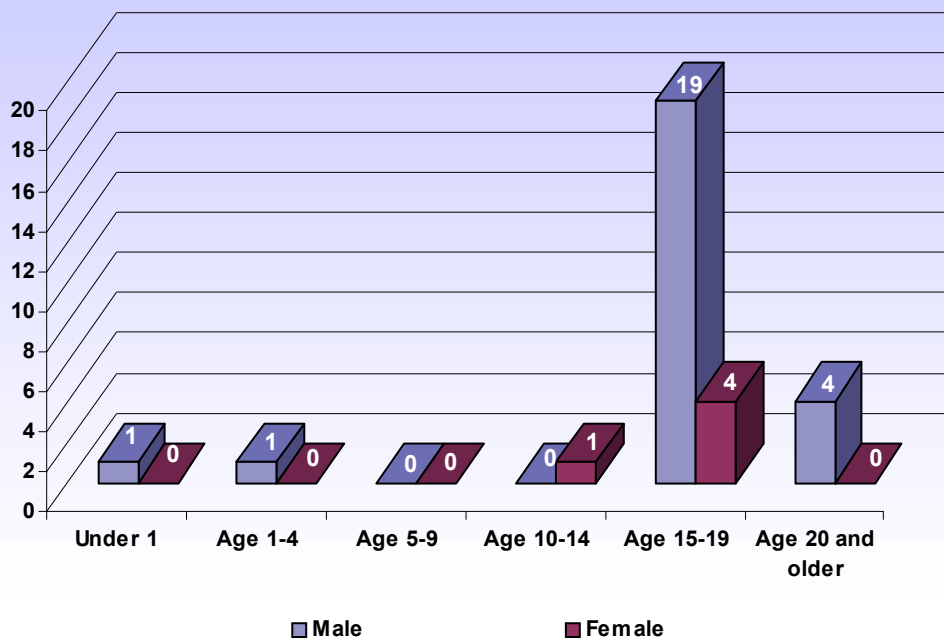


Homicides

Thirty (25%) of the 119 cases reviewed by the Committee were Homicides. The Committee utilizes the following categories to describe the fatal events of child homicide victims:

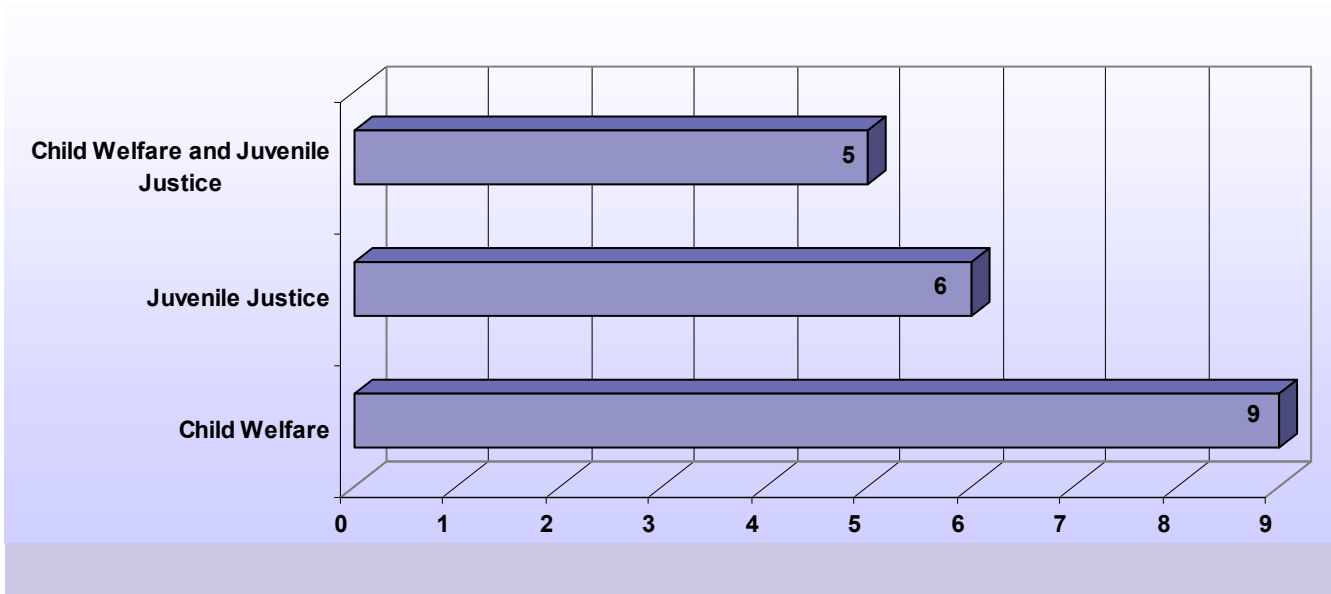
- ◆ **Youth Violence Homicides** are cases involving juvenile victims and are usually associated with criminal activity, arguments, or retaliation.
- ◆ **Fatal Child Abuse and Neglect** occur at the hands of a parent, legal custodian or person responsible for the child’s care at the time of the fatal incident.
- ◆ **Other Child Homicides** are the result of an act of violence by a perpetrator who is not the parent/caretaker of the child.

Figure 12: Age and Gender of CFRC Homicide Victims N=30



The majority of homicide cases reviewed by the Committee in 2011 were youth violence victims between the ages of 15 to 20 years (87%, 26). All except one of the decedents died as the result of gunshot wounds. The cause of death of the remaining homicide victim is unknown. All of the youth homicide victims were Black.

Figure 13: CFRC Homicide Victims Involvement with Child Welfare and Juvenile Justice

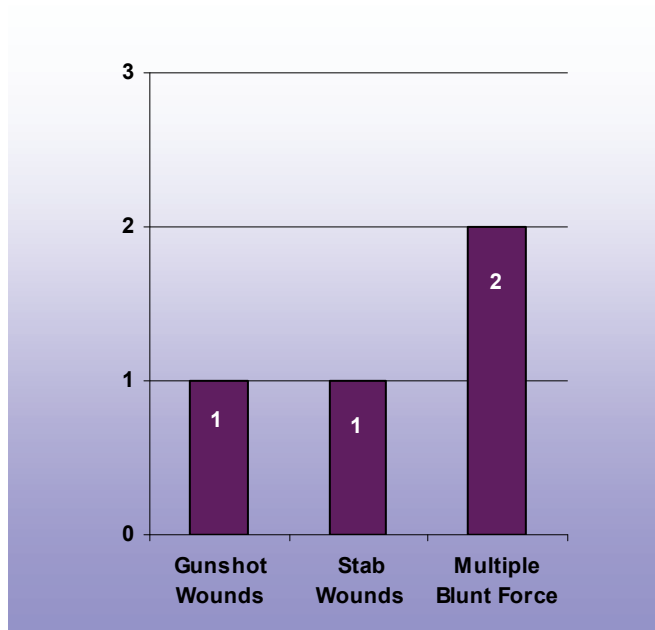


Fatal Child Abuse

Four of the thirty Homicide fatalities reviewed in 2011 were the result of fatal child abuse. In one case, the mother's paramour was the perpetrator; in the other three cases the father was the perpetrator.

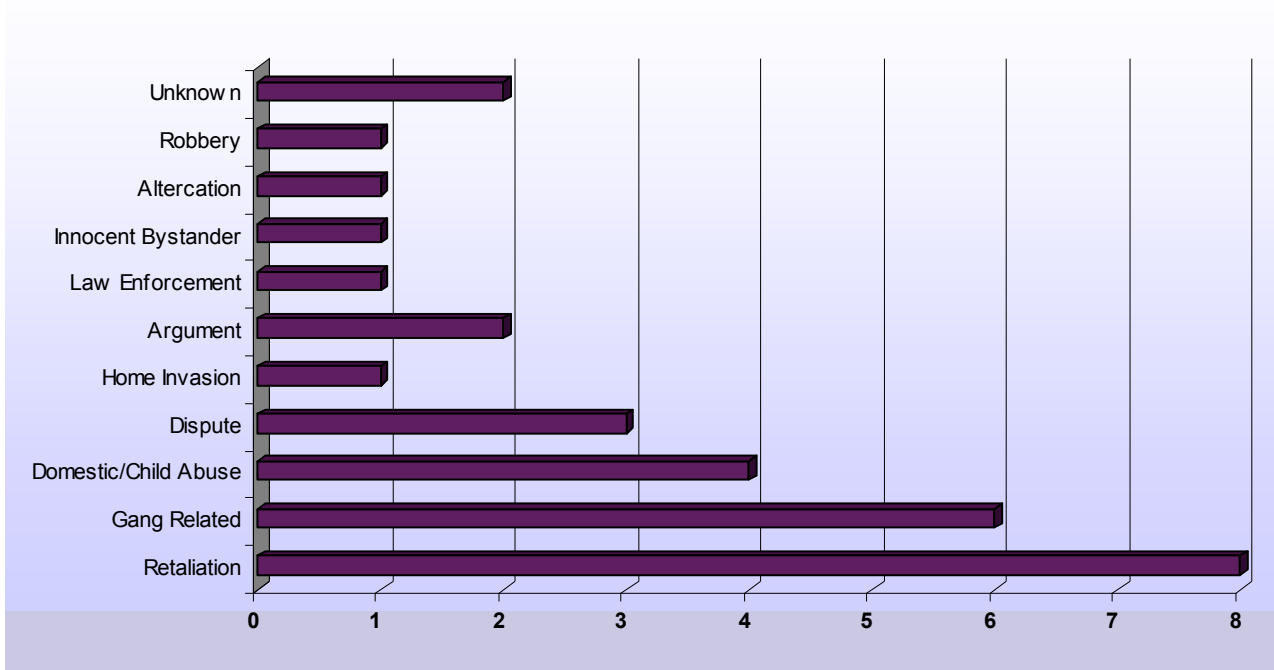
- ◆ Three of the four fatal child abuse victims were known to the District's child welfare program before their deaths.
- ◆ Two of the fatal child abuse victims died as a result of Multiple Blunt Force Injuries. One victim died from Gunshot Wounds and one from Stab Wounds.
- ◆ In two of the fatal abuse cases, records indicated the decedent's immediate family has a history of domestic violence. In these cases, domestic violence contributed to the circumstances leading to the fatal event.

Figure 14: Methods of Fatal Child Abuse N=4



Cause of Death and Motives for CFRC Homicides

Figure 15: CFRC Child/Youth Homicide Motives



Of the 30 homicide cases reviewed by the CFRC in 2011, Retaliation (8) and Gang associations (6) were the leading motives of child/youth homicides. Gunshot wounds were the leading cause of death among child/youth homicide victims (26).

TABLE 6—Causes of Death of CFRC Homicide Victims		
Method	Fatal Child Abuse	Youth Violence
Gunshot Wounds	1	25
Stab Wounds	1	0
Blunt Force	2	0
Unknown	0	1
Total	4	26

CFRC Recommendations for Homicide Fatalities

The Committee developed the following recommendations geared toward improving outcomes for children and youth. The recommendations address five major areas of concern associated with Homicide fatalities: (1) collaboration and communication among District Government agencies, (2) addressing the special education needs of adjudicated youth, and (3) mandating annual domestic violence training for the District of Columbia's child welfare employees and contractors.

Recommendation #1: The Child Fatality Review Committee recommends that the District of Columbia continue to advocate for the funding of the middleware for the HIPPA Compliant Database System (also known as the Unified Case Management System resulting from the Jacks-Fogle legislation). This database system will allow the Health and Human Services cluster agencies to share information regarding the District's most vulnerable residents, and improve outcomes for children and families.

Response: The Deputy Mayor for Health and Human Services accepts this recommendation with modifications. In lieu of the recommendation to secure funding for middleware for a Unified Case Management system, the Deputy Mayor for Health and Human Services recommends that the Committee recommend that the District of Columbia continues to seek funding for an inter-agency case management system (also known as a Unified Case Management system) to allow the Health and Human Services cluster agencies to share information regarding the District's most vulnerable residents, and improve outcomes for children and families. Best practices require that governmental agencies be able to share data on the clients with whom they are in contact in order to provide each other with relevant information while maintaining the privacy of the clients. OCTO, DHS and DHCF are currently working to secure federal funding and create an advanced planning document on how such a data sharing system would work. Once federal funding is secured, the District will decide which product best suits our needs and will procure it. After procurement of a case management system, the District will implement this system. In the interim, the District has begun to model the best practice described above with the Truancy Memorandum of Agreement (MOA) from the Truancy Task Force. This MOA allows DCPS, DYRS, CFSA, OSSE, MPD, DHS, DMH and Court Social Services to share information as it pertains to students who are chronically truant. With the creation of a inter-agency case management system, the Deputy Mayor for Health and Human Services expects there to be an elimination of duplication of process and services as well as improved case management and communications between agencies.

CFRC Recommendations for Homicide Fatalities

Recommendation #2: The Child Fatality Review Committee Recommends that all youth committed to the Department of Youth and Rehabilitative Services must receive and participate in educational programs which address their specific academic levels to prepare the youth for his/her eventual return to the community.

Response: The Department of Youth Rehabilitative Services (DYRS) accepts this recommendation with modification. The agency currently has protocols in place to provide Academic Transition Specialists for youth returning from out-of-state secure detention. Youth returning from New Beginnings Youth Development Center are similarly supported by Student Advocates from the Maya Angelou Academy at New Beginnings. DYRS has also established a partnership with the District of Columbia Public Schools (DCPS) through which all returning youth are assisted with school enrollment by dedicated staff at the Office of Youth Engagement (OYE) Student Placement office. The OYE Student Placement Office engages the DCPS Office of Special Education (OSE) in all cases in which a youth's individual special education needs cannot be met by a neighborhood school. It is imperative that reentry planning includes planning for seamless enrollment into appropriate educational programming upon a youth's return to the community. DYRS has been collaborating with DCPS and the Office of the State Superintendent of Education (OSSE) to establish expectations for all out-of-state residential facilities regarding academics communicate regularly with DYRS and DCPS staff regarding individual youth academic progress and reentry education planning. Within the next 45 days all DYRS residential facilities will receive a letter describing these expectations. In addition, the DYRS Office of Education and Workforce Development (OEWD) is planning a training series for all case managers on a variety of education topics in order to better support youth across all education options. Expected topics to be covered include: Enrollment Process (DCPS, Charter Schools, Surrounding County Public Schools); Special Education Overview (IEP Basics, IEP Team Placement Decisions); GED Preparation & Testing (GED vs. Diploma Decision, Choosing Programs, Upcoming Changes); College Admission & Financial Aid. DYRS Office of Education and Workforce Development (OEWD) has begun compiling descriptions and data around DCPS, charter school and GED and adult education programming that will become the basis of a DYRS resource for all case managers. OEWD has already distributed to all case managers information regarding charter school lottery and enrollment information for the upcoming school year. OEWD will also be surveying the case managers to ensure that planned trainings are meeting existing needs. Academic expectations will be communicated to all residential facilities serving DYRS youth. DYRS case managers will be offered ongoing training on education topics in order to better support committed youth.

CFRC Recommendations for Homicide Fatalities

Recommendation #3: The Child Fatality Review Committee recommends the Child and Family Services Agency should mandate annual domestic violence training for all staff social workers, contracted social workers, and paraprofessionals who provide direct services to children and their families who come into contact with the agency as a result of abuse and neglect. This will ensure that all direct service providers within the agency will be able to appropriately assess the family's needs and factor risks associated with domestic violence.

Response: The Child and Family Services Agency accepts the recommendation with the following modification: The Child Fatality Review Committee recommends the Child and Family Services Agency develop a phased approach and community partnership to providing domestic violence training for social workers and paraprofessionals who provide direct services to children and their families who come into contact with the agency as a result of abuse and neglect. This will ensure that child welfare direct service providers will develop skills necessary to assess the family's needs and risk factors associated with domestic violence and make appropriate referrals for domestic violence services in accordance with client's consent to services. Agency practitioners will be able to assess for and identify safety and risk factors associated with domestic violence and make appropriate referrals for services in accordance with clients consent to services. CFSA will identify community providers who will partner to share training resources and expertise. CFSA will identify opportunities within current training system and develop appropriate training curriculum to meet the training needs. the following dates: February 3, April 28 and 29, June 13 and 27, July 18, 21, 27, 28, and December 2. CFSA will identify community providers who will partner to share training resources and expertise. CFSA will identify opportunities within current training system and develop appropriate training curriculum to meet the training needs. CFSA has begun to include Domestic Violence Training for new direct service hires through pre-service training . In-service training will include "Domestic Violence and Traumatic Brain Injury"- the target population for this training is direct service practitioners and resource parents. CFSA sponsored 12 trainings on domestic violence in 2011. SAFE and the DC Coalition Against Domestic Violence co-sponsored/facilitated 10 of these 12 trainings. They were held on the following dates: February 3, April 28 and 29, June 13 and 27, July 18, 21, 27, 28, and December 2.

ACCIDENTAL DEATHS

In 2011, the Committee reviewed five child fatalities resulting from accidental events.

- ◆ The ages of the 2011 accidental death victims ranged from 1 month to 7 years.
- ◆ All five decedents in this category were Black.
- ◆ Four decedents were male and one was female.

TABLE 7	
CFRC ACCIDENTAL DEATHS	
Fire	2
Motor Vehicle/Transportation	1
Asphyxia	1
Drowning	1
Total	5

The following tables provides details regarding the accident related child fatalities reviewed by CFRC in 2011.

TABLE 8: Fire Related Fatalities					
<i>AGE/RACE/ GENDER</i>	<i>Time of Injury</i>	<i>Ward of Residence/ Location of Fatal Incident</i>	<i>Place of Incident</i>	<i>Contributing Factors#1</i>	<i>Risk Factors</i>
7/Black/ Male 5/Black/Male	5:54 pm	4/MD	Family Home	Unattended food cooking on stove	Smoke Detector Failure/ Child left Unattended

2011 Child Fatality Review Committee Annual Report
Accidental Deaths

TABLE 9: TRANSPORTATION RELATED ACCIDENTS						
<i>AGE/ RACE/ GENDER</i>	<i>Time of Injury</i>	<i>Ward of Residence/ Location of Fatal Incident</i>	<i>Type of Victim</i>	<i>Type of Vehicle</i>	<i>Contributing Factor #1</i>	<i>Contributing Factor #2</i>
4/Black/ Male	6:53 pm	1/1	Pedestrian	Automobile	Driver Violation/ Collision	Unattended Child

TABLE 10: ASPHYXIA FATALITY				
<i>AGE/RACE/ GENDER</i>	<i>Place of Injury</i>	<i>Ward of Residence/ Location of Fatal Incident</i>	<i>Contributing Factor #1</i>	<i>Contributing Factor #2</i>
1 month Black/Male	Family home	1/1	Inappropriate Sleep Environment	Parental Alcohol Use

TABLE 11: DROWNING FATALITY				
<i>AGE/RACE/ GENDER</i>	<i>Place of Injury</i>	<i>Ward of Residence/ Location of Fatal Incident</i>	<i>Contributing Factors #1</i>	<i>Contributing Factor #2</i>
6/Black/ Female	Pool	1/5	Unattended Child	Swimming without Life Preserver

SUICIDE DEATHS

There was one suicide death among the cases reviewed in 2011. Suicide rates among the children and youth in the District of Columbia remain low. The CFRC case review provides insight on the delivery of mental health services to youth with mental illness. The table below provides information pertaining to and including the identified CFRC risk factors associated with this case.

TABLE 12: SUICIDE DEATH			
<i>Age/Race/ Gender/</i>	<i>Method</i>	<i>Ward of Residence/Location of Fatal Incident</i>	<i>Contributing Mental Health And Social Factors</i>
16yr/Black Male	Hanging	5/5	<ul style="list-style-type: none"> • Complicated Medical History • Unresolved History of Depression • Prior Suicide Attempt • History of Juvenile Arrest • History of Neglect and Abandonment

UNDETERMINED DEATHS

In 2011, six infants and children reviewed by the CFRC had an Undetermined manner of death. Four of these case reviews indicated the deaths were sudden, unexpected, or unexplained, and a definitive cause of death remained elusive despite the thorough forensic death investigation and examination. Three of the deaths involved infants who were 20 days to 4 months of age and one case involved an 18 month old child. Risk factors associated with the three infant deaths are presented in Table 14. Other findings associated with the three other deaths are presented in Table 15.

Undetermined Deaths and Associated Risk Factors

TABLE 13: FINDINGS OF SUDI FATALITY REVIEWS

<i>Age/Race/ Gender</i>	<i>Ward of Residence</i>	<i>Medical History</i>	<i>Sleep Environment</i>	<i>Other Risk Factors</i>
4month/ Black/ Female	7	Healthy Full Term	Infant placed on pillow to sleep	<ul style="list-style-type: none"> • Infant left unsupervised • Excessive clutter in home • No crib or bassinet in home
20days/ Black/Male	8	Healthy Full Term	Infant placed in adult bed	<ul style="list-style-type: none"> • Inappropriate bedding surrounding Infant • Adults in bed with Infant
1month/ Black Male	6	Healthy Full Term	Prone sleep position	<ul style="list-style-type: none"> • Inappropriate bedding in bassinet

TABLE 14: FINDINGS OF OTHER UNDETERMINED FATALITIES

<i>Age/Race/ Gender</i>	<i>Ward of Residence</i>	<i>Cause of Death</i>	<i>Risk Factors</i>
10month/ White/ Female	4	Asphyxia	<ul style="list-style-type: none"> • Infant left unsupervised • Baby monitor cord found in crib
18month/ Black/Male	8	Sudden Unexplained Death in Childhood	<ul style="list-style-type: none"> • None Known
4 year/Black Female	4	Thermal Injuries including Smoke Inhalation and Cutaneous Burns	<ul style="list-style-type: none"> • Unsupervised Child

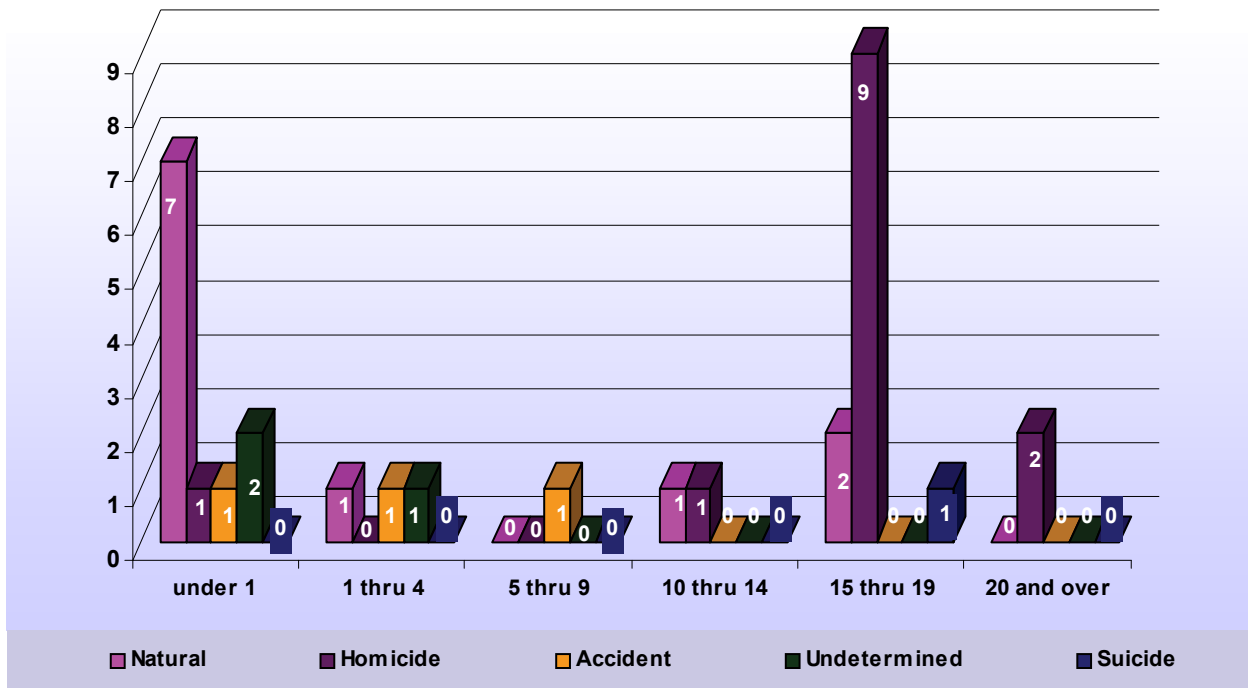
SECTION II:

**SUMMARY OF CHILD WELFARE
AND
JUVENILE JUSTICE DECEDENTS**

CFRC Child Welfare Decedents

In accordance with District Law, the CFRC is mandated to review the fatalities of children and youth known to the District’s child welfare agency within four years of the fatal event.

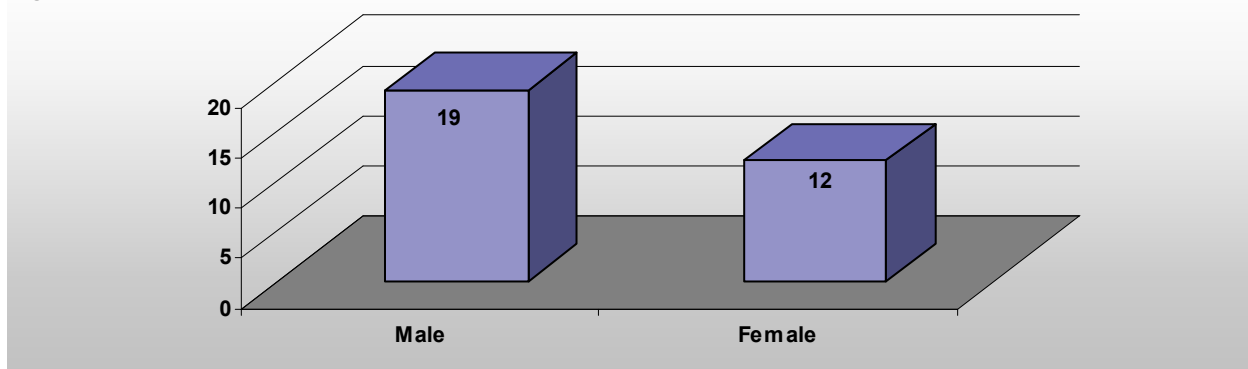
Figure 16: CFRC Child Welfare Decedent Age by Manner of Death (N=31)



Of the 119 cases reviewed by the Committee in 2011, 26% (31) of the children and youth were involved with the District’s child welfare within four years of the fatal event.

- The majority of child welfare cases reviewed by the Committee in 2011 involved youth between the ages of 15 through 19 (12) and infants (11).
- As shown in figure 16, most of the child welfare fatalities were due to natural causes and homicides. Thirteen children and youth succumbed to Homicide. Eleven children and youth died of natural causes. Three cases associated with Accidents and Undetermined manners of death included children known to child welfare. One youth whose death was the result of Suicide was known to child welfare prior to the fatality.

Figure 17: 2011 CFRC Child Welfare Decedent Gender (N=31)



CFRC Juvenile Justice Decedents

The CFRC is mandated to review the deaths of youth who were involved with the District's juvenile justice program within two years of the fatal event. In 2011, eleven of the CFRC cases reviewed met this criteria. All of the decedents, who were between the ages of 16 and 20 years old were Black males. The majority of these decedents resided in Ward 4 and Ward 8, with three decedents in each.

Figure 18: 2011 CFRC Juvenile Justice Decedent Age (N=11)

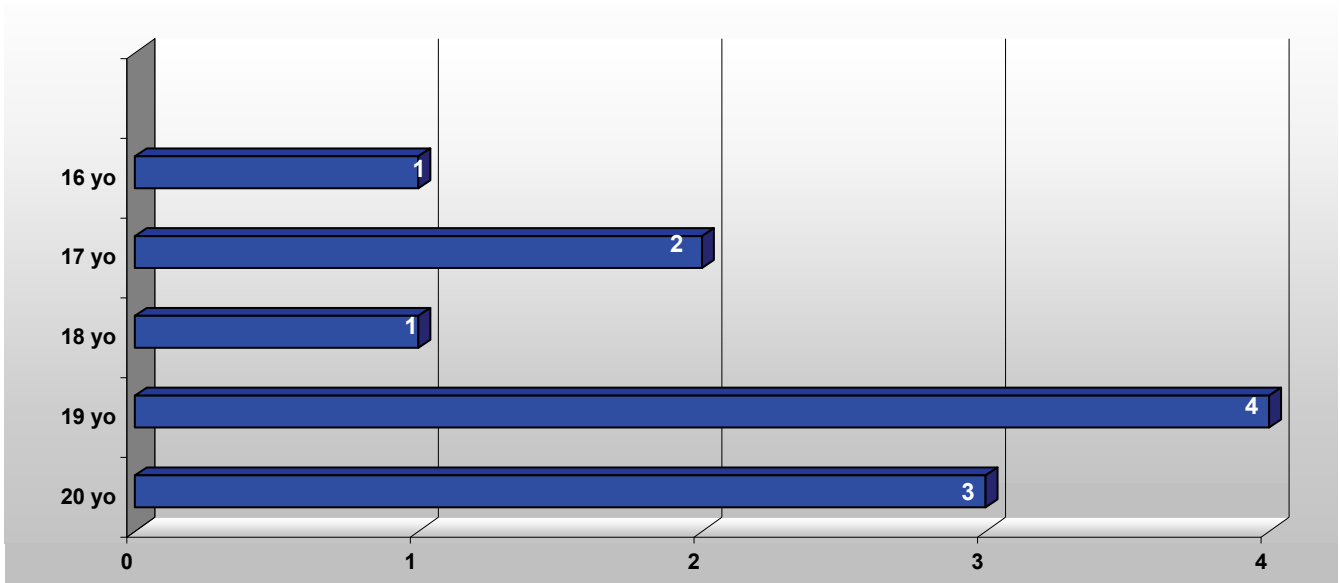
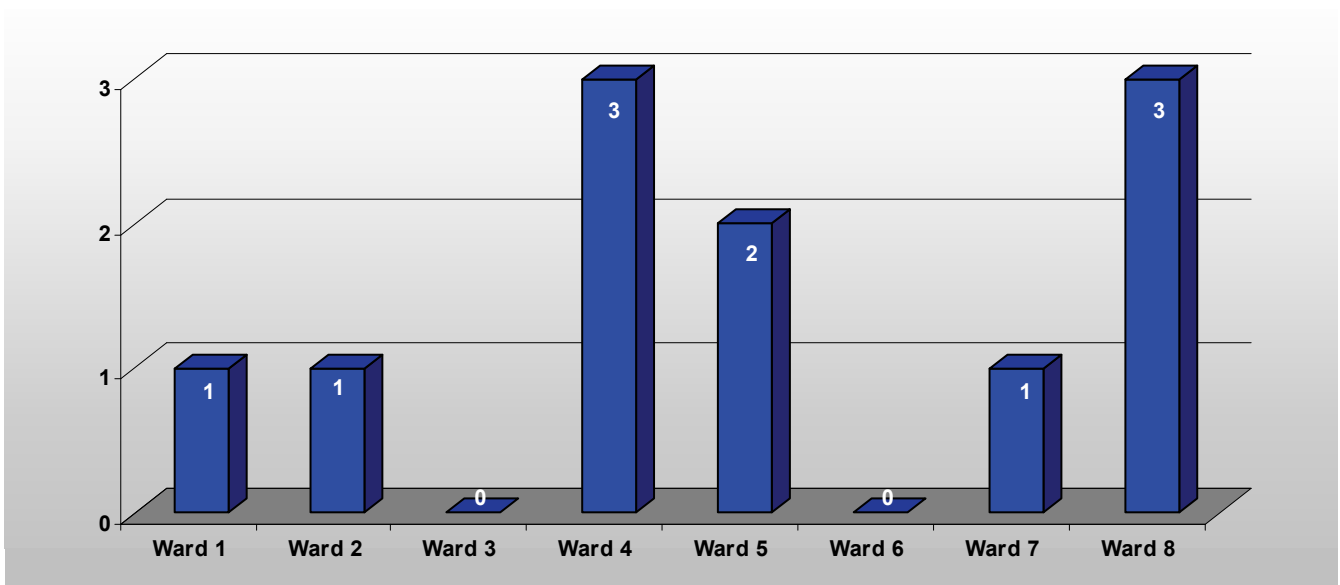


Figure 19: 2011 CFRC Juvenile Justice Decedent Ward of Residency (N=11)



Dual District Agency Involvement

Of the cases reviewed by the Committee in 2011, five of the decedents were known to both juvenile justice and child welfare programs prior to the fatal event. All of these youth were victims of homicide, and all were Black males.

Fatality reviews of decedents known to child welfare and juvenile justice programs provide the most comprehensive information with regards to the decedents personal and family history prior to the fatal event. As a result of the comprehensive record review of government and community based programs the Committee noted the effect of social issues on outcomes for children and youth. In cases involving youth, school truancy and decedent substance abuse were leading issues affecting outcomes for youth who were involved with government programs.

TABLE 15	
Social Issues Observed in Cases Where Decedents were known to Both Child Welfare and Juvenile Justice	
Family Domestic Violence	3
Decedent Substance Abuse	8
Decedent Mental Health Problems	3
School Truancy	13
Parental Substance Abuse	3
Financial and/or Housing Problems	1

APPENDICES



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).

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