Government Of the
District of Columbia

Office of the
Chief Medical Examiner

# CHILD FATALITY REVIEW COMMITTEE
# 2013 ANNUAL REPORT

# District of Columbia
# Child Fatality Review Committee

# 2013 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

DECEMBER 2014

*Greetings,*

The Office of the Chief Medical Examiner (OCME) was established in 1971. The system began as coroner system in the early 1870's and existed as such for 100 years before becoming a medical examiner system. It is with great pleasure and humility that I become the 12th Chief Medical Examiner for the District of Columbia.

The OCME now resides within the brand new Consolidated Forensic Laboratory (CFL) in Southwest. This state of the art facility is equipped with much of what is needed to carry out the mission of death investigation, forensic toxicology, and mass fatality management for the District of Columbia.

Our role as the Medical Examiner is not limited to the determination of cause and manner of death only. Equally as important is the work we do within our fatality review committees. The Child Fatality Review, Developmental Disabilities Fatality Review and Domestic Violence Fatality Review Committees are intended to develop systemic recommendations that can be used to inform evidence-based programs and policy. We take this obligation very seriously and are working to improve our processes of review and reporting.

The Child Fatality Review Committee (CFRC) has worked to improve much of its processes during 2014. Improvements that we believe are reflected even within this 2013 Annual Report. In particular, we have added Maps depicting the geographic location of child/infant deaths within the community. Where deaths occur in the District is as equally important as Age, Race, and Gender.

The work performed by the CFRC, the analysis of mortality data and the recommendations contained within this report are critical to understanding risk factors surrounding preventable deaths of the children who reside in the District of Columbia.

Thank you to the membership of the CFRC, participant Agencies and Community Members who contributed to this report. We will continue to serve as a voice for those lost children towards sustainable system change.

Yours in Truth and Service,

Roger A. Mitchell, Jr. MD FASCP
Chief Medical Examiner

# District of Columbia
# Child Fatality Review Committee

## Dedication

This Annual Report is dedicated to the memory of the children and youth of the District of Columbia who lost their lives due 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 these children, we can succeed in positively affecting the future of our infants, children and youth 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 18th Annual Report. This Report covers data from 91 child/youth fatality cases reviewed by the CFRC in 2013.

The CFRC is a citywide collaborative effort authorized by the Child Fatality Review Committee Establishment Act of 2001 (see Appendix B: DC Code, § 4-1371.01 *et. seq.*). This 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 of the District of Columbia, or were known to the child welfare or juvenile justice systems of 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 CFRC are: the Office of the Chief Medical Examiner (OCME), the Department of Health (DOH), the Child and Family Services Agency (CFSA), and the Metropolitan Police Department (MPD).

## KEY CHILD FATALITY REVIEW DATA FINDINGS

### DECEDENT DEMOGRAPHICS

The age of the 91 decedent cases reviewed by the CFRC in 2013 ranged from birth to 22 years of age. Select demographic information is bulleted below:

- Seventy-one percent (71%, 65 cases) of the decedents were infants.
- Eighty-one percent (81%, 74 cases) of the decedents were African American.
- Sixty percent (60%, 54 cases) of the decedents were males.

### MANNERS OF DEATH

**Natural Deaths**

In 2013, the CFRC reviewed sixty-six (66) natural cases involving infants, children and youth. Eighty-five percent (85%) of these were infants. Thirty-four (34) of those infants died of causes related to premature birth. Of those thirty-four (34) premature birth cases reviewed by the Infant Mortality Review Team (IMRT), maternal infection was the leading known risk factor in twenty-one (21) or sixty-two (62%) of the cases reviewed.

**Homicide and Suicide**

The CFRC reviewed eleven (11) fatalities of infants, children and youth whose deaths resulted from acts of violence. Two (2) cases involved the suicide of two (2) youth. Three (3) of these cases involved the fatal abuse of three (3) infants.

**Accidental Deaths**

The CFRC reviewed six (6) accidental deaths involving children and youth. The circumstances leading to these accidental deaths were motor vehicle collisions and fires.

**Undetermined Deaths**

The CFRC reviewed eight (8) infant and child fatalities in which the manner of death was classified as undetermined. In four (4) of these cases, Sudden Unexplained Infant Death associated with an unsafe sleep environment was the cause of death.

# INTRODUCTION

The District's child fatality review process is the only formally established mechanism within the District for tracking infant, children and 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 for service delivery systems to better address the needs of children and families served. It is an opportunity for self-evaluation of District government systems, policies, and programs, 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 or Committee) is divided into two teams; the Infant Mortality Review Team (IMRT) reviews the deaths of District infants from birth through 12 months. The Child Fatality Review Team (CFRT) 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 applicable child and family-serving agencies. Records are reviewed, and a summary is developed for presentation during the monthly case review meetings.

In accordance with DC Official Code §4-1371.04, Committee membership is multidisciplinary, representing public and private child and family servicing agencies and programs. Most important, Committee membership includes community members representing the District of Columbia's 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. The Committee is also charged with identifying potential system improvements and making recommendations for the prevention of deaths.

This annual report summarizes data collected from 91 child and youth fatalities reviewed by the Committee during calendar year 2013. The statute mandates the publishing of an annual report 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 III: Recommendations**: This section contains the Committee's recommendations and the agency responses.

# SECTION I:

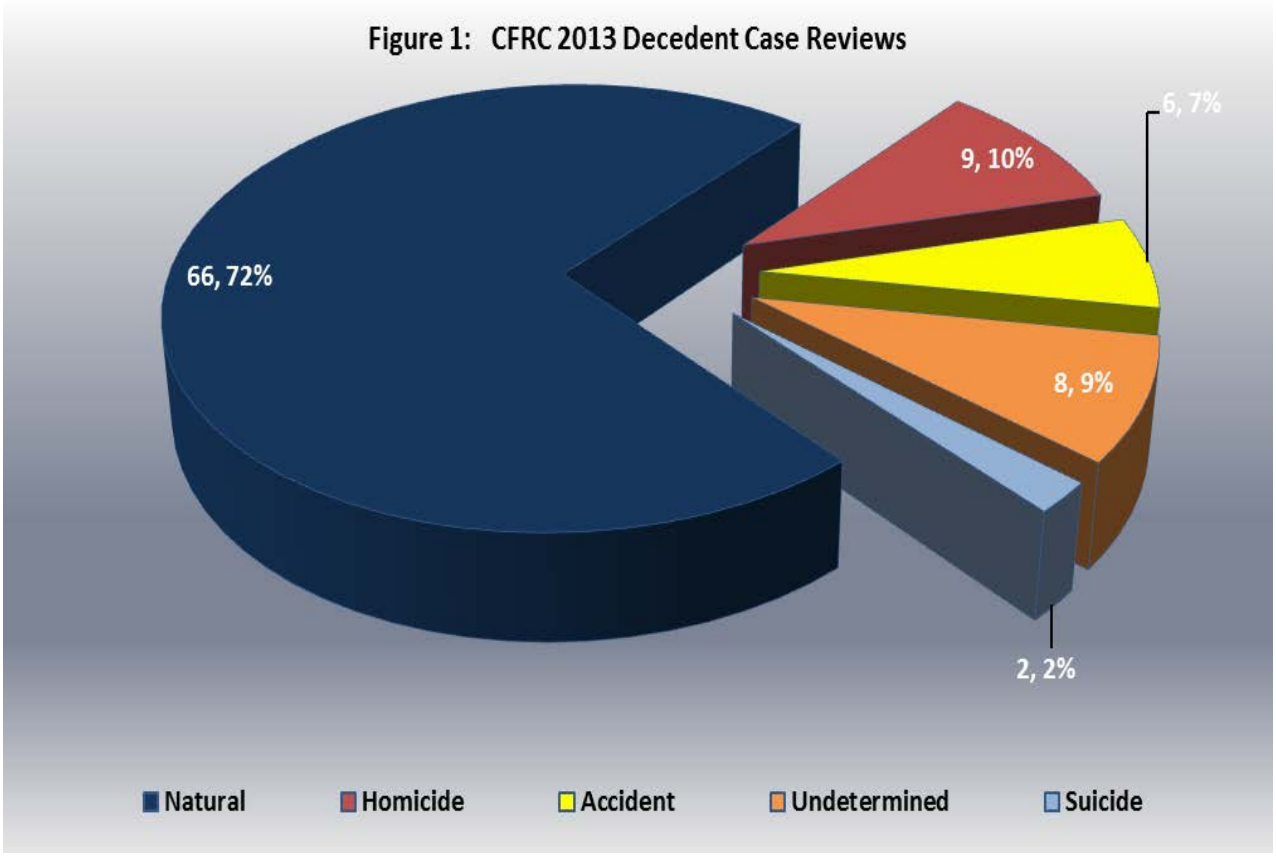
# SUMMARY OF CASE FINDINGS

## Manner of Death of Cases Reviewed by the CFRC in 2013

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

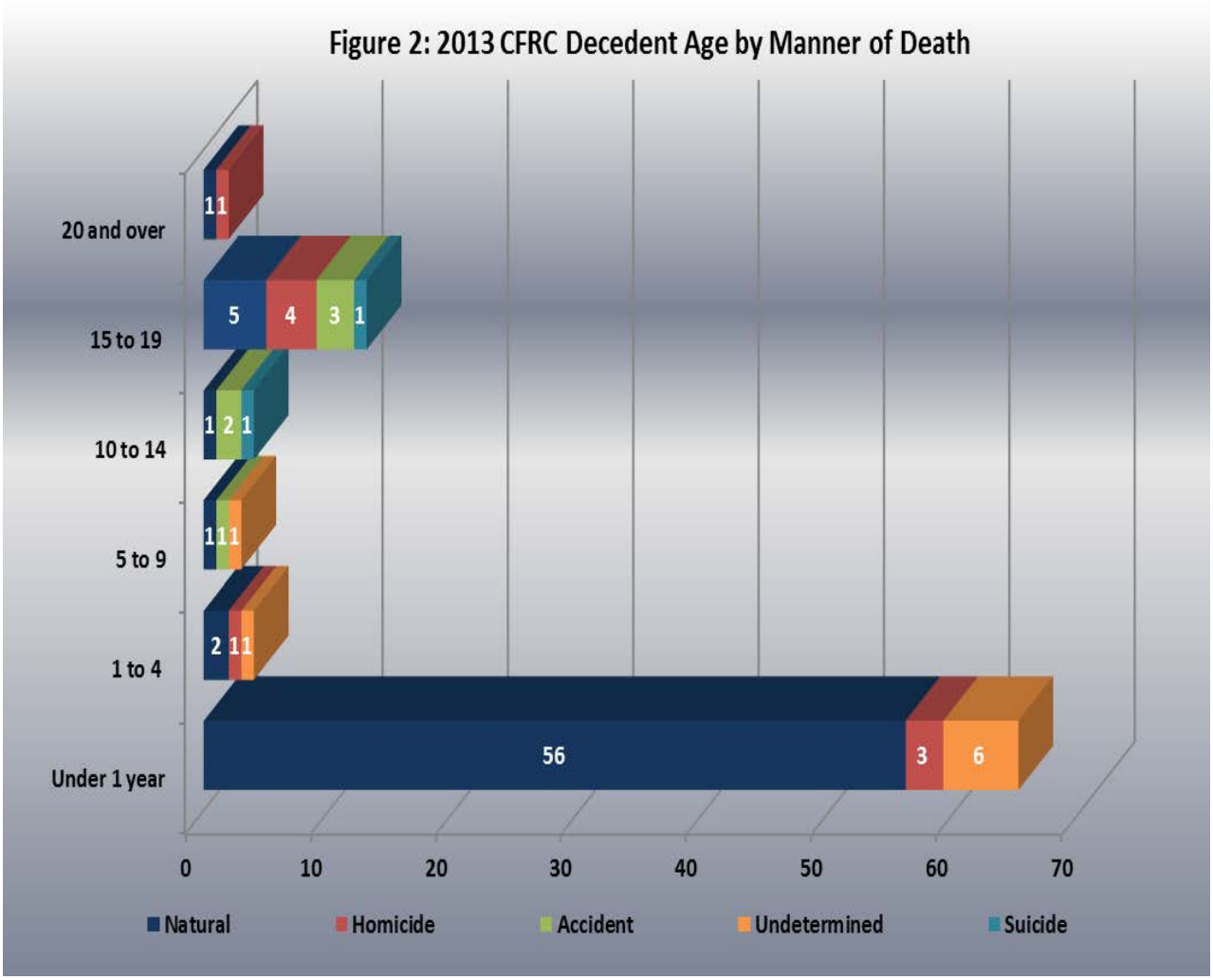
In 2013, the Committee reviewed 91 death cases of infants, children, and youth.

- Sixty-six (66) cases involved infants, children and youth who died of natural causes.
- Nine (9) cases involved infants, children and youth whose manner of death was homicide.
- Eight (8) cases involved infants, children, and youth were the manner was undetermined.
- Six (6) cases involved the accidental deaths of children who died in motor vehicle accidents or fires.
- Two (2) cases involved the suicide of youth.



## DECEDENT DEMOGRAPHICS BY MANNER OF DEATH

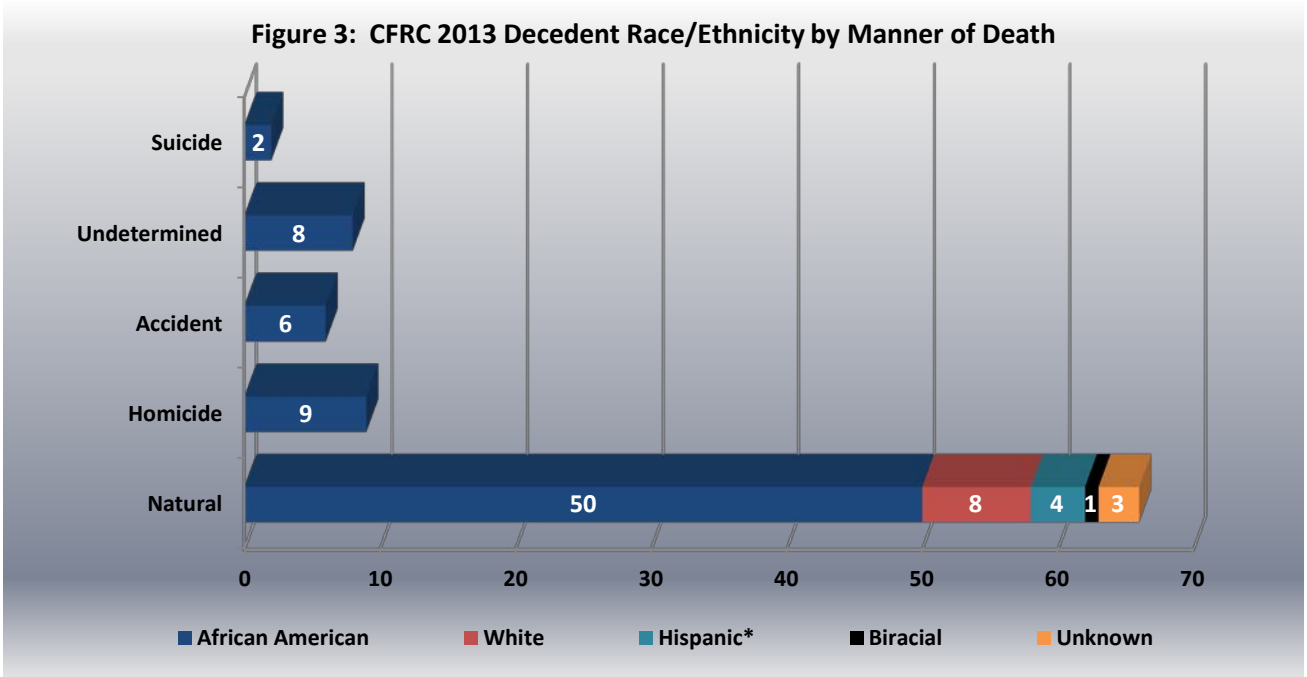
Sixty-five (65, 71%) of cases reviewed involved the fatality of infants. The second largest (14%) age group involved youth ages 15 to 19. The figure below further details the age and manner of death of cases reviewed by the CFRC.

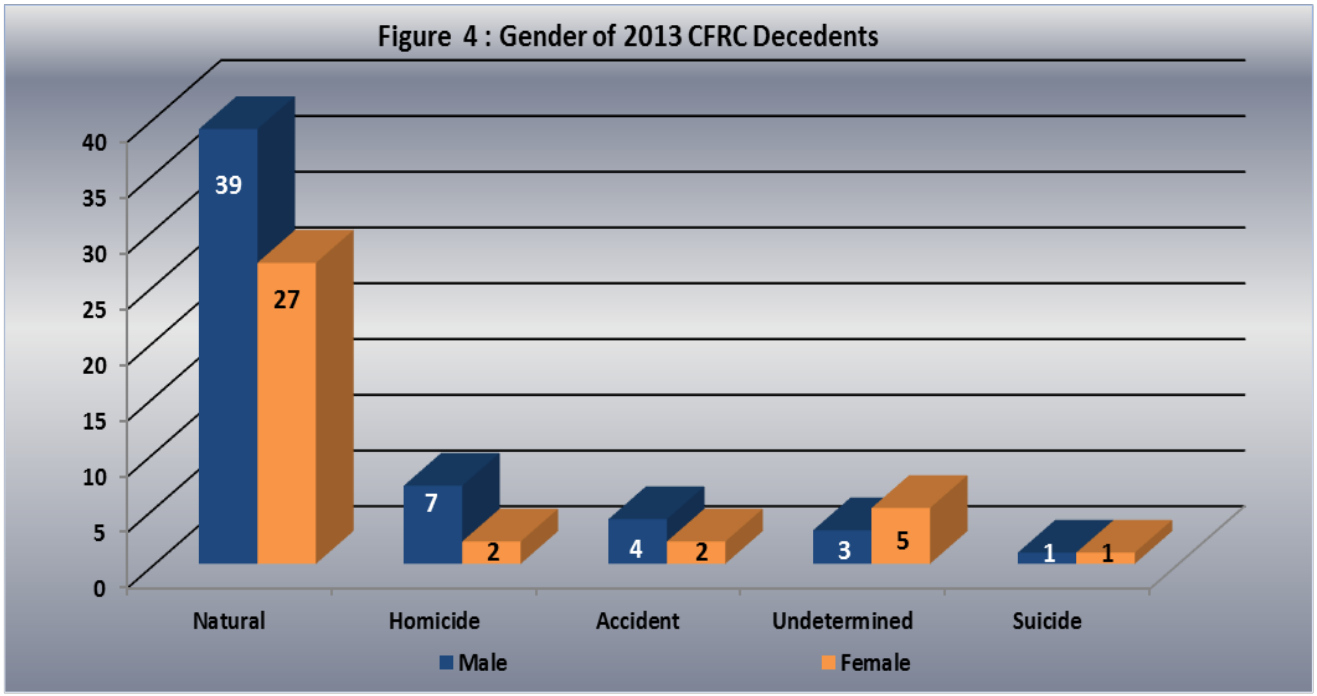


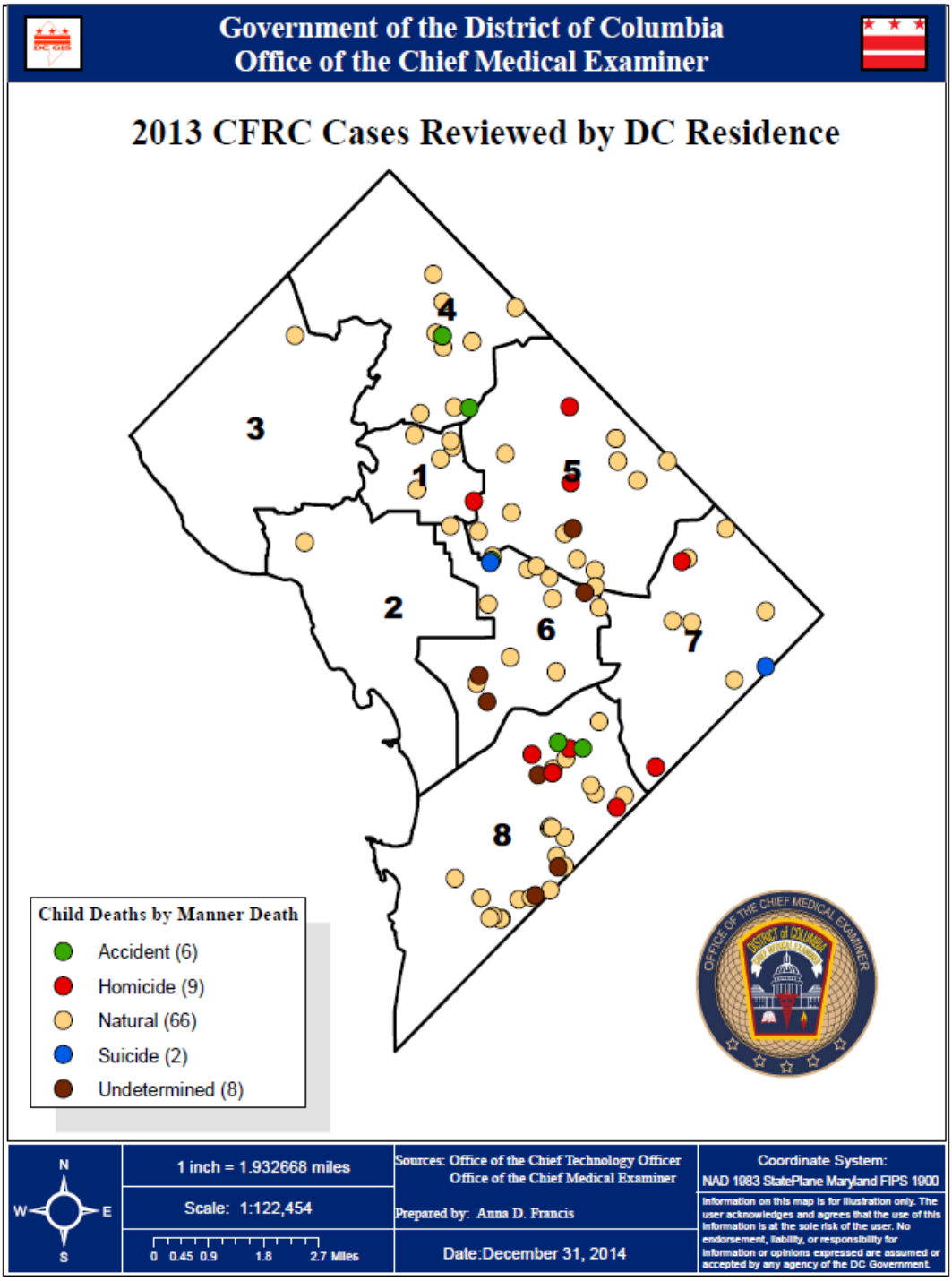
# DECEDENT DEMOGRAPHICS BY MANNER OF DEATH

## RACE AND GENDER BY MANNER OF DEATH

Seventy-five (75) of the cases reviewed by the Committee were those of African American children and youth, representing 82% of the total CFRC decedent cases reviewed in 2013. Eight (8) cases involved White infants and children.




Government of the District of Columbia
Office of the Chief Medical Examiner
2013 CFRC Cases Reviewed by DC Residence
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2
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7
8
Child Deaths by Manner Death
Accident (6)
Homicide (9)
Natural (66)
Suicide (2)
Undetermined (8)
OFFICE OF THE CHIEF MEDICAL EXAMINER
DISTRICT of COLUMBIA
N
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E
S
1 inch = 1.932668 miles
Scale: 1:122,454
0 0.45 0.9 1.8 2.7 Miles
Sources: Office of the Chief Technology Officer
Office of the Chief Medical Examiner
Prepared by: Anna D. Francis
Date:December 31, 2014
Coordinate System:
NAD 1983 StatePlane Maryland FIPS 1900
Information on this map is for illustration only. The user acknowledges and agrees that the use of this information is at the sole risk of the user. No endorsement, liability, or responsibility for information or opinions expressed are assumed or accepted by any agency of the DC Government.

## Decedent Ward of Residency

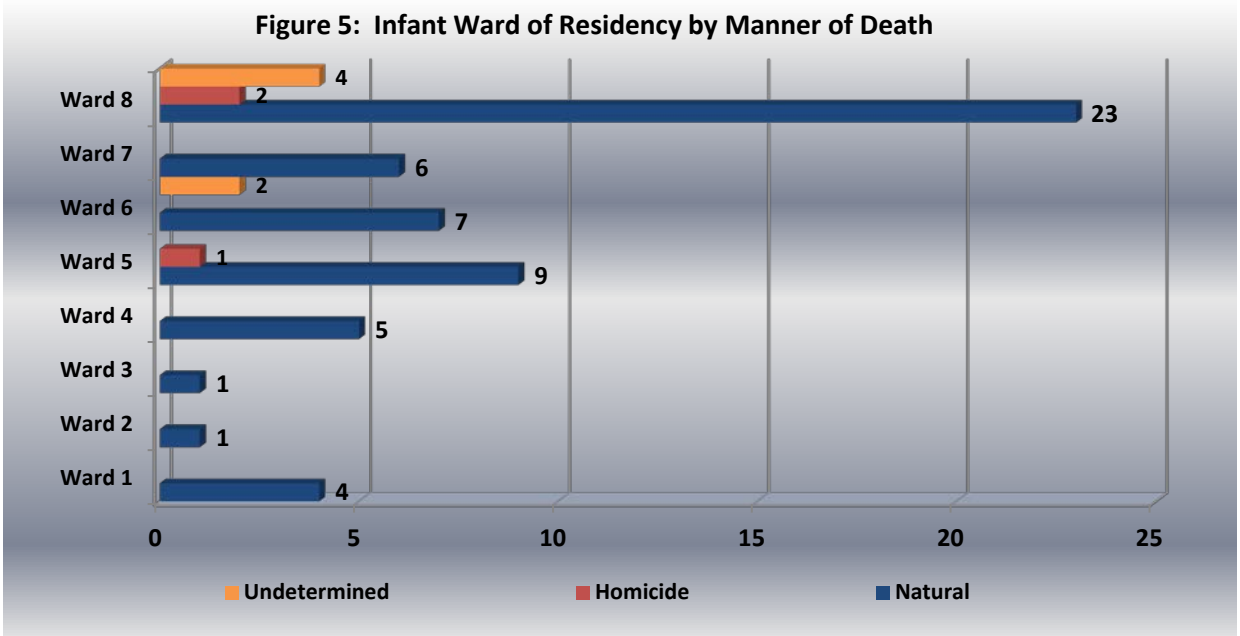
All of the CFRC decedents were residents of the District of Columbia. The decedent's ward of residency is determined by information contained on the death certificate and other supporting documentation provided to the CFRC for review (i.e., child welfare, public assistance records/databases, etc.).

Sixty-five (65) death cases reviewed involved infants less than 1 year of age. The Committee reviewed fifty-six (56) cases involving infants who died of natural deaths, six (6) undetermined, and three (3) homicides. Deaths of infants affected every residential Ward within the District of Columbia. The majority of the infant cases reviewed by the CFRC continue to be those infants who resided in **Ward 8** equaling twenty-nine (29) total deaths. Of these, twenty-three (23) infants died of natural causes, two (2) were homicide victims, and four (4) died of undetermined causes associated with bed sharing. Ward 5 was the far second residential area affected by infant deaths totaling ten (10) cases reviewed. Of these cases, nine (9) infants died of natural causes, and one (1) infant died of homicide. (Figure 5)

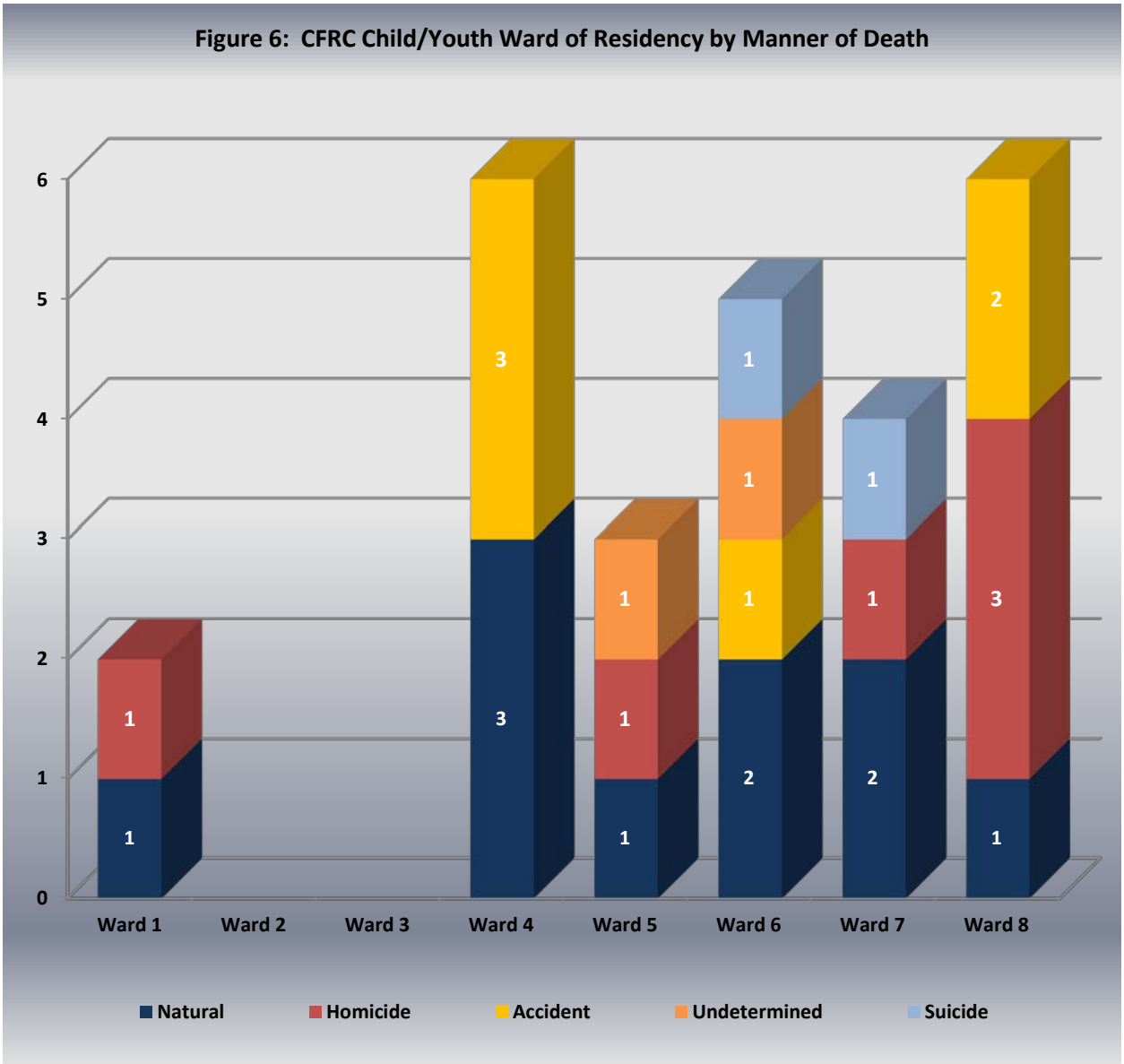
Twenty-six (26) deaths reviewed involved children greater than or equal to 1 year of age. The majority of these cases were natural deaths (10) followed by homicides (6) and accidental deaths (6). Children and youth residing in Ward 4 and Ward 8 at the time of their death represented the majority of cases reviewed by the CFRC in 2013.

The data reveals that Ward 8 is disparately represented for all deaths reviewed in 2013. This information may be used to direct policy and programs towards decreasing this disparity within the District of Columbia.

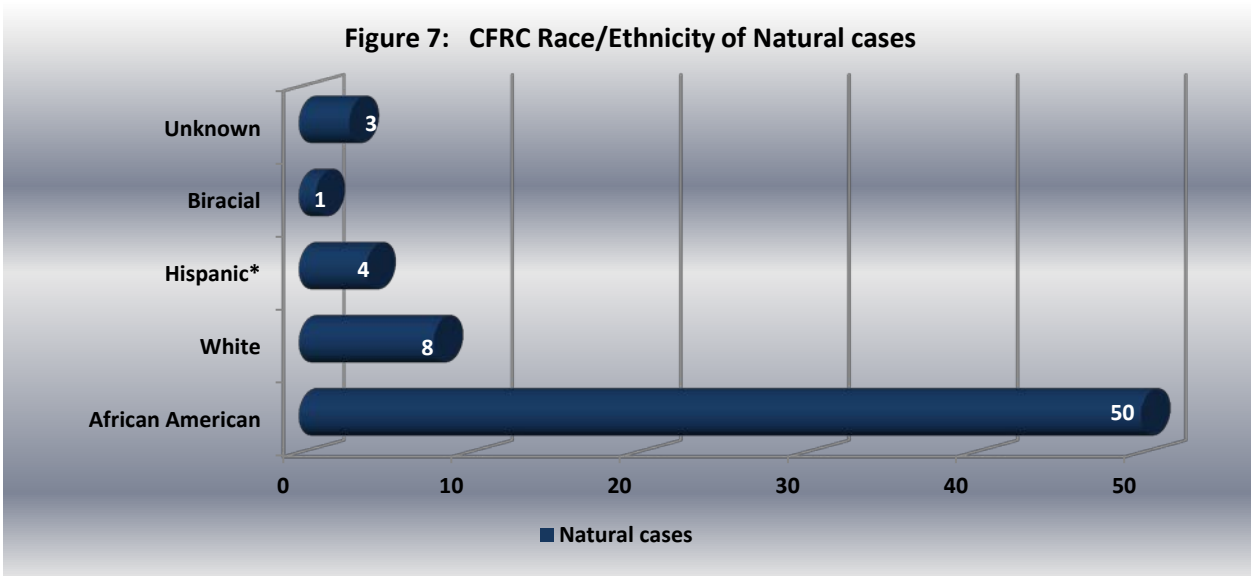
**Figure 5: Infant Ward of Residency by Manner of Death**

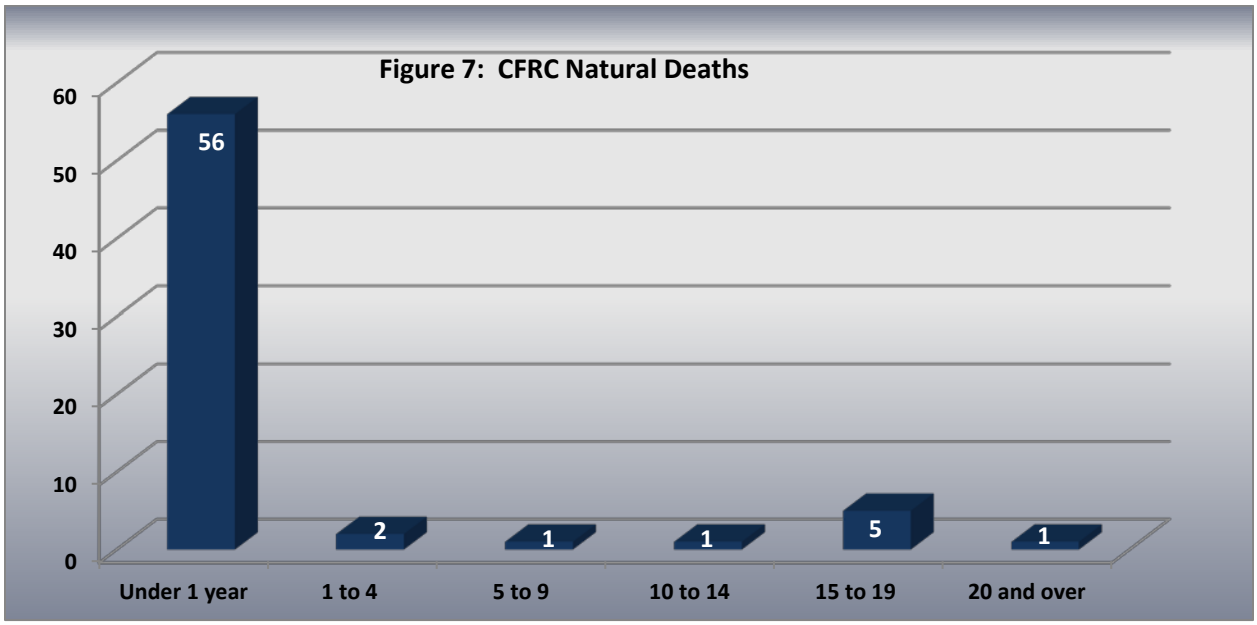


## Decedent Ward of Residency



## Decedent Demographics – Natural Deaths



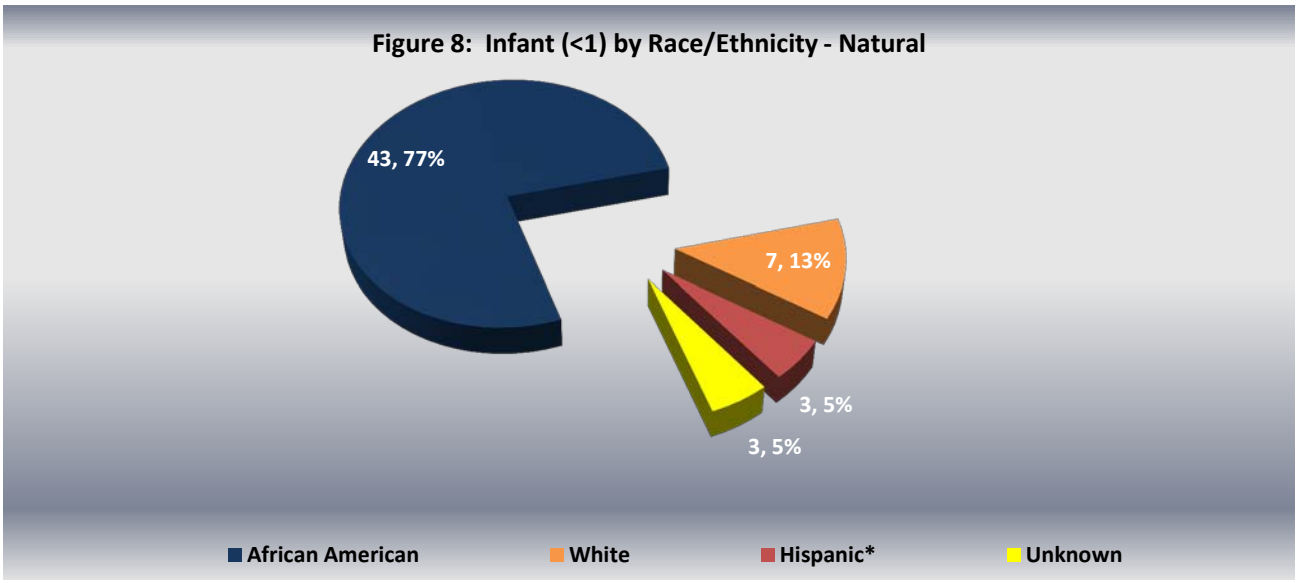


Figure 8: Infant (<1) by Race/Ethnicity - Natural
43, 77%
7, 13%
3, 5%
3, 5%
African American
White
Hispanic*
Unknown

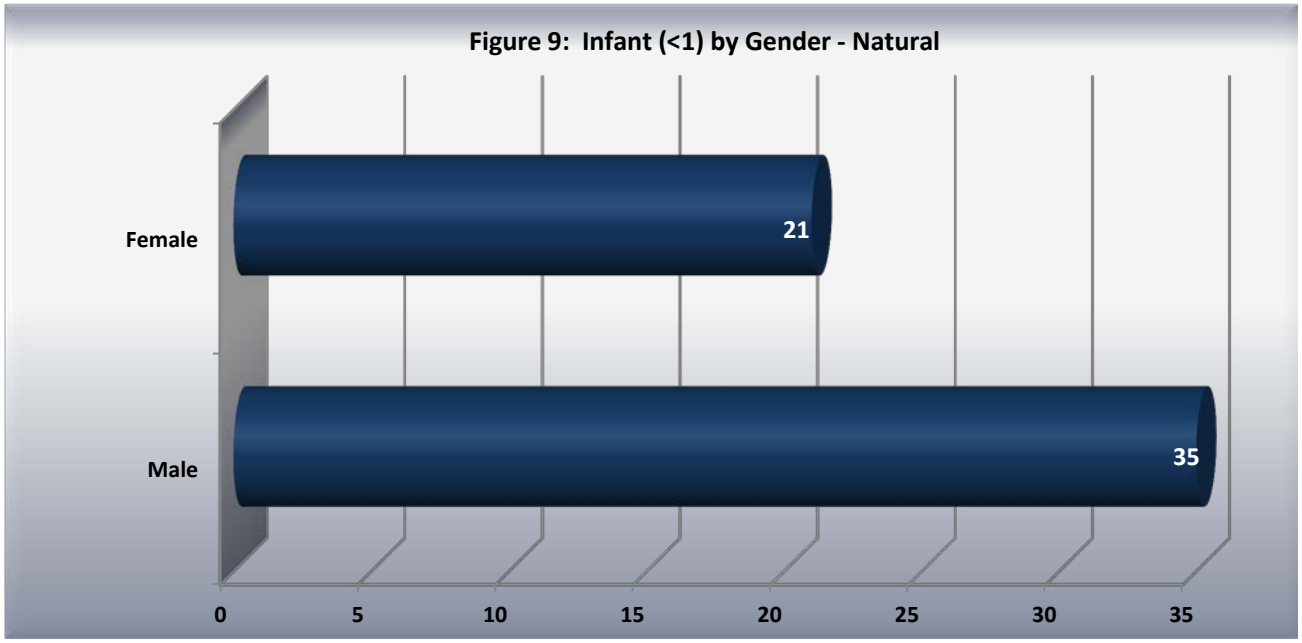


Figure 9: Infant (<1) by Gender - Natural
Female
Male
21
35
0
5
10
15
20
25
30
35

## Natural Deaths - Deaths Related to Premature Births

Thirty-four (34) of the fifty-six (56) natural deaths reviewed of infants less than 1 year of age died as a complication of prematurity. Many risk factors were identified upon review of these cases including those affecting the mother and infant.

### Maternal Risk Factors

***Prenatal Care***

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 sixteen (16) of the thirty-four (34) premature infant deaths reviewed.*

An article published by the American Journal of Perinatology concluded that risk factors, including prematurity, still birth, and infant death are associated with poor prenatal care, particularly in young mothers, African American and Hispanic women, and women who do did not complete their high school education (Partridge, Balayla, & Holcroft, 2012). The Routine prenatal care visits are recommended on the following schedule throughout the pregnancy:

- An initial visit in the 1st trimester (gestation week 1 to week 12)
- Prenatal care visit once every 4 weeks until the 28th week
- Prenatal care visit once every 2 weeks until the 36th week
- After the 36th week, a prenatal care visit should occur once a week until delivery

Also, expectant mothers should comply with their obstetricians prescribed medications, recommended procedures, and diet.

Through its review of infant fatalities, the IMR team determined that inadequate prenatal care was associated with almost half (47%) of the premature cases reviewed. This includes late entry into prenatal care without a visit during the first trimester as well as missed prenatal visits throughout the course of the pregnancy.

***Premature Rupture of Membranes (PROM)***

*Of the thirty-four (34) total premature infant cases reviewed, ten (10) presented with premature rupture of membranes.*

Premature rupture of membranes (PROM) refers to a patient who has presented with rupture of membranes (ROM) prior to the onset of labor before 37 gestational weeks. PROM is a cause of premature birth (US Department on Health and Human Servicves National Institute of Health, 2014).

## Natural Deaths - Deaths Related to Premature Births

***Infection***
*A diagnosis of infection was made in twenty-one (21) of the premature birth cases reviewed. Of these cases, thirteen (13) had either a history or a current diagnosis of sexually transmitted disease.*

Infection is a complication of pregnancy that can negatively affect the outcome of the pregnancy. Research shows that infections, including group B strep, sexually transmitted disease, and food born infections such as Listeriosis can lead to premature birth and serious illnesses in the infant. (US Department on Health and Human Services Office of Women's Health, 2010).

***Incompetent Cervix***
*Cervical incompetence was present in seventeen (17) of the premature infant cases reviewed.*

This is a medical condition in which a pregnant woman's cervix begins to dilate (widen) and efface (thin) before her pregnancy has reached term with resultant premature expulsion of the fetus. Risks of an incompetent cervix include premature birth and fetal death. (Mayo Foundation for Medical Education and Research, 2014).

***Obesity***
*Maternal obesity was a recognized risk factor in thirteen (13) of the premature infant cases.*

Several studies report a negative impact of excessive maternal weight on the outcome of a pregnancy. Obesity is also a risk factor for pre-eclampsia, which is a multi-system disorder that has negative manifestations for both the mother and the fetus. Women with a BMI greater than 30 have double the risk of pre-eclampsia. (Nelson-Piercy, 2006).

## Infant Risk Factors

***Gestational age and birth weight***
The American Academy of Pediatrics defines a preterm birth as "any delivery, regardless of birth weight that occurs before thirty-seven (37) completed weeks from the first day of the last menstrual period." Infant mortality increases in infants born less than thirty-two (32) weeks of gestational age, as these infants have not had an opportunity to fully develop. The following are birth weight categories as established by the American Academy of Family Physicians (Trachtenberg, 1998):

- ***Low birth weight*** infants are those weighing <2,500 grams
- ***Very low birth weight*** infants are those weighing <1,500 grams
- ***Extremely low birth weight*** infants are those weighing <1,000 grams

## Natural Deaths - Deaths Related to Premature Births

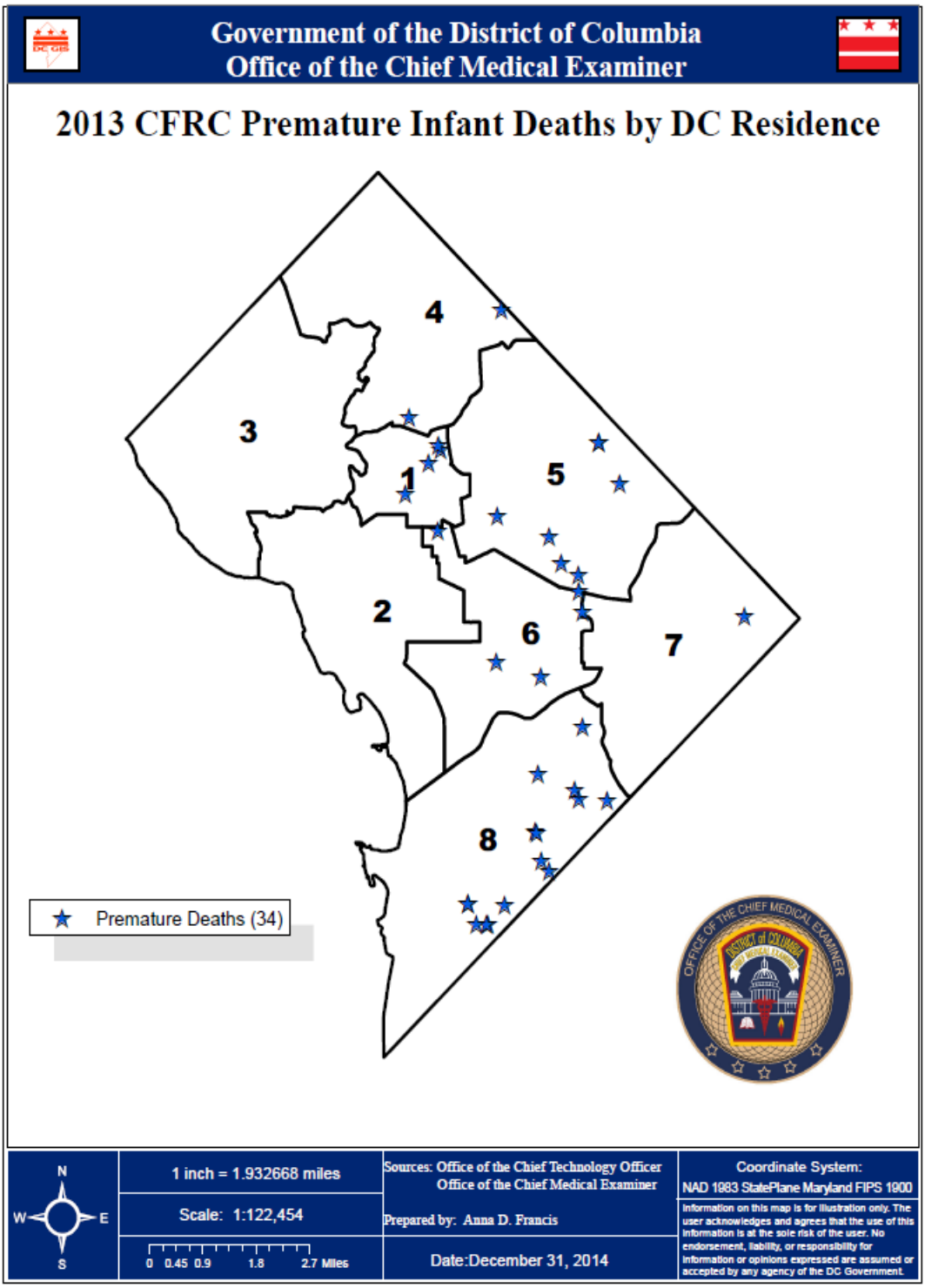
As illustrated in Table 1, the IMR Team's review of the thirty-four (34) infant cases found seventeen (17) infants weighed between 100 to 500grams; thirteen (13) weighed between 501 and 1500grams; and four (4) weighed between 1501 to 2500g.

| Table 1: IMR Premature Decedent Weight | |
|---|---|
| ***Weight*** | ***Number of Infants*** |
| **≤ 500 g** | **17** |
| **501 – 1500 g** | **13** |
| **1500 – 2500 g** | **4** |
| **Total** | **34** |

***Other Risk Factors***

Additional risk factors identified by the IMR Team included illicit drug use, alcohol use, and cigarette smoking. Three (3) infants who died as a complication of prematurity were identified to be associated with families who had a history of involvement with Child Welfare Services.

| Table 2<br>Other Risk Factors | |
|---|---|
| **Risk Factor** | **# of cases** |
| **Illicit Drug Use** | **8** |
| **Family History of Involvement with Child Welfare** | **3** |
| **Alcohol Use** | **4** |
| **Smoking Cigarettes** | **5** |


Government of the District of Columbia
Office of the Chief Medical Examiner
2013 CFRC Premature Infant Deaths by DC Residence
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Premature Deaths (34)
OFFICE OF THE CHIEF MEDICAL EXAMINER
DISTRICT of COLUMBIA
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1 inch = 1.932668 miles
Scale: 1:122,454
0 0.45 0.9 1.8 2.7 Miles
Sources: Office of the Chief Technology Officer
Office of the Chief Medical Examiner
Prepared by: Anna D. Francis
Date:December 31, 2014
Coordinate System:
NAD 1983 StatePlane Maryland FIPS 1900
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## Natural Deaths – Deaths Not Related to Prematurity

### Other Causes of Natural Infant Deaths

The remaining twenty-two (22) infants who died of natural deaths and were not associated with prematurity are discussed below. The majority of these deaths were not preventable (Table 4). Following prematurity, Congenital Anomalies were identified as the second leading cause of death for infants reviewed by the IMR Team in the 2013 review year.

**TABLE 3**

**Other Natural Causes of Death in CFRC Infants**

| Cause of Death | Number of Deaths |
|---|---|
| Congenital Anomaly | 8 |
| Congenital Heart Disease | 5 |
| Infection | 4 |
| Placental Abruption | 2 |
| Therapeutic Complications | 1 |
| Hepatic Liver Failure | 1 |
| Pulmonary Hypoplasia | 1 |
| **Total** | **22** |

### Natural Causes of Death in Children and Youth

The CFRC reviewed ten cases (10) involving children and youth between the ages of one and 20 years old who died of natural causes. Medical conditions associated with the Central Nervous System (e.g. cerebral palsy), and Cancer were the leading causes of natural death in this age group.

**TABLE 4**

**Natural Causes of Death in Children and Youth**

| Cause of Death | Number of Deaths |
|---|---|
| Central Nervous System (Brain) | 3 |
| Cancer | 2 |
| Congenital Anomaly | 1 |
| AIDS | 1 |
| Sudden Unexpected Death in Infancy* | 1 |
| Respiratory Disease | 1 |
| Connective Tissue Disease | 1 |
| **Total** | **10** |

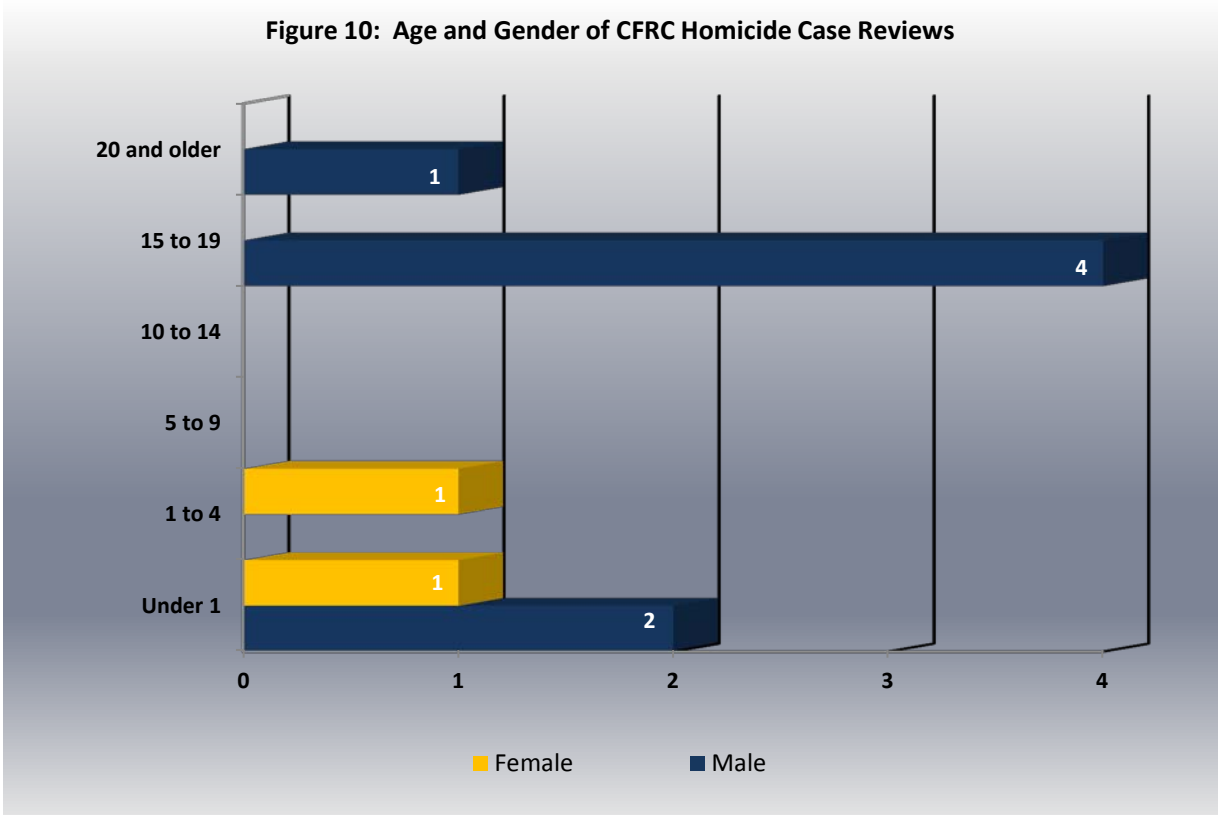
## Homicides

Nine (9) of the cases reviewed by the CFRC were Homicides involving infants, children and youth. The following section outlines information collected for these nine deaths, including the type of homicide, age gender, causes of death and risk factors. All of the homicide decedents were African American.

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. Four (4) of the cases reviewed meet this definition.
- ***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. Five (5) of the cases reviewed meet this definition.
- ***Other Child Homicides*** are the result of an act of violence by a perpetrator who is not the parent/caretaker of the child. None of the cases reviewed by the Committee meet this definition.

**Figure 10: Age and Gender of CFRC Homicide Case Reviews**



## Homicides – Causes of Death

Gun violence is the major factor associated with youth fatalities. Four (4) of the youth homicide cases reviewed by the CFRC in 2013 were firearm related. All of these youth were between the ages of 15 and 22 years old. All of the victims were African American males. MPD records indicate the motives for these homicides were retaliation (2 cases), feud (1 case), and argument (1 case).

Fatal abuse is the leading cause of homicide in cases reviewed involving infants and children. Five (5) of the fatal abuse homicide cases reviewed by the Committee in 2013 involved three (3) infants, one (1) child and (1) youth. The causes of death included sharp force injury (i.e. stab wounds), blunt force injury, asphyxia, thermal injuries, and improper prescription drug administration (Table 5).

**TABLE 5—Causes of Death of CFRC Homicide Victims**

| Method | Fatal Child Abuse | Youth Violence |
|---|---|---|
| Firearm Related | 0 | 4 |
| Sharp Force | 1 | 0 |
| Blunt Force | 1 | 0 |
| Asphyxia | 1 | 0 |
| Thermal Injuries | 1 | 0 |
| Improper Prescription Drug Administration | 1 | 0 |
| Total | 5 | 4 |

## Risk Factors Associated with Homicides

A key tenet of the CFRC case reviews is to identify risk factors associated with the death of children. Table 6 and 7 identify risk factors observed by the Committee during the review of fatal abuse and youth homicide cases.

| Table 6: Family Risk Factors Associated with Fatal Abuse Homicides | |
|---|---|
| **Family Risk Factors** | **# of Victims** |
| Family Mental Health Issues | 2 |
| Poor Family Support | 3 |
| History of Parental Neglect | 2 |
| Exposure to Violence in the Home | 3 |
| Inexperienced/Unlicensed Caregiver | 1 |

| Table 7: Risk Factors Associated with Youth Homicide Case Reviews | |
|---|---|
| **Risk Factor** | **# of Victims** |
| Access to Firearms | 4 |
| Youth living in High Crime Neighborhood | 4 |
| Youth living in Poverty | 5 |
| Active in Drug and Gang Activity | 4 |
| Poor School Attendance/School Failure | 4 |
| History of Parental Neglect | 2 |
| Youth Substance Abuse | 3 |

## ACCIDENTS

In 2013, the Committee reviewed six (6) child fatalities resulting from accidental events. Basic demographic information is bulleted below:

- The ages of the 2013 accidental death victims ranged from 5 to 18 years old.
- All six (6) decedents in this category were African American.
- Four (4) decedents were male, and two (2) were female.

The following tables provide details regarding the accident related child fatalities reviewed by the CFRC in 2013:

| TABLE 8 | |
|---|---|
| **CFRC Accidental Deaths** | |
| **Fire** | **1** |
| **Motor Vehicle Accident** | **5** |
| **Total** | **6** |

| TABLE 9: Fire Related Fatality | | | | |
|---|---|---|---|---|
| ***AGE/RACE/ GENDER*** | ***Time of Injury*** | ***Ward of Residence*** | ***Place of Incident*** | ***Contributing Factors*** |
| **5 /AA/Female** | **4:37 PM** | **8** | **Prince Georges County, MD** | **Electrical Malfunction No Smoke Alarm** |

| TABLE 10: TRANSPORTATION RELATED ACCIDENTAL FATALITIES | | | | | | |
|---|---|---|---|---|---|---|
| AGE/RACE/ GENDER | Time of Injury | Ward of Residence/ Location of Fatal Incident | Type of Victim | Type of Vehicle | Contributing Factor #1 | Contributing Factor #2 |
| 18/AA/Male | 3:04 AM | 4/4 | Driver | Auto | Speeding (Lost Control) | Stolen Vehicle |
| 14/AA/Male | 8:20 PM | 8/8 | Driver | Scooter | Speeding (Lost Control) | Unlicensed Driver/No Helmet |
| 14/AA/ Male | 1:10 AM | 4/MD | Passenger | Auto | Lost Control of Vehicle | Stolen Vehicle |
| 16/AA/ Male | 1:10 AM | 4/MD | Passenger | Auto | Lost Control of Vehicle | Stolen Vehicle |
| 16/AA/ Female | 6:06 PM | 6/6 | Pedestrian | Auto | Jaywalking | High Traffic Intersection |

## UNDETERMINED DEATHS

In 2013, the deaths of eight (8) infants and children reviewed by the CFRC had an undetermined manner of death. Five (5) 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. These five cases are identified as Sudden Unexpected Infant Deaths (SUID). In these cases the death occurred after the infant was placed to sleep. Table 10 provides details related to the infant's sleep environment and other issues observed in CFRC SUID case reviews. The CFRC's position statement (Appendix A) related to SUID addresses risks identified in the infant's sleep environment.

**TABLE 10: FINDINGS OF SUID FATALITY REVIEWS**

| *Age/Race/ Gender* | *Ward of Residence* | *Birth Outcome* | *Sleep Environment* | *Other Medical and Environmental Issues* |
|---|---|---|---|---|
| **21Days/AA/Male** | **8** | **Healthy Full Term** | **Infant placed on Boppy© Pillow in adult bed** | **Infant shared sleep environment with adult** |
| **1month 27 days/AA/Female** | **8** | **Healthy Full Term** | **Infant placed on Boppy© Pillow in adult bed** | **Infant shared sleep environment w/ adult and three siblings Adult smoking in the home** |
| **27 Days/AA/Male** | **8** | **Preterm 36 Weeks Gestation** | **Infant placed in adult bed with parents** | **None** |
| **2 months/AA/ Female** | **8** | **Preterm 36 weeks Gestation/ 4.1 pounds** | **Prone sleep position placed on pillow** | **Adult smoking in the home** |
| **6 months/AA/Male** | **6** | **Preterm 32 weeks gestation/4.6 pounds** | **Placed in adult bed in prone position** | **Utero methadone exposure** |

## Undetermined Deaths and Associated Risk Factors

Risk factors associated with the three (3) remaining undetermined deaths reviewed by the Committee are identified in Table 11.

**TABLE 11: FINDINGS OF OTHER UNDETERMINED FATALITIES**

| *Age/Race/ Gender* | *Ward of Residence* | *Cause of Death* | *Risk Factors* |
|---|---|---|---|
| **18 days/AA/Female** | **6** | **Undetermined** | **(1) Pregnancy complicated by chronic illness**<br>**(2)Exposure to illicit drugs in utero** |
| **13 months/AA/Female** | **5** | **Positional Asphyxia** | **(1)Medically fragile**<br>**(2)Family utilized crib that mal - functioned** |
| **5 year old/AA/ Male** | **6** | **Undetermined** | **Medically fragile child** |

# SECTION II:

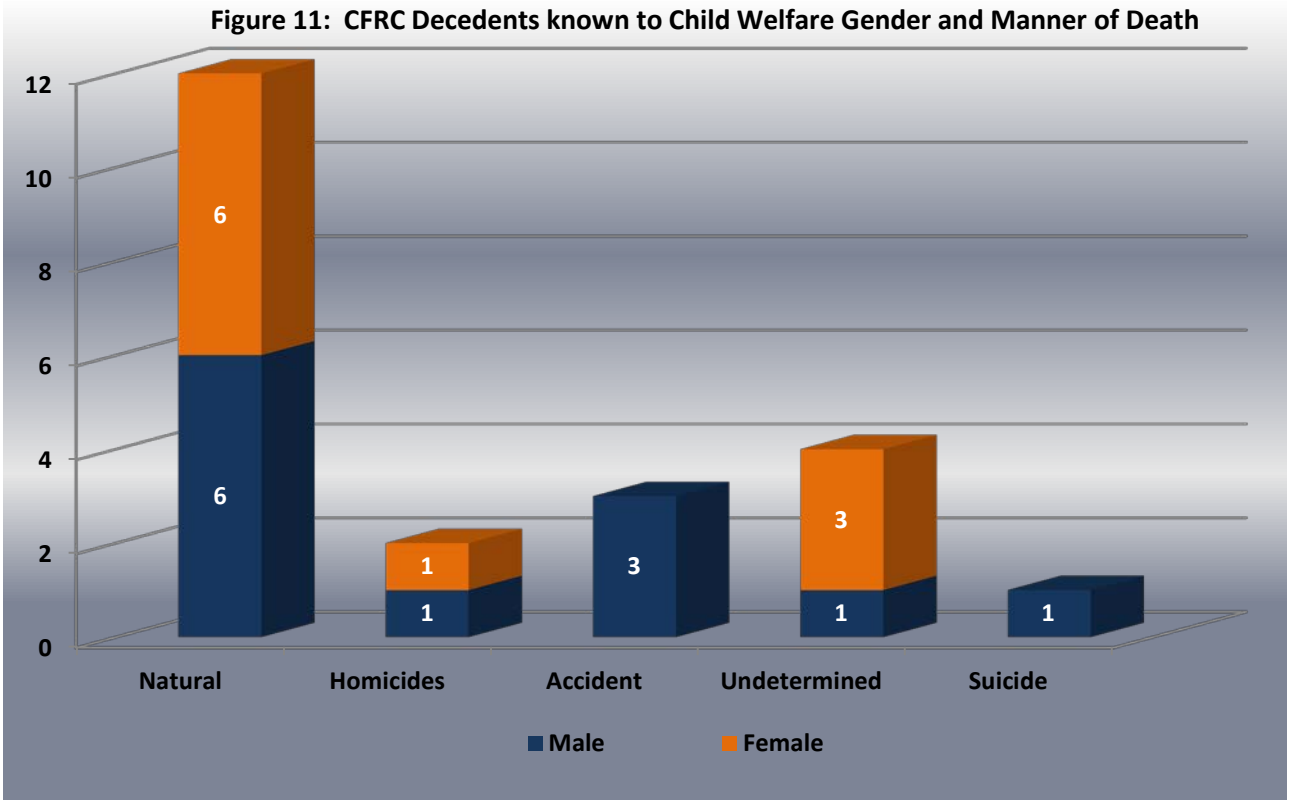
# SUMMARY OF DECEDENTS WITH CHILD WELFARE AND JUVENILE JUSTICE HISTORY

## CFRC Decedents known to District's Child Welfare Agency

In accordance with the CFRC Statute, the Committee is mandated to review the fatalities of infants, children and youth who have a history of involvement with the District's child welfare agency within four years of the fatal event.

Of the 91 cases reviewed by the CFRC in 2013, twenty-two (22, 24%) of the infants, children and youth had contact with the District's child welfare system within four years of the fatal event. The term "contact" includes a referral to the CPS hotline that was screened for investigation or family assessment; or, a foster care or in-home services case monitored by CFSA or a contracted partner agency. Of these decedents, twelve (12, 55%) died of natural causes; four (4, 18%) died of undetermined causes; three (3, 14%) died of accidental causes; and two (2, 9%) were victims of homicide. One youth known to child welfare died as a result of suicide.

All of the decedents were African American, and half (50%) were infants.



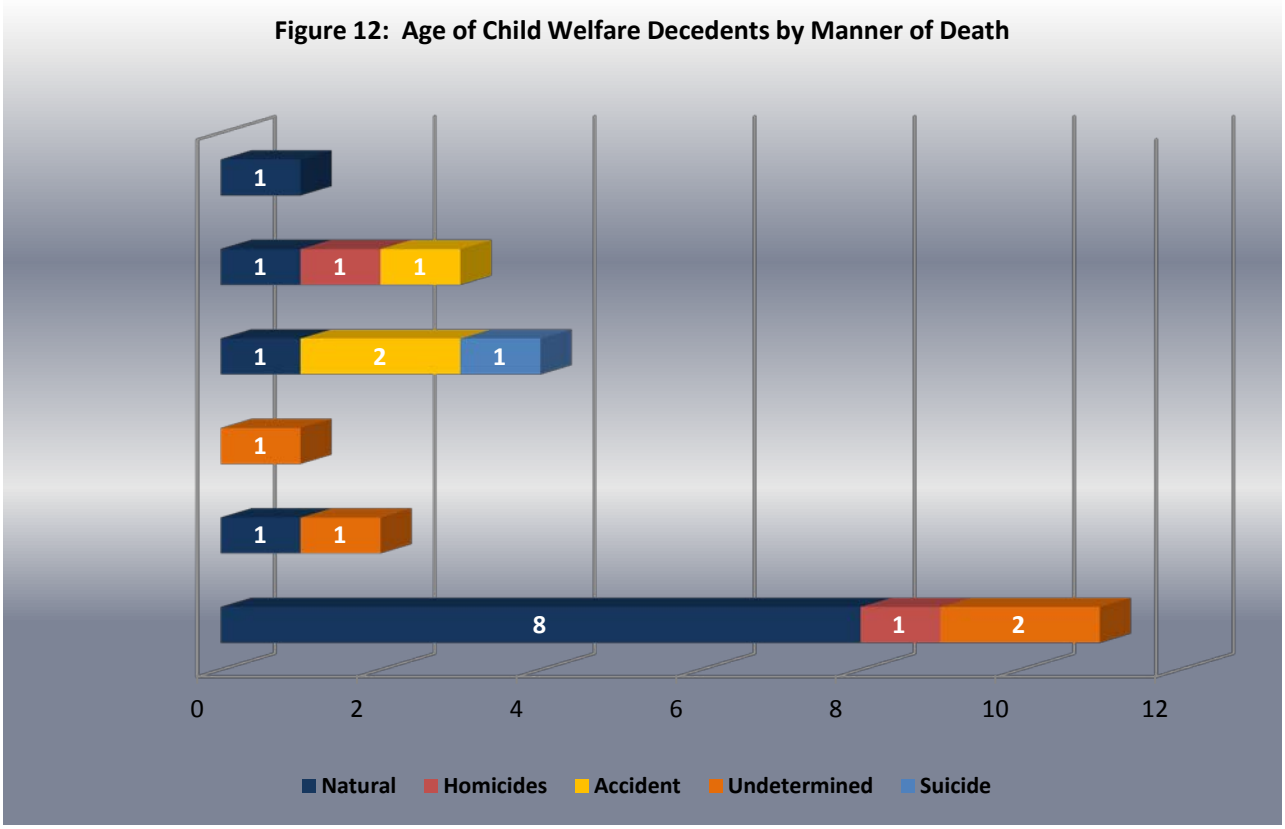
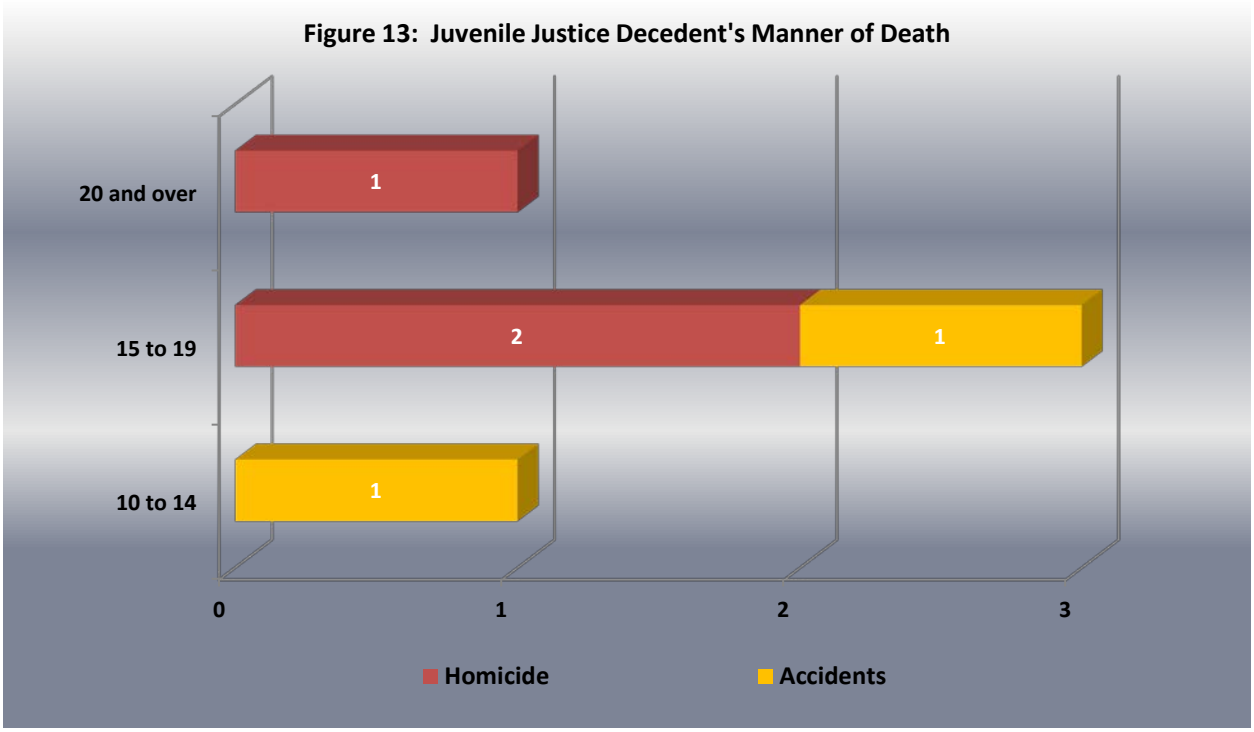


Figure 12: Age of Child Welfare Decedents by Manner of Death
1
1 1 1
1 2 1
1
1 1
8 1 2
0 2 4 6 8 10 12
Natural Homicides Accident Undetermined Suicide

## CFRC Decedents known to the District's Juvenile Justice Programs

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 2013, five (5, 5%) of the CFRC cases reviewed met this criteria. All of these decedents, who were between the ages of 14 and 22 years old, were African American males. One decedent was known to both juvenile justice and child welfare programs. Three (3) of the five (5) decedents were victims of homicide. The remaining two (2) decedents' death was determined to be accidental.

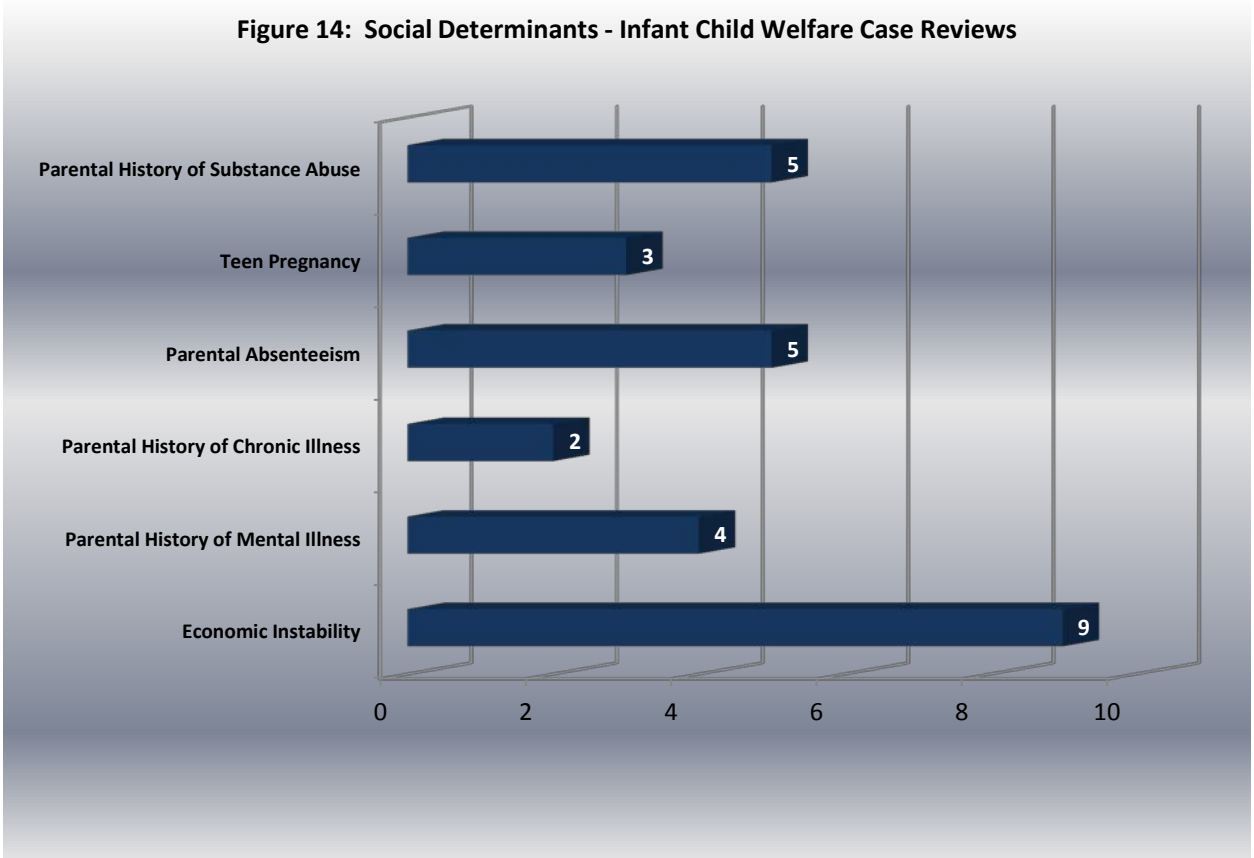


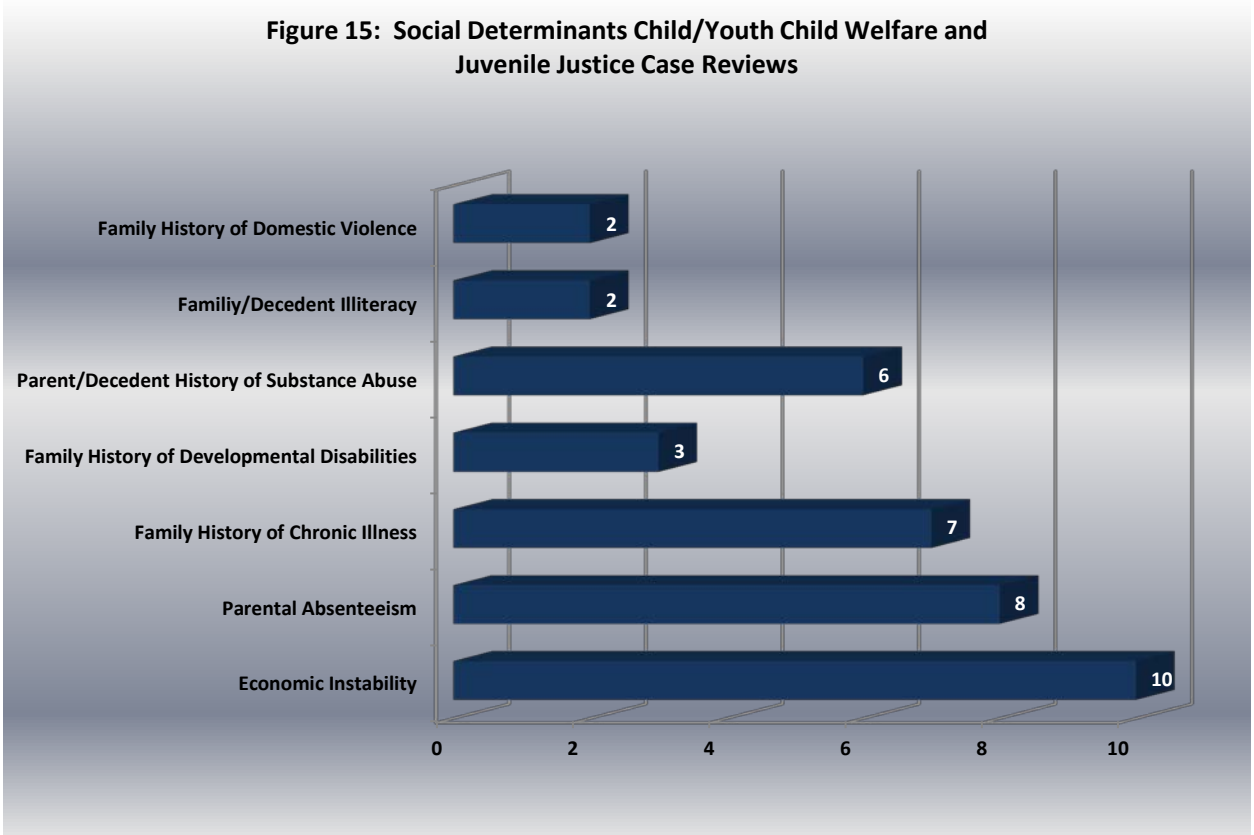
# Social Determinants Observed in Child Welfare and Juvenile Justice Case Reviews

The fatality review of the child welfare and juvenile justice cases provide Committee members with an opportunity to review documentation that addresses a full range of medical, legal, educational and community based services provided to the decedent and their families prior to and at the time of the fatal event. As a result of this comprehensive record review, Committee members become acquainted with the social determinants – circumstances of one's environment that effect their overall outcomes –that families faced prior to and throughout the course of their involvement with government programs.

In the eleven (11) infant child welfare cases reviewed economic stability was an issue in nine (9, 82%) of the cases reviewed. This is determined by the family's participation in the Temporary Assistance to Needy Families (TANF), housing subsidies, and the parents' history of unemployment as documented in case records. Parental history of substance abuse and parental absenteeism (father) were each observed in five (5, 45%) of cases. Parents coping with mental illness (4, 36%), teen pregnancy (3, 27%), and parents coping with chronic illness (2, 18%) were other issues affecting these infants family's overall outcomes.

**Figure 14: Social Determinants - Infant Child Welfare Case Reviews**






In sixteen (16) child welfare and juvenile justice cases reviewed involving children and older youth, economic stability was the leading social determinant (10, 63%). Parental absenteeism (one parent or both) was experienced by half (8, 50%) of the children and youth in this category. Families coping with chronic illness (7, 44%), as well as parental and/or decedent substance abuse (6, 38%) was also observed in these cases as social issues affecting the families outcomes. Parents and children with developmental disabilities were observed in three (3, 19%) of the cases reviewed, while illiteracy and domestic violence were each observed in two (2, 13%) cases.

# SECTION III:

# RECOMMENDATIONS

# CFRC 2013 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.

| Area of Focus | Recommendation | Response |
|---|---|---|
| **Dual Agency Policy and Practice** | The Metropolitan Police Department, in collaboration with the Department on Behavioral Health and Advisory Neighborhood Commissioners should develop a program that provides intervention services for youth affiliated with gangs or at risk of gang involvement to include: Mental health services, medical services, conflict resolution/mediation services by 3rd party, collaboration with MPD in the identification, intelligence gathering and preventive safety measures with conflicting neighborhoods, and the identification of "safe havens" in locations of rival neighborhoods for youth identified as members of gangs/crews (safe haven could be churches, community centers) | **Agreed** |
| | Department of Health in collaboration with the Office of the Chief Medical Examiner should provide classes or website instructions to physicians on how to correctly complete a death certificate. Instructions should emphasis that clinical factors underlying the cause of death should be incorporated on the death certificate. | **Agreed** |
| | The Department of Health, in collaboration with the Department on Health Care Finance and the Unity Clinics should devise a method/protocol to offer long acting, reversible contraceptives (funded by Title X) to mothers at the time of hospital discharge associated with maternal delivery. | **Agreed with Modification** |
| | The Department of Health should devise an agenda to improve the nutrition of mothers before and during pregnancy to reduce the risk factors associated with obesity and pregnancy outcome. The following practices are recommended:<br>➢ Nutrition counseling should be offered to women as part of pre-conception counseling.<br>➢ Nutrition counseling should occur at 1st prenatal visit and at subsequent visits.<br>➢ Prenatal clinics should provide pamphlets and brochures depicting appropriate food choices to control weight gain before and during pregnancy | **Agreed** |

# CFRC 2013 Recommendations

| Area of Focus | Recommendation | Response |
|---|---|---|
| **Agency Policy and Practice** | The Department of Health should convene a group of obstetricians and gynecologist to assess and evaluate best practices to address pre-conceptual counseling, and discuss best practices to address pregnancy risk factors such as incompetent cervix. This will assist with recognizing risk factors and providing education to women about their options. | **Agreed** |
| | The Child and Family Services Agency should provide training to staff that specifically addresses intervention strategies when interfamily violence is a presenting issue (arguing and fighting between parents and their teen children) in investigations and ongoing cases. This training could be a component of the domestic violence training the agency provides to its direct service social work staff and contractors. | **Agreed with Modification** |
| | The Department of Health, in collaboration with the DC Hospital Associated should promote cardiology screening in newborns prior to the discharge following delivery. | **Agreed** |
| **Dual Agency Policy and Practice** | The Department on Disability Services in collaboration with the DC Campaign and the Department of Health should develop a comprehensive sexual awareness program for individuals served by DDS. This will ensure that individuals are provided with the information they need to make decisions about family planning as well as made aware of sexually transmitted diseases and methods to protect themselves. | **Agreed with Modification** |
| **District Government Policy and Practice** | The Deputy Mayors for Health and Human Services, Public Safety and Education should design and implement a multi-agency, multidisciplinary "triage" process to address the needs of youth who have multiple interactions with government services as a result of high risk activity (including but not limited to child neglect, substance abuse, unsafe housing, truancy, missed mental health and medical appointments). This process should include a clear collaborative communication model that agencies within the human services, education and public safety clusters will utilize to address the needs of children, youth and families with multiple agency contacts. Barriers to collaborative communication among these government clusters should be identified and addressed to allow for innovative policies and practices that will among other things enhance resiliency among this high risk population. | **Agreed** |

# Full Agency Responses to CFRC Recommendations

**Recommendation to the Metropolitan Police Department**

The Metropolitan Police Department, in collaboration with the Department on Behavioral Health and Advisory Neighborhood Commissioners should develop a program that provides intervention services for youth affiliated with gangs or at risk of gang involvement to include: Mental health services, medical services, conflict resolution/mediation services by 3rd party, collaboration with MPD in the identification, intelligence gathering and preventive safety measures with conflicting neighborhoods, and the identification of "safe havens" in locations of rival neighborhoods for youth identified as members of gangs/crews (safe haven could be churches, community centers) .

**Response: Metropolitan Police Department**

MPD has already initiated a multi-agency collaborative approach to identify at-risk youth and refer them for appropriate intervention. Beginning in 2013, MPD initiated weekly Youth Violence Prevention Meetings. These meetings are attended by representatives from MPD's Intelligence Branch, School Safety Division, and Youth Division as well as representatives from DCPS, DYRS, CSS, Shaw/Columbia Heights Collaborative, and the National Center for Children & Families. The meetings are intended to identify youth who may or may not already be involved in criminal activity but are in a volatile situation in which it appears they may be heading in that direction or to identify youth who are in situations in which it appears they may be targeted for a violent assault.

It is recommended that the Department of Behavioral Health attend one of these meetings each month as they are a valuable resource for some of the youth that have been identified as in need of services. Recently, MPD invited P.G. County Schools to send a representative to the meetings and they have agreed to do so. Due to the privacy laws regarding youth, Advisory Neighborhood Commissioners may not attend the meetings. However, it is recommended that if they learn of any youth in need, they report the information to their District Commander.

Finally, in order to streamline MPD's service to youth, MPD is placing the School Resource Division under the domain of its Youth Division. This will be effective in 2015.

**Response: Department on Behavioral Health**

The Department of Behavioral Health (DBH) will participate in the Youth Violence Prevention meetings led by MPD at least one time per month to provide information, resources, and consultation around behavioral health and supports available to youth and families. This collaboration with MPD and other community groups/agencies will allow for increased awareness of DBH supports available to the community and ensure that youth/families that are in need of and interested in supports are connected to services through DBH in a timely, coordinated fashion. An interactive community mental health resource guide will be made available by the Department of Behavioral Health (DBH); this resource guide will include a listing of DBH provider agencies and other community resources available to youth, adults, and

families. This resource guide, available in paper form and on the DBH website, will be made available to MPD and other agencies who work with youth and families. Expected completion date of the resource guide is June 2015.

In March 2013, DBH hired a Social Marketing Coordinator to increase community-based education around mental health. Youth Mental Health First Aid (MHFA) training is available to MPD, community stakeholders, and parents through DBH and it is free. In November 2014, a second train-the-trainer series was held for the DBH Children and Youth Services Division (CYSD) Speaker's Bureau. This speaker's bureau will be utilized to increase mental health awareness and knowledge of the supports available to youth and families through DBH.

**Recommendation to the Department of Health and the Office of the Chief Medical Examiner**

Department of Health in collaboration with the Office of the Chief Medical Examiner should provide classes or website instructions to physicians on how to correctly complete a death certificate. Instructions should emphasis that clinical factors underlying the cause of death should be incorporated on the death certificate.

**Response: Department of Health and the Office of the Chief Medical Examiner**

The New York City Vital Records Division has developed a training video focused on improving physician cause of death reporting, and has given permission to the District of Columbia, Vital Records Division to modify for its use by District of Columbia physicians. The training video focuses on the importance of cause of death reporting, key roles in death certificate completion, completing the death certificate, and medical examiner cases. The DC Medical Examiner's office has reviewed the NYC training video and supports its implementation. Specific actions towards implementation include:

1. Meet with DC Vital Records Division Registrar to discuss requirements for development/implementation- October 2014
2. Provide funding support for DC development/implementation- December 2014
3. Develop 1st draft of DC training video for review, comment and input- December 2014
4. Meet with DC Licensure Board to discuss training video and physician requirements- January 2015
5. Develop final draft of DC training video- February 2015
6. Develop marketing/outreach campaign regarding training video-February 2015
7. Physicians required to view training video prior to providing access to the Vital Records Division Electronic Death Registration System (EDRS)- March 2015
8. Physicians required to view training video for licensure renewal- June 2015

The following are the expected outcomes:

1. Physician completion of training video prior to access the Vital Records Division Electronic Death Registration System (EDRS) by March 2015, and
2. Physician completion of training video for licensure by June 2015

**Recommendations to the Department of Health and the Department on Health Care Finance**

Recommendation #1: The Department of Health, in collaboration with the Department on Health Care Finance and the Unity Clinics should devise a method/protocol to offer long acting, reversible contraceptives (funded by Title X) to mothers at the time of hospital discharge associated with maternal delivery.

Recommendation #2: The Department of Health should devise an agenda to improve the nutrition of mothers before and during pregnancy to reduce the risk factors associated with obesity and pregnancy outcome. The following practices are recommended:

- Nutrition counseling should be offered to women as part of pre-conception counseling
- Nutrition counseling should occur at 1st prenatal visit and at subsequent visits.
- Prenatal clinics should provide pamphlets and brochures depicting appropriate food choices to control weight gain before and during pregnancy.

**Response: Department of Health and the Department on Health Care Finance**

**Recommendation #1**
DOH and DHCF discussed the first recommendation concerning coverage of long acting, reversible contraceptives (LARCs), and want to ensure that the CFRC understands that LARCs are available and covered under the District's Medicaid program. Recently, DHCF issued a transmittal to provide guidance to physicians, hospitals and clinics enrolled in Medicaid to clarify coverage of LARCs, prior authorization requirements and billing procedures. Transmittal 14-24 was issued on September 22, 2014 and explains new policies undertaken by DHCF to ensure more access to LARC services, including: (1) rate changes for services provided to fee-for-service beneficiaries effective 10/1/14; (2) providers able to bill for LARC in an inpatient setting for fee-for-service beneficiaries; (3) DHCF encourages hospitals and Medicaid MCOs to examine coverage and reimbursement policies for LARC to ensure there are no impediments or barriers to access; and (4) annual review of Medicaid fee schedule for LARC reimbursement.

Based on this recent transmittal to ensure LARC coverage for Medicaid beneficiaries, we recommend that the 1st recommendation should focus on the education for providers/hospitals on Medicaid coverage of LARC services.

**Recommendation #2**
Through the ***Stronger Together*** initiative released on September 30, 2014, DOH has developed an agenda to not only address obesity in pregnant women but identify measures, including a six-week disease management course, to help residents achieve their optimum health prior to pregnancy. ***Stronger Together*** will utilize three advisory committees: Policy Advisory Committee, Technical Advisory Committee and Community Advisory Committee. These committees will work in tandems to identify and address those risk factors that lead to poor birth outcomes. ***Stronger Together*** will also implement practice guidelines to assist providers in the identification and referral for those risk factors leading to poor birth outcomes.

**Recommendation to the Department of Health**

The Department of Health should convene a group of obstetricians and gynecologist to assess and evaluate best practices to address pre-conceptual counseling, and discuss best practices to address pregnancy risk factors such as incompetent cervix. This will assist with recognizing risk factors and providing education to women about their options.

**Response: Department of Health**

Mayor Gray and the Department of Health (DOH) launched the Stronger Together initiative to combat infant mortality on September 30, 2014. Stronger Together is a public-private partnership to secure committed partners interested in building an integrated system of care across the District's private and public health care continuum, to:

- Ensure a high quality of maternal and child health care provision for all;
- Build systemic infrastructures that support integrated care for all;
- Educate parents, families, and the broader community on the importance of maternal and child health, and how to access quality care; and
- Identify and target specific drivers of disparity.

Three advisory groups have been established to provide oversight and guidance for the Project. The "Policy Advisory Group" (PAG) will serve as the principal source of regular outside advice for the Project, and will have representation from the legislative body and other integral District agency partners. Two additional sources of guidance for the policy have been constituted, namely the "Technical Advisory Group" (TAG) composed of providers of health and social/behavioral services for women and infants and the "Community Advisory Group" (CAG) composed of DC women who have been pregnant and delivered an infant within the past five years.

Within the TAG, obstetricians and gynecologist have begun to assess and evaluate best practices to address pre-conceptual counseling, and discuss best practices to address pregnancy risk factors such as incompetent cervix. The expected outcome is to decrease infant mortality to five births per 100 live births by 2020.

**Recommendation to the Child and Family Services Agency**

The Child and Family Services Agency should provide training to staff that specifically addresses intervention strategies when interfamily violence is a presenting issue (arguing and fighting between parents and their teen children) in investigations and ongoing cases. This training could be a component of the domestic violence training the agency provides to its direct service social work staff and contractors.

**Response: Child and Family Services Agency**

The CFRC's recommendation asks us to incorporate training on interfamilial violence into our curriculum for social work staff, and mentions the possibility of including this issue in our existing training on domestic violence. Upon discussion with our consultants and experts in the

field we feel that adding this topic to our current or planned training on domestic violence is not the most effective response.

CFSA is exploring the use of a new model to address domestic violence. This will involve various levels of training and changes in practice and will replace our current training in this area that staff receives on an intermittent basis. This new model is called the **Safe and Together** Model and is a perpetrator pattern-based, child-centered, survivor strengths approach to working in the area of domestic violence. The model provides a way to assess how domestic violence impacts the children involved and also how to intervene. Contingent upon funding approval, we will begin training on this model throughout FY 15 and FY16.

Although this model focuses on intimate partner violence, and not the parent-teen interactions that are identified in the committee's recommendation, we believe that upon being trained in this model staff will be better able to recognize patterns of abuse and violence on the part of adults that are repeated in child-parent violence. Additionally, CFSA has been working with an organization called KVC Health Systems, Inc. to increase our staff's awareness and capacity to address the impact of trauma on children. CFSA will be implementing on December 1, 2014 a trauma screening tool called the Child Disorders Stress Checklist. This is a trauma screen used to identify past trauma that might have an effect on the child's current situation, including current behavior patterns. We feel that the trauma informed tools that we are incorporating into our practice will further help our staff identify and respond to the types of interfamilial violence the Committee has observed.

We therefore accept the committee's recommendation with the modification because we believe that the training of the staff on a model of domestic violence specifically honed for child welfare, along with the incorporation of trauma-informed services and tools, will be the most effective way of preparing staff to address interfamilial violence.

**Recommendation to the Department on Disability Services and the Department of Health**

The Department on Disability Services in collaboration with the DC Campaign and the Department of Health should develop a comprehensive sexual awareness program for individuals served by DDS. This will ensure that individuals are provided with the information they need to make decisions about family planning as well as made aware of sexually transmitted diseases and methods to protect themselves.

**Response: The Department on Disability Services**

The Department on Disability Services currently supports sexual awareness and planned parenting through a collaborative with the Georgetown University Health Initiative. This effort includes the referral of persons served by DDS to a qualified Health Educator to provide training and resources individually as requested or determined necessary by their guardian, health care decision maker and circle of support. This initiative has provision for the training of DDS residential provider and DDS Service Coordination staff in the support of persons living with disabilities in making decisions regarding their sexual expression, safe sex practices, and birth control as requested.

Upon receipt of the Child Fatality Review Committee recommendation: "*the Department of Health should develop a comprehensive sexual awareness program for individuals served by DDS. This will ensure that individuals are provided with the information they need to make decisions about family planning as well as made aware of sexually transmitted diseases and methods to protect themselves",* DDS has conferred with staff from the Department of Health (DOH), Perinatal and Infant Health Bureau and its Child, Adolescent and School Health Bureau, as well as the DC Campaign to Prevent Teen Pregnancy.

The Department of Health reportedly does not have the expertise or the resources to develop a comprehensive sexuality education curriculum for the special population (ages 22 and over) served by DDS, however; The DC Campaign to Prevent Teen Pregnancy agreed to provide DDS with support to develop and enhance its evidenced-based curriculum and community-based training offering to improve upon efforts DDS is presently engaged.

DDS will convene a workgroup with the Georgetown University Health Initiative and the DC Campaign to Prevent Teen Pregnancy to share resources.

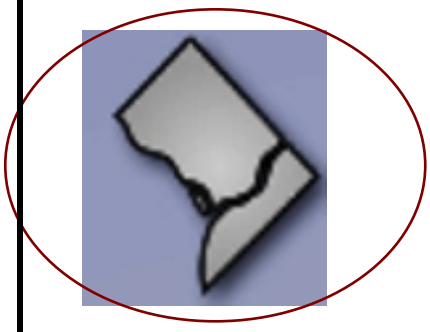
**Recommendation to the Executive Office of the Mayor**

The Deputy Mayors for Health and Human Services, Public Safety and Education should design and implement a multi-agency, multidisciplinary "triage" process to address the needs of youth who have multiple interactions with government services as a result of high risk activity (including but not limited to child neglect, substance abuse, unsafe housing, truancy, missed mental health and medical appointments). This process should include a clear collaborative communication model that agencies within the human services, education and public safety clusters will utilize to address the needs of children, youth and families with multiple agency contacts. Barriers to collaborative communication among these government clusters should be identified and addressed to allow for innovative policies and practices that will among other things enhance resiliency among this high risk population.

**Response: Deputy Mayor on Health and Human Services**

The CFRC's recommendation for a joint Deputy Mayor task force to address the needs of youth who have multiple interactions with government services as a result of high risk activity is in concert with the collaborative approach taken by the Gray Administration to address at-risk youth. Currently, through the leadership of the Criminal Justice Coordinating Council, *Partnership for Success Stat* (P4S Stat) focuses on strategies to reduce juvenile violence in the District, improve case management services to high risk youth, enhance coordination among partners for those youth who are jointly supervised by juvenile and adult agencies and to provide additional programming supports for the P4S youth. Stakeholders to P4S Stat include the Office of the Deputy Mayor for Public Safety and Justice, Metropolitan Police Department, the D.C. Superior Courts, the Office of the Attorney General, Court Social Services, Court Services and Offender Supervision Agency, Pretrial Services Agency, D.C. Public Schools and the Department of Youth Rehabilitation Services. At each meeting, partners are connected with resources aimed at promoting a successful transition for their youth, including educational supports, housing options and gainful employment. The committee conducts case reviews of youth who have identifiable barriers to successful rehabilitation in an effort to pool resources and

brainstorm options for intervention. By expanding this current workgroup to include the Offices of the Deputy Mayor for Health and Human Services and Education, their appropriate subordinate agencies, the Children and Youth Investment Trust Corporation, and relevant community-based providers, P4S Stat will be able to address all at risk youth, not just those with contacts to the criminal justice system.



## DISTRICT OF COLUMBIA'S 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 Infant Death (SUID) 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 SUID. 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 SUID. Public education is essential, and should be designed to target not only parents, but infant caregivers (fathers, paramours, and extended family members).

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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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