# DISTRICT OF COLUMBIA
# CHILD FATALITY REVIEW COMMITTEE

FIFTH ANNUAL REPORT
CALENDAR YEAR 1997

## Protecting the Wellbeing of Children

June 1999

GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF HUMAN SERVICES
COMMISSION ON SOCIAL SERVICES
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# DISTRICT OF COLUMBIA
# CHILD FATALITY REVIEW COMMITTEE

# 1997 ANNUAL REPORT

**MISSION:**

**To reduce the number of preventable child fatalities in the District of Columbia through identifying, evaluating and improving programs and systems which are responsible for protecting and serving children and their families.**

**PRESENTED TO:**

**The Honorable Anthony A. Williams, Mayor, District of Columbia,**
**The Council of the District of Columbia**
**and The Community**

**June 1999**

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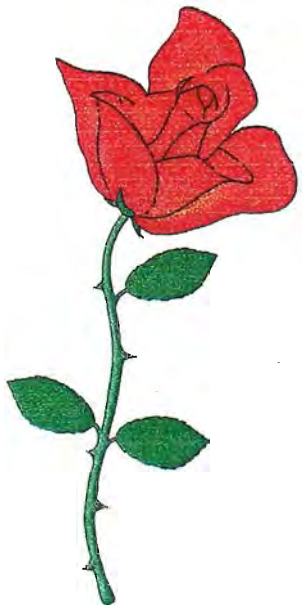

# *DEDICATION*

As always, the Child Fatality Review Committee Annual Report is dedicated to the children whose fatalities were reviewed by the District of Columbia Child Fatality Review Committee. During 1997, there were 51 fatalities reviewed that involved children who lost their lives to medical problems, accidents, suicide, senseless acts of violence and unknown causes.

## *A Message from the Co-Chairs*

On behalf of the District of Columbia Child Fatality Review Committee, we are pleased to present the fifth Annual Report. The purpose of this Report is to inform the Mayor of the District of Columbia and the public of the activities that have occurred related to furthering our goals of reducing preventable child deaths and promoting the health and well-being of children. This Report includes the findings and recommendations that resulted from the 1997 child death reviews, as well as information related to Committee activities and efforts that were directed towards continuing the process of self reflection and improvement.

The Committee completed another successful year in regard to conducting an increased number of fatality reviews and sustaining the commitment of its members. The review process brings together dedicated public and private professionals from all child-oriented services and community members to examine fatalities of specific District children. These devoted individuals have unrelentingly participated in the reviews and other activities to achieve a better understanding of the ways in which children are dying, the circumstances surrounding their deaths and the ability of our service delivery systems to respond to the needs of children at risk of abuse/neglect, other forms of fatal injury or untimely death.

It is striking and disconcerting to consider the fact that out of the 51 deaths reviewed during 1997, 19, or 37 percent of these children suffered from intentional and accidental injuries. Out of this number 74 percent were the victims of violence and 50 percent of these children died at the hands of a parent or caretaker. It is also disturbing to consider that out of the 27 who died natural deaths, 81 percent were under one year of age. Prematurity, low birth weight and congenital abnormalities were the principal contributing factors in these deaths.

Over the past five (5) years, the child fatalities reviewed have presented similar community and systemic issues that require aggressive and comprehensive strategies for resolution. The majority of these deaths are preventable when it is considered that prevention requires some level of social, child welfare, health, legal or community awareness or early intervention in order to address many of the problems faced by these and so many other families in similar situations. The concept of prevention has been the impetus for the work of the Committee and the motivator for our members.

***"We cannot live only for ourselves. A thousand fibers connect us with our fellow men; and among those fibers, as sympathetic threads, our actions run as causes, and they come back to us as effects."***
Herman Melville

There is no greater compensation for individuals who contribute their time, energy and personal resources than to see the creation of a more viable future for our children and District residents. We would like to again thank the CFRC members for another successful year and we look forward to working with you in the future.

Sincerely,

A. Sue Brown
Co-Chair

Yvette Reid, MD
Co-Chair

# *EXECUTIVE SUMMARY*

**Never doubt that a small group of thoughtful, committed citizens can *change* *the World.* Indeed, it's the only thing that ever has.**

Margaret Meade

As mandated by Mayor's Order 92-121, the District of Columbia Child Fatality Review Committee (CFRC) is required to develop a report annually which summarizes the findings, statistical data and recommendations that result from the fatality reviews conducted. This report represents the Committee's fifth year of operating.

The 1997 CFRC Annual Report is representative of the District's continuing commitment to improving the safety, well-being and overall quality of life for our children. As required by Mayor's Order 92-121, this report serves as a means of sharing with the Mayor, the City Council and the community the Committee's work during calendar year 1997. It highlights those activities related to fatality reviews that were conducted and improvements to the structure of the Committee.

Since 1993, the Committee has reviewed 151 fatalities of District children. This Annual Report presents information from specific child deaths that occurred during the 1997 calendar year. This report provides information that was abstracted from 51 child fatalities that occurred during 1997. These deaths were selected from a total universe of 242 child fatalities. The number of cases identified as meeting CFRC criteria for review continued to increase for 1997, representing a 13 percent increase from the 45 reviewed in 1995; a 113 percent increase from 1995; a 200 percent increase from the 17 in 1994 and 264 percent increase from the 14 deaths reviewed from 1993. Statistics indicated that the majority of these children were African-American males, who were 10 years of age and under (n = 42).

Statistical data from 1997 deaths reviewed, again, reveal both similarities as well as differences from 1996 and other years' data. The leading manner of death for 1997 fatalities continued to be natural, with the actual number of deaths that were attributed to medical problems remaining identical to 1996 (n = 27). Natural deaths remained the primary manner of death, not only among the cased reviewed by CFRC, but also for the total number of child/youth deaths for the District.

The number of children who died from homicides rose during 1997, while the number of accidents remained the same as 1996. Fourteen (14) children died violently compared to nine (9) in 1996, representing a 56 percent increase. The homicide victims again included too many children who died from fatal abuse or neglect. Seven (7), or 50 percent of the 14 homicide deaths that occurred during 1997 were children who died at the hands of their parents or caretakers. A few died brutally due to prolonged intentional assaults, while in other cases the injuries may not have been deliberate, however, they were no less devastating. The causes of death included blunt force trauma, acute morphine intoxication, commotio cordis, and smothering. These children ranged in age from one (1) month to 11 years of age. Accidents ranked third during 1996 and 1997. During both years five (5) children died from injuries determined to be unintentional. The accidents included motor vehicle, fire, drowning and positional asphyxia.

Many of the families had received a multitude of public and private services. An alarming fact was the number of families that were known to the child protective services system. In 35, or 69 percent of the total cases reviewed from 1997, prior incidents of alleged child abuse and neglect were reported on these families. Based on the investigations of these reports, the allegations were supported on 29 families and cases were open and serviced for varying periods. With six (6) families, the allegations were determined to be "unsupported" and the cases were closed. Ninety-two (92) percent of the total families were known to the public assistance program. Services included, either singularly or in combination, TANF, Food Stamps and Medicaid.

***"A 1997 Homicide Death Of a One Year Old Child"***

On a cold winter night in northwest Washington, the MPD responded to a call of an unconscious individual. Once on the scene, they were informed by the apartment security guard that the child, a 1 year old female, had already been transported to a nearby hospital by an ambulance. The child was pronounced dead only 10 minutes after arriving in the emergency room. The investigation revealed that the mother had left the child twice on the day of the fatal incident with a neighbor and friend. Once was in the early morning while she dropped her older child at school. The second time was around 5:00 P.M. while she went to the store. The mother also stated that she also spent a great deal of the day with the same friend and that she never noticed anything unusual with her infant until she returned to pick her up the second time. When she returned from the store she noticed her child lying on her friend's couch asleep or unconscious. She took her child upstairs to her apartment and after a few minutes she noticed that something was wrong with her child. So she went back downstairs to her friend to get help. They went back upstairs to check on the infant. Her friend took the child downstairs to the security officer who performed CPR and called 911. This family became known to the child welfare system 3 months prior to the child's death.

**Cause of Death:** Blunt Force Trauma to Head

## *Strategy for Change*

In examining the statistical data revealed from reviews conducted by CFRC within the past five (5) years, the most apparent and disturbing fact is too many children and youth are needlessly dying from violence, unintentional injuries and other preventable causes. Determining ways to prevent the unnecessary deaths of children is the most important goal of the District's child

fatality review process. In an effort to achieve this goal, each review concludes with discussions related to the possible contributing factors, gaps in service interventions, resources and community awareness of the problems associated with child deaths; and the development of data-driven recommendations for solutions. These recommendations offer the District a ray of hope for the future by exploring all possibilities for systemic reforms and clarifying the roles each entity plays, as agencies and concerned community individuals, in the process of saving and improving children's lives.

Following are examples of some of the recommendations being offered by the Committee to reduce child deaths caused by medical problems, homicides, accidents, and suicides:

- Advocate for increased community-based early intervention and primary prevention programs as a means of preventing child abuse and neglect.

- Develop a risk assessment instrument to determine the risk level of families with medically fragile newborns, prior to discharge. Advocate for city-wide use of the instrument in local hospitals.

- Strengthen gun control laws and the enforcement of these laws, to reduce the number of teen deaths caused by gunshot wounds.

- Incorporate conflict resolution and peer counseling in the public school curriculum that begins at the elementary level and intensifies in the junior and high school grades.

- Ensure that public community swimming pools are maintained in a safe, clean and sanitary manner and are properly staffed in order to accommodate the high number of children utilizing these facilities during the summer and respond appropriately to emergency situations.

- Improve the quality of the child death investigations. Finalize and begin utilizing the protocols drafted during 1996 for child death investigations. Training should be provided to police officers to ensure consistency in the use of this instrument and overall practice among officers responsible for this function.

- Perform autopsies on all children committed to the care and custody of the District of Columbia.

- Increase community awareness of the following:
  - SIDS, the associated high risk factors and prevention measures, i.e., safest sleeping positions and environment for infants.
  - Hazards of shaking an infant or child.
  - Preventability of accidental child deaths and the importance of providing age

appropriate supervision to children and teaching children age-appropriate safety measures.

- Importance of family planning, pregnancy preparation and prenatal care.
- Fire arm safety measures, gun control laws and penalties for violation of these laws.
- District's law that protects children from abuse and neglect; the obligation of mandated reporters and the general community related to reporting suspected incidences of abuse and neglect; the process and penalties for not reporting.

Following are examples of recommendations to restructure and improve the child fatality process:

- Continue efforts to identify funds to implement public education recommendations and other Committee activities.

- Advocate for adequate and sustainable resources for the Committee to support the planned expansion of responsibility.

- Advocate for the enactment of CFRC legislation which would ease confidentiality restrictions sufficient to facilitate the sharing of pertinent information and improve cooperation and collaboration among member agencies.

- Advocate for the resolution of issues related to sharing child death information on residents from surrounding states who die in the District and District residents who die in these jurisdictions.

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# SECTION ONE: INTRODUCTION

# INTRODUCTION

*HOMICIDE SUSPECTED IN DEATH OF D.C. GIRL, 4*

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*BATTERED CHILD'S DEATH RULED A HOMICIDE*

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✦ ✦ ✦

*D.C. MAN PLEADS GUILTY TO KILLING CHILD IN HIS CARE*

The headlines above were abstracted from a series of articles from the Washington Post between September 24 and December 13, 1997. These articles told the devastating story of the life of a four (4) year old female child cut short at the hands of her mother's paramour. This 1997 death was the second child death experienced by the same family. Three (3) years before this tragic death, the family experienced the lost of the two (2) year old brother, who died while in the care of the same man. As a result of the recent death, authorities quickly decided to re-examine the autopsy and investigation to determine whether the death of the two year old, which had been ruled accidental, was truly an accident.

The premature death of any child is tragic but those younger and more vulnerable victims of fatal child abuse or neglect are the most catastrophic and senseless. The death described above was one of 14 homicide deaths that occurred during 1997. Six (6) or 43 percent of these children were victims of fatal child abuse and neglect. While half of these deaths were the result of the more typical cause of blunt force trauma, there were several causes that were unique to those cases reviewed by the Child Fatality Review Committee (CFRC). Other causes included smothering, acute morphine intoxication and commotio cordis (which occurred as a result of several blows to the chest). The majority (n = 5) of these children were under the age of three (3) years.

Second to homicide deaths, many of the accidental deaths reviewed by CFRC were determined to be as tragic. Based on information that arose during the reviews, at least three (3) of the accidental deaths were directly associated with the negligence of the parent. The factors that contributed to these child fatalities, as well as the interventions that were highlighted as being necessary for these families, lead to the conclusion that, at a minimum, the majority of the homicide and accidental deaths could have been prevented.

The District's Child Fatality Review Committee (CFRC) was established in 1993, by Mayor's

Order 92-121 (see Appendix A), with a mission of reducing the number of children who die from preventable causes. As reported in previous years' annual reports, the CFRC objectives are as follows:

- To identify trends and patterns of child deaths by collecting, reviewing and analyzing standardized data to improve the understanding of the causes and factors that contribute to child fatalities.

- To ensure that all systems, both public and private, which are responsible for protecting children, are effective, efficient and accountable.

- To improve and optimize systemic responses to child abuse and neglect by evaluating existing statutes, policies and procedures.

- To recommend appropriate modification of existing systems, and develop new mechanisms to reduce the incidence of unexpected and preventable child fatalities.

- To encourage the development of guidelines for interagency and interdisciplinary education, communication, cooperation, coordination and collaboration in the prevention of child fatalities.

Since its inception, the Committee has always placed a special emphasis on preventing child deaths caused by abuse and neglect. With this purpose in mind, CFRC brings together professionals from various disciplines and organizations, as well as concerned community individuals (see Appendix B: CFRC Membership List) to examine the circumstances surrounding the fatal incident; characteristics of the families; the services provided; and the various systems involved with the families. Based on the information generated in the reviews related to the social, health, education, law enforcement, and legal factors that may have contributed to circumstances surrounding the child's death or quality of life, the review teams explore ways to improve our systems, services and community response to the needs of children and their families.

The review process serves as a quality assurance function for most public and private services and/or organizations responsible for serving children and families. It serves to affirm good practice, programs, systems and standards, as well as to surface systemic deficits which may exist and need improvement and/or revision. It ensures that issues related to child deaths are reviewed in a systematic and timely manner. It is only by reviewing the "worst case" situations that we can identify issues and work to make necessary changes through the entire child/family-serving community.

The death of a child is a community-wide concern and thus, requires a coordinated community-wide response. Prevention of future deaths or improvement of the quality of children's lives through the enhancement of services, programs and systems is the desired result and primary focus of most child death review systems. Therefore, it is imperative to conduct reviews in a manner that does not focus solely on the negative and does not encourage punitive solutions to the problems identified. The Committee feels that its review strategy satisfies these process and outcome goals.

***"A 1997 Natural Death"***

The MPD responded to a radio call of an unconscious person in an apartment in the southeast quadrant of the city. As they arrived on the scene, they were advised by the Fire Department that a 6 week old male infant was found by the mother unconscious and unresponsive in his bed. Resuscitation efforts were initiated on the scene and the child was transported to a community hospital. Emergency room staff worked diligently on the infant, finally resuscitating him and placing him on a ventilator. Soon after reviving the infant, he was transported to the Neonatal Intensive Care Unit of a local pediatric hospital. Despite the more intensive life saving measures that were made, the infant was pronounced dead approximately 4 hours after he was initially discovered. It was revealed during the review that the infant was born premature. He was released from the hospital 19 days after birth on a heart monitor. The investigation disclosed that the mother and father had conflicting accounts regarding where the infant was sleeping. However, both indicated that the heart monitor was on the infant yet they never heard an alarm. It was later revealed that the apartment was still without electricity and the monitor was operating on a battery that was being charged at a neighbor's home. The autopsy revealed that the child died of natural causes and the death was not related to the questionable functioning of the monitor.

**Cause:** Group B Streptococcal Sepsis with Meningitis

The 1997 Annual Report provides a detailed analysis of the data that resulted from the 51 fatalities that were selected for review. It is important to remember that each number represents the life of a child and each has a special story with special circumstances that surrounded the fatal incident. Each life was significant and must be honored by ensuring that the needs of families and children in similar situations are more effectively and appropriately addressed. The fatality review process provides us the means of identifying gaps and needed modifications in service delivery systems. It has also provided a process for compiling comprehensive demographic data regarding the ways children are dying, which can assist in planning new and refining old services, policies and practices, with a particular emphasis on prevention and early intervention.

# SECTION TWO:
# A TRANSFORMING CHILD FATALITY REVIEW PROCESS

# A TRANSFORMING CHILD FATALITY REVIEW PROCESS: STRUCTURE AND OPERATION OF CFRC

*1997* represented a year of transformation for CFRC. The knowledge and experience gained during the past five (5) years of operating were the bases for the Committee's interest in improving the quality of the fatality reviews through enhancing the effectiveness and efficiency of the review process. After several years of self-evaluation and the identification of existing barriers related to the review method, the process of change was initiated during 1997.

During January of 1997, the Commission on Social Services sponsored and planned in collaboration with the Committee, the first Child Fatality Review Committee Training Advance. The purpose of the two-day Advance was to provide a forum for Committee members to reflect on past years' experiences and to discuss ways to improve CFRC operations, the process of reviewing child fatalities and the method of utilizing the information resulting from the reviews. The format for the Advance dealt specifically with the problems outlined in the 1995 and 1996 CFRC Annual Reports. These problems included the following:

- ***TO ESTABLISH A MORE EFFECTIVE SYSTEM OF NOTIFICATION***
- ***TO REDEFINE THE CRITERIA FOR CASE REVIEW***
- ***TO ESTABLISH A MORE FORMALIZED AND ROUTINE PROCESS FOR OBTAINING INFORMATION FOR REVIEW PLANNING***
- ***TO DEVELOP A MECHANISM TO COORDINATE THE TWO FATALITY/MORTALITY REVIEW PROCESSES IN THE DISTRICT***
- ***TO ESTABLISH A MORE EFFICIENT REVIEW PROCESS***
- ***TO INSTITUTIONALIZE CFRC AND PROVIDE ADEQUATE STAFF SUPPORT***

It was decided early during the planning phase that the Advance participants should be limited to CFRC and Infant Mortality Review Team members. Limiting participation would facilitate a more interactive process that would allow for critical thinking, more productive discussions, decision-making and development of follow-up strategies. The Advance was well attended. During the two-day period, over 100 persons participated. While funds were limited, the Commission was able to secure the assistance of the Child Fatality Specialist at the American Bar Association to participate in the planning and to moderate some of the workshops and working sessions.

The program (see Appendix C) for the Advance was full and productive. It was developed with an outcome in mind, which was to close with agreement among members, as to whether restructuring was necessary and if so, the major components of the new CFRC structure. While it included formal presentations from city officials and directors of CFRC member agencies, a major portion included panel presentations from a national and local perspective and concurrent workshops that dealt with specific problem areas that were unique to the District.

***"This job is extremely important and the impact on children will carry through the rest of their lives."***

Linda Cropp
Chairperson
Human Services Committee
Council of the District of Columbia
(CFRC Advance 1997)

The panel presentation entitled, "Overview of Child Fatality Review in the United States," included presentations from national experts and representatives from child death review teams from other states. The states that were represented included Virginia, Maryland, South Carolina, Ohio and Oregon. These presentations were invaluable in that the CFRC and Infant Mortality Review Team (IMRT) members were able to hear first hand how other state fatality review systems operated, their accomplishments, as well as any persistent problems. The majority of the state representatives stayed during the entire two day period and assisted with or participated in the Advance.

The last three (3) hours of the second day of the Advance were spent in two working sessions that included all participants. The goal of these sessions was to design a new procedure for fatality review in the District, through the development of recommendations and to devise the strategy for follow-up work that is necessary to implement the recommendations. The major recommendations included the following:

- Draft legislation in order to provide the Committee with the necessary authority to access critical information and the participation of critical programs and service providers. It was also decided that due to the extensive time required to enact legislation, the Mayor's Order should be revised to incorporate the recommendations from the Advance to facilitate the Committee operating within the new criteria and procedures.

- Incorporate IMRT under the auspices of the CFRC, as one of the review teams. Infant mortality reviews should continue to be planned, coordinated and sponsored by the Department of Health.

- Expand the review criteria to include all fatalities of children from infancy through 18 years of age.

- Limit the LaShawn A. fatality criteria to children between the ages of 0 through 18 years and those who were or had been known to child welfare within no more than five (5) years prior to the death. It was agreed that the Committee should work with the Plaintiff and

the Center for the Study of Social Policy (LaShawn A. Monitor) to obtain agreement to limit this population of child fatalities.

- Establish four (4) types of review teams with distinct selection criteria. The review teams should include Infant Mortality, Community Multiagency, LaShawn A. Multiagency and Cluster.

- Develop data elements to be maintained on all child deaths, including those that do not meet the criteria for one of the four (4) types of reviews.

- A common data instrument should be developed to be completed by all review teams and on all child fatalities.

- Resources should be identified to support a CFRC Office that will include a minimum of three (3) positions: a Coordinator, Program Assistant and an Administrative Assistant/Secretary.

The decisions and recommendations that resulted from the Advance set the parameters for the work of the Committee for the year. Five (5) work groups were established during the Advance to complete the work necessary to implement the recommendations above. Following is a summary of the work groups that were organized, their objectives and the status of work at the close of 1997:

- *LEGISLATION WORK GROUP*

  *OBJECTIVE:* To review legislation from other states and draft legislation for the District's Child Fatality Review Legislation. This Committee was also responsible for revising the Mayor's Order to ensure that it incorporated the same requirements as the legislation. The Order would give the Committee authority to operate based on the new criteria and procedures until the legislation was finalized.

  *STATUS:* At the close of 1997, legislation for the District's Child Fatality Review Committee was drafted and the Mayor's Order was revised. Both were undergoing final reviews by Committee members, in preparation for transmittal to the Mayor and/or the Council of the District of Columbia.

- *PROTOCOLS WORK GROUP*

  *OBJECTIVE:* To revise the operating procedures for the Committee to improve the effectiveness and efficiency of the review teams and collaboration among CFRC member agencies.

*STATUS:* Key components of the protocols were drafted to reflect the required changes in Committee and Review Team operations based on the basic structural changes with the Committee. This information was submitted to the CFRC Coordinator for inclusion in the final revised protocols.

- *RECOMMENDATIONS WORK GROUP*

*OBJECTIVE:* To develop a strategy for the implementation of CFRC recommendations and monitor recommendation implementation.

*STATUS:* Strategy was finalized and implementation was initiated during 1997.

- *DATA WORK GROUP*

*OBJECTIVE:* To revise the CFRC data instrument to make it more user friendly and to capture more of the data identified as necessary during the Advance and to identify the software and hardware necessary to establish a common computer data base.

*STATUS:* The data instrument was finalized (see Appendix D). The CFRC began using the instrument during 1997 reviews as a working draft. Refinements of the instrument continued through 1997. The essential components and requirements of the computer data base were identified.

- *INFANT MORTALITY/CHILD FATALITY CONNECTION WORK GROUP*

*OBJECTIVE:* To devise a method of coordinating and sharing information between the two groups that will maintain the basic requirements of infant mortality reviews; reduce duplication of reviews; improve the quality and quantity of reviews; and support shared annual reporting.

*STATUS:* A process was outlined and partial implementation began during 1997.

***"A 1997 Homicide Death Of A 17 Year Old Male"***

On an October afternoon, a Metropolitan Police Department officer responded to a report of gun fire in an alley in Northeast D.C. When the officer arrived he found a 17 year old black male, in blue jeans, a white shirt and a black jacket, lying face down between a parked car and a fence. He was suffering from multiple gunshot wounds, one to the right side of the face, another on the rear portion of the right leg, and another in the back. The victim was transported to a hospital by an ambulance, where he was pronounced dead. The decedent had been known to the juvenile justice system since 1995, when he was arrested for assault with a dangerous weapon and drug charges. He was enrolled in a community-based detention and drug treatment program until July of 1997. His case was closed in August 1997.
**Cause of Death:** Gunshot Wounds to the Head and Chest

# SECTION THREE:
# SUMMARY OF CASE REVIEW FINDINGS

# SUMMARY OF CASE REVIEW FINDINGS

***"1997 Natural Death of a Ten Year-Old Female"***

On a Saturday evening in November, the D.C. General ER admitted a 10 year-old girl suffering from a severe asthma attack. Upon responding to an emergency call, paramedics had begun treatment at the scene, then brought her to D.C. General. In the ER attempts were made to revive her for about 55 minutes, whereupon, she coded. She was pronounced dead at about 7:00 P.M. by the hospital physician. According to the decedent's mother, the child had a history of underdeveloped lungs and asthma and had received care at Children's Hospital on several occasions.

**Cause of Death:** Bronchial Asthma

During 1997, 242 children died in the District of Columbia[1]. These children ranged in age from birth through 20 years. This represents a 19 percent decrease from the 287 child deaths reported in the 1996 CFRC Annual Report. Consistent with the data from 1995 and 1996, the majority of the children (n = 219, or 90 percent) who died in 1997 were African American, while the remaining 23, or 10 percent were Caucasian or from other racial backgrounds. Also consistent with the 1996 data, the majority of the 1997 child deaths were males (n = 163, or 67 percent).

***Total Number of District Child Fatalities***

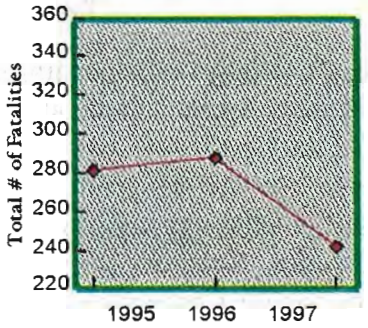


Figure 1 - 1997 CFRC Data

Out of the total number of 1997 child fatalities, the majority of the children (n = 124, or 51 percent) were between the ages of birth through 4 years and 104 of these children were under the age of one (1) year. This data has been constant since CFRC began reviewing child fatalities in 1993. The leading cause of death among these children was prematurity and other health related problems. The second largest group of child deaths was among children 15 years of age and older. Eighty-seven (87), or 36 percent died in this age category and the leading cause of death was homicide and other types of legal interventions.

In accordance with the criteria outlined in Mayor's Order 92-121 (see Appendix A), 1997 fatalities that required CFRC review were identified and selected between January 1997 and March of 1998. A total of 51 cases was selected from the total universe of 242 child deaths and reviews were conducted through August of 1998. This represents approximately 21 percent of the total number of child deaths that occurred in the District.

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1 Provisional Data from the Office of State Health Statistics, Vital Records Division

## CASE SELECTION PROCESS

Since 1995, the Committee has focused on improving several operational procedures that will expedite the reviews. One critical area that has been enhanced is the case identification and selection process. The improvements made in this area have been the primary catalyst for the increased number of cases identified and reviewed. However, despite the progress made in this area, the Committee remains concerned that the process continues to be lengthy and problematic.

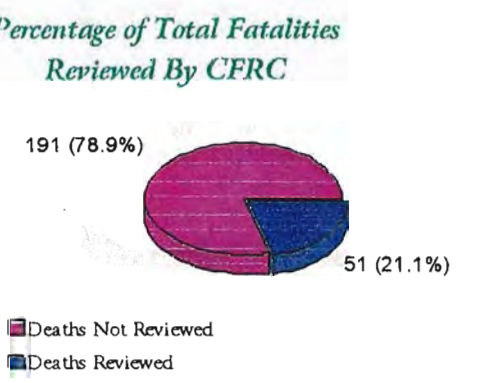


Figure 2 - 1997 CFRC Data

During 1997, the Committee continued to work towards improving the method of agency collaboration related to identification of cases. As a result, stronger relationships and working procedures were established with the Child and Family Services Agency, Medical Examiner's Office, Vital Records, Metropolitan Police Department and the District of Columbia General Hospital (public hospital). These agencies/organizations have become the primary sources of notification of child deaths for CFRC. Notification is received through various forms of written and verbal communication. Written communication includes computer print-outs, unusual incident reports and death reports. These documents provide the Committee with vital demographic information on the child and his/her family, the cause/manner of death, and circumstances surrounding the death. All telephone contacts are documented by completing a Child Death Notification Form and Child Death Log. All cases selected are logged in based on the order in which they were identified. Cases logged in are given a CFRC number, which becomes the primary means of identification.

After identification of child deaths, the first step in the case selection process is to determine whether the family was known or at risk of being known to the District's child welfare system in order to determine whether the child meets the LaShawn A. fatality definition. This definition is broad, thus capturing the majority of the children who are reviewed by CFRC. The definition has two components. First, those children who are or have been known to the Child and Family Services Agency (CFSA) within ten years prior to death. The second part includes those children who should have been known to the CFSA (at-risk). For purposes of the Committee, the at-risk category was limited to children of families who were referred to CFSA and, based on the investigation, the allegations were unsupported or supported and the case closed.

Excluding the at-risk population, the primary mechanism for identifying LaShawn A. children has always been through written notification (Unusual Incident Report) from a CFSA social worker. These cases typically involve fatalities of children who are part of open or recently

closed child protective services, foster care or adoption cases. In situations where the case has been closed for six (6) months or more, notification rarely comes from the program. This is primarily attributed to the fact that the social worker/agency is no longer in contact with the family and consequently is unaware of the death. Therefore, identifying fatalities of children of closed child welfare child protection services (CPS) cases and at risk cases requires more work and time of the Committee.

CFRC's method of identifying the full LaShawn A. category of child deaths and other categories of fatalities continued to be based on a process of elimination. The monthly computer print-out which is received from Vital Records is the most essential document used to initiate the selection process. This document lists every child who has died in the District, with basic information including, date of birth/death, mother's name (if available), place of residence, place of death, cause/manner of death and whether an autopsy was conducted. Using this list, cases are eliminated that do not meet the basic criteria. This includes children who were not born in and did not reside in the District at the time of death; and those cases where there is insufficient information for any participating agency to determine whether the family was ever known to the agency (child is under one (1) month of age and there is no mother's name).

After all non-eligible cases are eliminated, a new list is developed and sent to the child welfare and juvenile justice agencies with a request for review of the records to determine if the child and/or family was involved with the program within the past 10 years. Based on the information CFRC receives from the program, the last social worker is contacted to provide notification of the child's death and request a fatality report and the agency record.

Once it has been determined which children or families were known to the child welfare program, the second phase of case selection is to determine which of the remaining fatalities met the criteria for general community cases. This procedural phase also requires a second review of the Vital Records computer print-out and the further elimination of cases that do not meet the criteria outlined for general community cases.

Case exclusion for general community cases is based primarily on the child's age and the cause/manner of death. This category of fatalities includes children who are District residents where there is no documented evidence of involvement with the child welfare system. It is further limited to children 14 years old or younger who committed suicide, and children ages five (5) years or younger where there is evidence that one or more of the following factors exist:

- The cause of death remains undetermined after the medical examiner's investigation;
- The child had head trauma, except where the case is clearly not abuse or neglect;
- The child was malnourished or neglected, including failure to thrive cases;

- The child drowned;
- The child suffered from asphyxia or suffocation/strangulation;
- The child showed evidence of drug ingestion or poisoning;
- The child suffered fractures;
- The child suffered blunt force trauma;
- The child sustained burns, except where the cause is clearly not abuse or neglect;
- The death resulted from child abuse or neglect;
- The child was sexually abused; or
- The child suffered a gunshot wound.

After eligible LaShawn A. and community cases have been selected for review, the CFRC begins the research process that requires contacting hospitals and community service agencies to obtain information on the family related to any involvement with the child and family, either prior to or at the time of the child's death.

***"A 1997 Natural Death"***

On an October morning, a woman was conducting some business at a District government office when she noticed that her 3 year old daughter, who was with her, had become unresponsive. Believing that her child was having a seizure, the mother rushed her, by car, to the nearest hospital. There was no sign of life when they arrived and resuscitation efforts by hospital were unsuccessful. This family was known to CFS because of a report of negligence which stated that the mother had not completed the necessary training for her child to be discharged to her care. The child had been hospitalized since birth due to a seizure disorder. The hospital stated that the mother was active in the child's care up until the time that she was supposed to be discharged. The charge of neglect was supported because the social worker felt that the mother was overwhelmed with the responsibility of caring for five other children including a mentally retarded adult daughter. The CFS investigation revealed that the mother was hesitant about having her child discharged into her care because of her multiple medical needs. The child was born with partial brain damage, lung disease, seizure disorder, poor pituitary function and was premature (weighed 1lb).

**Cause of Death:** Seizure Disorder; Hypoxic Ischemic Encephalopathy of Undetermined Etiology

The number of cases referred to, identified, selected and reviewed by the CFRC has been on a steady incline since the Committee was established in 1992. However, between 1995 through 1997, the percentage of increase was dramatically higher due to the diligent and continued efforts of the Committee to improve the identification process.

The 51 child fatality cases identified from calendar year 1997 represent a 13 percent increase from the 45 cases identified from calendar year 1996; 113 percent increase from the 24 cases reviewed from 1995, a 200 percent increase in the 17 cases reviewed from 1994 and a 264 percent increase from the 14 fatalities reviewed in 1993. Figure 3 illustrates the significance of the increase in the cases identified and reviewed by CFRC over the past five (5) years, using the same criteria outlined in Mayor's Order 92-121.

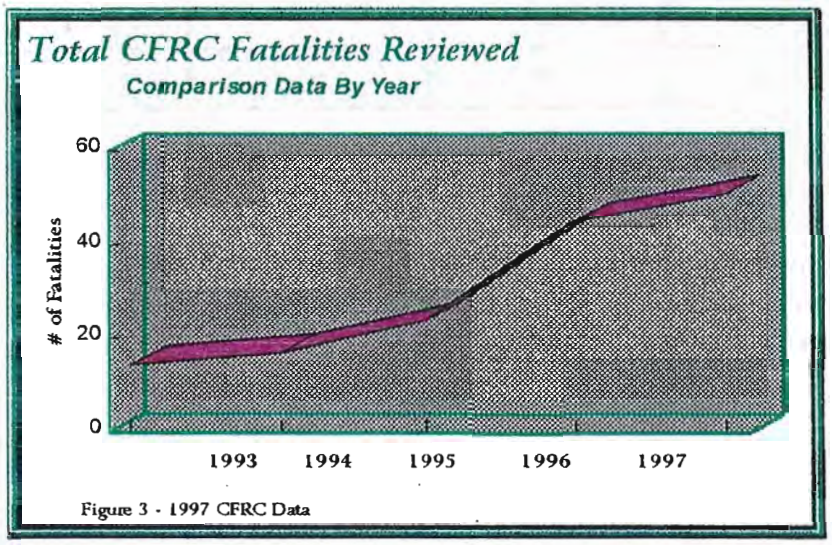

Figure 3 - 1997 CFRC Data

*It is one of the most beautiful compensations of life that no man can sincerely try to help another without helping himself."*
Ralph Waldo Emerson

While the increase in case identification has been constant since 1994, the most significant increase occurred during 1996 from 24 fatalities reviewed in 1995 to 45 in 1996. During 1997, as the identification process became more formalized and accepted among stakeholders, the numbers began to stabilize. Thus, the increase from 1996 to 1997 was not as dramatic an upsurge as in the previous year. The table below illustrates the exact number of cases that have been reviewed for each calendar year since the establishment of the Committee and the actual number and percentage of increase.

| CALENDAR YEAR | # OF FATALITIES REVIEWED | ACTUAL # OF INCREASE * | ACTUAL % OF INCREASE * |
|---|---|---|---|
| 1993 | 14 | NA | NA |
| 1994 | 17 | 3 | 21 |
| 1995 | 24 | 7 | 41 |
| 1996 | 45 | 21 | 88 |
| 1997 | 51 | 6 | 13 |

Table 1 Comparison Data - Total CFRC Fatalities *Increase from previous year

The Committee feels strongly that this data supports the initial belief that the increase was more related to the improvements made in the area of notification and case selection as opposed to an actual increase in the number of children dying.

***"A 1997 Natural Death of a 4 Year-old Twin"***

On a January evening the D.C. Fire and Rescue Services responded to a report of an unconscious and unresponsive child. The decedent's mother reported that her daughter and her twin brother had been born full term and were apparently healthy at birth; however, the daughter had a history of asthma since she was approximately 5 months old. The mother stated that the decedent's uncle had taken her to the clinic for asthma related problems at about 1:30 in the afternoon prior to the death. She was prescribed three medications. Later that day the mother had used a nebulizer on the child, after which she appeared to be doing okay. At about 7:30 p.m. the child began to have an asthma attack, stopped breathing and became unconscious. The mother called an ambulance and neighbors began CPR until the paramedics arrived. Medical records at the hospital described a hospital admission for this child on December 3rd, the prior month, for acute asthma and bronchial spasms. Records indicate that during the course of this treatment, the mother removed her daughter from the hospital against medical advice. However, the mother reports that she took her to the clinic following the departure, and stated that she was concerned about her daughter's care at the hospital because of a previous misdiagnosis from staff at the hospital. Reports further indicate an additional admission for this child about 9 months prior to the death, during which she was hospitalized for several days.

**Cause of Death:** Asthma

# AUTOPSY

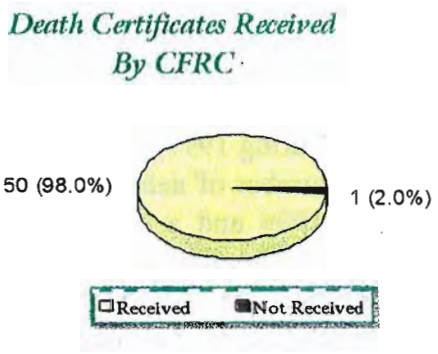


Figure 4 - 1997 CFRC Data

Death certificates were received on 50 or 98 percent of the fatality cases selected for review. Three (3) children died in surrounding states, however, CFRC was successful in obtaining only two (2) of the out-of-state death certificates. The one (1) child whose death certificate was not received is not included in the following data.

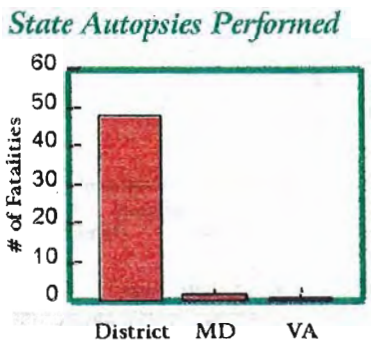


Figure 5 - CFRC Data

As illustrated by Figure 6, based on the death certificates received for 50 child fatalities reviewed, autopsies were conducted on 44, or 88 percent. Six (6), or 12 percent of the fatalities had no autopsy.

According to District statutes, the Medical Examiner's Office (MEO) is required to "make inquiry" regarding all unnatural deaths that occur in the District. Additionally, all deaths which are unexplained or unnatural must be reported to the MEO. An unnatural death is defined as one that is "not the direct result of a natural, medically recognized disease process. Any death where an outside intervening influence, either directly or indirectly is contributory to the individual's demise, or accelerates and exacerbates an underlying disease process to such a degree as to cause death would fall into the category of unnatural."[2]

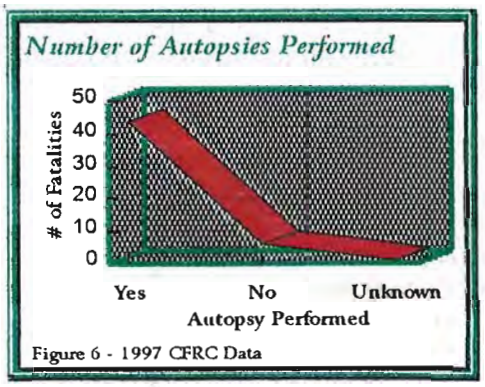


Figure 6 - 1997 CFRC Data

Out of the 44 autopsies that were conducted on the 1997 fatalities reviewed, 38, or 86 percent were performed by the District's Medical Examiner's Office. This represents an 11 percent increase over the 75 percent of the autopsies that were conducted by the MEO during 1996. Four (4), or 9 percent of the autopsies that were conducted on 1997 fatalities were performed by District hospitals and two (2), or five (5) percent were conducted by surrounding states (Maryland and Virginia).

[2] Information obtained from the District of Columbia Medical Examiner Office.

The manner of deaths for the 38 autopsies performed by the MEO included: 15 naturals, 14 homicides, five (5) accidentals, one (1) undetermined and three (3) pending. There were no suicides during 1997 that met the criteria for review by CFRC. Figure - 7 illustrates a comparison of the manners of death for 1996 and 1997 cases reviewed by CFRC. The most significant increases were in the natural and homicide area. During 1997, there was a 26 percent increase in the number of natural deaths from the 11 reviewed in 1996 and a 42 percent increase from the eight (8) 1996 homicides reviewed. The accidental deaths were the same, five (5) in 1996 and 1997. The number of deaths that remained pending tripled during 1997 and undetermined reduced by half.

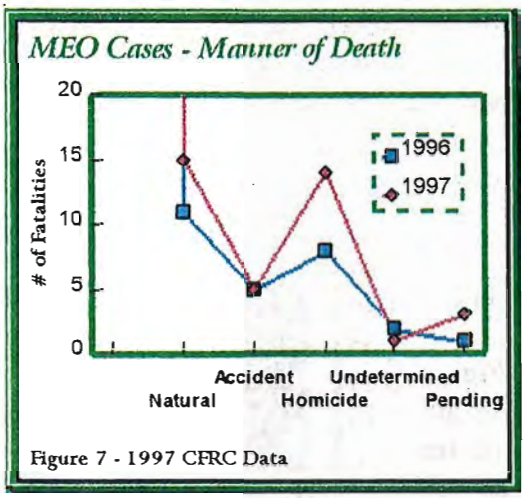

Figure 7 - 1997 CFRC Data

Of the four (4) autopsies performed by local hospitals, the manner of death for all was natural. The death certificates for three (3) of these cases indicated that the fatalities were not referred to the MEO and one (1) did not include information on referral to MEO. Death certificates were received for one (1) of the two (2) deaths for which autopsies were performed outside of the District of Columbia and the manner of death was natural. Because the death certificate has not been received for the other fatality that occurred outside the District, for purposes of this report the manner/cause of death has been categorized as unknown.

***"A1997 Natural Death"***

Around 9:30 on a November morning, a mother woke up and realized that her one month old infant did not wake up for her early morning diaper change. She immediately went to change the infant and noticed that she was unconscious and unresponsive. She then touched the infant's arms, which were cold, and observed that the infant was lying on her back, which was not the position that the mother left her in. The mother of the decedent then screamed for her mother, who then called 911, while another member of the household began CPR under the instruction of the Fire Department dispatcher. The paramedics arrived shortly after and continued the resuscitation efforts but were unable to establish a pulse. The infant was transported to a local hospital, where she was pronounced dead. At birth the decedent was found to have contracted group B strep from her mother and was placed on antibiotic therapy. She was also mildly jaundiced and was initially a poor eater. The infant was seen by medical personnel four times after her birth for problems including: child not feeling well, cold, upper respiratory infection, and mild seborrheic dermatitis. The Medical Examiner's office ruled that these conditions did not lead to the infant's death.

**Cause of Death:** SIDS

# MANNER OF DEATH

The manner of death relates to the circumstances under which the death took place. This determination is made based on the specific information and details that are available on each case. Many factors are considered, including the police investigation, the autopsy and the social, familial, medical and other specific events of the fatal injury or incident. Unlike the cause of death, manner can differ depending on the conditions and contributing factors revealed. In the District there are six (6) manners associated with fatalities. Following are the definitions[3]:

*NATURAL* - A death caused exclusively by disease.

*SUICIDE* - A violent death caused by an act of the decedent with the intent to kill him/herself.

*HOMICIDE* - A violent death at the hands of another person.

*ACCIDENT* - A death caused by violent means, not due to an intentional or criminal act by another person.

*UNDETERMINED* - A death where a reasonable classification cannot be made.

*PENDING* - A death where the final determination of manner is awaiting the completion of the investigation, tests, etc.

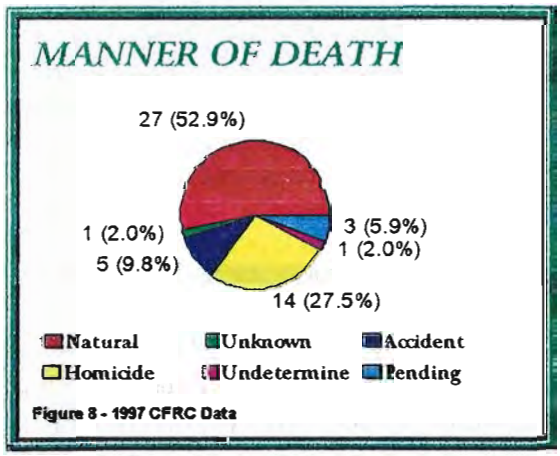

Figure 8 - 1997 CFRC Data

As indicated in Figure 8, the statistical data resulting from the 1997 fatalities reviewed demonstrated that while there were similarities in data from previous years, there were also immense differences in the manner in which children died. Based on 1997 data, it was determined that the leading cause of death continued to be natural, representing 27, or 53 percent of the total 51 fatalities that were reviewed. While this data represents the same number of natural deaths that were reviewed in 1996, it also represents a slight decrease in the percentage of the total number of cases reviewed (in 1996, 27 was equal to 60 percent of the 45 cases reviewed).

[3] Spitz's and Fisher's Medicolegal Investigation of Death - Guidelines for the Application of Pathology to Crime Investigation, 3rd Edition, Editor Werner U. Spitz.

The 1997 data, in regards to the number of natural deaths is consistent with data collected in the prior two (2) years. Natural death has remained the primary manner of death, not only among the cases reviewed by the CFRC, but also for the total number of child/youth deaths for the District.

***Comparison Data - Manner of Death***

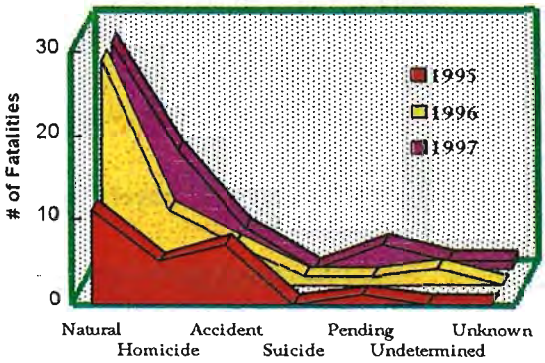


Figure 9 - 1997 CFRC Data

As with 1996, data from calendar year 1997 revealed that the second leading manner of death was homicide (see Figure 9). The number of homicides continued to rise, while the number of accidents remained the same as 1996. Fourteen (14) children, or 27 percent of the fatalities reviewed were of children who died from homicides, compared to nine (9) children, or 20 percent of the total number of cases reviewed in 1996. The 1997 data represents a 56 percent increase from 1996 and a 1300 percent increase from the one (1) fatal child abuse death reviewed in 1995. The 1997 data indicated that seven (7) of the homicide deaths were of children who died from fatal incidents of child abuse or neglect. This represented 50 percent of the 14 homicide cases reviewed from 1997 compared to six (6), or 67 percent of the nine (9) reviewed from 1996. These children died at the hands of their parents or caretakers.

***"A 1997 Accidental Death"***

On a night in August, a mother of three was preparing her family for bed. The mother, her 15 and 4 month old daughters all shared the same twin mattress, which was located on the living-room floor of a two bedroom apartment. Her 7 year old son slept on sofa cushions next to the mattress. The mother awoke around three in the morning to find her 4 month old lying face down between the mattress and the cushions. Not noticing that her child was unconscious the mother proceeded to change the infant's diaper. After doing so, she realized that her child was not breathing. She called 911 and attempted to perform CPR. The infant was transported to an area hospital where she was pronounced dead shortly thereafter.

**Cause of Death:** Positional Asphyxia

Accidental deaths ranked third during 1996 and 1997. 1997 data revealed that the number of accidental deaths remained at five (5), which was the same as in 1996. Additionally, during 1997, there was one (1) death where the manner was undetermined and three (3) that remained pending, which represents a decrease and increase respectively. Also, during 1997 there were no fatalities reviewed that involved a suicidal death. This represents a reversal to 1993, 1994 and 1995 data. Additionally, due to the fact that CFRC was unable to obtain a copy of the death certificate for a child who died in Maryland, the manner of death remains unknown, according to CFRC records.

The following table illustrates the number of children who died by year and manner of death:

| Manner of Death | 1995 | 1996 | 1997 |
|---|---|---|---|
| Natural | 11 | 27 | 27 |
| Accident | 7 | 5 | 5 |
| Homicide | 5 | 9 | 14 |
| Suicide | 0 | 1 | 0 |
| Undetermined | 0 | 2 | 1 |
| Pending | 1 | 1 | 3 |
| Unknown | 0 | 0 | 1 |
| TOTAL | 24 | 45 | 51 |

Table 2: Manner of Death

## Number of Deaths By Manner Per Month

1997 data revealed that the majority of the cases, 24, or 47 percent, involved deaths that occurred during the months of September, October and November. The majority (n = 13, or 54 percent) of these deaths resulted from natural causes. Six (6), or 25 percent were homicides. The following table illustrates the number of deaths that occurred during each month by manner:

| Month | Natural | Accident | Homicide | Undetermined | Pending | Unknown | Total |
|---|---|---|---|---|---|---|---|
| January | 2 | | 1 | | | | 3 |
| February | 3 | | | | | | 3 |
| March | 2 | | 1 | | | | 3 |
| April | 1 | | 2 | | | | 3 |
| May | 2 | | | | | | 2 |
| June | 2 | 1 | | | | | 3 |
| July | 1 | 2 | 1 | | | | 4 |
| August | 1 | 1 | 1 | | | | 3 |
| September | 2 | 1 | 1 | | 1 | 1 | 6 |
| October | 7 | | 4 | | | | 11 |
| November | 4 | | 1 | 1 | 1 | | 7 |
| December | | | 2 | | 1 | | 3 |
| TOTAL | 27 | 5 | 14 | 1 | 3 | 1 | 51 |

# CHILD FATALITIES BY DISTRICT WARD

The District of Columbia is divided into eight (8) Wards, which represent political subdivisions of the city. Each Ward is unique in regard to its population characteristics, land use characteristics, economic status, community/neighborhood structures, services available, strengths and weaknesses. A brief description[4] of the District Wards is as follows:

*WARD ONE* - Located in the Northwest quadrant, near the center of the District. It is the smallest Ward with the largest total population. The racial composition is 57 percent Black, 30 percent White and 13 percent other races. The Hispanic population is 18 percent, which is the largest in any Ward. The median household income of the residents is $26,798, which is 13 percent less than the city median.

*WARD TWO* - Includes parts of the Northwest, Southwest and Southeast quadrants of the city and contains a large part of the Potomac River shoreland. The racial distribution is 35 percent Black, 57 percent White and eight (8) percent other races. The median household income of the residents is $31,716. More than 15 percent of the total housing units are subsidized rental housing, which represents the highest number for any Ward.

*WARD THREE* - Includes Rock Creek Park and the area west of the Park. It is the fourth most populated area of the District with the lowest population density. The racial composition is six (6) percent Black, 88 percent White and six (6) percent other races. The median annual household income is $48,967, which is 59 percent above the city median. It has the highest assessed real estate value.

*WARD FOUR* - Located north of Ward one (1) and east of Ward three (3). It contains a significant number of the city's health care facilities. The third most populous Ward, with a racial composition of 85 percent Black, 12 percent White, and three (3) percent other races. The median household income is $33,025, which is seven (7) percent higher than the city median. Fifty-three (53) percent of the homes are owned, which is the highest for any Ward.

*WARD FIVE* - Contains the greater part of the District's Northeast quadrant with 17 major neighborhoods. The racial distribution is 90 percent Black, nine (9) percent White and one (1) percent other, with Hispanics (may be any race)

[4]Washington, D.C., America's First City, Indices - A Statistical Index to District of Columbia Services (1994 - 1996). This information is the same as that included in the 1996 report and the most current information that is available due to the fact that it is based on 1990 census data.

making up two (2) percent of the total population. The median household income of the residents is $26,874.

*WARD SIX* - Includes acreage east and west of the Anacostia River in three quadrants of the city (Northeast, Northwest and Southeast). The racial composition is 72 percent Black, 26 percent White and two (2) percent other. The median household income was $32,647 in 1990 with 15 percent of households living in poverty.

*WARD SEVEN* - Located in the eastern region of the District. Blacks represent the majority (97 percent) of the population. The median household income was $25,556 in 1990 with 18 percent of the families living in poverty.

*WARD EIGHT* - Located in the southern region of the city with racial distribution of 91 percent Black, eight (8) percent White and one (1) percent other. It has the lowest number of housing units of all Wards. The median household income was $21,312 in 1990 with 26 percent of the families living in poverty.

Table 4 (below) depicts the Ward or the state of residence for the deceased child's biological family or guardian and the manner of death. For families who were involved with the child welfare system, the table depicts the last known Ward/state of residence which may not reflect the Ward or state of residence for the child at the time of death.

| Ward | Natural | Accident | Homicide | Suicide | Pending | Undetermined | Unknown | Total |
|---|---|---|---|---|---|---|---|---|
| One | | 1 | 3 | | | | | 4 |
| Two | 3 | | 1 | | 1 | | | 5 |
| Three | | | | | | | | |
| Four | 2 | 1 | | | | | | 3 |
| Five | 2 | 1 | 2 | | | | | 5 |
| Six | 5 | | 1 | | 1 | 1 | | 8 |
| Seven | 3 | 1 | 3 | | 1 | | | 8 |
| Eight | 10 | 1 | 4 | | | | | 15 |
| Maryland | 2 | | | | | | 1 | 3 |
| TOTAL | 27 | 5 | 14 | 0 | 3 | 1 | 1 | 51 |

Table 4: Death By Ward of Family Residence

Consistent with data from previous years, during 1997, the child fatality cases that were selected as meeting the established CFRC criteria involved deaths from families who lived in all Wards except for Ward three (3).

***"A 1997 Homicide Death"***

On a cool December night, a thirteen year-old boy became the victim of random gunfire. The young man was at a local playground at the same time that two other teenagers were engaged in a "shoot out." He attempted to flee the scene but was struck three times, once in the shoulder and twice in the neck. The paramedics who responded were able to revive him at the scene, however, his injuries were too severe to overcome and he passed away six days later. Earlier on the day of the fatal incident, the MPD had received a report of alleged sex abuse of the decedent's sisters. That morning, based on the investigation, the police officer removed the siblings from their home. If the decedent had been present in the home at that time, he would have also been removed, placed with relatives and thus, may not have been at the playground at the time of the shooting.

**Cause of Death:** Gunshot Wounds of the Neck

In regard to the Wards that had the highest number fatalities, the 1997 data showed a slight deviance from previous years. During 1997, the highest number (n = 31, or 61 percent of fatalities reviewed involved children who resided in Wards six (6), seven (7) and eight (8), with Ward eight continuing to have the highest number of deaths (n = 15, or 29 percent). Wards six (6) and seven (7) had equal number of fatalities (n = 8).

There were three (3) fatalities where the parents were residents of Maryland. These cases were or had been opened with the District's child welfare system. Two (2) of these cases had been closed for several years and after closure the families moved to Maryland. The third case was of a family with an active child welfare case. Several of the children had been placed in foster care, during which time the mother moved to Maryland. The decedent in this family was born and died in Maryland.

The following table illustrates the Ward or state of the fatal incident.

| Ward | Natural | Accident | Homicide | Suicide | Pending | Undetermined | Unknown | Total |
|---|---|---|---|---|---|---|---|---|
| One | | 1 | 2 | | | | | 3 |
| Two | 2 | | | | 1 | | | 3 |
| Three | | | | | | | | |
| Four | 2 | 1 | | | | | | 3 |
| Five | 5 | 1 | 2 | | | | | 8 |
| Six | 3 | | 3 | | 1 | 1 | | 8 |
| Seven | 2 | 1 | 1 | | | | | 4 |
| Eight | 8 | 1 | 4 | | 1 | | | 14 |
| Md/WVa | 1WV/4Md | | | | | | 1 Md | 6 |
| Unknown | | | 2 | | | | | 2 |
| TOTAL | 27 | 5 | 14 | 0 | 3 | 1 | 1 | 51 |

Table 5: Ward By Child's Residence At Time of Death

As is evident, there is a slight difference in the parent's or guardian's original place of residence and the child's residence at death. In the majority of the cases (n = 27, or 53 percent), the Ward or state where the fatal incident occurred was the same, primarily because the child either died in the family's home, in the home of a relative/family friend who lived in the same Ward or died on the street of the neighborhood where the child lived due to homicides or accidents.

There are several situations where the fatal incident occurred outside of the Ward/state of family residence. Based on information revealed during the review, children died outside their original place of residence for various reasons including, the family relocated, the child was placed with a third party caregiver (relative or family friend) by either the parent or the child welfare system, the child was placed in a foster care facility/home or juvenile facility, the child was placed in a convalescent home; or died on the streets of the District, as a result of a homicide. As the table indicates, at the time of the fatal incident, six (6), or 12 percent of the total fatalities reviewed, the children either resided or were being cared for outside the District.

While the Ward distribution changed slightly between 1996 and 1997, one fact remained constant -- there were no fatalities reviewed of children who were residents of, or where the fatal incident occurred in Ward three (3). There were two (2) where the location of the fatal incident was unknown. These youth were known to the child welfare system and had moved outside the District. Both died from gunshot wounds and were transported to hospitals by unknown individuals.

*"THREE 1997 NATURAL DEATHS"*

An eight month old child was discovered by his mother to be unconscious and unresponsive. She called 911. Attempts were made to resuscitate him while transporting him to a local hospital. Life saving efforts continued at the hospital, however, they were unsuccessful and the child was pronounced dead. The mother indicated that she had fed the infant and placed him face down on the sofa. It was revealed that the decedent and his 18 month old sibling had a history of asthma.

**Cause of Death:** Status Asthmaticus

A seventeen year old female, group home resident, with Down's syndrome was admitted to a hospital complaining of a stomach ache. She was subsequently diagnosed with fluid in her lungs and treated. In about ten days her condition began to stabilize and plans were being made for her discharge. A few days later her condition began to deteriorate and she went into cardiac arrest. She was revived twice but the third time she could not be resuscitated.

**Cause of Death:** Eisenmenger's Syndrome

A five year old boy was taken to his doctor by his foster father because of a swollen leg. The doctor instructed them to go to the emergency room, where he was hospitalized the same day. After the hospital conducted a battery of tests, the child was diagnosed with a septic infection of unknown origin. He was placed on intravenous antibiotics and was ready to be discharged. The foster father was uncomfortable about his ability to maintain the IV antibiotics and it was agreed that the child should go to a children's convalescent facility until he had completed the antibiotic treatment. Within a few days the child's condition began to deteriorate and he was readmitted to the hospital. When admitted he had a high fever, an enlarged liver and swollen lymph nodes. A battery of tests were performed but his condition continued to deteriorate. He was soon transferred to the critical care unit, where shortly after he went into cardiac arrest and could not be revived. The birth mother of the decedent was known to CFS since 1993, due to allegations of neglect. She was a known substance abuser with a history of mental health problems. Her children were eventually removed from her care and were placed with foster parents. **Cause of Death:** Cardiac arrest due to congenital heart failure.

# CAUSE OF DEATH

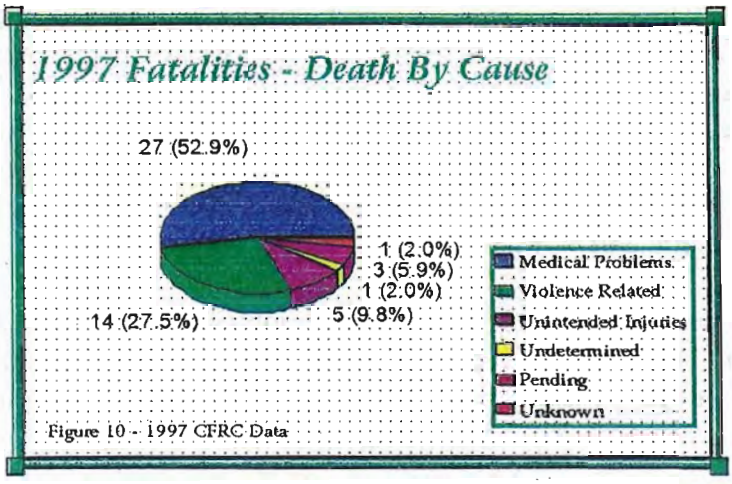


Figure 10 - 1997 CFRC Data

Figure 10 above depicts the causes of death for the 51 fatality cases selected for CFRC review. As in all previous years, the leading cause of death was natural for the 1997 fatalities reviewed. The natural cause category involved twenty-seven (27) children, or 53 percent of the total child fatalities reviewed, who died from a range of medical problems. As in 1996, the second and third leading causes of death for 1997 were violence related and unintentional deaths, with the actual numbers of fatalities for these categories being 14 and five (5) respectively.

As Figure 11 indicates, the ranking of the causes of death for 1997 fatalities reviewed was analogous to those reviewed for 1996, with medical, violence and unintentional ranking first, second and third. While in several categories for both years the numbers of deaths were identical, the percentages of the total in each category differed due to the overall increase in number of cases selected and reviewed for 1997. The category "other" includes deaths where the cause remained pending or was unknown by CFRC and where the final cause was undetermined for 1996 and 1997.

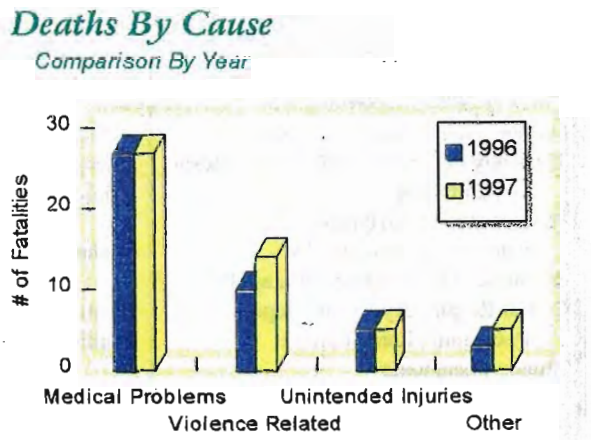


Figure 11 - 1997 CFRC Data

## *Medical Problems*

As indicated above, fatalities attributed to medical problems have ranked first since 1995. This has been largely due to the criteria for the LaShawn A. cases. As indicated in Section IV, "Summary of LaShawn A. Fatalities" the criteria for this category are broad, encompassing any death where the family is or has been known to the District child welfare system. As a result, the types of deaths reviewed are reflective of the overall child fatalities occurring in the District. As with the overall population, the two top ranking manners of death for children known to the child welfare system are natural and homicide.

Unlike previous review years, the 1997 fatality population included children 21 years of age and under. The oldest individual was 21 years and one (1) month, and had spent the majority of this life in the child welfare system. He expired one (1) month after terminating from foster care, on his 21st birthday.

Fourteen (14), or 52 percent of the 27 children who died from medical problems were under six (6) months of age. These children died from medical problems associated with prematurity and Sudden Infant Death Syndrome (SIDS). The second largest age group was 16 to 18 year olds. Four (4), or 15 percent of the medical related deaths were in this age category. In addition to prematurity and SIDS, other medical related deaths included problems associated with congenital anomalies, infectious disease, cancer, HIV/AIDS, neurological disorders, perinatal conditions, cardiac disease, pulmonary conditions, seizure disorder, asthma and renal failure. The table below indicates the causes by age for deaths associated with medical problems.

| **Birth thru 2 Years** (Total Deaths - 15) | **3 thru 5 Years** (Total Deaths - 4) | **6 thru 10Years** (Total Deaths - 1) |
|---|---|---|
| Sudden Infant Death Syndrome (7) | Seizure Disorder/Hypoxic Ischemic Encephalopathy of Undetermined Etiology | Bronchial Asthma |
| Tetralogy of Fallot w/Pulmonary Atesia w/ Ventricular | | |
| Pneumonia/Coma/Hypoxic Ishemic/Encephalopathy | Asthma | |
| Respiratory Failure/Pneumonia/AIDS | | |
| Cardio Respiratory Failure/Sepsis/ Pneumonia/Renal Failure | Ventricular Dysrhythmia/Dilated Cardiomyopathy/Marfan Syndrome | |
| Bronco-pneumonia | | |
| Extreme Prematurity/Birth Asphyxia | Cardiac Arrest/Congenital Heart Failure | |
| Respiratory Arrest/Encephalocele | | |
| Group B Streptococcal Sepsis w/ Meningitis | | |

| 11 thru 15 (Total Deaths - 3) | 16 thru 20 (Total Deaths - 3) | 21 Years (Total Deaths -1) |
|---|---|---|
| Seizure Disorder/Aspiration Pneumonia/Anoxic Encephalopathy | Brain Herniation/Acute Thrombotic Cerebrovascular Accident | Cardiopulmonary Arrest/ Constrictive Pericarditis |
| Respiratory Failure/Graft vs. Host Disease/Renal Failure/ Heart Failure | Eisenmenger's Syndrome/AV Canal | |
| Clinical Anoxia/Bronchial Asthma w/ Seizure Disorder | Comatose, Respiratory Arrest/AIDS w/ Wasting Syndrome | |

Table 5: Cause of Natural Deaths

*"A 1997 Natural Infant Death"*

A police officer was dispatched on a Fall morning to a call for an unconscious person. Upon arrival, a mother reported that her baby was non-responsive and unconscious. She reported that her 2 month old infant daughter had awakened early that morning and was fed 9 ounces of formula, then placed on her stomach, with her face to the side - her favorite sleeping position. The infant and her mother were sleeping in the mother's full size bed. When the mother awakened, startled that it was already 9:30 and the infant hadn't cried for her 8:00 diaper change - as she normally did - the mother immediately checked on her. She realized that the infant's arms were cold and that she was on her back (contrary to the position she was left in). The mother then realized the infant was unconscious and screamed for her mother (the maternal grandmother), who called 911, requesting an ambulance. The infant had no significant history of medical problems, except a short period of jaundice at birth which resolved within a few days. The mother notes that she sometimes heard a slight wheeze when her daughter slept. Recent pediatric visits noted that the infant had experienced feeding difficulties and symptoms of a cold, for which treatment recommendations were made. Follow-up investigation identified a quite disorderly environment in the home. However, the room where the deceased infant slept was cleaner, and while there was some disarray, it appeared related to an overabundance of infant products. There were no identified environmental factors related to the infant's death.

**Cause of Death:** Sudden Infant Death Syndrome

## *Unintentional Injuries*

For purposes of this report, unintentional injuries are those incidents where death was not the intended result. This category may include violent and non-violent conditions that were determined by autopsy to be accidental. Figure 12 (right) depicts those 1997 deaths that were due to unintended injuries. The injuries included two (2) blunt impact injuries, one (1) drowning, and two (2) asphyxia. The blunt impact injuries were associated with motor vehicular accidents that involved children who were ages 3 and one year old. The drowning occurred at a public recreational/community pool that involved a 12 year

*1997 Fatalities - Unintentional Injuries*

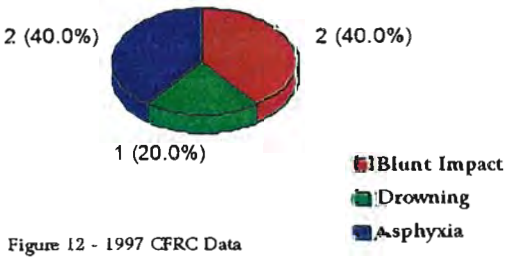


Figure 12 - 1997 CFRC Data

old youth. The two (2) asphyxia deaths involved a six (6) year old who died in a house fire and a four (4) month old who was wedged between a pillow and a mattress on the floor. All these children were residing with their parents and at the time of the fatal incident four (4) were in the care of their parents. The caretaker's negligence was determined to be a factor that contributed to the deaths in two (2) of the unintentional or accidental injuries.

*"A 1997 Accidental Death"*

On a winter evening, in the Northwest quadrant of the city, a mother, her two children and her two younger brothers were in the basement of a three level row house. The mother reported that she was cleaning up sunflower seeds and the children were playing nearby. The mother turned her back for a short period and was alerted by her brother that her 10 month old female child had fallen, head first, into a bucket. The mother immediately ran to the bucket, which was partially filled with water, and removed her child. She called 911 and requested an ambulance. She indicated to the police that she attempted to expel water from the child by pushing inwards on her abdomen and then proceeded to administer CPR while awaiting the ambulance. The medics continued CPR while transporting the child to a local hospital. The infant was admitted in critical condition and placed in the Intensive Care Unit. Two days later the infant was pronounced dead.

**Cause of Death: Drowning**

## *Violence Related Deaths*

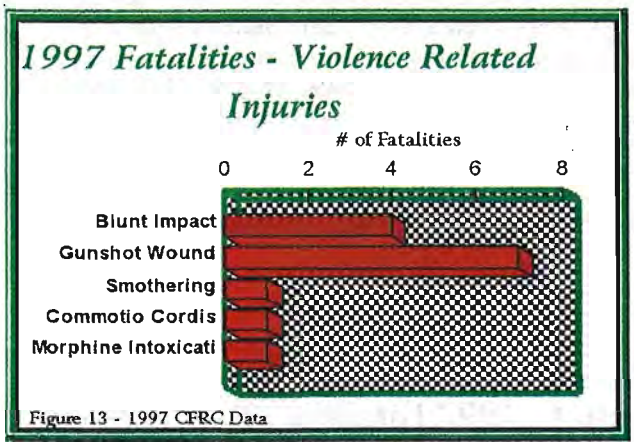

Figure 13 - 1997 CFRC Data

For purposes of this report, a violent death may include homicidal, as well as, suicidal fatalities. Figure 13, illustrates the violence related deaths that occurred in 1997. All these deaths were determined to be homicides. The majority of the fatalities (n = 11, or 79 percent of the total homicides) were caused by gunshot wounds and blunt impact/force injures. As with previous years, the seven (7) gunshot wounds (GSW) involved older youth between the ages of 13 and 18 years old. All the decedents were males and of the African American race. Additionally, based on the information shared during the reviews, in five (5) of the seven (7) GSW incidents, the decedent was the intended victim. One GSW fatality involved a 17 year old who was shot while he and a friend were playing with a gun. The seventh and youngest GSW fatality, involved a "shoot out" between other teenagers and the decedent was in the line of fire. The youth was shot on the day that his case opened with the child welfare system and had he been home earlier, he may have been removed and placed in a relative's home along with his sisters. The other six (6) GSW victims were also known to the child welfare agency and four (4), or 57 percent were known to the juvenile justice system. Blunt impact/force injuries, the second leading cause of violence

related deaths, represented 29 percent (n = 4) of the 14 cases reviewed by CFRC. The decedents were all females, who ranged in age from one (1) month to four (4) years. At the time of the fatal injuries, three (3), or 75 percent of the children were not in the care of their parents. Care was provided by a relative, mother's boyfriend and a friend/babysitter. The fourth child was the victim of a hit and run motor vehicle accident.

In the remaining three (3) violence related fatalities, the specific causes of death included smothering, acute morphine intoxication and commotio cordis, which resulted from a blow to the chest. These children were majority males (n = 2, or 67 percent) and they ranged in age from one (1) to 11 years. At the time of the fatal injuries, the children were in the care of a parent, a friend of a child's godmother, and a friend/baby sitter.

Only one of the homicide cases had no involvement with the child welfare system prior to the death. The families of 13, or 93 percent of the 14 homicide fatalities had been referred to protective services due to allegations of abuse or neglect. However, based on the child welfare investigations, reports were supported on 12, or 86 percent and unsupported on one (1), or 7 percent of the families.

***"A 1997 Homicide Death Of A 1 Year Old Infant"***

In October the Fourth District Police Precinct received a call reporting an unconscious person. When the officers arrived on the scene they discovered that the unconscious person was a one year old infant. CPR was initiated and the infant was transported to a local hospital where the emergency room staff pronounced her dead. The emergency room staff related that the only thing unusual about the infant's death was that there was an unusual amount of blood in her lungs. The mother of the infant was not present at the time of the incident. She had left her child in child in the care of the decedent's godfather and his paramour. During the police investigation the godfather admitted to smothering the infant. He stated that around 1:30 in the morning, the infant began crying and would not stop so he placed his hand over her mouth for about 10 seconds. However the crying continued, so he then placed his hand over her mouth and nose for 30 seconds to a minute. When he released her she had stopped crying and was making some gasping sounds, but with the crying stopped, he went back to sleep. He woke up at 8 a.m. and noticed that the infant was unresponsive, cold and had blood coming from her nose and mouth. He then called 911. The godfather related that he just did not want the infant to wake his grandmother.

**Cause of Death:** Smothering

## *Investigation/Prosecution of Violence Related Deaths*

The District's criminal justice system is unique, in that it functions as a combination state, county and municipal government through a combination of Federal and District governmental entities. The Superior Court of the District of Columbia, United States Attorney's Office, Office of Corporation Counsel and the Metropolitan Police Department are major participants in the criminal justice process. The delineation of responsibilities for these governmental entities is as follows:

- District of Columbia Superior Court - the local "trial court of general jurisdiction"[5] for the District. As a court of general jurisdiction, the D.C. Superior Court has the authority to handle virtually all legal matters, both civil and criminal, originating in the District.

- United States Attorney's Office - prosecutes all adult felony and serious adult misdemeanors for the District.

- Office of Corporation Counsel - serves as the general counsel for the District. This Office is additionally responsible for prosecuting certain adult misdemeanors, all cases of juvenile delinquency (including juveniles charged with major crimes) and handling all cases involving child neglect, abuse, and persons in need of supervision.

- Metropolitan Police Department is the primary law enforcement agency in the District. During 1997, the MPD Criminal Investigation Division was responsible for the investigation of all homicides.

***"A 1997 Homicide Death"***

At approximately 10:00 p.m. in mid January, in the hallway of an apartment in the southeast quadrant of the city, two youth were playing with a gun. As they passed the gun between them, it went off, striking the decedent in the chest. An ambulance transported the youth to the nearest hospital, where he was pronounced dead at 10:30 P.M. The fatal incident occurred in the neighborhood where the decedent lived. The victim was 17 years old and the assailant was 14. The assailant was arrested, however, based on the investigation, the death was determined to be an accident, therefore, the assailant was not prosecuted and the case was closed. The decedent was known to the child welfare, juvenile justice, public schools and mental health systems.
**Cause of Death:** Gunshot Wound of Chest

[5] Inside the Courts, Government and Law Libraries of the District of Columbia, First Edition, The Practical Guide, David F. Hallberlin, Esquire, Patuxent River Press

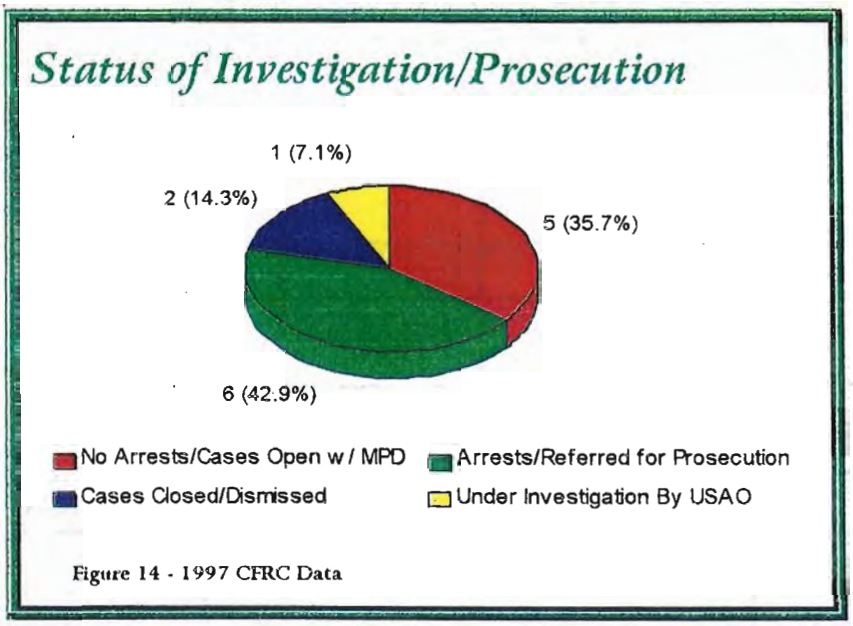


Figure 14 - 1997 CFRC Data

As illustrated by Figure 14 above, the investigations of the 14 homicide deaths reviewed from 1997 revealed that in five (5), or 36 percent, the assailants had not been identified. However, these cases remain open with the Metropolitan Police Department (MPD). The perpetrators were identified for eight (8), or 57 percent of the homicide cases. Arrests were made in six (6) of these fatalities and the cases were referred to the U.S. Attorney's Office (USAO) for prosecution. In one (1) case the decision was made not to indict the alleged perpetrator for murder because it was uncertain as to who actually committed the fatal offense (on the day of the death the child had spent significant amounts of time with the mother and the babysitter/ neighbor). In the remaining two (2) fatalities where the perpetrators were identified, the cases were not referred to the USAO. One of these cases was closed by the MPD because the investigation determined that the fatal incident involved an accidental shooting between teenagers playing with a gun. The last case was dismissed during an arraignment hearing due to the lack of probable cause and the Judge's ruling that the death was accidental. On the latter case, a grand jury investigation was requested and was ongoing as of the date of this Report. A sixth case was referred to the USAO for investigation. It is unknown as to whether a suspect has been identified, however, the investigation was pending as of the date of this Report.

Out of the six (6) cases that were prosecuted, the charges included one (1) Murder I, three (3) Murder II, two (2) Manslaughter, one (1) Voluntary Manslaughter and one (1) Child Abuse. In four (4) of the cases the perpetrators plea bargained and received sentences ranging from six (6) years to life. In two (2) of the cases, the trials were scheduled to occur in early 1999.

The following table provides a summary of the information related to the investigation and prosecution of the 14 homicide fatalities reviewed by the CFRC:

| Cause of Death | Perpetrator | Charge | Status |
|---|---|---|---|
| Smothered | Godfather/Babysitter | | Indictment Dismissed/Grand Jury Active |
| Gunshot Wound | Friend | | Case closed - accident |
| Blunt Impact Injuries | Mother's Paramour | Murder II | Plea - Voluntary Manslaughter<br>Sentenced - 10 to 30 Years |
| Blunt Force Trauma | Babysitter | Child Abuse | Trial Scheduled |
| Commotio Cordis | Father | Murder II | Plea - Manslaughter<br>Sentenced - 6 to 18 Years |
| Gunshot Wound | Acquaintance | Murder I | Plea - Murder II<br>Sentenced - 16 Years to Life |
| Gunshot Wound | Random Assailant | Murder I | Trial Scheduled |
| Gunshot Wound | Acquaintance | Unknown | Plea - Voluntary Manslaughter<br>Sentenced - 8 to 24 Years |
| Blunt Impact Injuries | Uncertain | N/A | Investigation Pending |
| Blunt Impact Injuries | Unknown | N/A | No Arrest |
| Acute Morphine Intoxication | Unknown | N/A | No Arrest |
| Gunshot Wound | Unknown Assailant | N/A | No Arrest |
| Gunshot Wound | Unknown Assailant | N/A | No Arrest |
| Gunshot Wound | Unknown Assailant | N/A | No Arrest |

Table 7: Summary of Investigation and Prosecution of Homicide Fatalities

## *Pending, Undetermined and Unknown*

As indicated on page 16, a fatality categorized as pending is one where the final determination of manner is awaiting the completion of the police investigation, tests, etc. In accordance with Mayor's Order 92-121, any death that remains pending over 45 days must be reviewed by CFRC. Sixteen (16), or 31 percent of the 51 fatality cases identified by CFRC had an initial manner and cause of death as pending. Fifteen (15), or 94 percent of the pending cases remained pending over 45 days. The average number of days the 15 cases remained pending was 261 days, with the fewest days being 48 and the greatest being 527 days. The manner of death for the 15 fatalities that remained pending over 45 days, included two (2) homicides; one (1) undetermined and nine (9) natural deaths. As of November 6, 1998, three (3) of the deaths were still pending. There was also one (1) fatality where the cause and manner of death remained unknown to CFRC. This was a case where the child was part of a family with an active child welfare case in the District. After the case was opened, the mother moved to Maryland and thus, the decedent was born and died in Maryland. The social worker and the CFRC were unsuccessful in obtaining a death certificate. While the parents indicated that the cause of death was SIDS, this information could not be verified.

During 1997, there was one death where the final cause/manner was undetermined. This case involved a nine (9) month old male child, who was in the care of the mother and father at the time of the fatal incident.

***"A 1997 Undetermined Death"***

On a cold winter morning, at approximately 5:50 a.m., a mother was awakened by the sounds of her 8 month old male infant vomiting. The mother reported that she attempted to assist him by raising his arm and patting his back. She also changed his bottle from formula to juice, thinking that he may have become ill from sour milk. The child vomited throughout the day. Therefore, at approximately 7:00 p.m. the mother began giving him Pedialyte, which he also threw up. The mother indicated that the child began "looking funny," describing him as appearing pale and his lips bluish. At approximately 9:00 p.m., she called the child's physician, who advised her to take the child to the hospital. The mother indicated that she dressed the child and laid him on the bed. She then called the ambulance. While waiting for the ambulance, the father picked the child up and while holding him, he lost consciousness. The mother began CPR, however, in a panic she ran to get assistance from a neighbor. The neighbor attempted to revive the child while the mother waiting outside for the ambulance. When the paramedics arrived, the child was unconscious and unresponsive. They immediately began CPR and transported the child to the nearest hospital. Despite all life saving efforts, the child was pronounced dead at 11:15 p.m.

**Cause of Death:** Undetermined

## PLACE OF DISCOVERY

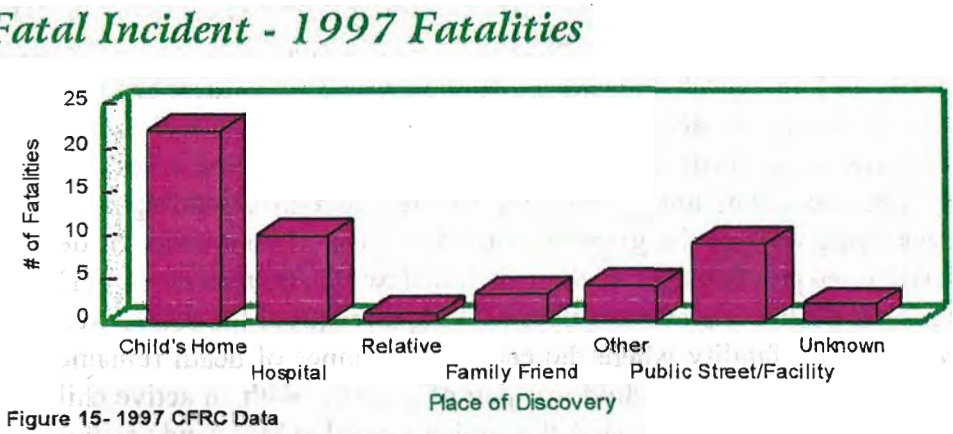


Figure 15- 1997 CFRC Data

As illustrated by Figure 22 above, data from 1997 reviews disclosed that the majority of fatal incidents occurred at the child's home or in hospitals (n = 32, or 63 percent). Twenty-two (22), or 68 percent of these cases involved children who were discovered at home by their caretakers. The 10 cases where the child was discovered in the hospital, three (3) involved infants who were born premature and never left the hospital after birth. The remaining seven (7) cases involved children who had been admitted for illnesses or chronic medical problems and died as an in-patient.

Ten (10), or 20 percent,of the total fatalities reviewed involved children who were discovered in public areas. These areas included alleys, streets, public pools, playgrounds, a basketball court and a government office. The remaining nine (9) cases included two (2) children who were discovered by family friends; one (1) by a relative; and four (4) children discovered in other residences and institutions.

# CHARACTERISTICS OF DECEDENTS

## Gender of 1997 Fatalities

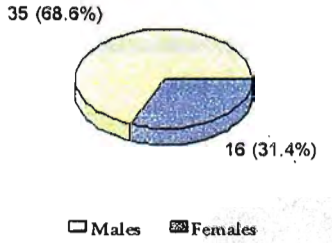


Figure 16 - 1997 CFRC Data

As with 1996 data, there were substantially more male than female deaths in 1997. Figure 15 depicts the gender of the decedents for the 1997 fatality cases reviewed. The actual number of female deaths was sixteen (16), or 31 percent and the number of male deaths was 35, or 69 percent of the total fatalities reviewed for 1997. *1997* female deaths represent a 13 percent (n = 2) reduction from 1996 data.

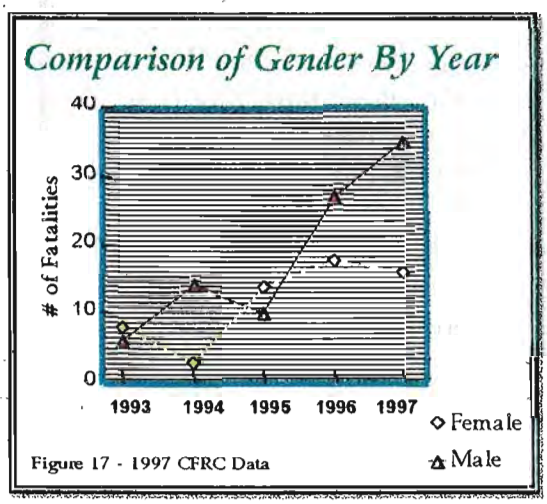


Figure 17 - 1997 CFRC Data

Figures 16 and 17 illustrate the differential death rates between male and female children as revealed by the data from CFRC reviews held between 1993 and 1997. Males were leading in all manners of death, representing 63 percent (n = 17) of natural, 64 percent (n = 9) of homicides, 80 percent (n = 4) of accidents, 100 percent of undetermined, pending and unknown deaths.

As with 1996 data, the leading manners of death for both genders were identical, with natural, homicides and accidents ranking first, second and third. This data is consistent with national data which indicates that males have a poorer survival rate and adolescent males are more victims of youth/gang violence, which represented 50 percent (n = 14) of the 1997 homicides reviewed. Out of the six (6) child abuse related homicides, more females (n = 4, or 67 percent were victims than males (n = 2, or 33 percent). The higher incidence of child abuse related deaths among females was also consistent with 1996 data. However, unlike 1996, the 1997 data revealed that perpetrators extended beyond family members to include unrelated caretakers.

## AGE AND BIRTH ORDER OF DECEDENTS

While there were similarities with the 1996 data, 1997 data provided notable differences as well. The 1997 data revealed that the age range of the 51 fatalities reviewed was from less than one month to 21 years. ***1997*** has been the only year, since the existence of CFRC, where a fatality was reviewed of an adult. This case involved an individual who had spent the majority of his life in foster care and had suffered from a congenital heart problem who died one (1) month after terminating from foster care at the age of 21 years. The CFRC was notified of this death by the child welfare program. Because the decedent had been in foster care within a ten (10) year period prior to his death and his death occurred in such close proximity (one (1) month) to his termination from foster care, the fatality met the LaShawn A. criteria for review.

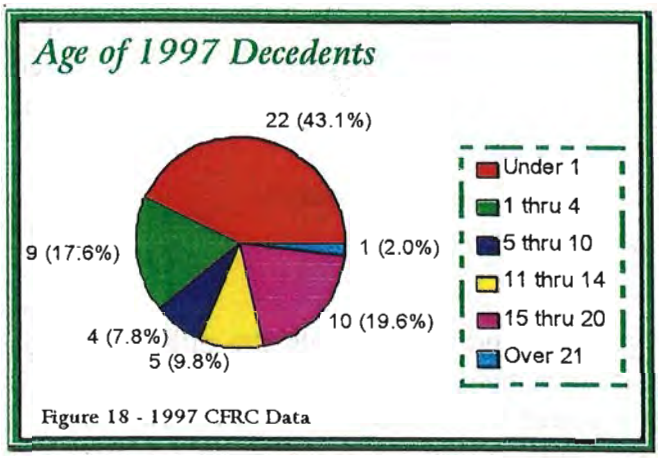

Figure 18 - 1997 CFRC Data

Additionally, as in all other CFRC years, the largest number of 1997 fatalities reviewed (n = 35, 69 percent were of children 10 years of age or under. However, 1997 data indicates a decline in the percentage of the total for this age category from past years. During 1993 through 1996, the percentage of the total for the 10 years and under category ranged from 93 percent in 1993 to 82 percent in 1996. While there has been some fluctuation in the percentage for this category, 1997 represents the smallest number of children in this age category. The decline in the percentage of the total is attributed to the decrease in the actual number of children in this category, as well as the increase in the number of cases identified and selected for review during 1997.

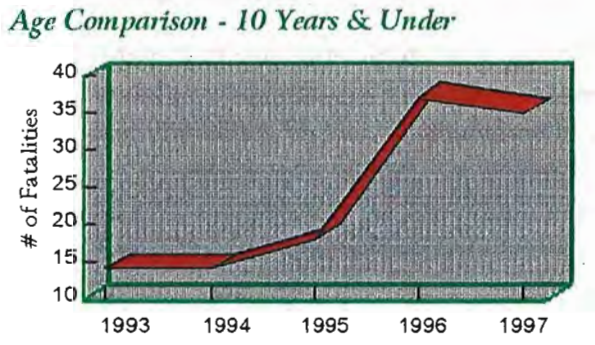

Figure 19 - 1997 CFRC Data

During 1997, the largest age category of fatality cases reviewed were children under the age of one (1) year. Twenty-two (22) children, which represents 63 percent of the total 10 year and under age category and 43 percent of the total number of cases reviewed (n = 51), were under one year of age; compared to 15, or 41 percent of children 10 and under for 1996. Four (4), or 18 percent, of the 1997 children who

were under one (1) year of age, were under one month, with the youngest child being three (3) hours old; compared to one (1), or seven (7) percent in 1996.

The leading manner of death for children 10 years of age and under was natural. Out of the 27 children who died from medical problems 20, or 72 percent, were children within this age range. Nineteen (19) of these children were five (5) years of age and under and 15, or 79 percent of these children were under the age of one (1). Prematurity, low birth weight, congenital abnormalities were direct contributors to these fatalities.

The second leading manner of death for children ten (10) years of age or under was homicide. Of the 14 children who died at the hands of another individual, six (6), or 43 percent, were 10 years of age or under. Additionally, four (4), or 80 percent, of the five children who died of accidental deaths and 100 percent of those who died from pending, undetermined and unknown causes were in the 10 year of age and under category. The majority of the children in the 10 and under age category were males [n = 20, or 57 percent (see Figure 22 below for more specific comparison of sex and age)].

Children over the age of 10 years of age represented 31 percent (n = 16) of the total universe of cases reviewed. However, the second largest age category for 1997 fatalities was youth between the ages of 15 through 20 years. Ten (10), or 63 percent, of the over age 10 category and 20 percent of the total (n = 51) cases reviewed involved youth ages 15 through 18 years of age. Fifty (50) percent(n = 5) of these children were 18 years of age. The majority of these children were males (n = 8, or 80 percent). The leading manner of death for youth 15 through 20 years was homicide (n = 6, or 60 percent) and the second manner of death was natural.

The deaths of five (5), or 31 percent, of children over the age of 10 and 10 percent of the total cases selected for review were of children between the ages of 11 and 14. One hundred (100) percent of these children were males and the same number died from homicide and natural causes (n = 2) and one was the victim of an accidental death. The following table (page 36) provides a summary of the genders of the decedents by cause of death for fatalities reviewed by CFRC during 1995, 1996 and 1997.

| YEAR | 1995 | | 1996 | | 1997 | | TOTAL | |
|---|---|---|---|---|---|---|---|---|
| NATURAL | M | F | M | F | M | F | M | F |
| Under 1 | 2 | 1 | 6 | 3 | 11 | 4 | 19 | 8 |
| 1 Thru 4 | 3 | 2 | 5 | 5 | 0 | 2 | 8 | 9 |
| 5 Thru 10 | 1 | 0 | 3 | 1 | 1 | 2 | 5 | 3 |
| 11 Thru 14 | 0 | 0 | 3 | 0 | 2 | 0 | 5 | 0 |
| 15 Thru 20 | 2 | 0 | 0 | 1 | 2 | 2 | 4 | 3 |
| Over 21 | 0 | 0 | 0 | 0 | 1 | 0 | 1 | 0 |
| **Total** | **8** | **3** | **17** | **10** | **17** | **10** | **42** | **23** |
| HOMICIDE | M | F | M | F | M | F | M | F |
| Under 1 Year | 0 | 0 | 1 | 0 | 0 | 2 | 1 | 2 |
| 1 - 4 | 0 | 1 | 1 | 1 | 1 | 3 | 2 | 5 |
| 5 - 10 | 0 | 0 | 1 | 2 | 0 | 0 | 1 | 2 |
| 11 - 14 | 0 | 1 | 0 | 0 | 2 | 0 | 2 | 1 |
| 15 - 20 | 2 | 1 | 2 | 1 | 6 | 0 | 10 | 2 |
| **Total** | **2** | **3** | **5** | **4** | **9** | **5** | **16** | **12** |
| SUICIDE | M | F | M | F | M | F | M | F |
| 15 - 20 | 0 | 0 | 1 | 0 | 0 | 0 | 1 | 0 |
| **Total** | **0** | **0** | **1** | **0** | **0** | **0** | **1** | **0** |
| ACCIDENT | M | F | M | F | M | F | M | F |
| Under 1 | 0 | 2 | 1 | 1 | 0 | 1 | 1 | 4 |
| 1 - 4 | 0 | 1 | 1 | 1 | 2 | 0 | 3 | 2 |
| 5 - 10 | 1 | 2 | 0 | 1 | 1 | 0 | 2 | 3 |
| 11 - 14 | 0 | 1 | 0 | 0 | 1 | 0 | 1 | 1 |
| **Total** | **1** | **6** | **2** | **3** | **4** | **1** | **7** | **10** |
| OTHER | M | F | M | F | M | F | M | F |
| Under 1 | 0 | 1 | 2 | 1 | 4 | 0 | 6 | 2 |
| 1 - 4 | 0 | 0 | 0 | 0 | 1 | 0 | 1 | 0 |
| **Total** | **0** | **1** | **2** | **1** | **5** | **0** | **7** | **2** |
| **GRAND TOTAL** | **11** | **13** | **27** | **18** | **35** | **16** | **73** | **47** |

Table 8: Comparison Data - Decedent's Gender and Cause of Death

Forty-one (41) or 80 percent of the total number of fatality cases selected for review had siblings at the time of their death. Nine (9), of the 1997 fatalities were only children, compared to four (4) in 1996. The number of siblings ranged from zero (0) to eight (8), with the largest percentage of decedents having one (1) or three (3) siblings. The birth order of the deceased children ranged from first to seventh, with the greater number (n = 17, or 33 percent) of the decedents again being the last born. There were three (3) cases where the decedent was a twin. In two (2) cases, the twins had other siblings and, in one (1), the twins were the only children.

## *Prior Sibling Fatalities*

As with 1996 fatalities, in 1997, there were four (4), or 8 percent, of the total cases reviewed, where families had experienced other child deaths. One case involved the death of two of the decedent's half sisters, who died violently as adults. Two cases involved siblings who were violently killed by paramours or friends of the family. In one of these situations, the same perpetrator killed both children but three (3) years apart. The fourth case involved the death of a sibling three (3) years prior to 1997 and according to the child welfare record, the child died from Sudden Infant Death Syndrome.

***"A 1997 Natural Death"***

While playing a game of basketball at Job Corps. in Harper's Ferry, West Virginia on a September afternoon, a teen collapsed from what was later identified as a stroke. He was taken to a local hospital, but because of the severity of his injuries, he was transported to a hospital in Virginia. He died there two days later. The decedent, abandoned by a drug abusing mother, was taken in by his great aunt and uncle. He was known to have a history of drug and alcohol abuse. Earlier in the year, the decedent was hospitalized after playing a game of "pass out" in which the participants drink until the first person passes out. As a result the decedent suffered an alcohol overdose.

**Cause of Death:** Brain Herniation; Acute Thrombotic Cerebrovascular Accident

## RACIAL BACKGROUND OF DECEDENT

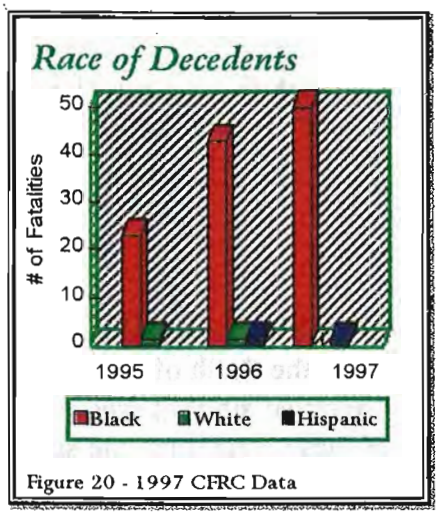

Figure 20 - 1997 CFRC Data

In the District of Columbia African Americans make up 66 percent of the population[6]. However, as in all previous years, they represented 98 percent (n = 50) of the fatalities reviewed by CFRC. While Whites make up 30 percent of the population, fatalities of children from this racial background have consistently represented an extremely low proportion of those determined to be eligible for review. Hispanics and other races represented four (4) percent of the District's population, and the fatalities among them have been proportionately represented. During 1997, there was one (1) death reviewed that involved a Hispanic child and there were no deaths of White children reviewed. Figure 23 illustrates the significant racial disparity among African Americans, Whites and other racial backgrounds in the fatality cases identified as meeting the criteria for CFRC review from 1995, 1996 and 1997 calendar years.

Based on the racial configuration of the fatalities reviewed, African American children have a mortality rate that is significantly and disproportionately higher than other races in the District. This disparity is partly attributed to the higher infant mortality rate among minority families, the higher incident of substance abuse and youth violence in the District. In many ways the data contained in this Report are indicators of the well-being of African American children residing in the District of Columbia and the capacity and ability of systems, public and private, to address their needs.

The D.C. Children's Trust Fund reported in the 1997 "Every Kid Counts in the District of Columbia" that "there are encouraging signs that improvement may be occurring in conditions affecting children's health in the District." This finding was based on the decline in the number of low birth weight infants, efforts to improve prenatal care, reduction in the infant mortality rate and reduction in the number of teenage violent

***"A 1997 HOMICIDE DEATH"***

In 1992, a mother of six was incarcerated for stabbing her friend. As a result, her children were placed with relatives. In 1996, one of her sons was arrested for possession of cocaine with intent to distribute. Later that year, he was arrested again for possession of a dangerous weapon. One night in March of 1997, he attempted to rob a drug dealer. During the robbery, it was reported that he shot at the drug dealer, who in turn shot him in the head. He was taken to an area hospital where he was pronounced dead. The relative, with whom the decedent was placed, has custody of another sibling who is reportedly doing well in school and home. Hopefully, his life will continue to follow a different path.

**Cause of Death:** Gun Shot Wound to the Head.

[6] 1990 Census Data as reflected Indices: A Statistical Index to District of Columbia Services (1994 - 1996)

deaths. While a corresponding decline in deaths is not reflected in the CFRC Annual Report, consideration must be given to the fact that the Committee has made major improvements in the identification and notification process and thus is still experiencing increases in the total number of cases being reviewed. It is hoped that as our process is completely formalized and refined, the data will stabilize and reflect the more positive outcomes for African American children in our city, which have been proclaimed by the Trust.

***"A 1997 Pending Death"***

During the early morning hours of a warm summer day, the grandmother of a 9 month old male infant entered the living room of her 2 story home and found her grandson lying on his stomach on the couch in an unconscious state. She immediately called 911while another relative began CPR. A police officer arrived on the scene and took over CPR until the paramedics arrived. The child was transported to a local hospital with CPR in progress. He was pronounced dead shortly after arrival at the hospital. Information shared during the review indicated that the mother of the decedent had left her son in the care of her sister. The aunt indicated that she fed the child at approximately 9:30 P.M. At 11:00 p.m. the aunt reported seeing the child sitting on the couch watching television. The next time she reported seeing the child was at 6:00 a.m. She stated that she observed the infant lying on the couch and he appeared to be fine. Another relative stated that he was lying on the other end of the couch when the child fell asleep. He also indicated that he was awakened when the aunt checked on the child at 6:00 a.m. Once she indicated that the child was okay he fell back asleep. It was reported that the decedent had major medical problems and that his only injury occurred several days prior to the fatal incident. While he was attempting to walk around the edge of his bed he fell and bumped his head on a carpeted floor, which resulted in a minor bruise. It was also revealed by the paramedics that on the night of the fatal incident, the child was sleeping on the couch with a man who weighted over 300 lbs.

**Cause of Death:** Pending Further Studies

## CHILD'S BIRTH INFORMATION

According to information gathered prior to and shared as part of the fatality reviews, 10, or 20 percent,of the total population were born premature, 10 were not and the information was unknown on 18 cases.

## CHILD'S CUSTODY STATUS AND CARETAKER AT TIME OF DEATH

*1997* data revealed that a higher number of children were in the care and custody of their families at the time of death than in 1996. Forty-six (46), or 90 percent of the 1997 children were in the custody of their families, as opposed to 33, or 73 percent in 1996. Out of the 46 children, 41, or 89 percent resided with their parents. Similar to previous years, the larger portion of children resided with their mothers (n = 28, or 68 percent of the total number with parents).

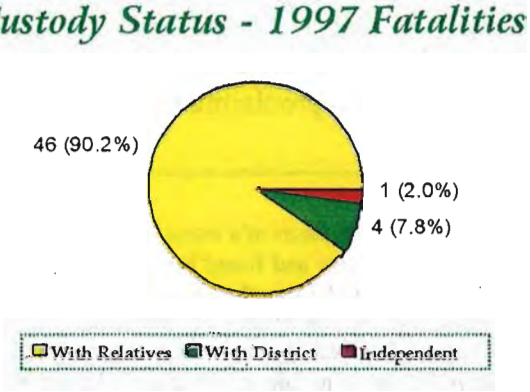


Figure 21 - 1997 CFRC Data

Unlike previous years, 1997 data indicated that a larger number of children resided with both parents. Twenty-two (22) percent ( n = 10) as opposed to seven (7) percent, or two (2) children during 1996. Data from 1997 reviews also revealed that three (3) children were in the custody of their fathers and five (5) were placed with relatives. Placement and custody were court ordered for two (2) children. This included one (1) who resided with a relative and one (1) who resided with a father. Of the remaining two (2) children, where custody remained with the family, one child was placed with the mother's paramour and the other was placed with a female friend.

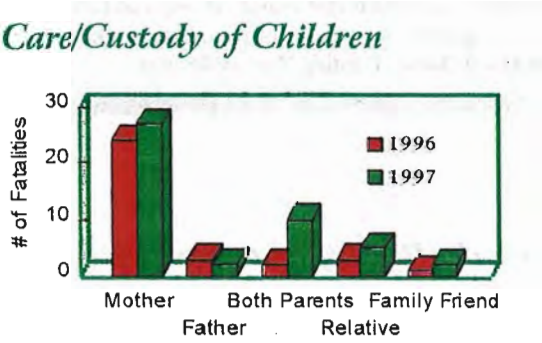


Figure 22 - 1997 CFRC Data

The remaining five (5) children, or 10 percent of the 51 cases reviewed from 1997, were in the custody of the District or independent adult at the time of death. This group of children reduced significantly from the 12, or 27 percent of the 1996 fatalities reviewed of children who were in the category. The four (4) children who were committed were placed in agency foster homes, group homes or the Job Corps.

# PARENT/FAMILY CHARACTERISTICS

Historically, the CFRC has not been successful in obtaining consistent data/information on parents of decedents. Information on mothers has been easier to secure, primarily because the mother is the primary caretaker in the majority of the situations. Most service-oriented systems generally maintain information on both the caretaker and child. While the data elements are similar for service providers, the completeness and accuracy of the information are based on the person completing the forms. Therefore, while information on mothers is more abundant, it is not necessarily consistent or reliable.

Obtaining information on fathers is much more difficult because they typically are not the caretakers, and as such intervene less frequently in the child's life than mothers. The majority of the service records of the decedents and their families indicate that the mother was a single parent and the father or his whereabouts was unknown. One (1) mother and three (3) fathers were deceased at the time of the child's death. The mother was murdered at the age of 18, when the decedent was two (2) years of age. The circumstances surrounding the deaths of the three (3) fathers were unknown. The following parent/family data are provided based on record reviews for the 1997 decedents, information obtained from various information sources and disclosures shared during the reviews.

***"Father is Charged In Beating Death of District Boy, 11"***
***A 1997 Homicide Death***

One night in April, D.C. Fire and Rescue Services received a call for an unconscious child. When they arrived at the home they discovered the body of a ten year old boy with no vital signs. Efforts to revive the child were started and he was transported to the local hospital where he was pronounced dead. According to the decedent's paternal grandmother, his legal guardian, the child had suffered from no serious or chronic illnesses nor was he currently taking any medication. (She was awarded custody of the child because his mother suffered from mental illnesses and had thrice tried to take her own life.) During the police investigation of the case, it was revealed that the father of the decedent, frustrated because his developmentally delayed son could not tell time, had struck him twice in the chest with a closed fist. After the second blow the child collapsed and stopped breathing. The father admitted to the assault and has been charged.

**Cause of Death:** Commotio Cordis

## AGES OF PARENTS

Information was available on the age of the mother on 46, or 90 percent of the 51 cases reviewed. The ages of the mothers at the time of the birth of the decedents ranged from 15 to 40 years. Unlike 1996, the data from 1997 revealed that the majority of the women were under the age of 25. Thirty (30), or 65 percent of the mothers were in this age category, as opposed to 58 percent in 1996. Sixteen (16), or 35 percent were 25 years of age or younger. The average age of the mothers of the 1997 decedents was 24, with the median being 27 and the mode 18.

Following is a break-out of the specific age ranges of the mothers of the 1997 decedents:

- 18, or 39 percent, were between the ages of 15 and 20 years;

- 12, or 26 percent, were between the ages of 21 and 24;
- eight (8), or 17 percent, were between the age of 25 and 30 years;
- four (4), or nine (9) percent were between 31 and 35 years; and
- four (4), or nine (9) percent, were between 36 and 40 years.

Information on the age of the father was available on 13, or 25 percent of the 51 cases reviewed. The ages of these fathers ranged from 19 through 44 years. Six (6) of the 13 fathers were under the age of 25 years, with the majority being 21 years of age. Seven (7) of the fathers were 25 years of age and over.

## PARENTS' EDUCATIONAL LEVEL

***"A 1997 Natural Death of a Five Year Old Girl"***
In May of 1997, a 5 year old girl died from Marfan's Syndrome, a genetic disorder characterized by abnormal length of the extremities, and other complications including cardiovascular abnormalities. The decedent was the daughter of a drug abusing woman who had relinquished her parental rights to her sister. The case was active with the child welfare system.
**Cause of Death:** Ventricular Dysrythmia; Dilated Cardiomyopathy due to Marfan Syndrome

The educational level of parents of the decedents is not a data element that is consistently captured by any service system, including social, child welfare, health and law enforcement. As with all other previous years, during 1997, information was only available on the highest educational level completed for 29, or 56 percent of the mother's of the fatality cases reviewed. This was the identical percentage of cases where this information was found during 1996. Out of the 29 cases where the information was available, a lower number and percentage of mothers completed high school. The data revealed that 18, or 62 percent of the mothers had completed the 11$^{th}$ grade or less. The 7$^{th}$ grade was the lowest grade completed by mothers in this group. The majority of the mother's (n = 16) had completed the 9$^{th}$, 10$^{th}$ or 11$^{th}$ grades.

Eleven (11), or 38 percent of the 29 mothers, where information was available, had completed high school or above. Seven (7) had completed high school, while one (1) had completed the freshman year and three (3) completed the sophomore year of college.

The educational level of the father was available in only four (4) cases. This information indicated that one (1) father completed the 10$^{th}$ grade and the remaining three (3) completed their high school education.

## PARENTS' HEALTH STATUS

The number of mothers who were suffering from health problems was extremely low for the 1997 cases reviewed. There were four (4) who had sexually transmitted diseases, however none had HIV/AIDS. The diseases included syphilis, gonorrhea and chlamydia.

In six (6), or 12 percent of the total cases reviewed, it was documented that the mother was dealing with mental health issues. This represents a decrease from the eight (8), or 18 percentof the total fatalities reviewed from 1996 that involved mothers with similar issues. In all the 1997 cases the mothers were receiving or had received mental health services. Some of the documented illnesses included depression, violent/oppositional behavior disorder, borderline personality disorder and suicidal attempts. In one case the mother had a history of being hospitalized for her mental health problems.

The 1997 data also revealed that three (3) mothers had developmental issues. They had been diagnosed as persons with mental retardation, developmental delays or borderline intelligence.

Based on information received on the fathers, one had the sickle cell trait and none had documented or diagnosed mental health or developmental issues.

## *Parents' Marital Status*

*1997* data revealed that the majority of the mothers were single. In 44, or 86 percent of the 51 cases reviewed, the mothers were single. Three (3) of the mothers were living with the decedents' father. One of these couples were separated at the time of the child's death due to a domestic violence incident. Seven (7), or 14 percent of the mothers were married. Two (2) of the mothers were not married to the father of the decedents.

## *Parental Substance Abuse/Involvement with Crime*

*1997* data revealed a reduction in the number of cases that involved parental substance abuse and parental participation in criminal activities prior to the child's death. Out of the 51 fatalities reviewed, 20, or 39 percent involved mothers with a substance abuse problem as opposed to 27, or 60 percent of the total cases reviewed in 1996. Nine (9), or 45 percent of these women used both alcohol and drugs, as opposed to 14, or 51 percent of the mothers of the 1996 fatalities. During 1997, eight (8) of the mothers admitted to using drugs only and three (3) admitted to only alcohol abuse. The primary drugs used were crack cocaine, heroin, passion and marijuana.

During 1997, seven (7), or 14 percent, of the fatalities reviewed involved mothers who had a history with the criminal justice system. This represents a 42 percent decrease from the 10 mothers reported during 1996. One (1) of the seven (7) women from 1997 was incarcerated at the time of the child's death. The charges included unauthorized use of a vehicle, disorderly conduct, assault/fighting, stabbing and prostitution.

Based on the limited information obtained on fathers, it was found that only six (6) were known to abuse drugs and alcohol. Additionally, only three (3) fathers were known to have been

involved with the criminal justice system and two (2) were incarcerated at the time of the child's death. The charges were drug distribution, robbery and delinquent child support payments.

***"A 1997 Accidental Death"***

On a warm July evening, the D.C. Fire Department responded to the report of a fire. Upon their arrival, they observed heavy smoke billowing from the second floor of a three story apartment building. While the Fire Department was battling the flames, they discovered the body of a forty year old female near the front door. Further in the building, they found the body of a young boy who had been badly burned and apparently overcome by smoke inhalation. The child was removed from the bathroom of the apartment in which the fire began. The paramedics at the scene started resuscitation efforts and transported the two people to the local hospital. Both victims were pronounced dead approximately an hour after the call was received by the Fire Department. During the police investigation, it was revealed that the decedents were mother and child. The apparent cause of the fire was the young boy's playing with matches, setting fires in several places throughout the apartment. The family left behind a daughter who was not present on the day of the fire. She currently resides with the maternal aunt.

**Cause of Death:** Asphyxia Due to Soot and Smoke Inhalation

## *Family History of Domestic Violence*

Five (5) cases reviewed from 1997 indicated that the family of the decedent had a history of domestic violence. This represented 10 percent of the total cases, which is a significant decrease from the 10, or 22 percent of the cases reviewed from 1996. All but one of these cases involved the decedent's mother and her husband or paramour. However, similar to 1996 data, one (1) of the cases included violence between the decedent's maternal grandmother and her paramour. There was no information shared during the review or abstracted from service agency records that indicated that any of the families were receiving formal counseling in this area.

## *History of Child Abuse/Neglect*

There was also documentation of a history of child abuse and neglect in the maternal family in six (6) of the 1997 cases reviewed. The neglect involved the decedents' mother and maternal grandmother, resulting in the cases being active with the child welfare program.

## PUBLIC SERVICES

### Families on Public Assistance

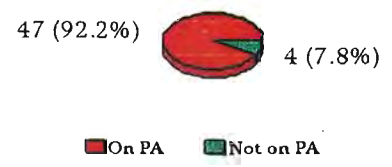


Figure 23 - 1997 CFRC Data

Based on information obtained from the Automated Client Eligibility Determination System (ACEDS), 47, or 92 percent, of the 51 fatalities involved families who were known to the District's public assistance service network. These families were either receiving services at the time of the child's death or had received services within five (5) years prior to the death. These families were receiving Temporary Assistance for Needy Families (TANF), Food Stamps or some type of Medical Assistance.

### Public Assistance Services Received

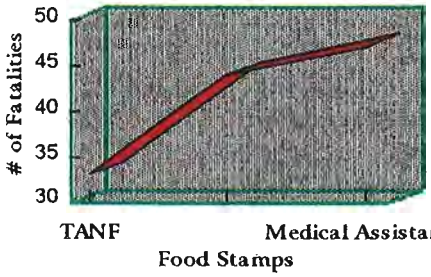


Figure 24 - 1997 CFRC Data

Out of the 47 families who received services, all received medical assistance, 44, or 97 percent, received food stamps and 33, or 70 percent, received TANF. The majority of the families (n = 37, or 79 percent, of the total families receiving services) were receiving assistance at least through the month of the child's death. Public assistance had terminated prior to the children's deaths for the remaining 10 families. One family, receiving all three public assistance services, terminated from the District's program in 1993, moved to Maryland and was receiving public assistance in that state at the birth of the decedent. The majority of the families who were receiving public assistance were living in public or assisted housing.

***"A 1997 Homicide Death"***

In October, a 17 year old male was talking on a pay phone at an intersection of four roadways in a residential neighborhood of Northwest Washington when gunfire broke out. The teen attempted to flee the scene, but was shot and collapsed about a block from the phone. When the police arrived they reported finding the body of a black male lying on the ground, suffering from multiple gunshot wounds. The decedent was transported to a local hospital, where he died the next day. The victim was known to CFSA since 1989 when a report of negligence was filed against his mother. The report charged that the mother was a substance abuser who had just given birth to a drug exposed infant. Another report was filed later that year citing the mother for neglect and indicating that the decedent was displaying serious behavior problems in school. The decedent was committed to the juvenile system in July of 1996. There he underwent a psychological exam which revealed that he was functioning on the level of a 9 or 10 year old. He was manic depressive and was on drugs. It was revealed that the decedent had been prostituting and selling drugs since he was 12 years old. The social worker indicated that she contacted the decedent's father and notified him about his son's death and he appeared disinterested.

**Cause of Death**: Multiple Gunshot Wounds

# SECTION FOUR: SUMMARY OF LASHAWN A. CHILD FATALITIES

# SUMMARY OF LASHAWN A. CHILD FATALITIES

A LaShawn A. fatality was initially defined as "deaths of all children in the care and custody of the Department of Human Services or who are or should be known to the Department as at risk of abuse or neglect." This definition was broadened as a result of a court order issued in October 1994, which mandates that LaShawn A. fatalities include "the deaths of all children who are or were class members at any point in a period of ten years prior to the child's death."[1] This includes all children of families who are or have been known to the protective services, foster care and adoption systems.

***"A 1997 Homicide Death Of A 1 Year Old Child"***

One August night at approximately 8:30 PM, a woman dropped off her 1 year old child at the babysitter's apartment. A few hours later the child became ill and was running a temperature. The babysitter could not get in touch with the mother of the child so she called his father who came and picked up his son. The father stated that the child seemed to be having problems breathing, so he shook him and blew in his face. The child then vomited on his father's shoulder and at that point he got in his car and drove to the nearest hospital. When they arrived, the child was not breathing and was unresponsive. The medical staff attempted CPR but it was unsuccessful. An autopsy revealed that the cause of death was acute morphine intoxication and the Medical Examiner ruled the death a homicide. The Metropolitan Police Department has had trouble establishing where the child ingested the morphine (at the babysitter's or at home), and there were no signs of the drug being injected.

**Cause of death:** Acute Morphine Intoxication

In accordance with the Prevention of Child Abuse and Neglect Act of 1977 (D.C. Law 2-22), the child welfare program operates under a bifurcated system. The Family and Youth Services Division, Metropolitan Police Department, has responsibility for investigating reports c abuse. Services are provided to families of supported abuse cases by the Court Social Service Division (CSSD) of the D.C. Superior Court.

Child and Family Services Agency (CFSA), which has been under General Receivership sinc August of 1995, is responsible for the investigation and provision of ongoing services to familie of supported neglect cases. CFSA also receives referrals from CSSD to provide services to famil cases involving abuse, when the decision is made to remove the child from his/her home and plac him/her in the foster care system.

As a result of the District's bifurcated method of operating, LaShawn A. child fatality cases can b generated from either the CFSA or CSSD. Because of the definition of LaShawn A. fatalities, case can include a deceased child/youth up to age 21 years, and the case can be either open o closed. Once a LaShawn A. fatality case is identified, it requires two reviews, an internal CFS/ review and a CFRC review, which has multi-agency and multi-disciplinary representation.

[1] Court order issued by Judge Thomas Hogan, United States District Court for the District of Columbia, dated October 4, 1994.

Mayor's Order 92-121 and the CFRC protocols require the Committee to conduct LaShawn A. fatality reviews within 45 calendar days of a child's death. The Order and protocols also require the CFSA to conduct an internal fatality review prior to the CFRC review. The purpose of the internal review is to evaluate the quality and effectiveness of child welfare services that were provided to the child and family; the adequacy of communication among all parties involved; the adequacy of agency resources available to social work staff and community resources available to families; and whether there were any issues related to compliance with agency policies and social work practice. As mandated by CFSA policy, the internal review occurs within 15 days of the child's death. Attendance at these reviews includes child welfare staff or contractors who were involved in the case from the point of intake to case closure. Additionally, in an effort to facilitate information sharing and continuity, and reduction of duplication among the two review processes, a representative from the CFRC also participates in the internal reviews. CFSA is responsible for preparing a report that reflects the discussion from the internal review, including a summary of the case history, services provided, issues and recommendations. Pertinent information contained in this report becomes part of the discussion of the CFRC reviews.

Coordination among all public and private agencies involved with families and children is critical to the success of the child fatality process. However, because one of the primary goals of CFRC is to prevent deaths attributed to child abuse, neglect and other forms of maltreatment and, since the existence of CFRC, the LaShawn A. population has accounted for the greater percentage of child death cases reviewed, collaboration with CFSA is critical. Accordingly, the Committee and CFSA have acknowledged the need to maintain open lines of communication and a strong working relationship. This relationship has increased the capacity of both CFRC and CFSA to obtain information on child fatalities that meet this category. Today we have a better understanding of the needs of families, services provided and the circumstances surrounding the death. This information allows us to better coordinate reviews.

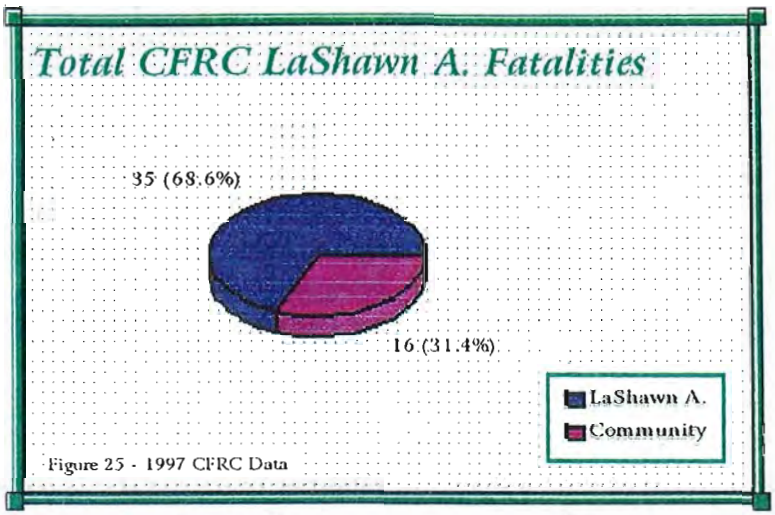

Figure 25 - 1997 CFRC Data

LaShawn A. fatalities continued to be the dominant population of cases reviewed by the CFRC. However, while the fatalities identified in this category continued to increase during 1997, the percentage and number of increase were not as great as previous years. The number of LaShawn A. fatalities identified from calendar year 1997 was 35, or 69 percent of the 51 cases reviewed. While this represents a slight increase in the 34 cases identified during 1996, it represents a reduction in the percentage of the totals for the two years (69 percent for 1997 compared to 77 percent for 1996). This reduction is significant especially considering the fact that the total population of cases identified for review continued to escalate. This data suggests that the process for identifying LaShawn A. cases has become an accepted practice, such that the number of cases being identified has begun to level off. The data also indicates that during 1997, the Committee began making strides in the area of improving the process of identifying general community cases (those not known to the child welfare system).

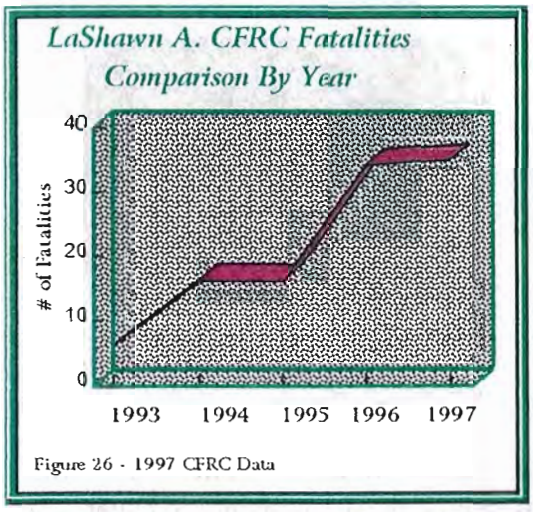

Figure 26 - 1997 CFRC Data

Even with the slight reduction in 1997, LaShawn A. cases continued to account for the highest percentage of fatalities reviewed by CFRC since 1994. The 35 cases reviewed in 1997 represent a three (3) percent increase from the 34 LaShawn A. cases reviewed during 1996; 119 percent from the 16 cases reviewed in 1995 and 1994.

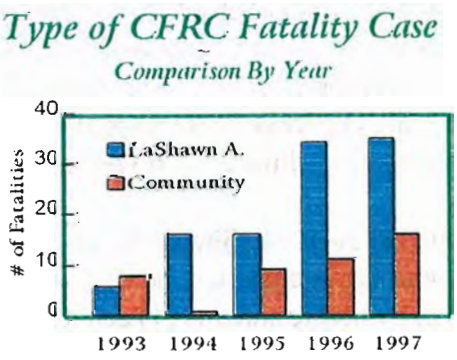

Figure 27 - 1997 CFRC Data

According to information retained by the Committee, notification was provided to the CFRC from the CFSA on 17, or 49 percent of the LaShawn A. fatality cases. The Committee, through the case identification process, was notified of 18 additional deaths (51 percent of LaShawn A. cases) by sources other than the child welfare agency (CFSA). This included the six (6) at-risk cases, eight (8) of the closed cases and four (4) of the active cases. The notification sources included the Medical Examiner's Office, Infant Mortality Review Team and hospitals. The majority of these cases involved situations where the family either lost contact with the child welfare agency because the case was inactive or a case was never opened. Additionally, there were several cases where the child died within six (6) months of birth and the CFSA worker was unaware of the birth.

## *Case Status*

Twenty-nine (29), or 83 percent of the LaShawn A. fatalities reviewed at one point were open and active with the child welfare system based on an investigation that supported the original abuse and/or neglect allegations made to the Intake Hotline. This is slightly lower than 1996 data, which revealed that 33, or 97 percent of the 34 LaShawn A. cases had been active. The remaining six (6) 1997 fatalities were of children of families that had been reported for suspected abuse/neglect, however, based on the investigations, the allegations were unsupported. These cases were reviewed as at-risk LaShawn A. fatalities.

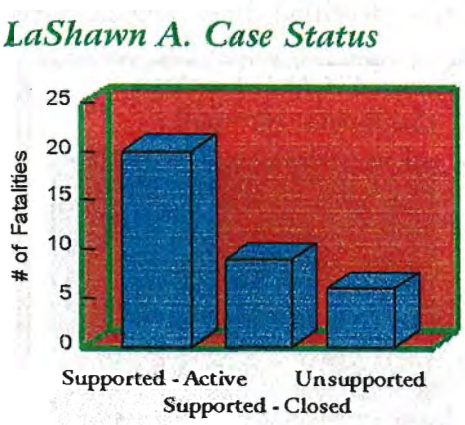

Figure 28 - 1997 CFRC Data

Twenty (20), or 69 percent of the supported LaShawn A. 1997 fatalities were active with the child welfare system at the time of the child's death. One of these cases was active based on a supported complaint of neglect involving the decedent's mother and maternal grandmother. The decedent's mother was a foster child living in an independent living facility with her child.

Nine (9), or 31 percent of the supported cases had been active but were closed at the time of the child's death. These cases had been closed for periods that ranged from one month to seven (7) years, with the average being two (2) years and two (2) months. The reasons for case closure included; (1) parental care improved, (2) termination from foster care due to child aging out of the system and (3) children removed and placed with relative, including the father.

The six (6) at-risk LaShawn A. cases involved children between the ages of 1 month to 18 years of age, with the average age being eight (8) years. The manners of death included three (3) natural, two (2) homicide and one (1) accidental deaths. The two homicides involved older youth (ages 17 and 18), who died of gunshot wounds. The reasons the families were reported to the child welfare

system included five (5) neglect and one (1) abuse complaint. The abuse complaint involved the maternal grandmother and the mother. This child died at the age of one (1) month from natural causes.

***"A 1997 Natural Death Of An 8 Month Old Child"***

In mid-September a 24 year old mother brought her 8 month old infant into the hospital complaining that he would not stop crying. She admitted that the infant had not had medical care since birth nor had he received any of his immunizations. The infant was diagnosed as having a heart defect. He died 2 weeks later. The family was known to CFSA since 1991 when a complaint was filed citing that the mother was neglecting her children. Another complaint was filed in 1993 stating that the mother did not provide proper supervision for her children. The mother had five children other than the decedent, ranging in ages from 2- 9, none of whom had received prenatal care or was properly immunized. Doctors from three different area hospitals were in agreement that due to the severity of the infant's birth defect, neither prenatal care nor early detection would have changed his medical condition.

**Cause of Death**: Tetralogy of Fallot with Pulmonary Atresia with Ventricular Septal Defect

## REASONS FOR CHILD PROTECTIVE SERVICES INVOLVEMENT

The families of the 35 LaShawn A. child fatality cases reviewed from calendar year 1997 were referred for child protective services for various reasons. They had also been known to the system for different lengths of time prior to the child's death. The number of referrals to the child welfare system which included the decedent decreased significantly during 1997. Sixteen (16), or 46 percent of the 35 referrals made to child protection services involved the decedents, as opposed to 30, or 88 percent for 1996. Thirteen (13), or 37 percent of the referrals did not include the decedent. The most prevailing reason (n = 10, or 77 percent the decedent was not included was the referral was made prior to the birth. The at-risk cases were not included in this data due to the fact that CFRC did not have access to information that provided the names of the children on the original child abuse/neglect report. However, out of the six (6) at risk cases, it is presumed that the abuse/ neglect referral for the three cases which involved the deaths of older youth (ages 12, 17 and 18 years) included the decedents.

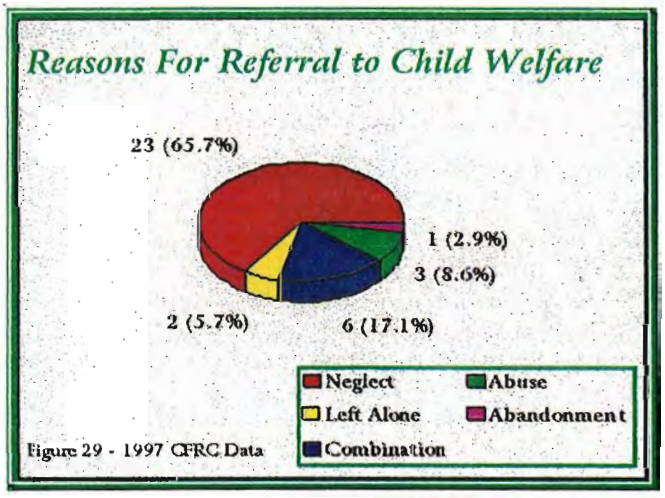

Figure 29 - 1997 CFRC Data

The primary reason the families of the LaShawn A. fatality cases were originally referred to CPS continued to be neglect. During 1997, this category increased by three (3) cases from the 1996 deaths reviewed. Twenty-three (23), or 66 percent of the total LaShawn A. families were referred to child protection services for neglect. Of the 23 neglect reports, 15 involved general neglect issues, i.e., lack of food, adequate clothing, housing, etc. Four (4) cases involved issues of medical neglect, one (1) involved a mother with a history of mental illness, one (1) involved a pregnant woman who was reported one (1) month prior to the birth of her child for drug use and using food stamps for drugs. There was also one (1) case that involved a combination of concerns, including general, medical and educational neglect. These children ranged in age from two (2) months to 20 years of age, at the time of their death.

The second largest reason for referral to child protection services was "combination" (two or more issues highlighted in the initial report/referral). There were six (6) cases that fell in this category. All except one (1) case involved issues of general neglect and children being left alone or with unwilling caretakers. One case included abandonment in addition to neglect and "left alone."

There were three (3) families who were reported as a result of abuse. There were two (2) cases where physical abuse was the primary issue reported. One case alleged that the grandfather had beaten the decedent and fed him poison. The other case involved two siblings who were sexually abused.

There were two (2) cases for which the primary reason for referral was "left alone." Both of these cases involved mothers who were arrested and as a result the police officers brought the children to the child protection office because they were considered to be without willing caretakers. The one (1) case of abandonment pertained to a referral made by an acute care hospital that alleged that the parents of a prenatally drug exposed infant neglected to visit and plan for the child's discharge. Their abandonment was directly related to the mother's chronic drug or alcohol abuse.

Figure 29 illustrates the similarities and differences in the reasons for referral to the child welfare system between the years 1995 through 1997. The data for these three (3) years reveal a consistent increase in the number of neglect reports and those involving a combination of child protection issues. It also illustrates a constant decrease in the number of children being categorized as "left alones" and abandoned. The abuse referrals have been erratic, with an increase from 1995 to 1996 and a decrease from 1996 to 1997. The greatest percentage of increase was in the combination category. There was a 200 percent increase in the number of referrals received that involved more than one concern, which resulted in a child's death. There was a 28 percent increase in the neglect only category. The greatest percentage of decrease was in the abandonment area. Abandonment reduced by 500 percent between 1996 and 1997. Abuse reduced by 33 percent.

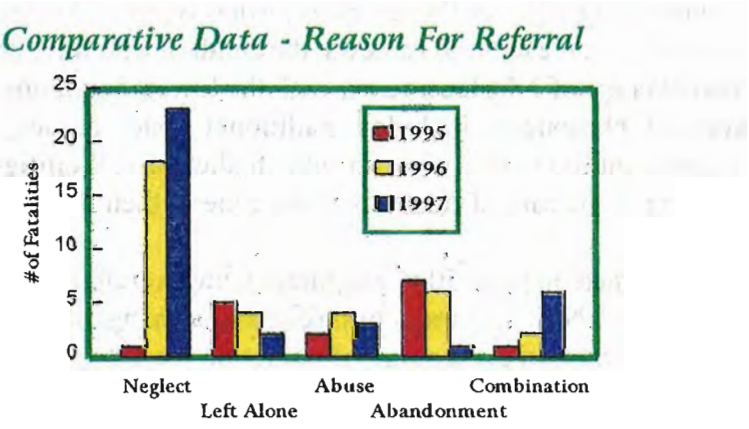


Figure 30 - 1997 CFRC Data

# *Legal Status of Children*

As with 1996, data from 1997 fatalities revealed that the majority (n = 14, or 70 percent) of the cases reviewed that were active with the child welfare system, involved children who were part of the protective services system, where custody remained with the family. Fifty-seven (57) percent (n = 8) resided with their mothers, while two (2) were in the care of their father and one was in the care of both parents. The remaining three (3) included two (2) children who were placed with relatives and one (1) was placed with the mother's boyfriend.

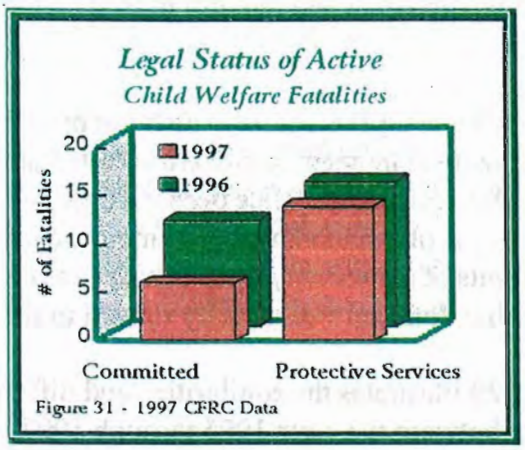

Figure 31 - 1997 CFRC Data

Six (6), or 30 percent of the decedents who were part of an active case, were committed to the care and custody of the District: five (5), to the foster care system and one (1), to the juvenile justice system. According to agency records and information shared during the internal reviews, the children who were committed to the District had been placed in an average of 3.5 placements, with the lowest being one (1) and the highest being nine (9). The types of placements included traditional foster homes, kinship foster homes, group homes, independent living facilities, chronic medical care facilities and juvenile detention facilities. Two (2) were in the care of relatives at the time of their deaths.

As mentioned on page 50 (Case Status), the overall number of active 1997 fatalities reviewed was lower than 1996. This reduction reflected a change in both the committed and protective services area. The greatest percentage of reduction for 1997 fatalities was in the committed area. During 1997, there were six (6) children committed to the District as opposed to 11 in 1996. This represents a 45 percent decrease between 1996 and 1997 in the committed status area alone. The reduction in the number of children who were in the protective services category (custody with family or third party caretaker) was also lower. The percentage of decrease in this area was seven (7).

The nine (9) LaShawn A. fatalities that were closed at the time of the child's death involved five (5) children who resided with their mother, one (1) who resided with the father, one (1) who resided with both parents, one (1) who resided with a relative and one (1) who was living independently with his girlfriend. The ages of these children ranged from 14 months to 21 years.

Five (5) of the six (6) at-risk LaShawn A. fatalities involved children who resided with their biological mothers and one (1) resided with a relative. The ages of these children ranged from one (1) month to 16 years.

## *Age, Race and Gender of the Deceased LaShawn A. Children*

The ages of the total LaShawn A. fatality population for 1997 ranged from one (1) day over 21 years. The majority (n = 20, or 57 percent) of the 1997 LaShawn A. child fatalities reviewed were under the age of ten (10) years. While this age category has consistently remained the largest group of children whose deaths are reviewed by CFRC, the 1997 data reflects a slight change in that the percentage of the total LaShawn A. cases for this group was significantly lower than previous years. In 1996 the number of children who were under the age of 10 years was 26, which represented 77 percent of the total LaShawn A. population for that year. Also similar to 1996, within this age category, the largest number of fatalities were reviewed of children under the age of one (1) year. During 1997, 14, or 70 percent of the children in the under 10 years of age category were one (1) year of age or under, with 13 being 11 months or younger.

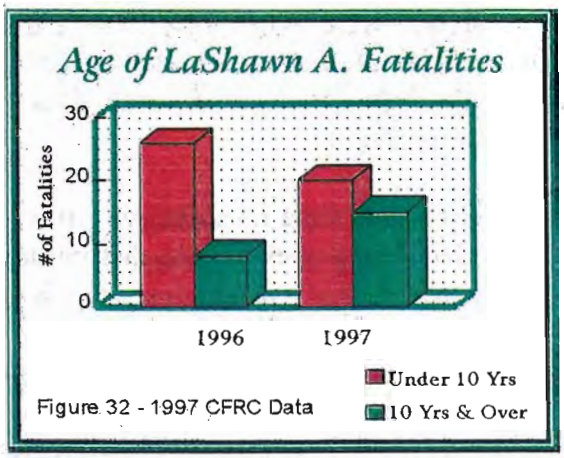

Figure 32 - 1997 CFRC Data

The remaining 15, or 43 percent of the total LaShawn A. fatalities reviewed from 1997 involved children ages ten (10) years of age and over. Within this age group, eight (8), or 53 percent of the fatalities involved youth 16 years of age and older.

Also consistent with the overall 1997 fatality data and data from all previous years, the majority of the children reviewed are African-American. During 1997, 35, or 100 percent of the LaShawn A. child fatality population were African-American. The majority of the LaShawn A. population were males (n = 25 or 71 percent). This is greater than the 21, or 62 percent, male cases reviewed from 1996.

## *Anti-Social Behavior, Drug and Other Problems*

The Committee continued to explore the effects of child abuse, neglect and the foster care experiences with the LaShawn A. fatalities reviewed by collecting data on various problems being experienced by children who were part of the child welfare system. Eight (8), or 23 percent of the total LaShawn A. population demonstrated various levels of mental health and antisocial behavior problems. Data from 1997 reveals that the number of youth and the percentage of the total LaShawn A. population is higher than those 1996 decedents who had outwardly displayed the same type of problems (as documented by numerous social, health and juvenile justice system). The eight (8) youth from 1997 fatalities represent a 33 percent increase from the six (6) children (18 percent of the total LaShawn A. population) from 1996 fatalities who had experienced similar problems

prior to their death. Also similar to 1996, data from 1997 revealed that all these children were older. During 1997, the children ranged in age from 16 through 18 years of age, compared to an age range of 13 through 19 years for 1996 data. Out of the total LaShawn A. population, there were nine (9) who fell in the 16 and older age category. Therefore, the number of children who were experiencing serious and chronic problems represented 89 percent of the total number of children between the ages of 16 through 21 years.

While the numbers were higher in the 1997 fatalities, the problems were not as serious and pervasive as in 1996. Information revealed from agency record reviews and during the internal and CFRC reviews of the eight (8) cases of youth who displayed some form of antisocial and behavior problems was as follows:

- Six (6) youth were involved with the juvenile justice system, charged with crimes that included drug possession and distribution, physical assault, unauthorized use of a vehicle, and possession of a dangerous weapon.

- Four (4) had displayed behavior problems in school, home and/or the community.

- Three (3) had diagnosed mental illnesses that included depression, manic depression and suicidal attempts.

- Two (2) had known problems with drugs and alcohol.

- Eight (8), or 100 percent, of the youth had experienced problems in school and were at least one (1) grade behind. At least four (4), or 50 percent died without completing high school. Three (3) of these youth were 18, one had completed the sixth, eighth and 10$^{th}$ grades. The third youth was 17 and had completed the sixth grade.

Even though only three (3) of the eight (8) youth were committed to the District at the time of their deaths, all had experienced placements outside their home. Two (2) youth were committed to the foster care system and one (1) was committed to the juvenile justice system. The foster care youth had only been known to the child welfare agency short periods of time. One (1) youth became active with CFSA a year and seven (7) months prior to her death. She had experienced three (3) placements, including two (2) foster homes and a chronic medical facility during that time. The other foster care youth had been known to the CFSA for 13 months and he had experienced nine (9) placements. The last placement was with Job Corps in West Virginia, where he died of a stroke on the basketball court.

The youth in the juvenile justice had been committed to the Youth Services Administration (YSA) 15 months prior to his death. He had experienced five (5) placements since his commitment, including a group home, a youth correctional facility, two (2) community-based juvenile facilities

(one was a psychiatric program) and one (1) with a family friend. A fourth youth had been committed to the foster care system since he was eight (8) months old. He experienced five (5) placements including several foster homes, a group home and a residential treatment facility. He aged out of the system on his 21st birthday, which was one (1) month prior to his death.

The remaining five (5) youth included three (3) who were part of an active child welfare case and two (2) were at-risk child welfare cases. Four (4) had active juvenile justice cases. The three (3) youth known to CFSA had experienced at least one (1) placement outside their homes. Two (2) were residing with relatives at the time of their death. However, one (1) was a detainee at the time of his death and had two (2) outstanding custody orders related his juvenile and neglect cases. He also had been released to a relative prior to his last charge. The cases of the two (2) at-risk child welfare youth were never open/active with CFSA beyond the point of intake because, based on the investigation, the allegations were unsupported. However, both had active juvenile justice cases. As a result, one had experienced several placements, including community-based detention and drug rehabilitation programs. His case closed two (2) months prior to his death.

***"A Homicide Death"***

In the early morning of a fall day, the MPD responded to a report of a shooting in the northwest quadrant of the District. Upon their arrival on the scene, the body of a African American male was observed lying on the ground suffering from multiple gunshot wounds. He was transported by ambulance to a local hospital in critical condition. He died one day later, 12 days after his 18th birthday. The youth's family was known to several systems, including public assistance, public schools, child welfare and juvenile justice programs. While he was committed to the District's juvenile justice program, he was placed with a family friend.

**Cause of Death:** Multiple Gunshot Wounds

The primary reasons for the families of the eight (8) youth being referred for child protection were for neglect (general, medical and educational), being left alone, inadequate supervision and abandonment. The reports indicate that the mothers were experiencing similar problems at the time the abuse and/or neglect reports were made as the youth were at the time of their deaths. The problems included, chronic drug use, assault, arrests and mental illness.

The leading manner of death for the eight (8) youth was homicide (n = 5, or 63 %). These deaths account for 36 percent of the 14 homicides for the total population of child fatality cases reviewed. They also account for 100 percent of the deaths caused by gunshot wounds. The only other manner of death for these youth was natural. The causes of these deaths included stroke, cardio-pulmonary arrest and AIDS.

## MANNER AND CAUSE OF DEATH

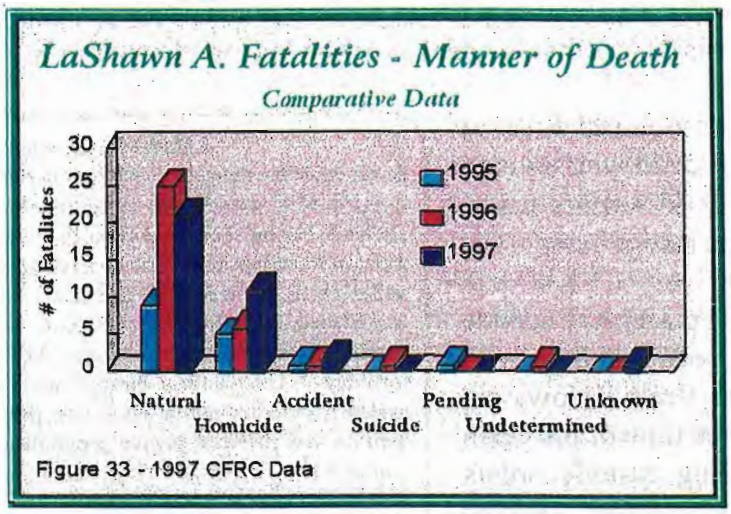

Figure 33 - 1997 CFRC Data

Figure 33 illustrates that the manner of death for CFRC fatalities reviewed which involved children who were known to the District's child welfare system has remained constant in several areas for the past three (3) years. Consistent with 1995 and 1996 data, the 1997 fatalities revealed that the leading (n = 21, 60 percent) and secondary (n = 10, or 29 percent) manners of death for children in the LaShawn A. population was natural and homicide respectively. This data is consistent with that for the overall 1996 and 1997 child fatality population, however, it is different from 1995 findings in that the secondary manner of death in 1995 was accidents. Since 1993, the LaShawn A. fatalities have accounted for the vast majority of the natural deaths reviewed. During 1997, the 21 LaShawn A. deaths represented 78 percent of the total natural deaths reviewed; 24, or 89 percent, of the 27 1996 natural deaths were LaShawn A. children; and the nine (9) LaShawn A. natural deaths represented 81percent of the overall natural deaths in 1995.

***"A 1997 Natural Death"***

In May, a woman walked into her home to find her boyfriend unconscious. She calls 911, but when the Paramedics arrive, they find him to have no vital signs and determine him to be deceased. The body was transported to the Medical Examiner's Office, where an autopsy was performed. A police investigation of the scene determined that there was no sign of foul play, and no visible signs of trauma. The decedent was known to CFSA because he was in long term foster care. He had been living with the same foster parents since 1992. The foster mother stated that the decedent had a congenital heart defect from birth which had been repaired. In recent weeks, he had complained of feeling weak, shoulder pain and vomiting. He had also recently been seen at two different hospitals. He visited the first hospital about 10 days prior to his death. He was admitted to the emergency room complaining of pain in his upper back, knees and neck. He was having difficulty walking and sitting up. An exam revealed that he had a heart murmur and a urinary tract infection. He was given antibiotics and was then released. Four days later he was admitted to the emergency room of another hospital, complaining of the same problems. He was given Motrin and appeared to be feeling better and was released with instructions to follow-up with a physician in 3-5 days. He died 6 days later.

**Cause of Death**: Cardiopulmonary Arrest due to Constrictive Pericarditis

Two (2) 1997 LaShawn A. fatalities included two (2) accidents, where the children (ages 6 and 12 years) died from asphyxia/soot and smoke inhalation and drowning. The manner and cause of the last LaShawn A. fatality were unknown. This involved a family who had an active child welfare case and had moved to Maryland at the time of the infant's death. CFRC was not successful in obtaining a copy of the death certificate or autopsy.

The actual causes of death for the 35 LaShawn A. fatality cases reviewed from 1997 are included on the chart on page 64.

## *District Wards For LaShawn A. Fatalities*

As with 1996 data, the majority (n = 23, or 66 percent) of the LaShawn A. families resided in Wards six (6), seven (7) and eight (8). Five (5) or more families resided in each of these three (3) Wards. However, the data from 1997 indicated that the greater number of families resided in Ward eight (8), as opposed to Ward seven (7), which was the finding reported in the 1996 Annual Report. Nine (9), or 26 percent of the families lived in Wards one (1), two (2), four (4) and five (5). Three families had moved to Maryland at the time of the children's deaths. Data from 1997 reviews indicate that there were no fatalities reviewed of families who resided in Ward three (3). This has been consistent since the existence of the District's review process.

The Ward of residence at the time of the child's death changed slightly. There were numerous reasons for the changes in addresses, including family relocation, child placed (either by family or CFSA) with relative, child placed in foster care facility or youth achieved independence from the foster care system. The majority of the families resided in Wards 5 and 8. However, there was also a 100 percent increase in the number who moved to Maryland. Five or more families resided in each of these three Wards and in Maryland (n = 20, or 57 percent) of the total LaShawn A. population). Twenty (20) , or 57 percent, of the LaShawn A. children remained in the same Ward, however, out of that number there were fourteen (14) who also remained at the same address.

Twenty (20), or 57 percent, of the families moved or the child was at a different location at the time of the fatal incident. These moves were both within and outside the original Ward of family residence. Six of (6) of the children who moved were committed to the foster care system and as a result, were placed in various types of foster care facilities, including foster homes, pre-adoptive homes, group homes, Job Corps or with a family friend. The remaining 14 children that changed addresses did so as a result of relocation with the mother or with a relative or family friend.

# PARENT/FAMILY CHARACTERISTICS

## AGE OF PARENTS

The age of the mothers at the time of the birth of the deceased child ranged from 15 through 40 years. The majority (n = 21, or 60 percent) of the LaShawn A. mothers were under the age of 25 years. Fourteen (14), or 67 percent, of these women were 20 years of age or younger. There were six (6) mothers who were between the ages of 15 and 17 and compared to two (2) in 1996 and four (4) in 1995. Twelve (12), or 34 percent, of the LaShawn A. mothers were 25 years of age or older. Four (4) of these mothers were between the ages of 25 through 29; four (4) were between the ages of 30 through 35 and four (4) were over the age of 36. The mother's age was unknown on two (2) cases. The average age for the 33 mothers, where the age was known, was 24 years and the most recurrent age was 18.

As with other years, very little information was available on the age of the decedent's father. The age was known for eight (8) fathers. Their ages ranged from 19 through 44, with the most frequent ages being 21 and 36.

## MARITAL STATUS

Consistent with prior years' data, the majority (n = 32, or 91 percent) of the mothers in LaShawn A. fatality cases were unmarried at the time of their children's births and deaths. Three (3), or 9 percent of the mothers were married and living together. Two (2) of the mothers were married to the child's father at the time of the child's birth.

## SUBSTANCE ABUSE AND CRIMINAL HISTORY OF PARENTS

According to 1997 data, the problem of substance abuse was not as prevalent as in previous years. Twenty (20), or 57 percent of the 35 fatality reviews held on 1997 deaths revealed that the mother had problems with substance abuse compared to 28, or 82 percent, of the 34 LaShawn A. fatality cases reviewed in 1996. Eight (8), or 40 percent, of these mothers used drugs only, one (1) used alcohol only and 11, or 55 percent, used both drugs and alcohol.

In addition to a reduction in the number of mothers using drugs and/or alcohol, 1997 data also revealed a reduction in the number who had criminal histories. During 1997 reviews, information shared indicated that seven (7), or 20 percent, of the mothers of LaShawn A. fatalities were involved with the criminal justice system. All had been arrested and one (1) was incarcerated at the time of the child's death. Some of the crimes these mothers were charged with included: prostitution, drug possession, assault, disorderly conduct and stabbing.

Additionally, 1997 data revealed that six (6) mothers had a history of mental illness. All were receiving treatment and one (1) had a history of hospitalization for depression and suicide attempts. It was also reported that three (3) families had a history of domestic violence. There was no indication that any of these families were or had actively participated in a remedial or therapeutic rehabilitation program.

***"A 1997 Natural Death"***

In January a twelve year old boy died after being in a coma for six years. In 1991, during a house fire, fire fighters found the child under a bed in an unresponsive state due to smoke inhalation. He was transported to a local hospital where he received various medical services aimed at stabilizing his condition and bringing him out of his coma. He was admitted into a convalescent home in May of 1992 and remained there until his death. A representative from the convalescent home stated that the child's condition remained the same until 1995, when he began to deteriorate. A neurological specialist was brought in from another state but his condition continued to decline until his death. This family was known to CFSA because the mother had been reported to the agency for neglect. She was an admitted drug abuser who was misusing the AFDC funds to purchase drugs. The maternal grandmother was awarded custody of the decedent's siblings but became ill and was no longer able to care for the children. The children were then placed with relatives and the case was closed. The decedent's mother often visited him while he was in the convalescent home.

**Cause of Death**: Seizure Disorder; Aspiration Pneumonia; Anoxic Encephalopathy

## *PUBLIC SERVICES*

Based on a record review of the 29 supported LaShawn A. cases, all the families received a wide range of services from numerous public and private community-based service agencies throughout the District. The purposes of these services were to alleviate the issues highlighted in the initial report and to address the other problems of the family, as agreed upon by the family and the assigned social worker. These families received one or more of the following services :

- Client Advocacy
- Individual and Family Counseling
- Family Planning
- Educational Assistance/Tutoring
- Drug Counseling and Treatment (in and out-patient)
- Crisis Counseling
- Grief Counseling and Burial Assistance
- Day Care
- Transportation
- Legal Assistance
- Parental and Life Skills Training
- Independent Living Services
- Vocational Training
- Mental Health Services

- Mentoring
- Housing Assistance and Emergency Shelter
- Homemaker
- Crisis Counseling
- Family Preservation
- Summer Programs
- Food and Furnishings

In addition, the Automated Client Eligibility Determination System (ACEDS), indicates that 32, or 91 percent of the 35 LaShawn A. fatalities (including supported and unsupported cases) were receiving public assistance services. The majority (n = 21, or 66 percent) of these families were receiving TANF payments, Food Stamps and medical assistance. However, in nine (9) cases the families were only receiving medical assistance and two (2) families were receiving both Food Stamps and medical assistance. One family moved to Maryland and continued to receive all three (3) services from Maryland's public assistance program.

## *SIBLINGS OF DECEDENTS*

The majority of the decedents (n=31, or 88 percent) had siblings. Four (4) were only children. The number of siblings ranged between one (1) and eight (8) children. The mean number of siblings was 3.5; the median was five (5) and the most recurrent number was three (3) siblings. Six (6) decedents had siblings who were 21 years of age or older. One (1) had four (4) adult siblings. The oldest sibling was 27 years of age. Two (2) decedents, who were murdered by the mother's paramour, had other siblings who had died. The perpetrator of one (1) 1997 decedent was also the perpetrator of the sibling.

*"A 1997 ACCIDENTAL DEATH"*

On a late Sunday, June afternoon, the MPD received a radio run to respond to a community pool in Northeast Washington for a possible drowning. When they arrived on the scene they observed medical personnel from the Fire Department working on the unconscious body of a 12 year old African American male. The victim was transported to a local hospital with CPR in progress. Despite all life saving efforts by hospital staff the victim was pronounced dead an hour later and 1 month before his 13th birthday. According to family members, the victim had not had formal swimming lessons, however, reportedly he was a good swimmer. He had gone to the pool with his 10 year old brother. One witness reported that she saw the victim at the bottom of the pool and tried to pull him up but he was too heavy so he called for help. Another witness stated that he saw him prior to arrival, walking and eating soup out of a can with a spoon. This was approximately 1 hour prior to the fatal incident. The MPD investigation found the pool warm and very cloudy and murky. Leaves, hair and bugs were observed in the water. The depth was from 4 to 8 ½ feet deep.

**Cause of Death:** Drowning

## *AUTOPSY*

Autopsies were performed on 28, or 80 %, of the LaShawn A. fatalities reviewed. Six fatalities did not receive an autopsy and one (1) case where the child died in Maryland, the Committee was unable to obtain a death certificate or information related to the autopsy. The majority (n = 21, or 75 percent) of the fatalities that received autopsies were performed by the District's Medical Examiner's Office, six (6) were conducted by District hospitals and one (1) by a Virginia hospital.

***"A 1997 Homicide Death of A 10 Month Old"***

On a November morning, the D.C. Fire Department received a call for an unconscious 2 year old female. The guardian, who was the child's great-aunt, informed paramedics that she had fallen from her bunk bed and hit the floor. The child was transported to a local hospital, where she was admitted in critical condition. Three days later she was confirmed as clinically and legally brain dead and was, therefore, removed from life support. On the day of the fatal incident, it was reported that the decedent was sharing the top bunk bed with her 12 year old cousin. The cousin reported that he got up during the night to go to the bathroom. On his way back he heard a "thump" and when he entered the room he saw the decedent lying on the floor unconscious. The great-uncle also heard the noise and when he entered the room he found the cousin on the floor with the decedent. The great-uncle began CPR while the great-aunt called 911. It was revealed during the review, that shortly after arriving at the hospital, the doctors attempted to relieve the pressure within the decedent's skull which was caused by the swelling of the brain. Physicians reported that upon opening the skull they found the decedent's brain to be so swollen that it literally flowed from her head. They also indicated that the severity of the decedent's head injury was more consistent with an injury sustained 12 to 24 hours prior to the fatal incident. It was also revealed that 10 days prior to fatal incident, the child had been seen at another hospital and was found to have an abrasion to the forehead, subconjunctival hemorrhaging in both eyes, bruises on both cheeks, bruises to the arms and legs with hyper and hypo-pigmented scarring and her front upper teeth were missing. The great-aunt had reported to the hospital and the police that the child had injured herself by hitting a door knob while running. The decedent had been in the care of the great-aunt for only 2 months. Prior to that time, she was in the custody of her maternal grandmother. However, due to a stroke, the grandmother could no longer care for her.

**Cause of Death:** Blunt Impact Head Trauma with Subdural Hematoma

# LISTING OF LASHAWN A. CHILD FATALITIES BY CAUSE, MANNER AND PERPETRATOR

## UNDER 1 YEAR OF AGE

| CHILD'S AGE | CAUSE OF DEATH | MANNER OF DEATH | PERPETRATOR |
|---|---|---|---|
| 1 Day | Extreme Prematurity, Birth Asphyxia | Natural | N/A |
| 9 Days | Cardio-Respiratory Failure/Arrest, Sepsis, Pneumonia, Renal Failure, Prematurity and Congenital Infection | Natural | N/A |
| 16 Days | Sudden Infant Death Syndrome | Natural | N/A |
| 23 Days | Broncho-Pneumonia | Natural | N/A |
| 1 Month | Group B Streptococcal Sepsis with Meningitis | Natural | N/A |
| 1 Month | Blunt Force Trauma To Head | Homicide | Friend/Neighbor |
| 3 Months | Sudden Infant Death Syndrome | Natural | N/A |
| 3 Months | Respiratory Arrest, Encephalocele | Natural | N/A |
| 4 Months | Sudden Infant Death Syndrome | Natural | N/A |
| 4 Months | Respiratory Failure, Pneumonia, AIDS | Natural | N/A |
| 6 Months | Unknown | Unknown | N/A |
| 9 Months | Tetralogy of Fallot w/ Pulmonary Atresia w/ Ventricular Septal Defect | Natural | N/A |
| 11 Months | Pneumonia, Coma, Hypoxic Ischemic Encephalopathy | Natural | N/A |

## 1 THRU 5 YEARS

| CHILD'S AGE | CAUSE OF DEATH | MANNER OF DEATH | PERPETRATOR |
|---|---|---|---|
| 1 Year/ 2 Months | Acute Morphine Intoxication | Homicide | Unknown |
| 2 Years/ 10 Months | Blunt Impact Injuries To Head | Homicide | Unknown |

| CHILD'S AGE | CAUSE OF DEATH | MANNER OF DEATH | PERPETRATOR |
|---|---|---|---|
| 3 Years/ 5 Months | Seizure Disorder/Hypoxic Ischemic Encephalopathy of Undetermined Etiology | Natural | N/A |
| 4 Years/ 3 Months | Multiple Blunt Impact injuries | Homicide | Mother's Paramour |
| 5 Years/ 3 Months | Ventricular Dysrhythmia, Dilated Cardiomyopathy, Marfan Syndrome | Natural | N/A |
| 5 Years/ 9 Months | Cardiac Arrest, Congenital Heart Failure | Natural | N/A |

## 6 TO 10 YEAR OF AGE

| CHILD'S AGE | CAUSE OF DEATH | MANNER OF DEATH | PERPETRATOR |
|---|---|---|---|
| 6 Years/ 10 Months | Asphyxia, Smoke and Soot Inhalation | Accident | N/A |
| 10 Years/ 11 Months | Commotio Cardis | Homicide | Father |

## 11 THRU 14 YEAR OF AGE

| CHILD'S AGE | CAUSE OF DEATH | MANNER OF DEATH | PERPETRATOR |
|---|---|---|---|
| 11 Years/ 3 Months | Seizure Disorder, Aspiration Pneumonia, Anoxia Encephalopathy | Natural | N/A |
| 12 Years/ 11 Months | Drowning | Accident | N/A |
| 13 Years/ 5 Months | Gunshot Wounds of Neck | Homicide | Random Assailant |
| 13 Years/ 6 Months | Respiratory Failure, Graft vs. Host Disease, Renal Failure, Heart Failure | Natural | N/A |

## 15 Thru 21 Years

| Child's Age | Cause of Death | Manner of Death | Perpetrator |
|---|---|---|---|
| 16 Years/ 2 Months | Brain Herniation/Acute Thrombotic Cerebrovascular Accident | Natural | N/A |
| 16 Years/ 4 Months | Gunshot Wound to Head | Homicide | Unknown Assailant |
| 17 Years/ 4 Months | Gunshot Wound to Chest | Homicide | Friend |
| 17 Years 11 Months | Multiple Gunshot Wound | Homicide | Unknown Assailant |
| 18 Years/ 1 Month | Gunshot Wound to Head | Homicide | Unknown Assailant |
| 18 Years/ 3 Months | Gunshot Wound to Neck | Homicide | Acquaintance |
| 18 Years/ 5 Months | Gunshot Wound to Head | Homicide | Acquaintance |
| 18 Years/ 8 Months | Eisenmenger's Syndrome, AV Canal/Trisomy 21/ Renal Failure | Natural | N/A |
| 18 Years/ 8 Months | Comatose, Respiratory Arrest, AIDS w/ Wasting Syndrome | Natural | N/A |
| 21 Years/ 1 Month | Cardio-Pulmonary Arrest, Constrictive Pericarditis, Status Post Remote Repair of Tetralogy of Fallot | Natural | N/A |

***"A 1997 Natural Death"***

In November, a young woman only eighteen years of age fell victim to AIDS. She was the child of a substance abusing mother, who had left her and her siblings in the care of their maternal grandmother. In her grandmother's home, the decedent was sexually abused at the age of seven and became sexually active at the age of thirteen. Doctors believed that she had been exposed multiple times by infected partners because she went from point of infection to full blown AIDS in less than four years. Her five siblings are still in the care of the maternal grandmother. The case file indicates that the decedent received excellent health care and state of the art medication which enabled her to live significantly longer than medically expected. She died in the home of her foster parents who cared for her and allowed her to remain with them despite her deteriorating condition.

**Cause of Death**: Comatose, Respiratory Arrest due to AIDS

# SECTION FIVE: SUMMARY OF COMMUNITY CHILD FATALITIES

# *SUMMARY OF COMMUNITY CHILD FATALITIES*

Community child fatality cases are those where the family has no connection with the child welfare system. Based on the criteria outlined in Mayor's Order 92-121, the CFRC is responsible for reviewing the deaths of children who are five years of age or younger where the following exists:

- The cause of death remains pending or undetermined after the medical examiner's investigation;
- The child had head trauma, except where the case is clearly not abuse or neglect;
- The child was malnourished or neglected, including failure to thrive cases;
- The child drowned;
- The child suffered from asphyxia or suffocation/strangulation;
- The child showed evidence of drug ingestion or poisoning;
- The child suffered fractures;
- The child suffered blunt force trauma;
- The child sustained burns, except where the cause is clearly not abuse or neglect;
- The death resulted from child abuse or neglect;
- The child was sexually abused; or
- The child suffered a gunshot wound.

During the process of selecting fatalities for review for previous years, there were numerous cases identified which involved children who had died from asthma. The Committee decided to include these fatalities in the review process beginning with the 1997 calendar year. It was suggested during a general CFRC meeting that with recent knowledge related to the causes and treatments for this medical problem, the number of children dying from this medical problem should be at a minimum. It was also suggested that there may be some issues related to the method of administering medication or prevention strategies that the District should be aware of in order to assist the medical community and the public to more appropriately and successfully deal with this problem. Many of the families of the children identified by the CFRC who died of asthma had been known to the child welfare system and, as a result, were eligible for inclusion based solely on the LaShawn A. criteria. However, several of the children who died from asthma had no prior history with child welfare and are, therefore, included in the 1997 community data.

With recent improvements in the notification and information sharing processes, the Committee was better able to obtain information related to child deaths from various systems prior to the fatality review. Information was routinely provided by the Metropolitan Police Department, the Medical Examiner's Office, the Fire Department and the Office of State Health Statistics. In most of the cases, the CFRC was able to obtain copies of the Death Reports, Death Certificates, Traffic Accident Investigative Reports and the Fire Marshal's Investigative Reports prior to the reviews. The Committee was also able to conduct on-site record reviews at the Medical Examiner's Office.

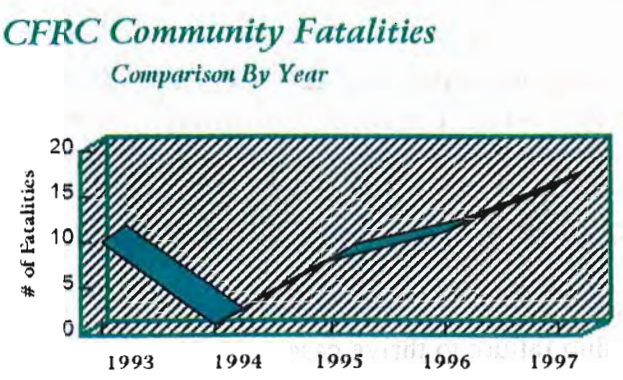

Figure 34 - 1997 CFRC Data

As with previous years data, the 1997 community child fatality population was the smaller category of cases reviewed by the CFRC. During 1997, 16 of the 51 fatalities reviewed were community cases. Figure 37 illustrates the steady increase in the number of community cases identified since the dramatic decline in 1994. While the actual number of community cases has continued to increase, the percentage of the total has fluctuated each year. *1997* data indicated that the 16 community cases represent 31 percent of the 51 CFRC fatalities reviewed. This represents an increase from the percentage of the total 1996 cases reviewed, a decrease from 1995, an increase from 1994 and decrease from 1993.

Families of the community fatality cases resided in six (6) of the seven (7) District Wards. There were no fatalities reviewed of families from Ward three (3). The majority (n = 9, or 56 percent) of the families of the community cases lived in Wards six (6), seven (7) and eight (8).

Fifteen (15), or 94 percent of the 16 community fatality cases involved children who were in the custody of and resided with their biological parents. Four (4) of these children resided with both parents and the remaining 11 resided with the mother. Two (2) of the children who resided with their mothers were in the care of a relative and godfather at the time of their deaths. One (1) child was in the custody of the maternal grandmother. However, at the time of death, due to the grandmother's illness, the child was in the care of the great aunt.

## *Age, Gender and Race*

All the children in this category were 15 years of age or younger. The majority (n = 14, or 88 percent) were under the age of five (5) years. Twelve (12), or 79 percent,of the 16 community fatalities were one (1) year of age or younger, nine (9) of whom died before reaching the age of 11 months.

The majority (n = 10, or 63 percent) of the children were males, while six (6) were females. Fifteen (15), or 94 percent, of the children were African American and one (1) was Hispanic.

## *Manner of Death*

Unlike other years, 1997 data indicated that the leading manner of death (n = 7, or 44 percent) for the community fatalities reviewed was natural. Because the criteria for community fatalities do not include natural deaths as a basis for CFRC review, the majority (n = 5, or 71 percent) of the natural deaths were reviewed because the initial cause and manner were pending. The causes of death for four (4) of the five (5) fatalities that were initially pending were eventually determined to be Sudden Infant Death Syndrome. The causes for the remaining three (3) natural deaths were determined to be Asthma.

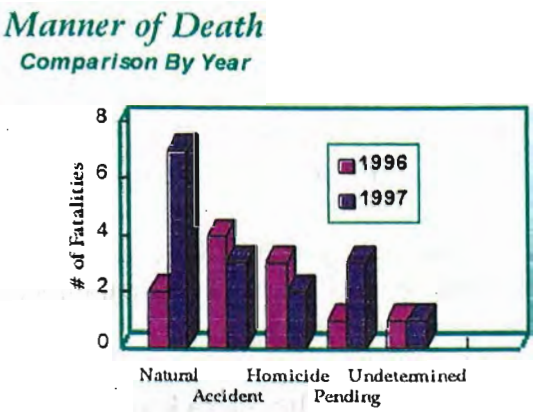


Figure 35 - 1997 CFRC Data

Three (3) fatalities were caused by accidental injuries. One of the children died from positional asphyxia and two (2) were involved in motor vehicle accidents and died from blunt force injuries. The three (3) children who died from accidental injuries were in the care of their mothers at the time of the fatal incident. In two (2) of the accidental deaths, the Review Team felt that the caregiver's negligence and inadequate supervision were a major contributors to the fatalities.

Two (2) children died from homicides. One (1),while in the care of a great aunt, died from blunt force injuries and the second was in the care of the godfather and died from smothering. Both children were females and were around the age of one (1) year. The remaining four (4) fatalities include one (1) undetermined death and three (3) that remained pending as of November 1998.

## *Community Family Characteristics and Other Facts*

- The age was known for 12, or 75 percent, of the mothers of the decedents. The ages ranged from 17 through 31. The average age was 23 years; and the median was 21. The age was known for four (4), or 25 percent, of the fathers of the decedents. The ages ranged from 20 through 32. The average age of the fathers was 24.

- Eleven (11), or 69 percent, of the decedents had siblings. The number of siblings ranged from one (1) to five (5), with the average number of siblings being two (2). The majority (n = 6, or 54 percent) of the decedents with siblings were the last born; three (3) were first and two (2) were twins. One (1) of the surviving twins is the only sibling.

- Fifteen (15), or 94 percent of the families were receiving public assistance. The majority (n = 11, or 73 percent) of these families were receiving TANF, Food Stamps and Medicaid. Two (2) families received Medicaid only and one (1) received Food Stamps in addition to Medicaid.

- Based on the review of records and information shared with the CFRC, as well as information revealed during the reviews of community fatality reviews, one (1), or 6 percent, of the mothers was a known drug abuser.

- Two (2), or 13 percent, of the families reported a history of domestic violence that involved the mother and father and/or paramour. The manner of death for both children of these families was pending.

- None of the families had a known history of involvement with the criminal justice system.

- Autopsies were conducted on all (100 percent) of the community fatalities. All the autopsies were completed by the District's Medical Examiner's Office and the deaths investigated by the Metropolitan Police Department.

***"A 1997 Accidental - Motor Vehicle Fatality"***

An eighteen month old child was playing with his 10 year old brother in a residential courtyard, with their parents seated at a table about 25 yards away. At the same time a parked pickup truck was being loaded with furniture. When the driver had finished loading the truck, he told the children to clear the area. He then entered the vehicle and began to pull off. The eighteen month old child walked in front of the vehicle as the truck pulled off and was struck by the front end. The witnesses of the accident began to scream and the truck stopped. The victim's brother picked him up. The victim's parents, made aware of the incident by the screaming, grabbed the child and rushed him to the hospital where he died the next day. A police investigation revealed that because of the height of the truck the driver was not able to see the child stepping in the path of the truck. The physician at the hospital indicated that the child had numerous head injuries including a skull fracture and abrasions to the face.

**Cause of Death:** Blunt Impact Injuries of the Head

# LISTING OF COMMUNITY CHILD FATALITIES BY CAUSE, MANNER AND PERPETRATOR

## UNDER 1 YEAR OF AGE

| CHILD'S AGE | CAUSE OF DEATH | MANNER OF DEATH | PERPETRATOR |
|---|---|---|---|
| 1 Month | Sudden Infant Death Syndrome | Natural | N/A |
| 1 Month | Sudden Infant Death Syndrome | Natural | N/A |
| 2 Months | Pending | Pending | N/A |
| 2 Months | Sudden Infant Death Syndrome | Natural | N/A |
| 2 Months | Sudden Infant Death Syndrome | Natural | N/A |
| 4 Months | Positional Asphyxia | Accident | N/A |
| 9 Months | Undetermined | Undetermined | N/A |
| 9 Months | Pending | Pending | N/A |
| 10 Months | Blunt Impact Head Trauma with Subdural Hematoma | Homicide | Unknown |

## 1 THRU 5 YEARS

| CHILD'S AGE | CAUSE OF DEATH | MANNER OF DEATH | PERPETRATOR |
|---|---|---|---|
| 1 Year/ 2 Months | Smothering | Homicide | Godfather |
| 1 Years/ 2 Months | Pending | Pending | N/A |
| 1 Years/ 7 Months | Blunt Impact Injuries to Head | Accident | N/A |
| 3 Years 7 Months | Blunt Impact Injuries | Accident | N/A |
| 4 Years/ 10 Months | Asthma | Natural | N/A |

## 6 To 15 Years of Age

| Child's Age | Cause of Death | Manner of Death | Perpetrator |
|---|---|---|---|
| 10 Years/ 7 Months | Bronchial Asthma | Natural | N/A |
| 15 Years/ 10 Months | Clinical Anoxia/Bronchial Asthma with Seizure Disorder. | Natural | N/A |

# SECTION SIX:
# STRATEGY FOR CHANGE AND CFRC ACCOMPLISHMENTS

## STRATEGY FOR CHANGE AND CFRC ACCOMPLISHMENTS

*"Vision is not seeing things as they are, but as they will be."*

The fundamental goal of the fatality review process continued to be determining ways to save children's lives. Thus, during each review the identification of risk factors that may have contributed to the child's death is carefully balanced with the identification of broad prevention strategies. Prevention strategies focus on not only improving those systems that are directly involved with children and families but also on implementing community-wide interventions that emphasize public education and behavioral change. It is hoped that these strategies will assist in reducing or preventing the premature and unnecessary deaths of children or improving their overall quality of life.

Historically, the majority of the CFRC recommendations have been geared towards improving services provided by numerous public agencies and private medical facilities. As a result of the Committee's longstanding concern related to implementation of the recommendations, a Recommendations Workgroup was established in 1997 to devise an approach for ensuring the implementation of the CFRC recommendations and to take the lead in activities related to the recommendations. It was decided that the CFRC needed to work closer with agencies in order to document progress made towards implementation of review recommendations. Therefore, during 1997, a strategy was devised and initiated to monitor the implementation of the recommendations. While this process has been laborious, it has also been rewarding. It has uncovered many problems and obstacles to implementation, and has been helpful in determining the appropriateness of the recommendations and documenting progress made towards systemic and community change.

## 1997 ACCOMPLISHMENTS

Based on feedback received from various public agencies, the following outlines some of the progress made towards implementing th CFRC recommendations:

- ***Reporting Child Abuse and Neglect***

  Since the establishment of the District's child death review process in 1992, countless reviews have documented problems related to early detection and reporting of suspected abuse and neglect. As a result, numerous recommendations were made related to reviewing the current statute and/or relevant agencies policies and practices to determine any areas of conflict or gaps and revise them, as appropriate. Several recommendations were also made related to providing training to ensure that mandated reporters are aware of their responsibilities under the law. Through the efforts of the Office of Corporation Counsel

(OCC), Child and Family Services Agency (CFSA) and the U.S. Attorneys Office (USAO) amendments to the Prevention of Child Abuse and Neglect Act of 1977 (D.C. Law 2-22) were drafted to clarify the definitions of abuse and neglect. At the close of 1997, the draft amendments were being finalized for submission to the Council of the District of Columbia. Additionally, OCC and USAO provided training to all the major hospitals on the reporting requirements under the law.

D.C. Public Schools (DCPS) revised and issued to all staff the policy directive on reporting suspected abuse and neglect to ensure consistency and compliance with D.C. Law 2-22. Training was provided to all school administrators, teachers and other appropriate personnel. DCPS also developed a new online reporting system. This system became operational in February of 1997. It is designed to "electronically capture critical information regarding incidents, accidents and security violations," which includes incidents of suspected abuse and neglect of students. The new online reporting system will improve the school system's ability to document incident reports and more efficiently transfer information and generate reports. Training was provided to school principals on the use of the reporting system.

The Metropolitan Police Department (MPD) provided training to DCPS school administrators on the identification and reporting of suspected child sexual abuse. Training also provided information on the investigation process and the role of the reporter in this process.

DCPS conducted two (2) staff development sessions for counselors, attendance aides and attendance officers to discuss issues, policies and practice related to the appropriate handling and reporting of chronic truancy cases as educational neglect.

### ❖ *Access to Unsupported Reports of Abuse and Neglect*

The CFRC has reviewed numerous cases of fatal abuse/neglect where families had been previously reported to the child protective services system. However, based on the investigation, the allegations were "unsupported" and the cases were closed. D.C. Law 2-22 currently requires the expungement of any identifying information on these cases. This has impeded the Committee's ability to obtain vital information needed to fully understand the family issues that caused the report, whether these issues were related to the fatal incident, the circumstances surrounding the child protection service investigation and the reasons the case was determined to be "unsupported." This loss of critical data has impacted the Committee's ability to determine whether services and interventions were adequate and to make meaningful recommendations to prevent similar situations from occurring. It also interferes with the child welfare program's ability to assess risk and child safety or conduct a comprehensive investigation when subsequent reports are received on the same families.

As a result of this problem, Fatality Review Teams have recommended a comprehensive review of several sections of D.C. Law 2-22 to determine whether the requirements are appropriate and, if not, to amend the law to allow for limited access to vital information related to the investigation of unsupported neglect and abuse cases.

Based on a review of District law and current practice, as well as a review of similar legislation from other states and Federal requirements, an amendment to D.C. Law 2-22 was drafted. The amendment expands the categorization of cases based on the outcome of the investigation, using terminology that is more consistent with the Federal requirements. It also clarifies and expands those categories where information must be retained in the Child Protection Register, and limits the cases where expungement of information is required to reports determined to be "false." At the close of 1997, the draft amendment was in the process of being finalized for submission to the Mayor and the Council.

❖ *Create Authority for Child Fatality/Mortality Review Processes*

The CFRC, in collaboration with OCC and other member agencies, initiated the process of drafting legislation to create the legal authority to operate and govern all activities related to the child fatality review process. The legislation will officially combine the two currently operating child death review processes (Infant Mortality and CFRC), promote increased collaboration and permit easier access to information and improve other operational procedures associated with child death review process.

❖ *Combine Two Child Death Review Processes*

In anticipation of the formal integration of the District's two (2) existing child death review processes, Infant Mortality Review Team and CFRC, the Department of Health, Office of Maternal and Child Health, Healthy Start Program and the CFRC worked together to outline the parameters to initiate the merger without violating confidentiality and distinct operational guidelines of either process. Prior to these discussions, the independent uncoordinated functioning of these Committees created duplication of reviews, barriers to data collection, sharing and reporting which limited the completeness of evaluations and inefficient utilization of resources.

This merger began with the Chair of the Infant Mortality Review Committee joining the CFRC as the new Co-Chair. Activities continued throughout 1997 with the cross participation in reviews; sharing of monthly data on child deaths and providing other information related to service record reviews. Additionally, during 1997, the Mayor's Order, which establishes the CFRC was revised to include Infant Mortality Review (IMR) as a vital component of the CFRC and submitted for approval.

❖ *Public Education Campaign*

The CFRC received Federal grant funds to facilitate the implementation of several recommendations related to increasing public awareness of issues surrounding deaths attributed to Sudden Infant Death Syndrome and numerous accidental injuries and ways to prevent or reduce the number of deaths in these areas. During 1997, the CFRC initiated the process of securing a public relations firm to assist in determining the most effective public education strategy and in the development of informational materials.

❖ *Improve CFRC Data Collection*

The above mentioned grant also provided funding to improve data collection and information sharing between the CFRC Coordinator and those member agencies currently serving as critical information sources. Funds were designated specifically for the purchase of four (4) computers and the development of a common data instrument and data base for the CFRC. During 1997, computers were ordered and the process for securing a consultant to design the data base was initiated.

## 1997 RECOMMENDATIONS

The recommendations contained in this Section were developed based on the case specific facts/information and data generated from the 51 fatalities reviewed from the 1997 calendar year. Additionally, they are specific to the various types of programs, dealing comprehensively with the need for service delivery, practice, legislative and public policy improvements and other issues. Many of the recommendations were included in previous CFRC Annual Reports. However, in situations where the recommendations were also made during1997 fatality reviews and the Committee is unaware of the current status of implementation efforts, the recommendations have been repeated for emphasis.

### HEALTH, SOCIAL AND CHILD WELFARE SERVICES

❖ Improve investigations of abuse and neglect, especially of those families reported more than once. Criteria should be established to refer families for family preservation and support services when more than one referral to child protective services has been received.

❖ Advocate for increased community-based early intervention and primary prevention programs as a means of preventing child abuse and neglect.

- Develop a risk assessment instrument to determine the risk level of families with medically fragile newborns, prior to discharge. Advocate for city-wide use of the instrument in local hospitals.

- Establish hospital protocols that require discharge planning for newborns to include at a minimum: discussions with the parent about the appropriate sleeping positions and environment for children; appropriate care of an infant; a home assessment to ensure that the mother is adequately prepared for the infant; and referrals for follow-up services, especially for parents of high risk or medically fragile newborn infants.

- Re-establish a "Home Visiting" program and make it available to high risk pregnant women and newborns, including medically fragile infants to provide support, assistance, monitoring and follow-up services.

- Develop a Sudden Infant Death Syndrome (SIDS) Program to provide grief counseling and other supportive services to parents, increase public awareness about the risk factors associated with SIDS and maintain data related to consistent patterns, trends, family/child characteristics, circumstances surrounding the child's death, and overall SIDS deaths that occur within the District.

- Grief counseling should be available as a supportive service to all District families that experience a child death. A directory of all community-based organizations/programs that provide grief counseling should be developed and widely distributed to medical and other child/family service systems.

- Expand services for substance abusing women and their children to include a range of treatment alternatives that are based on the varying needs of these families.

- Advocate for court oversight and involvement on cases where parents are chronic substance abusers and are not complying with drug testing and other case plan requirements, which place children at risk or jeopardize their safety.

- Advocate for making parenting skills training available as a preventive measure to recipients of public assistance and other public services. Services could be made available through referrals to appropriate public agencies or community-based programs.

- Strengthen lines of communication and collaboration between the public child welfare program and local hospitals to foster sharing of information and improved case work for mutual at risk families.

- Establish open lines of communication between child welfare and emergency medical personnel and develop a method for collaborating to ensure the safety of children observed in the process of emergency response activities.

### *Educational and Recreational Services*

- Incorporate conflict resolution and peer counseling in the public school curriculum that begins at the elementary level and intensifies in the junior and high school grades.

- Promote the development of structured community-based mentoring programs that will focus on providing youth with positive role models and alternatives to negative behaviors.

- Ensure that public community pools are maintained in a safe, clean and sanitary manner and are properly staffed in order to accommodate the high number of children utilizing these facilities during the summer and respond appropriately to emergency situations.

### *Policy, Legislative, Legal and Law Enforcement Services*

- Improve the quality of the child death investigations. Finalize and begin utilizing the protocols drafted during 1996 for child death investigations. Training should be provided to ensure consistency in the use of this instrument and overall practice among officers responsible for this function.

- Ensure that child death investigation protocol requires, at a minimum, routine contact and/or interviews with all individuals involved in the fatal incident, including family members and others present in the home, emergency medical services and hospital personnel.

- Strengthen gun control laws and the enforcement of these laws, as a means of reducing the number of teen deaths caused by gunshot wounds.

- Amend the Prevention of Child Abuse and Neglect Act of 1977 (D.C. Law 2-22) to eliminate the bifurcated abuse and neglect system.

- Amend D.C. Law 2-22 to provide clarification regarding the types of situations that should be referred to child protective services for investigation, especially situations related to infants born drug exposed and other critical indicators that will support allegations of abuse/neglect.

### *Medical Examiner Services*

- Perform autopsies on all children committed to the care and custody of the District of Columbia.

- Foster collaboration with the Metropolitan Police Department to clarify roles and responsibilities and standardize protocols required to improve the quality of the death scene investigations.

### *Public Awareness*

- Increase public awareness of the increase in the number of incidents of fatal abuse and neglect and the requirements of the District's law that protects children, the obligation of mandated reporters and the general community related to reporting suspected incidences of abuse and neglect, the process and penalties for not reporting.

- Increase community awareness of SIDS, the associated high risk factors and prevention measures, i.e., safest sleeping positions and environment for infants.

- Increase parental awareness of the hazards of shaking an infant or child.

- Increase parental and general public awareness of the preventability of accidental child deaths and the importance of providing age-appropriate supervision to children and teaching children age-appropriate safety measures.

- Increase public awareness of the benefits of family planning, pregnancy preparation and prenatal care.

- Increase public awareness of fire arm safety measures, gun control laws and penalties for violation of these laws.

- Educate hospital staff on those high risk indicators that would support a neglect referral to child protective services involving a woman who is a chronic substance abuser and is pregnant or recently delivered a drug exposed infant.

### *D.C. Child Fatality Review Committee*

- Develop a strategy for promoting a better understanding among Committee members of the common issues, trends and characteristics associated with the violent deaths of youth in

order to devise more appropriate recommendations focused on reducing the number of deaths of teenagers in the District.

- Continue efforts to identify funds to implement public education recommendations and other Committee activities.

- Advocate for adequate and sustainable resources for the Committee to support the planned expansion of responsibility.

- Continue work related to restructuring and formalizing the CFRC operations to establish more effective and efficient child death review process.

- Continue to improve collaboration efforts with the CFRC member agencies to facilitate the expeditious sharing of information related to child deaths.

- Advocate for the enactment of the CFRC legislation which would ease confidentiality restrictions sufficient to facilitate the sharing of pertinent information and improve cooperation and collaboration among member agencies.

- Advocate for the resolution of issues related to sharing child death information on residents from surrounding states who die in the District and District residents who die in these jurisdictions.

- Initiate contact with Maryland and Virginia to initiate discussions related to the need to collaborate and participate in fatality reviews where the death occurs in States outside the decedents area of residency.