

DISTRICT OF COLUMBIA
**CHILD FATALITY
REVIEW COMMITTEE
ANNUAL REPORT**

2018





DISTRICT OF COLUMBIA **CHILD FATALITY REVIEW COMMITTEE 2018 ANNUAL REPORT**

PRESENTED TO:

The Honorable Muriel Bowser, Mayor, District of Columbia

The Council of the District of Columbia

The Citizens of the District of Columbia

DECEMBER 2019



DISTRICT OF COLUMBIA
**CHILD FATALITY
REVIEW COMMITTEE
2018 ANNUAL REPORT**

**CHILD FATALITY REVIEW COMMITTEE
MEETING CO-CHAIRS**

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CHIEF MEDICAL EXAMINER, OCME
CO-CHAIR, CHILD FATALITY REVIEW
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Mission

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



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GREETINGS FROM THE CHIEF MEDICAL EXAMINER



The District of Columbia’s Child Fatality Review Committee (CFRC) continues to make progress in our endeavors to improve the fatality review process and inform evidence-based programs and policies throughout the District of Columbia. The CFRC provides an opportunity to reach out and address those pertinent public health issues that affect the lives of our most vulnerable residents.

During this review year, the CFRC members embarked on ground breaking initiatives with the hope to fully address systemic issues facing those populations served through the CFRC process. With the decriminalization of marijuana, the Infant Mortality Review Team (IMRT) convened a subcommittee to research the effects of marijuana on the newborn infant population. The IMRT has also developed discharge protocols that speak to the needs of medically fragile infants. The Child Fatality Review Team (CFRT) reviewed several natural death cases from which findings surrounding the needs of children and youth diagnosed with asthma and complex medical

diagnoses generated recommendations that will improve outcomes for our medically complex children and youth. With the multidisciplinary composition of pediatricians, neonatologist, child welfare and education advocates, public safety officers, university professors and community based public health specialist, the CFRC is moving toward being a leading voice in the prevention of child fatalities in the District of Columbia.

The CFRC is pleased to present its 23rd Annual Report covering mortality data from child/youth fatalities that were reviewed during calendar year 2018. This year the Committee reviewed 104 cases. This annual report highlights our continuing efforts to promote the health and wellness of the children of the District of Columbia. This report presents those lessons learned.

Thank you to the membership of the CFRC, participant agencies and community members who contributed to this report.

Yours in Truth and Service,

A handwritten signature in black ink, appearing to read "Roger A. Mitchell, Jr., MD".

Roger A. Mitchell, Jr., MD

CHIEF MEDICAL EXAMINER

DISTRICT OF COLUMBIA OFFICE OF THE CHIEF MEDICAL EXAMINER



DISTRICT OF COLUMBIA CHILD FATALITY REVIEW COMMITTEE 2018 ANNUAL REPORT

DEDICATION

This Annual Report is dedicated to the memory of the children and youth of the District of Columbia who lost their lives due to medical problems, senseless acts of violence, accidents and suicide. It is our vision that as we learn lessons from circumstances surrounding the deaths of our infants, children and youth we can succeed in reducing the number of preventable deaths while improving the quality of life of all residents.

THE INFANT MORTALITY REVIEW TEAM (IMRT)

Committee members and participants of the IMRT convene on the 1st Tuesday of each month. In 2018, members and meeting participants represented the following District Government agencies, medical providers, and community based organizations:

A DC MIDWIFE
AMERIHEALTH CARITAS DC
CENTER FOR THE STUDY OF SOCIAL POLICY
CHILD AND FAMILY SERVICES AGENCY
CHILDREN'S NATIONAL MEDICAL CENTER
DEPARTMENT OF BEHAVIORAL HEALTH
DC HEALTH
DC HOUSING AUTHORITY
DEPARTMENT OF HEALTH CARE FINANCE
DEPARTMENT OF HUMAN SERVICES
EVERMORE
GEORGE WASHINGTON UNIVERSITY HOSPITAL
HOWARD UNIVERSITY HOSPITAL
MARCH OF DIMES
NATIONAL INSTITUTES OF HEALTH-
CHILDREN'S HEALTH AND HUMAN DEVELOPMENT
OFFICE OF THE CHIEF MEDICAL EXAMINER
TRUSTED HEALTH PLAN
WASHINGTON HOSPITAL CENTER

THE CHILD FATALITY REVIEW TEAM (CFRT)

The CFRT convenes on the 3rd Thursday of each month. In 2018, members and meeting participants represented the following District Government agencies, medical providers and community-based organizations:

AMERIHEALTH CARITAS
CENTER FOR THE STUDY OF SOCIAL POLICY
CHILD AND FAMILY SERVICES AGENCY
CHILDREN'S NATIONAL MEDICAL CENTER
DC FIRE AND EMERGENCY MEDICAL SERVICES
DC HOUSING AUTHORITY
DC PUBLIC SCHOOLS
DEPARTMENT ON BEHAVIORAL HEALTH
DC HEALTH
DEPARTMENT OF HEALTH CARE FINANCE
DEPARTMENT OF HUMAN SERVICES
DEPARTMENT OF YOUTH REHABILITATIVE SERVICES
HOWARD UNIVERSITY SCHOOL OF SOCIAL WORK
METROPOLITAN POLICE DEPARTMENT
OFFICE OF THE ATTORNEY GENERAL
OFFICE OF THE CHIEF MEDICAL EXAMINER
OFFICE OF THE STATE SUPERINTENDENT OF EDUCATION
OFFICE OF THE US ATTORNEY FOR THE DISTRICT OF COLUMBIA
RESIDENTS OF THE DISTRICT OF COLUMBIA
SUPERIOR COURT OF THE DISTRICT OF COLUMBIA

SUPERIOR COURT OF THE DISTRICT OF COLUMBIA COURT SOCIAL SERVICES DIVISION

The DC Child Fatality Review Committee (CFRC) provides our residents, social advocates and government employees with the unique opportunity to answer a critical question following the death of our infants, children and youth - “What, if anything, could have been done to prevent this death?”

The District's child fatality review process is the only formally established mechanism within the District Government for assessing the circumstances surrounding their deaths and evaluating associated risk factors. This process identifies family and community strengths, as well as improvements needed for human services, public safety, educational and medical systems to better address the needs of children and families served. The CFRC is a collaborative effort to reduce the number of preventable deaths.

The CFRC reviews the death of District residents from birth through 18 years, and youth older than 18 who were known to child welfare within four (4) years of the fatal event or those known to intellectual and disability services¹ or juvenile justice programs within two (2) years of the fatal event. Committee membership is multidisciplinary, representing public and private child and family servicing agencies and programs, and includes community members representing the all eight (8) wards in the District of Columbia. All fatality review meetings are confidential. The statute mandates the publishing of an annual report reflecting the work of the Committee during the year of review.

During the CFRC case review meetings, members are informed of the interactions between children, their families and service providers within the District of Columbia. As their social and economic histories are also shared, the collection of unique experiences provides an in-depth look at the children's social determinants of health – the conditions within our environment that affect our overall health and outcomes. Armed with this knowledge, members engage in informed discussion for the development of findings based upon systemic issues identified throughout the members' case discussion and consensus. The frequency of these findings renders the formulation of recommendations that are sent to District Government agencies, medical providers and community based partners. The CFRC recommendation process provides an opportunity for the District of Columbia to directly address the social determinants of health, with Government agencies, medical providers and community based partners providing services to these children and their families.

This annual report summarizes data collected from 104 infant, child and youth fatalities that were reviewed by the CFRT in 2018. These cases represent a subset of fatalities that occurred in 2014, 2015, 2016, 2017 and 2018.

¹ None of the deaths reviewed by the CFRC in 2018 met the criteria for review due to the decedent's involvement with intellectual and disability services.

This report is comprised of two sections:

» Section 1

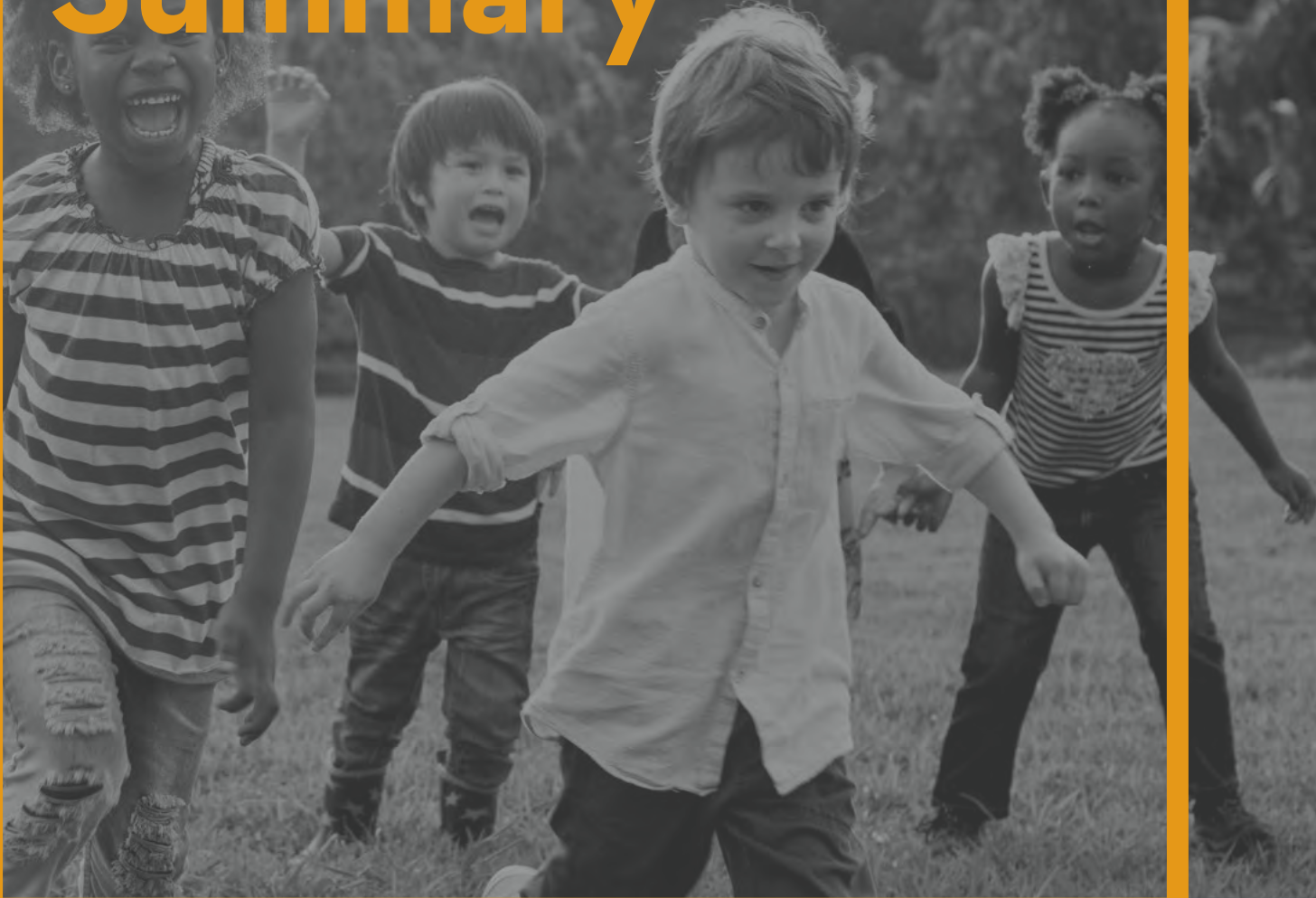
Summary of Team Findings - This section provides data derived from the Infant Mortality Review and the Child Fatality Review team meetings.

» Section 2

Committee Recommendations - This section provides the CFRC recommendations submitted to District Government agencies, medical providers and community based partners during the operational year.



Executive Summary



104 infant, child and youth fatality cases reviewed by the CFRC during meetings held in 2018.

The CFRC is a citywide collaborative effort authorized by the Child Fatality Review Committee Establishment Act of 2001 (see DC Official Code, § 4-1371.01 et. seq.). This Committee was established for the purpose of conducting retrospective reviews of the circumstances contributing to the deaths of infants, children and youth who were residents of the District of Columbia, or were known to the child welfare or juvenile justice systems of the District. The primary goals of the District’s child death review process are to: 1) identify risk reduction, prevention and system improvement factors, and 2) recommend strategies to reduce the number of preventable child deaths.

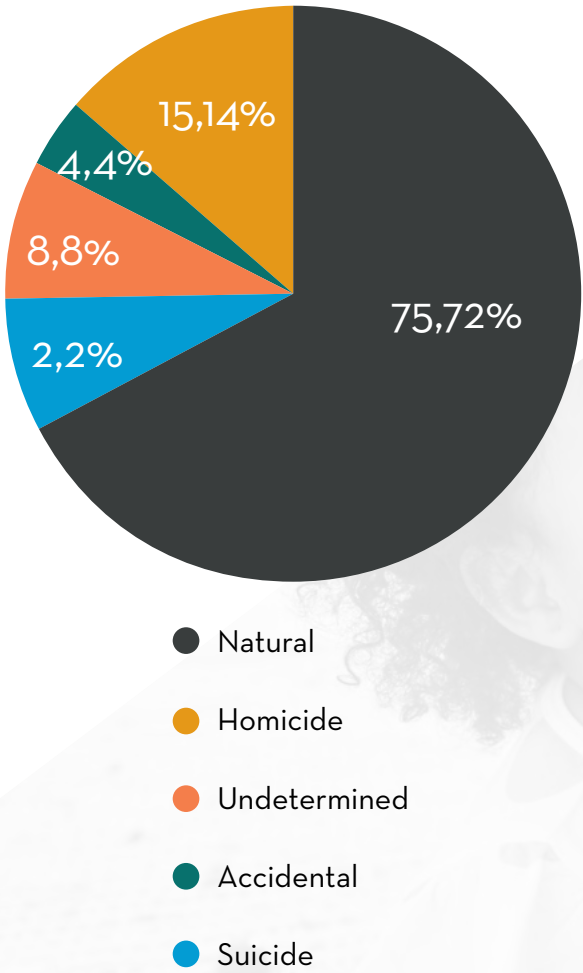
The CFRC is comprised of two teams, the Infant Mortality Review Team (IMRT), and the Child Fatality Review Team (CFRT). Each team convenes monthly to discuss the circumstances surrounding these deaths and discuss findings that will lead to recommendations. Due to the vulnerability of this population, each team is also charged with evaluating government-based systems that provided services to families prior to or at the time of the death. Each CFRC team also considers adverse environmental factors. These issues often become relevant in cases involving premature births, youth homicides, and the sudden unexpected death of an infant.

Table 1: 2018 Manners of Death in Children As Reviewed in the CFRC Cases (N= 104)	
CFRC 2018 MANNERS OF DEATH	CFRC Annual Report Definition
Natural Case Reviews	Deaths caused by the natural disease process and not an accident or violence
Homicide Case Reviews	The deliberate and unlawful killing of a person by another person
Undetermined Case Reviews	Following a thorough medical and legal investigation, a conclusive manner of death is not determined
Accident Case Reviews	Deaths caused unintentionally rather than by natural causes, suicide, or murder
Suicide Case Reviews	Deaths caused by self-inflicted behavior with the intent to die as a result

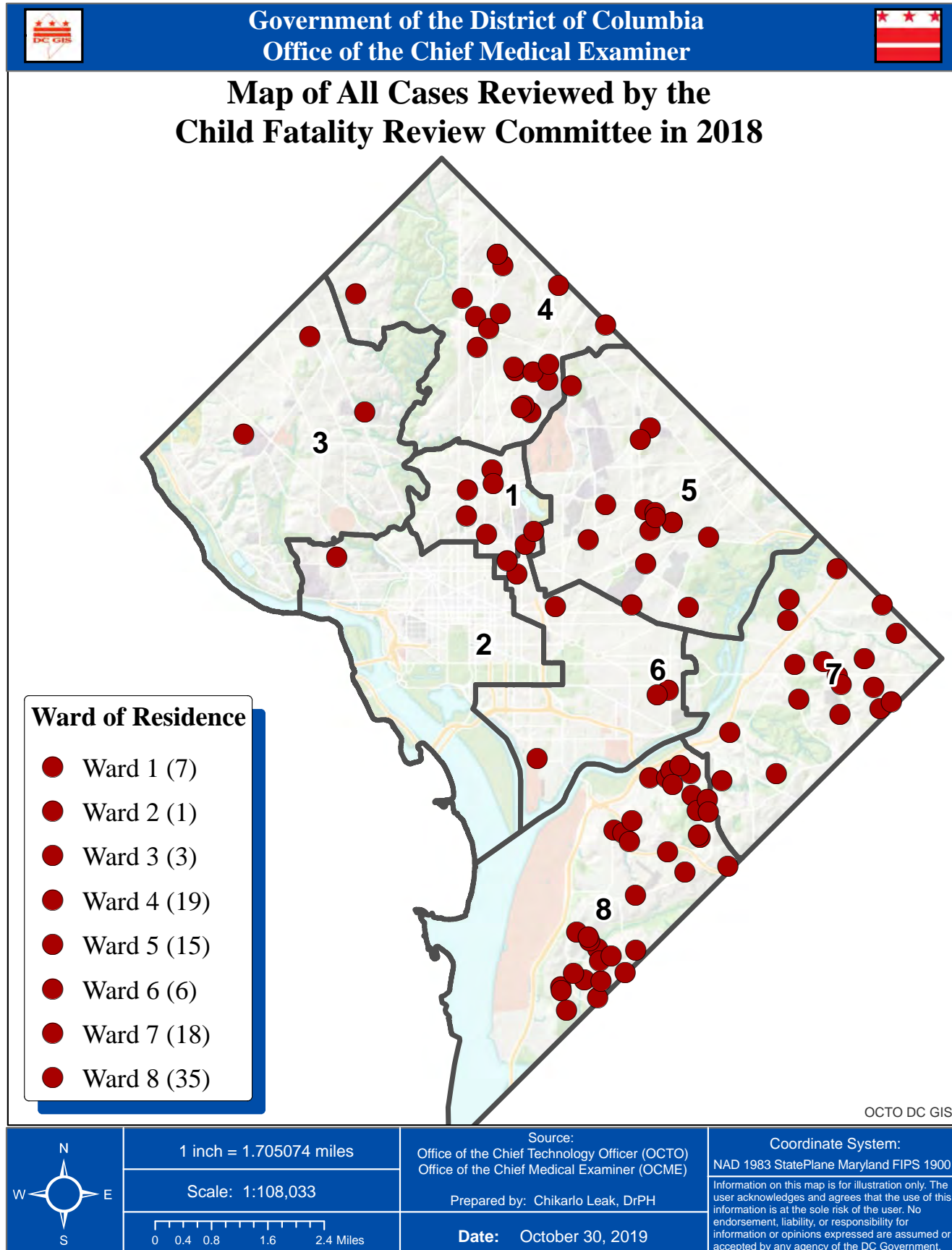
As shown in Figure 1:

- Seventy- five (75) cases involved infants, children and youth whose deaths were classified as natural
- Fifteen (15) cases involved infants and youth whose deaths were classified as homicide.
- Four (4) cases involved infants and children whose deaths were accidental.
- Eight (8) cases involved the deaths of infants whose deaths were classified as undetermined.
- Two (2) cases involved children that sustained self-inflicted behavior with the intent to die whose deaths were classified as suicide.

FIGURE 1: CFRC 2018 CASE REVIEWS



- Natural
- Homicide
- Undetermined
- Accidental
- Suicide



Section 01

SUMMARY OF TEAM FINDINGS

INFANT MORTALITY REVIEW TEAM FINDINGS



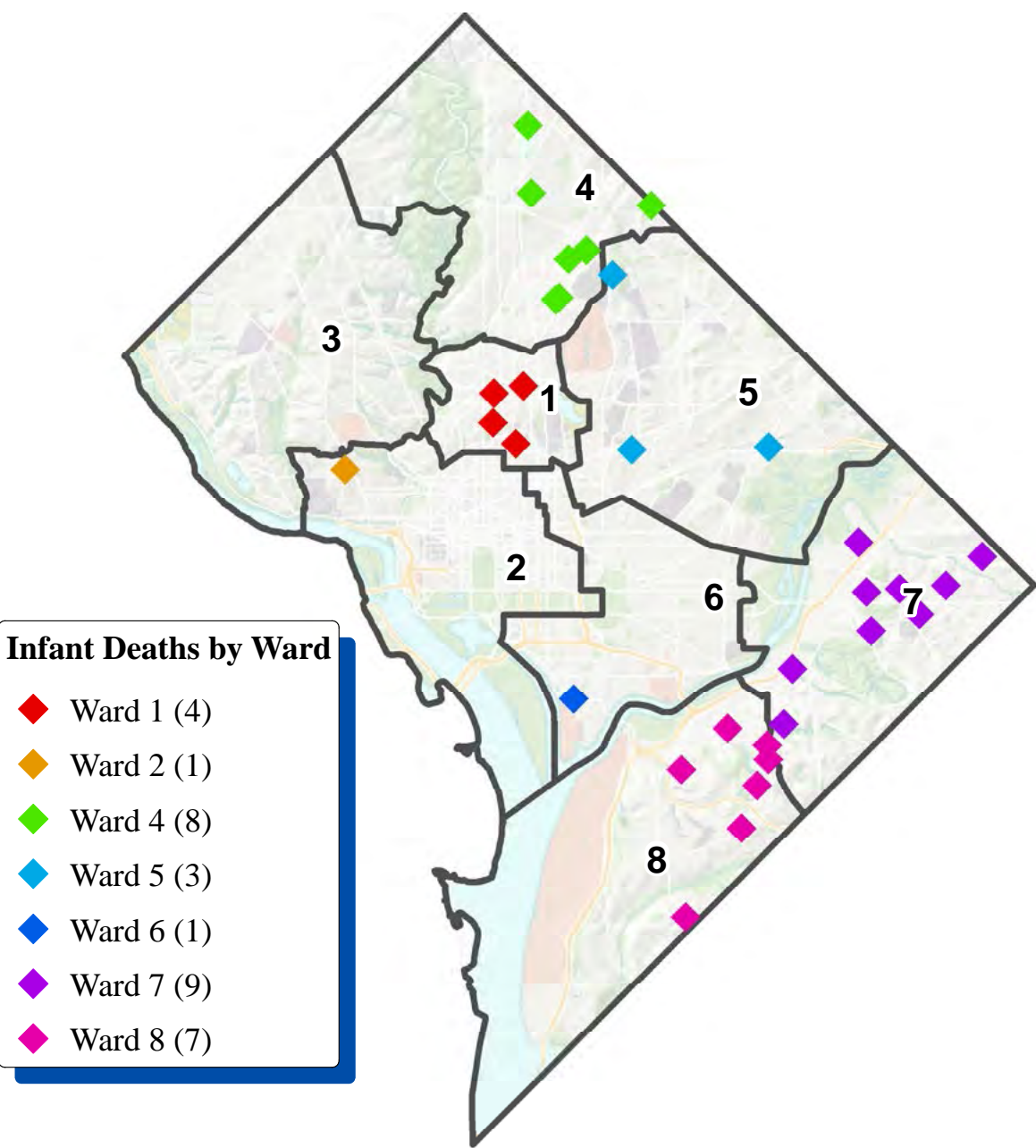
PREMATURE DEATHS STATISTICAL REVIEW

In 2018, the IMRT conducted a statistical review of 33 infants who died of natural causes in 2017 and met the criteria for review. These infant deaths occurred in the second trimester and were due primarily to disorders related to short gestation and low birth weight and other respiratory conditions originating in the perinatal period. These infants lived up to a matter of minutes, hours or days; none of whom lived longer than 27 days. The following is a summary of statistics obtained from the review of these cases utilizing information gathered only from the Department of Health (DC Health) Vital Statistics- Certificate of Live Birth and Certificate of Death².

- I am a 30 year old Black resident of Ward 4 and 7. I have my high school diploma and have taken some college courses. I have barriers to prenatal care 25% of the time
- My pregnancy risk factors include: previous poor pregnancy outcome, previous Cesarean section and previous pre-term birth

² This information is not statewide data. For statewide estimates of birth outcomes, including prematurity, low birth weight and infant mortality, please see the Perinatal Health and Infant Mortality Report at dchealth.dc.gov

Infant Deaths Among Women in their 2nd Trimester, 2017



Statistical Review-
Decedent Information

FIGURE 2: DECEDENT GENDER AND RACE

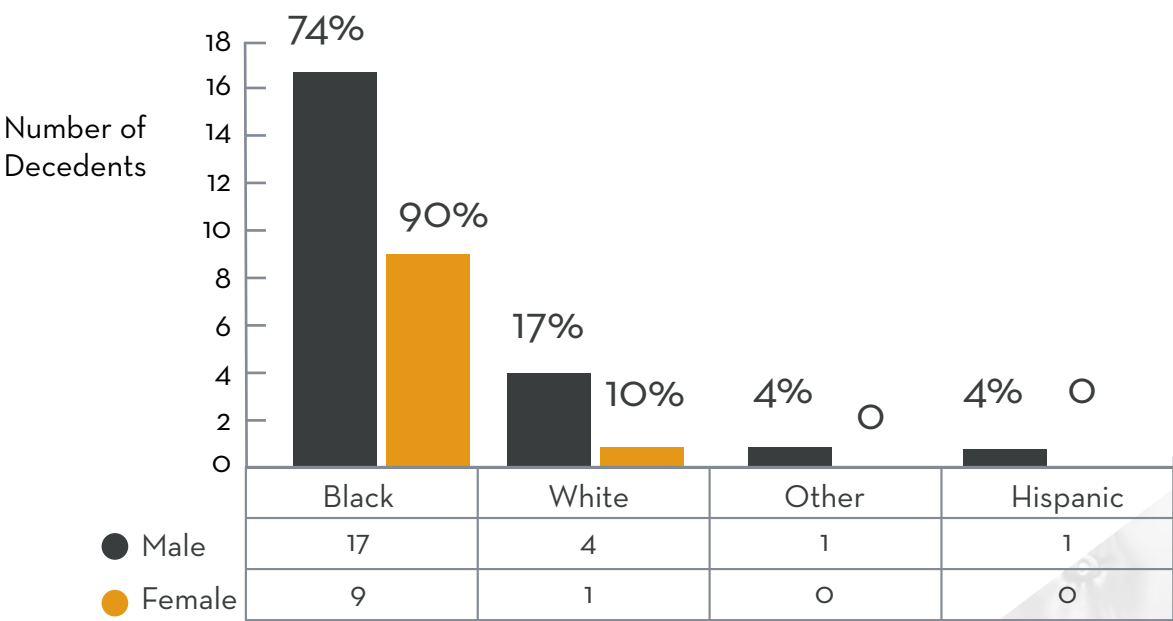


FIGURE 3: DECEDENT BIRTH PLURALITY

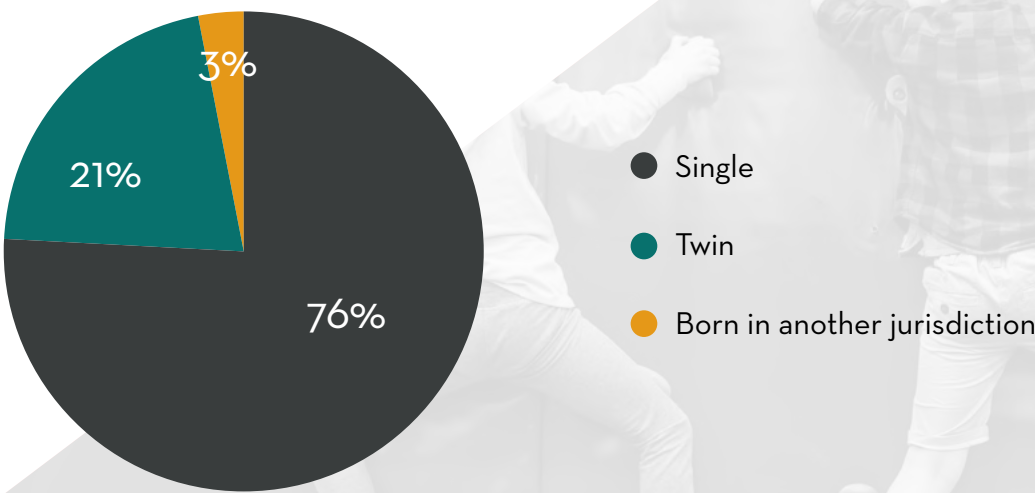
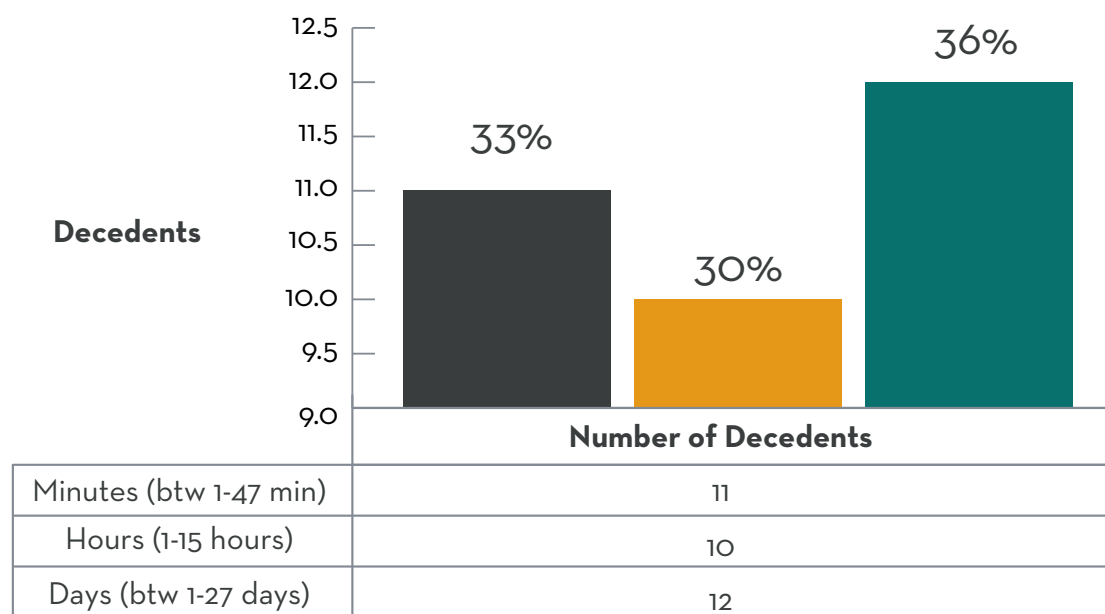
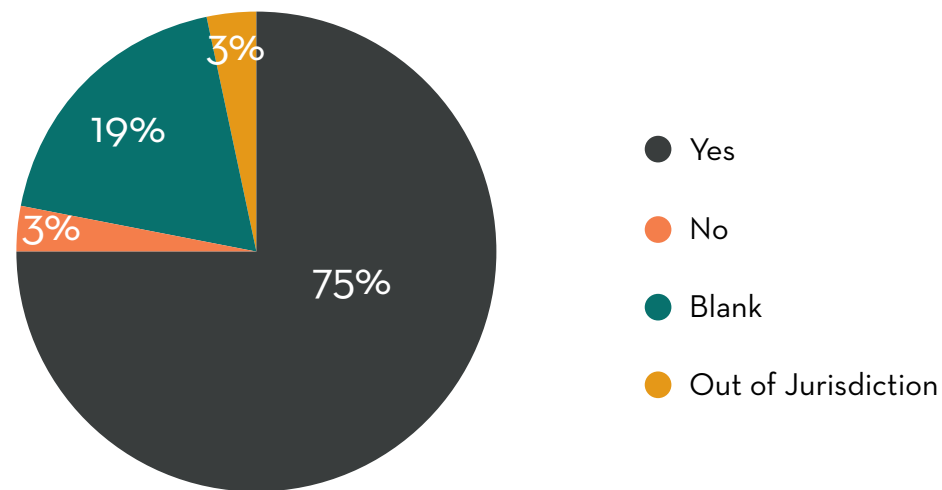


FIGURE 4: DECEDENT AGES (MINUTES, HOURS AND DAYS) AT BIRTH



Twenty-three (70%) male and ten (30%) female infant decedents were included in this statistical review. Of these, seventy-nine percent (79%) of decedents were Black. Wards 4 and 7 comprised the highest number of decedent deaths which accounted for 54% of the decedents reviewed in this sample. Seventy-six percent (76%) of decedents were born as a singleton pregnancy and twenty-one percent (21%) were born as a twin pregnancy³. The largest number of decedents, thirty-six percent (36%), lived between 1-27 days with an average number of seven (7) days lived. There was thirty percent (30%) of decedents who lived between 1-15 hours with an average of three (3) hours lived. Lastly, there was thirty-three percent (33%) of decedents who lived between 1 and 47 minutes with an average of 21 minutes lived.

FIGURE 5: ACCESSED PRENATAL CARE



³ One decedent's birth plurality was unknown due being born out of the jurisdiction and their vital statistics were not available for review. Of note, there was only one set of twins who died simultaneously and are captured in this statistical review. The other decedents identified as twins were one of a set of twins, one of whom died and one of whom survived.

FIGURE 6: FIRST RECORDED PRENATAL CARE VISIT FOR THIS PREGNANCY

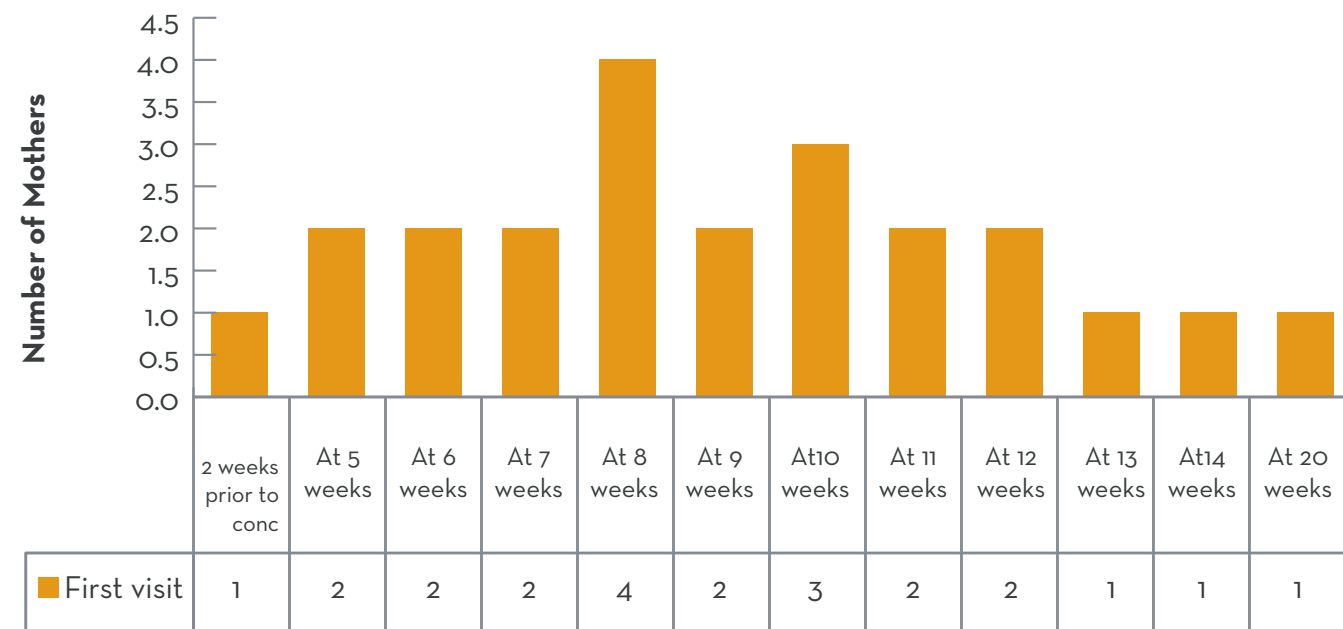


TABLE 2: DECEDENT BIRTH WEIGHT

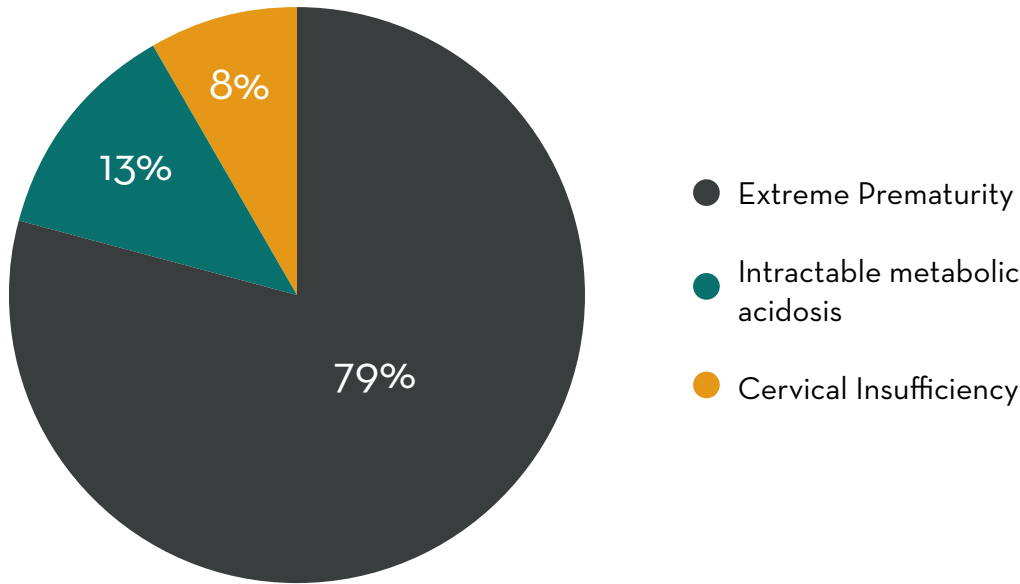
Gestational Age	Number of Decedents	Birth Weight (Range)	Sample Average Weight	Expected birth weight for gestational age
18 weeks	1	170 grams	170 grams	190 grams
19 weeks	2	227 grams	227 grams	240 grams
20 weeks	6	227 - 425 grams	322 grams	300 grams
21 weeks	4	312-425 grams	369 grams	360 grams
22 weeks	5	340-624 grams	459 grams	430 grams
23 weeks	8	482-680 grams	567 grams	501 grams
24 weeks	4	324-765 grams	528 grams	600 grams
25 weeks	1	539 grams	539 grams	660 grams
26 weeks	1	737 grams	737 grams	760 grams

There were no first or third trimester births that occurred in this sample. All of the births occurred during the second trimester with an average gestational age of 22 weeks.

Seventy-five percent (24, 75%) of mothers received prenatal care. Of the mothers with a first prenatal care visit recorded on the certificate of live birth, forty-six percent (11, 46%) attended their first prenatal visit on or before their 8th week of pregnancy.⁴

All of the decedents in this statistical review weighed 1,000 grams or less with a range of 170 grams – 737 grams and an average of 435 grams. These birth weights fall within the Extremely Low Birth weight category. Overall, the majority of decedents weighed less than the expected birth weight for gestational age .

FIGURE 7: TOP THREE CONDITIONS LEADING TO CAUSE OF DEATH (PART B)AS INDICATED ON CERTIFICATE OF LIVE BIRTH



Forty-five percent (15, 45%) of decedents in this statistical review died of disorders related to short gestation and low birth weight. Other respiratory conditions originating in the perinatal period accounted for the deaths of thirty-six percent (12, 36%) of decedents, and was the second highest cause of death.

Cardiac arrest/failure of newborn accounted for six percent (2, 6%) or the third highest cause of death.

Extreme prematurity was the top condition leading to the cause of death and intractable metabolic acidosis and cervical insufficiency were almost equal contributors to the leading causes of death.

⁴ Source: <https://www.babycenter.com/average-fetal-length-weight-chart>
Data from the birth/death certificate did not include occurrence of visits or whether the prenatal care visits were in alignment with the ACOG recommended guidelines for routine prenatal care.

FIGURE 8: DECEDENT APGAR SCORE AT 1 MINUTE

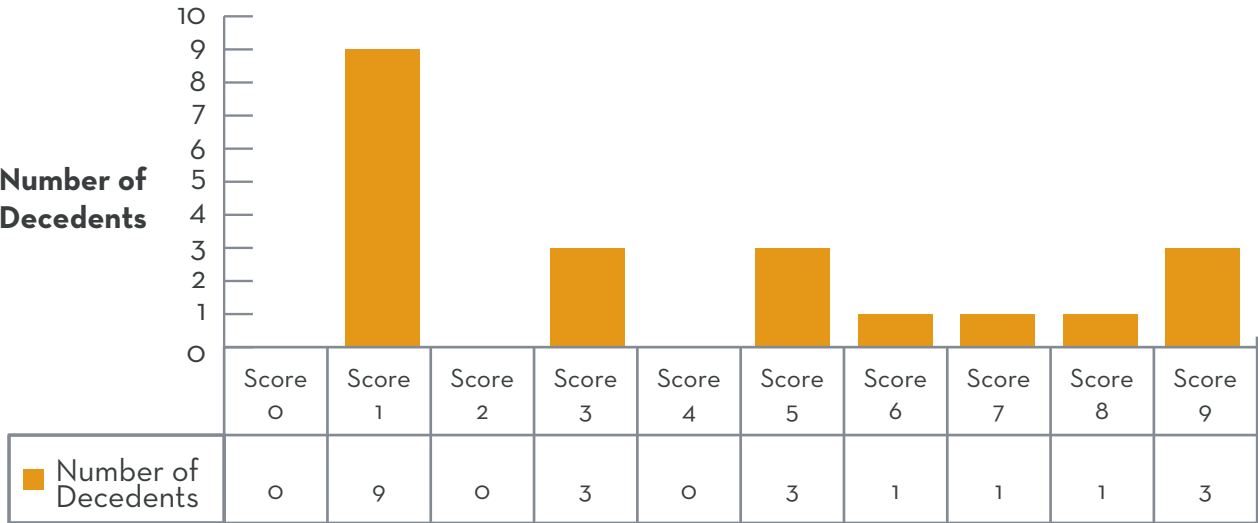


FIGURE 9: DECEDENT APGAR SCORE AT 5 MINUTES

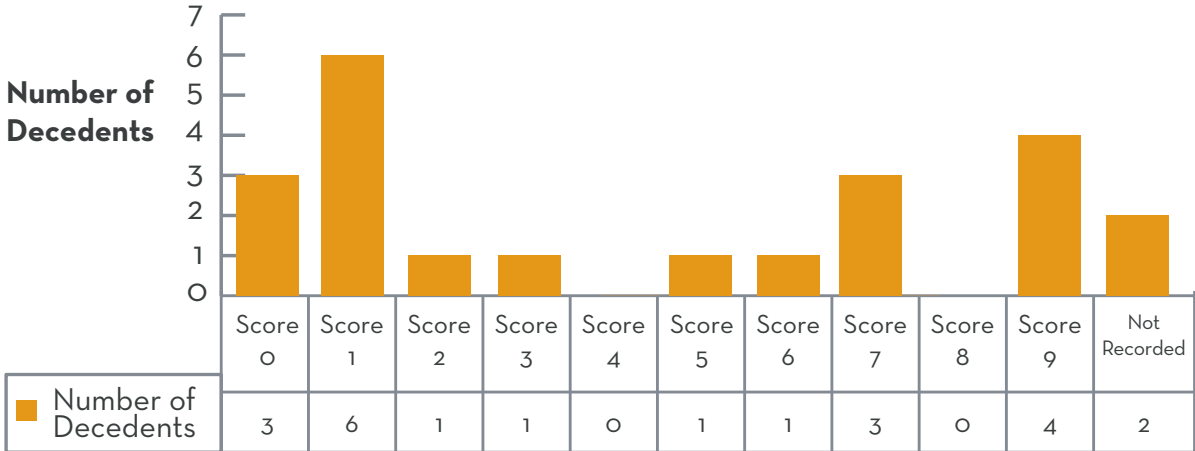
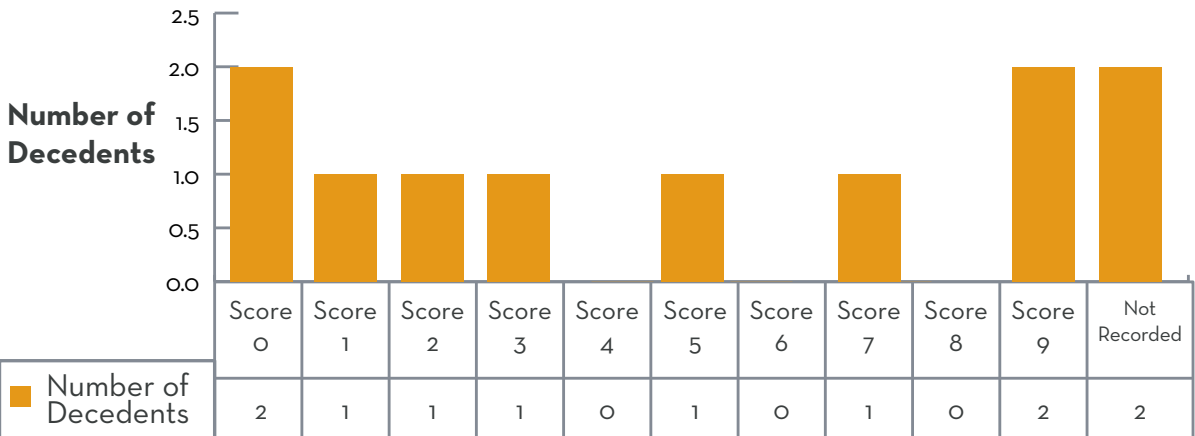


FIGURE 10: DECEDENT APGAR SCORE AT 10 MINUTES



The majority of decedents, seventy-three percent (24, 73%) were delivered by spontaneous vaginal delivery. Twenty-four percent (8, 24%) of decedents were delivered by Cesarean section. There were no vaginal/forceps or vaginal/vacuum deliveries noted.

Of the APGAR scores recorded at 1 minute, forty-three percent of decedents (9, 43%) had an APGAR score of one at one (1) minute indicating they did not tolerate the birthing process well. The majority of the decedent's scores either deteriorated or showed slight improvement at five (5) and ten (10) minutes.

Eighty-two percent (27, 82%) of decedents were not breastfed at the time of discharge. Fifteen percent (5, 15%) of decedents were breastfed at the time of discharge; most having moved to the NICU.

IMRT members believed adding additional information on the birth certificate to include the

distinction between a mother having and being able to express breast milk and the infant being able to receive breast milk was important.

Of the abnormal conditions of the newborn listed on the certificate of live birth, fifty-eight percent (19, 58%) of decedents did not have any abnormal conditions indicated. Twenty-four percent (8, 24%) of decedents required assisted ventilation immediately following delivery. Thirty-three percent (11, 33%) of decedents had a NICU admission immediately following their birth and twelve percent (4, 12%) received antibiotics to rule out neonatal sepsis.

The majority of decedents, ninety-one percent (30, 91%) did not have any congenital anomalies listed on their certificate of live birth. Three percent (1, 3%) of decedents had multiple congenital anomalies indicated, and three percent (1, 3%) of decedents did not have any information recorded.

» Maternal Information And Risk Factors

FIGURE 11: MATERNAL AGE

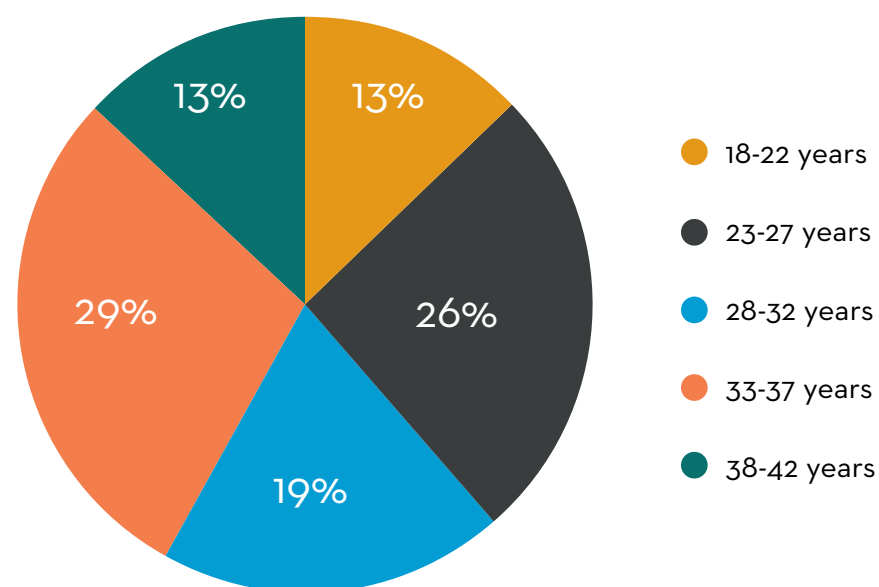
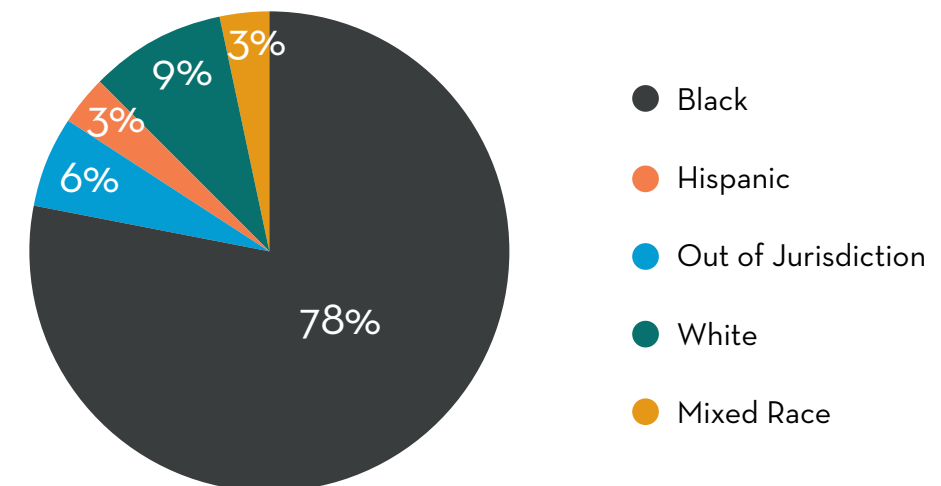
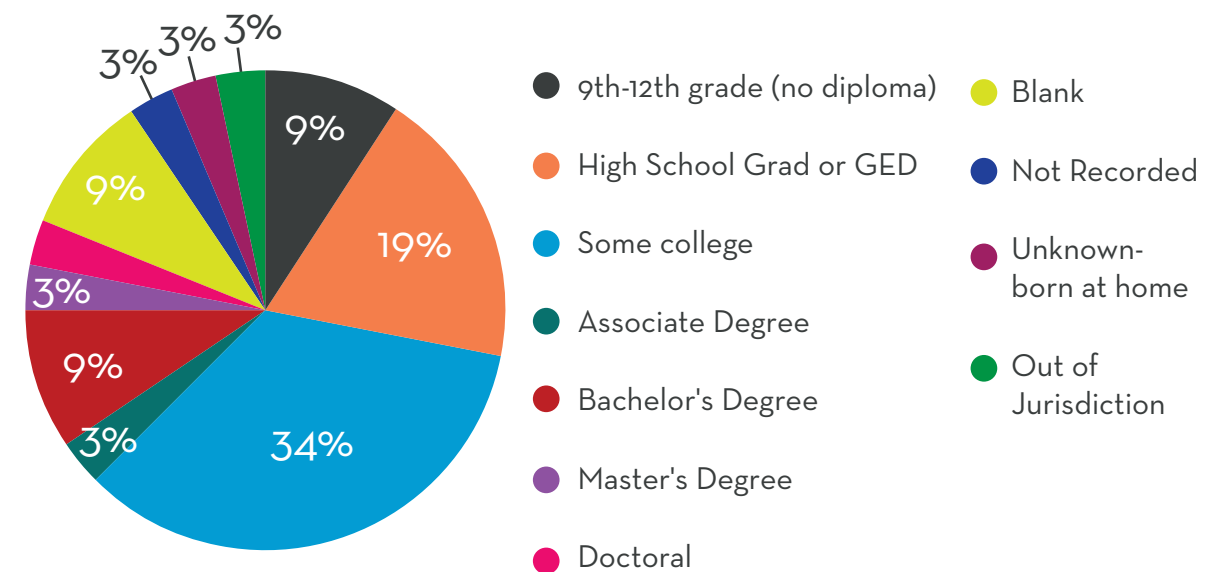


FIGURE 12: MATERNAL RACE



Sixty-four percent (23, 64%) of mothers whose infants' cases were reviewed in this cluster were between 23-27 years of age at the time of the decedent's birth with an average age of 30 years old. Seventy-eight percent (25, 78%) of the mothers were Black.

FIGURE 13: MATERNAL LEVEL OF EDUCATION



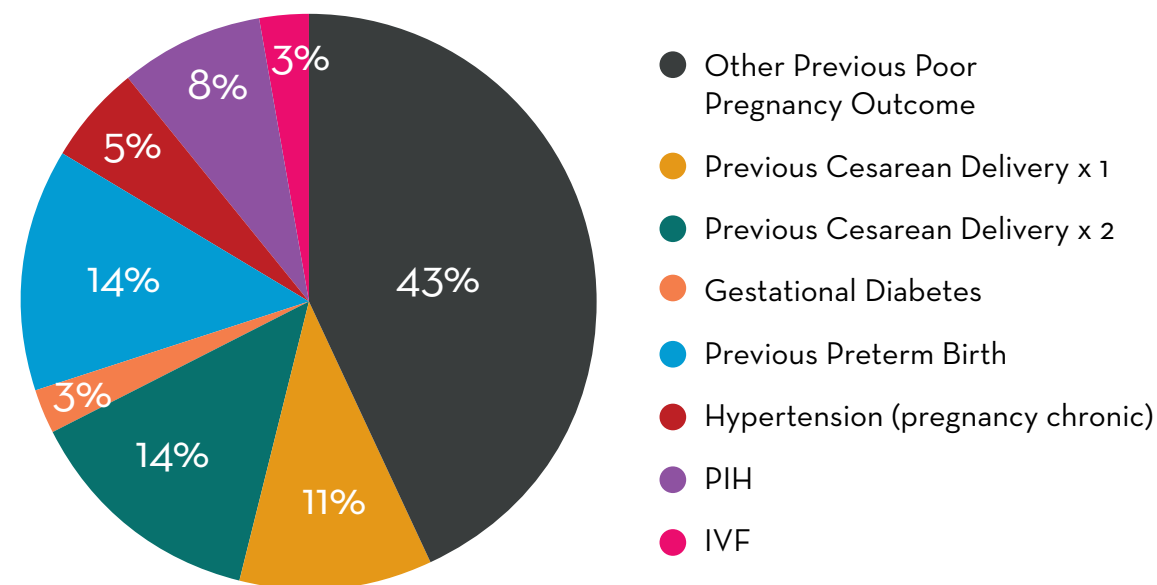
Case reviews identified that seventy-two percent (23, 72%) of mothers whose infants reviewed in this statistical review completed their high school education with an additional twenty-two percent (5, 22%) combined completing a Bachelor's, Master's or Doctoral Degree. Seventy-five percent (24, 75%) of mothers were not married or in a registered domestic partnership at the time the decedent was conceived, at the time of birth, or at any time between conception and giving birth. DC Medicaid insured sixty-six percent (21, 66%) of mother's in this statistical review.

Of the cases reviewed, the average maternal height of mothers included in this review was 5 feet 2 inches tall with an average pre-pregnancy weight of 173 pounds and BMI of 31.7. Forty-one percent (13, 41%) of mothers did not have any previous live births. The number of previous live births ranged from 0-7. There were forty-one percent (13, 41%) of mothers who did not have any other living children. The number of other living children ranged from 0-7. Ninety-four percent (29, 94%) of mothers did not have any deceased children and six percent (2, 6%) had one (1) deceased child.

When looking specifically at the number of spontaneous or induced losses or ectopic pregnancies mothers had experienced with previous pregnancies, forty-four percent (14, 44%) of mothers reported experiencing no previous induced losses or ectopic pregnancies. Nineteen percent (6, 19%) of mothers reported experiencing one (1) previous induced loss or ectopic pregnancy. Sixteen percent (5, 16%) of mothers reported experiencing two (2) previous induced losses or ectopic pregnancies while eighteen percent (3, 18%) of mothers reported experiencing three (3) or more such losses.

» Risk Factors

FIGURE 14: MATERNAL PREGNANCY RISK FACTORS



Of the cases reviewed, the greatest number of pregnancy risk factors for mothers was in the “other previous poor pregnancy outcome” category. Mother’s experiencing “other previous poor pregnancy outcomes” accounted for forty-three percent (16, 43%) of pregnancy risk factors.

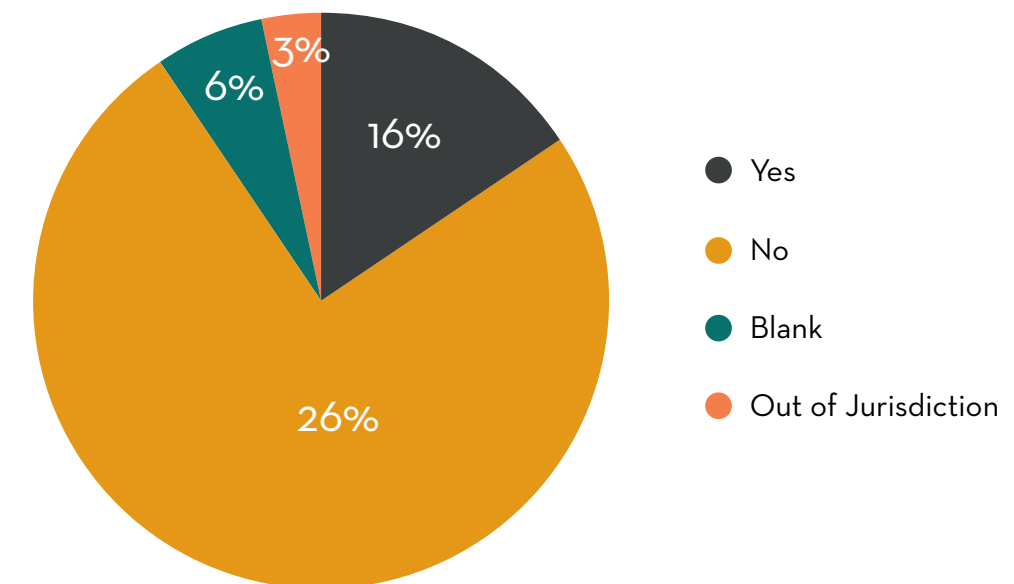
Other risk factors included previous Caesarean deliveries, previous preterm-births, gestational diabetes and chronic hypertension. Sixty-three percent (20, 63%) of mothers did not experience any pregnancy risk factors. Eighty-one percent (26, 81%) of mothers did not have any infections present or treated during their pregnancy and three percent each (1, 3%) had a diagnosis of HIV and chlamydia respectively. Eighty-four percent of mothers (27, 84%) indicated they did not smoke cigarettes prior to or during their pregnancy. Nine percent (three percent each respectively) reported smoking cigarettes 3 months prior to their pregnancy, prior to and during the first three months or their pregnancy and prior to and during their pregnancy.

TABLE 3: MATERNAL CHARACTERISTICS OF LABOR AND DELIVERY

Characteristics of Labor and Delivery	Number of Affected Mothers
Antibiotics used by mother	1
MAC	1
Out of Jurisdiction	1
Induction of labor	2
Epidural or spinal anesthesia during labor	6
Steroids for fetal lung maturation received by mother prior to delivery	8
None	13
Total	32

Forty-one percent (13, 41%) of mothers did not exhibit any characteristics of labor and delivery. Steroids for fetal lung maturation received by the mother prior to delivery was the most frequently reported characteristic of labor and delivery and accounted for twenty-five percent (8, 25%) of mothers.

FIGURE 15: WOMEN, INFANT AND CHILDREN (WIC) PARTICIPATION



Seventy-five percent (24, 75%) of mothers did not receive Women, Infants and Children (WIC) services for themselves for this pregnancy and sixteen percent (5, 16%) of mothers were receiving WIC. Six percent (2, 6%) of decedents did not have any information recorded for this question on the certificate

of live birth, and three percent of decedents did not have any information available due to their birth taking place out of the jurisdiction. The IMRT noted the low WIC enrollment rate despite a high WIC eligibility rate. It was suggested that WIC and TANF sites collaborating more or being colocated in the District such that increases in the WIC utilization rates occur is optimal. Further data and research in this area was also suggested.

» Paternal Information

FIGURE 16: PATERNAL AGE

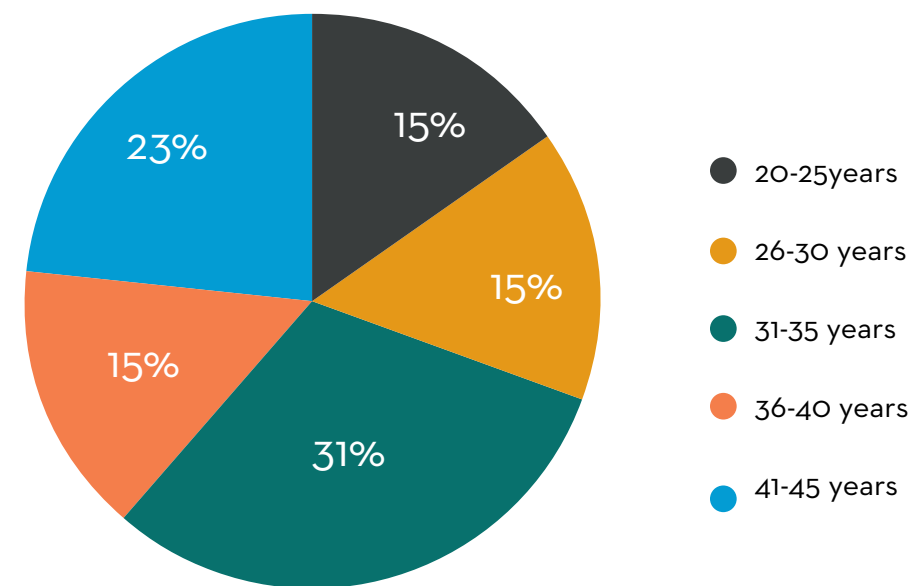


FIGURE 17 PATERNAL RACE

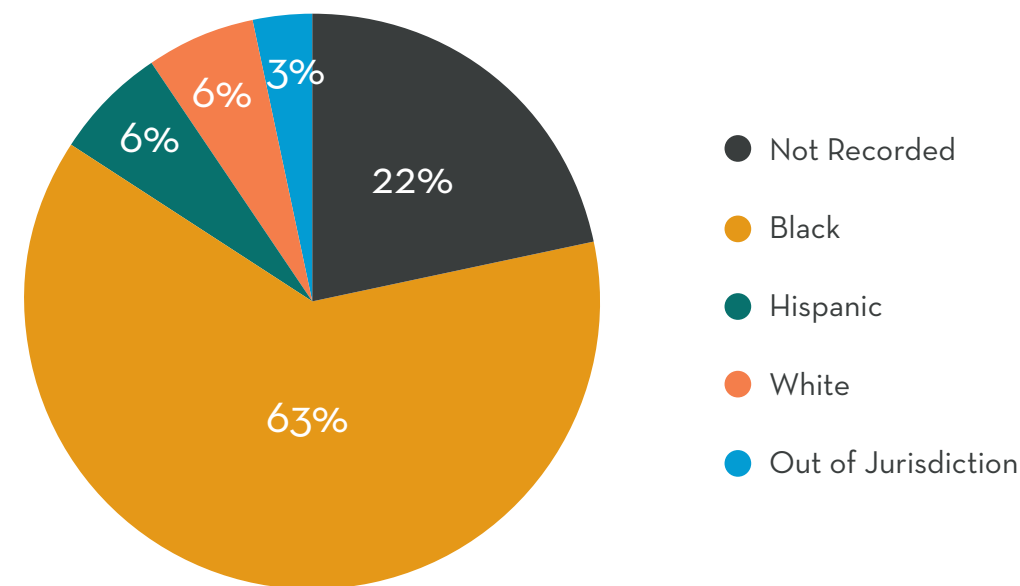
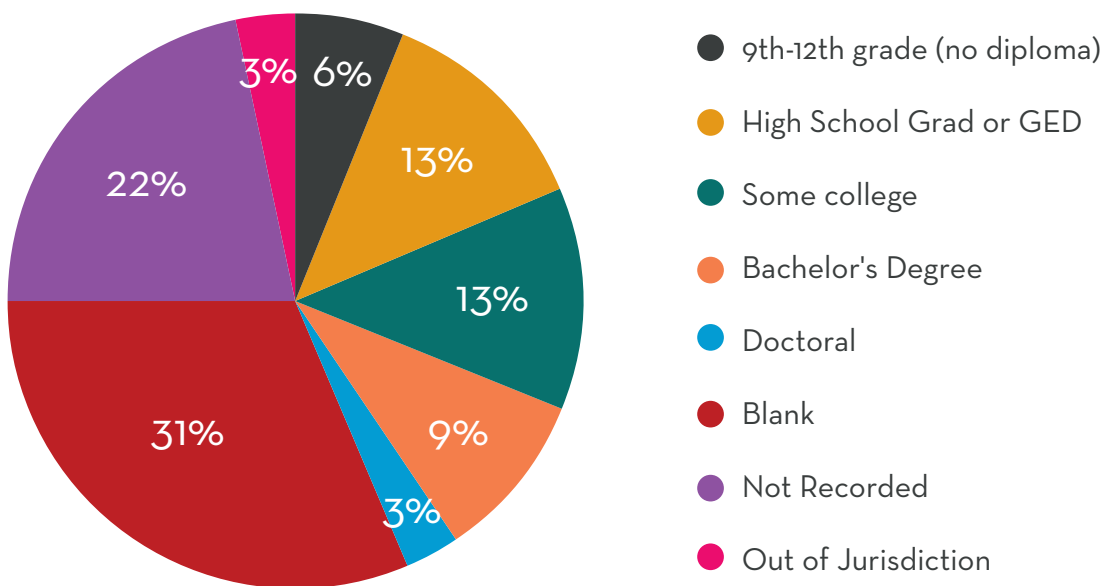


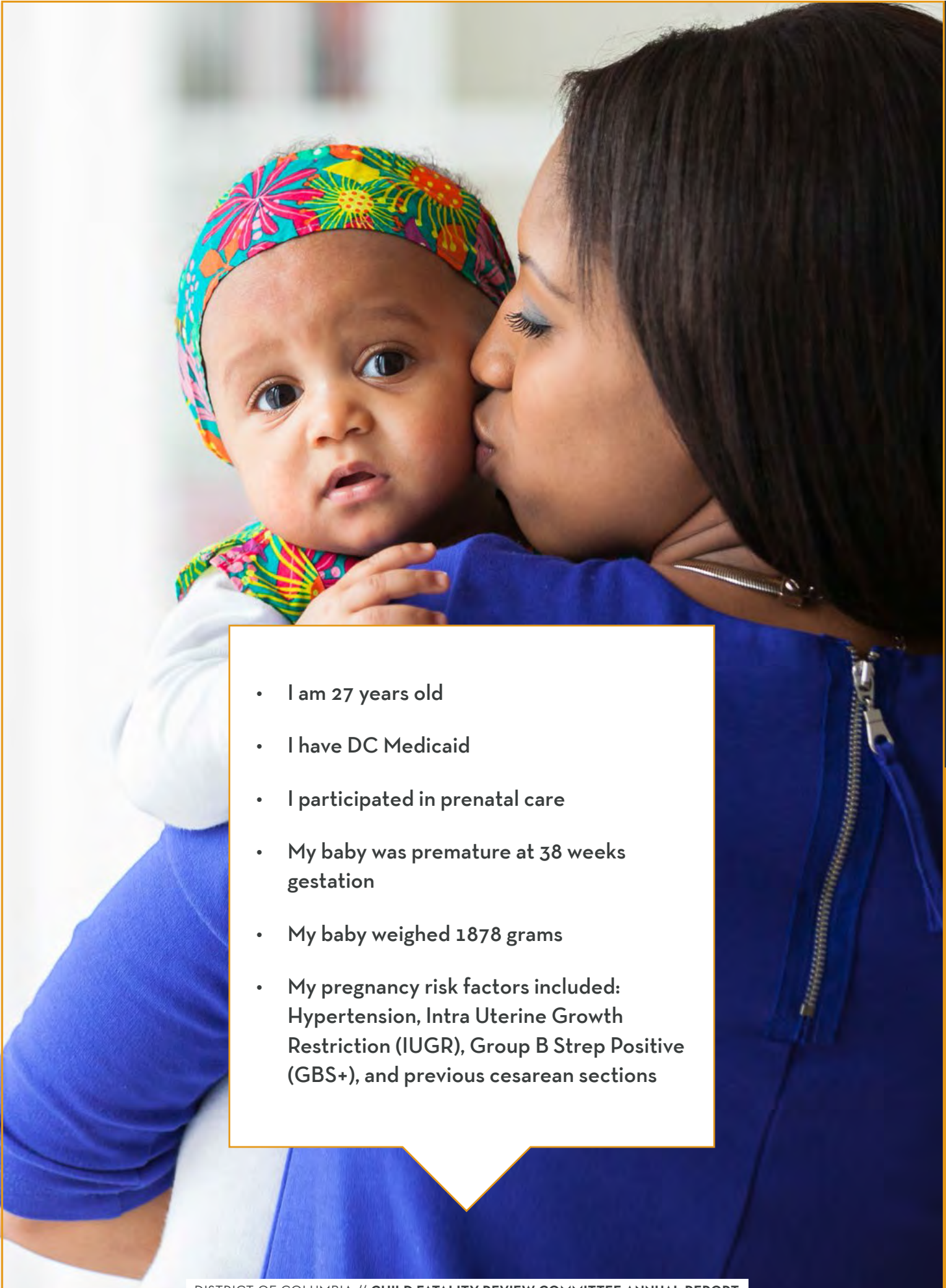
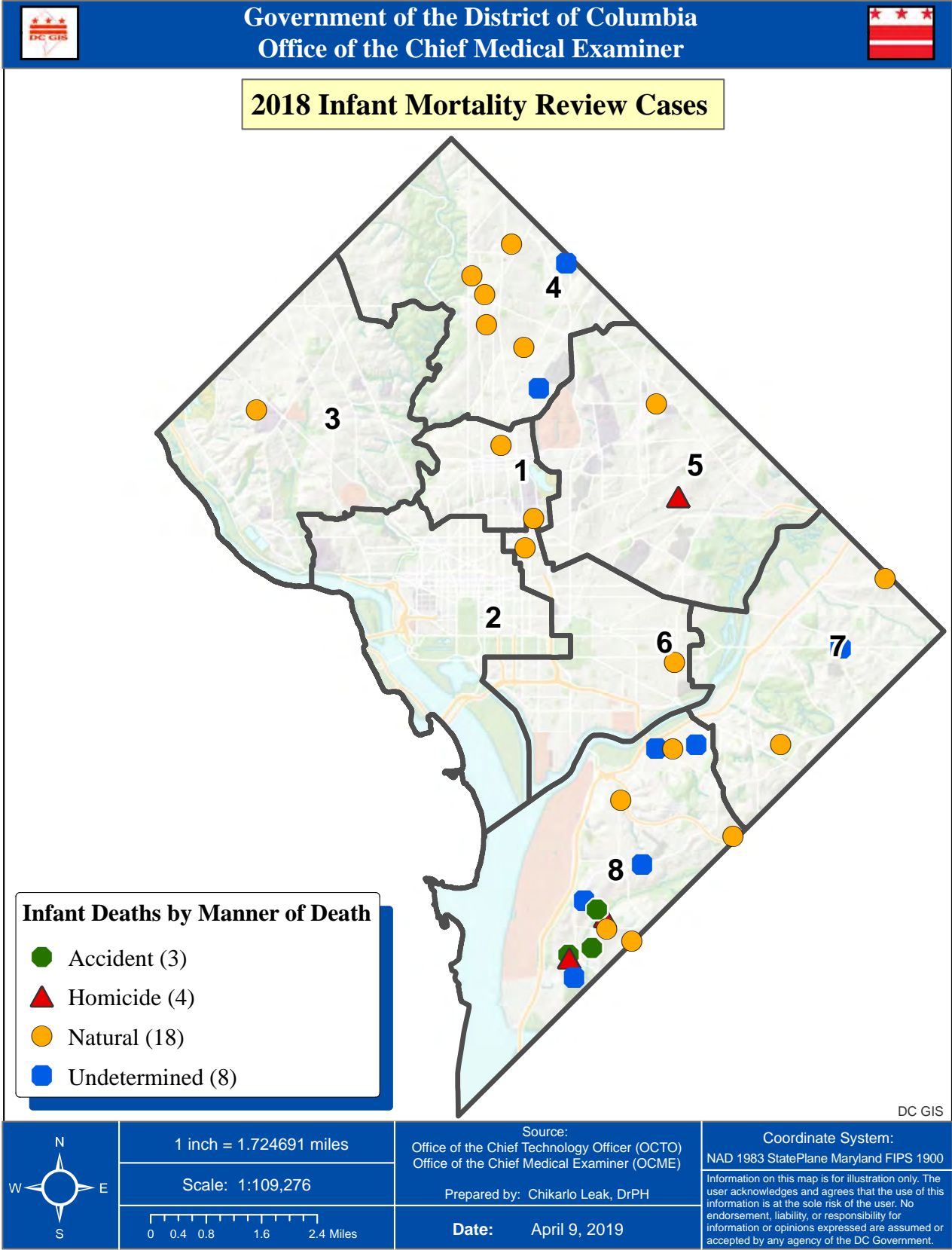
FIGURE 18: PATERNAL LEVEL OF EDUCATION



The average age of fathers of decedents who were reviewed as part of this statistical review was 35 years old with sixty-three percent (20, 63%) of father's being Black. Twenty-two percent (7, 22%) of the father's level of educational was indicated as being not recorded and thirty-one percent (10, 31%) was blank on the certificate of live birth. Six percent (2, 6%) of father's had attended school during their 9th - 12th grade years but did not obtain a diploma. Thirteen percent (4, 13%) had attained a high school diploma but did not further their education. An additional nine percent (3, 9%) of father's had attained their Bachelor's Degree and three percent (1, 3%) of father's obtained their Doctoral or Professional degree.

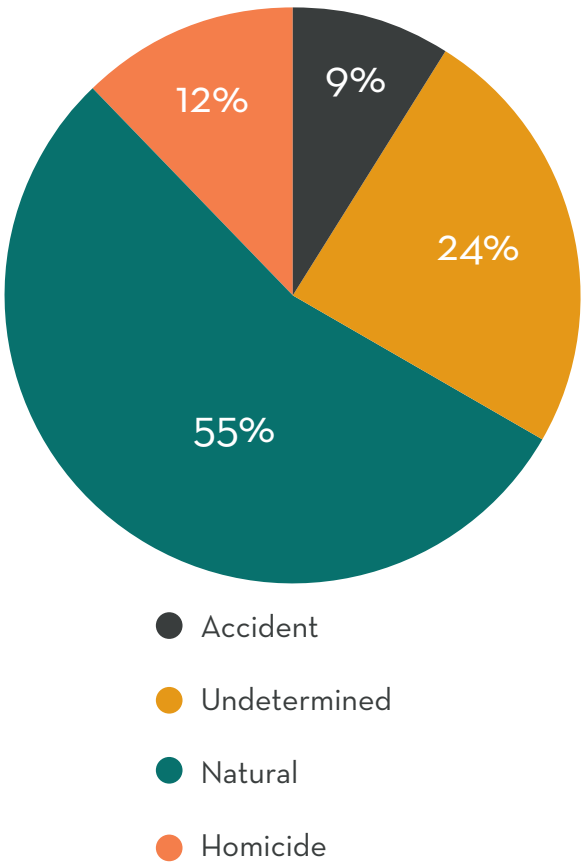


MAP OF IMRT DECEDENTS - FULL CASE REVIEW FINDINGS



- I am 27 years old
- I have DC Medicaid
- I participated in prenatal care
- My baby was premature at 38 weeks gestation
- My baby weighed 1878 grams
- My pregnancy risk factors included: Hypertension, Intra Uterine Growth Restriction (IUGR), Group B Strep Positive (GBS+), and previous cesarean sections

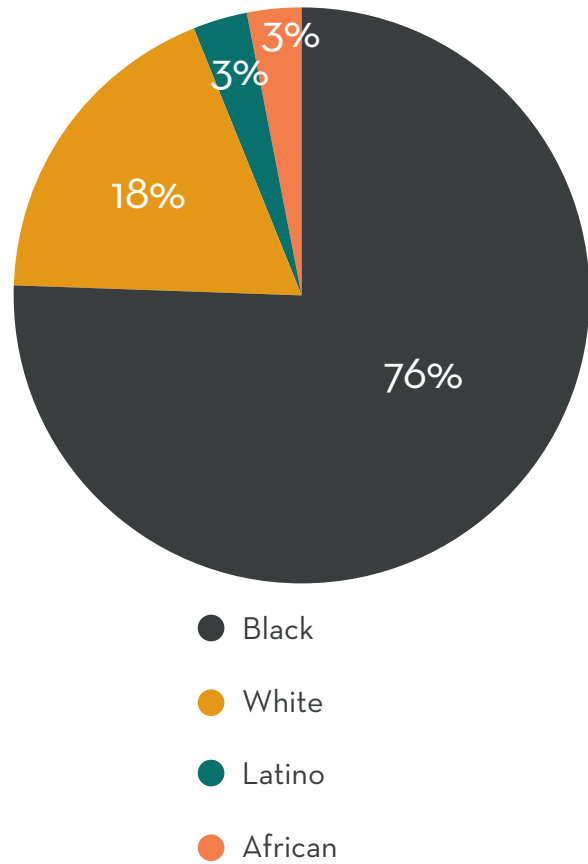
FIGURE 19: DECEDENT CAUSE OF DEATH



The Infant Mortality Review Team (IMRT) is tasked with the systemic review of all infant fatalities (<365 days and younger) who are residents of the District of Columbia. During the 2018 review year, the IMRT met every month (12 times) and completed a full multidisciplinary review of 33 cases. Most of the decedent’s died of natural deaths (18, 55%) and undetermined (8, 24%). Four deaths were the result of fatal abuse homicides.³²

Adverse childhood experiences and the impact the social determinants of health can translate to poor outcomes for infants and children were discussed during meetings. The social determinants of health are conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. Conditions (e.g., social, economic, and physical) in these various environments and settings (e.g., school, church, workplace, and neighborhood) have been referred to as “place.” In addition to the more material attributes of “place,” the patterns of social engagement and sense of security and well-being are also affected by where people live. Resources that enhance quality of life can have a significant influence on population health outcomes. Examples of these resources include safe and affordable housing, access to education, public safety, availability of healthy foods, local emergency/health services, and

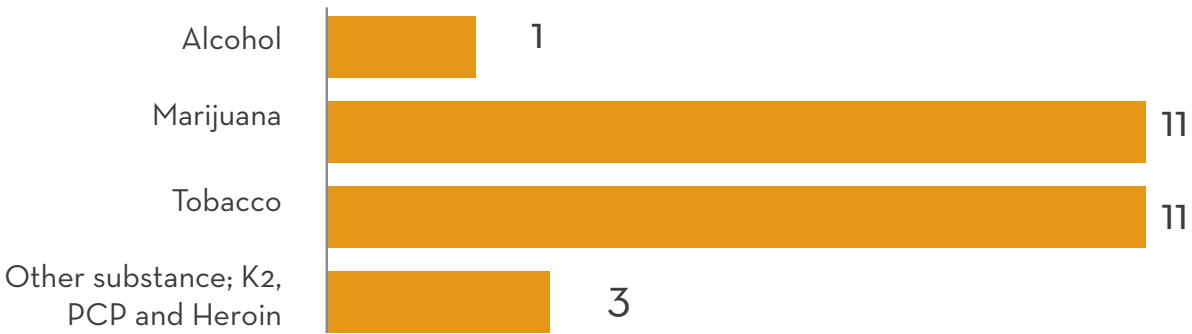
FIGURE 20: DECEDENT ETHNICITY



environments free of life-threatening toxins.⁵ The experiences of household dysfunction have been studied and in order to improve the stress experienced by mothers, systems and services should implement protective measures to counterbalance the trauma that has been previously experienced. A trauma informed lens should be active in programs that serve families helping to improve the poor outcomes associated with these experiences.⁶

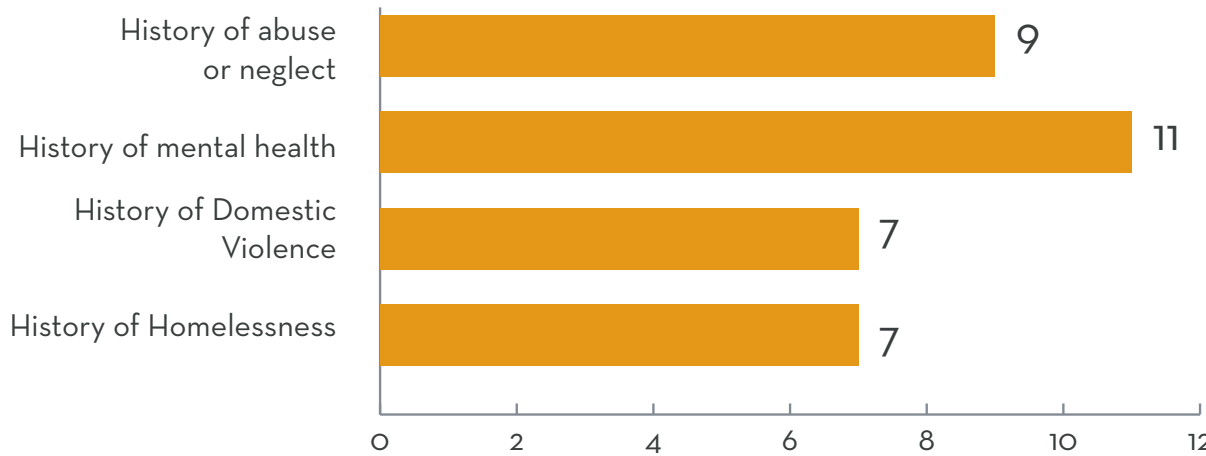
» Maternal Risks

FIGURE 21: MATERNAL SUBSTANCE USE



During case reviews, the IMRT observed several systemic trends that traversed a majority of the cases reviewed. In the three accidental fatalities, which had an asphyxia component, the decedent’s caregiver used either PCP or marijuana. In three out of the four homicide fatalities the decedent’s caregivers used either PCP or marijuana and in three out of the eight undetermined fatalities, the decedent’s caregivers used K2, Heroin or marijuana. In thirteen (13, 40%) of the 33 fatalities reviewed, caregivers admitted to using an illicit substance at the time of the fatality.

FIGURE 23: MATERNAL ENVIRONMENTAL RISK FACTORS



⁵ <https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health>
⁶ <http://www.astho.org/StatePublicHealth/Social-Determinants-of-Health-and-Infant-Mortality-Policies-and-Programs-to-Reduce-Exposures-of-Disadvantaged-People-to-Health-Damaging-Factors/Part-Two/10-25-16/>

Of the pregnant women insured by Medicaid, fourteen families were enrolled in a Medicaid Managed Care Organization (MCO) to receive their health care services and eight families were in Medicaid Fee-for-Service (FFS). Eight families were noted to have no health insurance coverage. Health Insurance coverage and the need for families to have access to a care coordinator or case manager arose repeatedly during the monthly fatality review meetings.

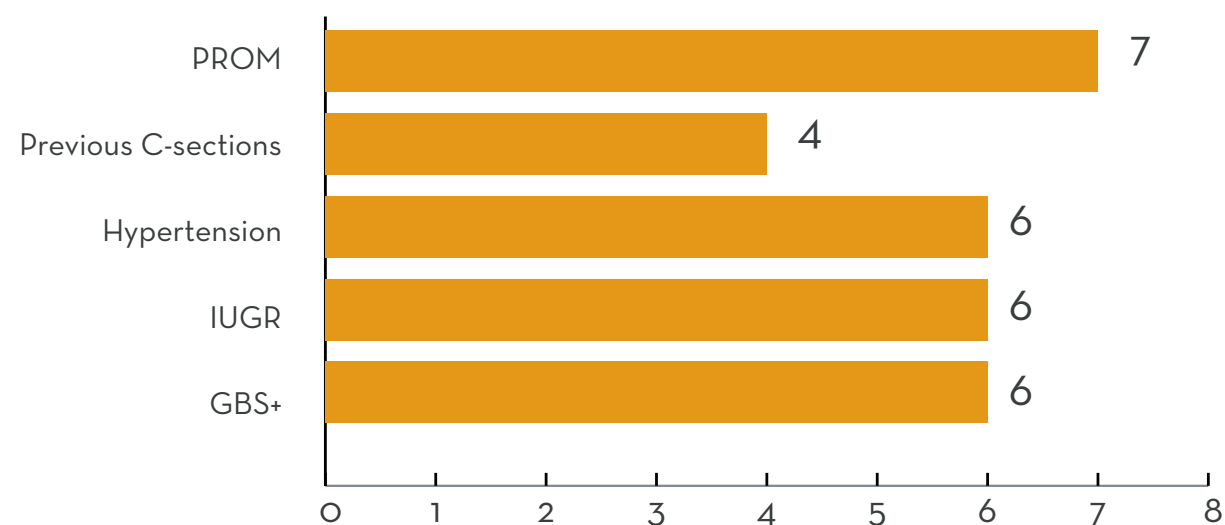
Ward 8 experienced the highest number of reviewed fatalities (16, 48%). Six of the fatalities were classified as Natural and five as Undetermined. Seven of the 16 deaths had an unsafe sleep environment component.

Mother's in Ward 8 had extensive maternal health complications to include; hypertension (6, 38%) and mental health disorders (4, 25%). Six (6, 38%) of the decedent's mothers had a history of domestic violence and ten percent (10, 63%), received services from the Department of Human Services (DHS).

» Medical care and treatment of mothers

The IMRT noted pre-pregnancy and post-natal counseling was not recorded in over half of the cases reviewed. The IMRT indicated that women of child bearing age should receive comprehensive education and counseling concerning the impact that their life choices have on sustaining a healthy full-term (>38week gestation) pregnancy. Obesity, substance use and preterm birth, were observed in over 50% of the cases reviewed. The IMRT noted that mothers did not have a medical moment to discuss their reproductive life and receive supportive health services (peer counseling, genetic counseling, mental health assessments, nutritional counseling). Three (3) cases revealed mothers who had experienced a fetal demise, or who had a history of intellectual disabilities. These women could have benefitted from a more robust discussion of the causes and potential outcomes for their infants, which would have warranted them being followed early by a maternal fetal medicine specialist.

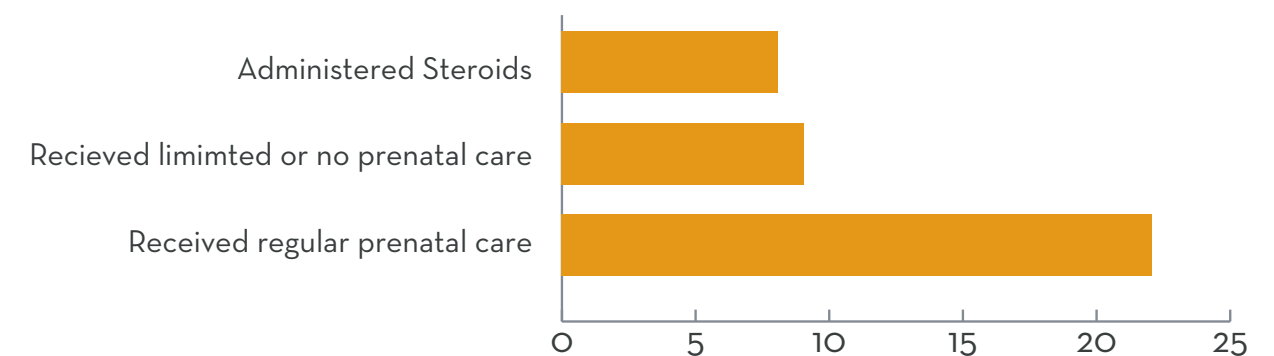
FIGURE 24: MATERNAL HEALTH RISK FACTORS



The IMRT highlighted the importance of the maternal interviewer in addressing the decisions made by families around the access to benefits and the economic and social constraints as it related to mother's non-compliance or poor use of medical services.

In 11 of the meetings, the importance of having a medical home to address fundamental concerns prior to becoming pregnant was discussed. Making routine medical care a part of the mother's life was emphasized as a mechanism to improve health literacy and trust between patients and the medical community. Although the IMRT observed that birth spacing and the associated risks were important factors to discuss and document in the medical records, it was noted that the maternal health screen was not adequately reimbursed for the providers, perhaps limiting the time spent on this protocol.

FIGURE 25: MATERNAL HEALTH CARE



The IMRT recognized that there may be barriers to obtaining this level of care: transportation, quality providers, time management or just being overwhelmed with the activities of daily living.

The IMRT championed the mother's need for medical advocates who have a sense of cultural humility to help navigate systems of care in a respectful and supportive way.

The IMRT continues to advocate that comprehensive care coordination and or case management services be provided and offered to all recipients of Medicaid Health Insurance, not just those enrolled in a managed care organization (MCO). It was noted that care coordination/case management is not authorized for all Medicaid recipients. The IMRT strongly requested that this gap be addressed and a creative solution be investigated to overcome what is observed as a necessary service for those individuals who have limited health literacy and who are hindered by the social determinants of health impacting their existence.

» Safe Sleep Environments

The National Institutes of Child Health and Human Development recommend that infants 1 year and younger be placed Alone, on their Backs, in a Crib in a Smoke free environment (ABC'S) as it is proven to decrease the incidence of suffocation or asphyxia in a child. Unintentional suffocation is the leading cause of injury death among infants under 1 year old in the United States. In a report in Pediatrics, CDC scientists and colleagues investigated infant suffocation deaths in CDC's Sudden Unexpected Infant Death (SUID) Case Registry from 2011 through 2014. It was found, in the CDC registry, that most

explained infant suffocation deaths (69%) were attributable to soft bedding like a blanket or a pillow.⁷ In 2018 the IMRT reviewed ten cases with an unsafe sleep component compared to six cases in 2017.

The IMRT noted that the messaging provided to caregivers regarding safe sleep environments can be lost between the first and sixth month(s) of life. Some infants may only return to their primary care providers once in this time frame for immunizations, unless they are ill⁸. It was also noted that infants might also miss regular pediatric appointments during this time frame if there are no perceived issues. The IMRT discussed the possibility of providing home visits for Medicaid recipients from their medical home at the second and third month mark to assess the sleep environment. It was also observed that in most of the fatalities where unsafe-sleep was a contributory cause, the caregivers knew what was needed to create a safe sleep environment, but chose not to provide a safe sleeping environment for the infant. Eight of the 10 cases reviewed with an unsafe sleep component had at least one crib, bassinet or other AAP approved sleep resource in the home at the time of the fatality. The IMRT felt that safe sleep education and feeding instructions for infants at the time of discharge from the hospital should be standardized. The IMRT also indicated that the standardized safe sleep training should be provided to all potential caregivers and not only mothers.

The IMRT observed that in the 2018 review of cases, where unsafe sleep was a contributory cause, the fatalities were functionally premature infants, with the risk factors of immature gasp reflex, excess carbon dioxide in the environment of a fragile infant and exposure to smoke environments.

The OCME in conjunction with DC Health –Safe Sleep are conducting joint observations of the training provided to individuals, child care employees, MCO's and District Agencies that work with families to assess the delivery of safe sleep information and the synthesis of the information. This collaboration is the precursor to the development of a robust safe sleep campaign that addresses the need for meaningful and effective resources for families as they create sleep environments that are safe and healthy for their children.

» Preterm Discharge Protocols Subcommittee

The IMRT is committed to improving health outcomes and life expectancy for infants in the District of Columbia. To that end, sub-committee work groups were implemented to address areas of concern that have been observed during the review of fatalities. One workgroup was dedicated to developing protocols to improve outcomes for preterm infants. The workgroup developed suggested protocols that could be implemented large or in part by hospitals and shared with qualified medical institutions. This resulted in the creation of a “Infant Mortality Review Committee Recommended Protocols For Discharge of a Preterm Infant” document (see X).⁹

⁷ <https://www.cdc.gov/sids/index.htm>

⁸ Although the American Academy of Pediatrics recommends 6 well-child visits to have occurred between the first week of life and six months of age.

⁹ The IMRT includes this information in the 2018 CFRC Annual Report for informational and discussion purposes. This workgroup comprised of Pediatricians, Neonatologist, Nurse Practitioners, Public Health Professionals and Health Care Finance Analysts reviewed current AAP and ACOG documents to help inform the dialogue and ultimately the finished product.

» Recommended Protocols For Discharge Of A Preterm Infant

I. PURPOSE:

Preterm neonates usually require a lengthy birth hospitalization. They remain at increased risk for morbidity and mortality following discharge from the neonatal intensive care unit (NICU). Their discharge may require technological support, compounded by complicated family dynamics, or an irreversible condition that may result in early death.

Comprehensive discharge planning is required to minimize their risk of morbidity and mortality. Shared information and resources will facilitate the coordination of care of premature infants and improve their outcomes. Improvement in the quality and continuity of follow-up care for premature infants after hospital discharge is paramount.

II. SCOPE:

- A. For premature newborns born before 37 weeks of post menstrual age (PMA).
- B. Discharge Protocol: A guideline that establishes and standardizes improved communication between hospital professionals discharging preterm infants to pediatric primary care providers (PCP) who will care for the infant in an out-patient setting. Protocols will be reviewed and updated annually by the Child Fatality Review Committee (CFRC) - Infant Mortality Review Team (IMRT), within the Office of the Chief Medical Examiner (OCME).

III. RECOMMENDED PROTOCOL:

1. The readiness for DISCHARGE of a premature infant is established by professional guidelines, (as referenced in the selection below) using a coordinated multidisciplinary approach. Discharge components should include:
 - a. Appropriate documentation (i.e. a complete discharge summary) should be provided to all parties (TBD) involved in the care of the infant in the out-patient setting, prior to initial appointments.
 - b. Parental education, to include breastfeeding/lactation support, aspiration precautions related to appropriate feeding, CPR and safe sleep instruction.
 - c. Apnea monitor, if required necessary with training and demonstrated competency for using it by parent.
 - d. Training and use of Durable Medical Equipment (DME)
 - e. Specific planning and scheduling of primary care and specialist appointments.
 - f. Consideration of Nurse Home Health Visits (NHV). A nurse home visit is essential for all who have high-risk medical, psychosocial and/or socioeconomic situations or receive any social service programs such as WIC or Medicaid.

2. Communication of all discharging parameters should be forwarded to the accepting pediatric primary care provider prior to the first appointment, at time of discharge. At a minimum the following should be provided:
 - a. A complete summary of the infant's hospital stay.
 - b. Maternal prenatal labs, labor and delivery summary and infant screenings (CCHD, Hearing screen, Hepatitis B vaccination (and HBIG- to include indication).
 - c. All pertinent labs, including newborn metabolic screen.
 - d. Car seat safety test
 - e. Infant's feeding plan, including any needs for lactation support.
 - f. Medications
 - g. Plans for NHV and durable medical equipment, such as apnea monitors and expected duration of need, should be documented.
 - h. Discharge summary should be submitted as a written transmittal via secured FAX/email communication is preferred, to include a confirmation of receipt of this document.
3. Nurse Home Health Visits (NHV) should be coordinated for all infants who would benefit. An initial visit should occur within 48-72 hours following discharge, intermittent of (or with) the initial outpatient provider visit.
 - a. For those infants with high risk medical condition(s) at the time of discharge, a NHV is needed. NHVs should continue until the infant reaches 40 weeks of post menstrual age (PMA). Specific instructions should be written by the discharging provider and will include the contact information of the out-patient pediatric provider who will care for the infant.
 - b. The NHV agency shall provide updates through the duration of the services ordered, to the infant's pediatric provider. NHV should notify infant's pediatric provider immediately if parent does not engage with services.
4. A Follow-up pediatric primary care provider should be secured prior to discharge, and informed of the upcoming initial visit with the premature infant.
 - a. Document insurance coverage for the premature infant, and establish contact with Medicaid Managed Care Organization (MCO) or DHCF for Fee-for-service Medicaid.
 - b. An initial appointment, date and time, should be made prior to discharge (TBD) and should occur within 1-2 days after discharge.
5. All prescribed medications should be procured by the infant's caregivers prior to discharge; to include required training on medication dosage and administration.

6. The accepting pediatric provider should document the presence of the newborn in the office, and should also alert the social worker/case manager of the managed care organization or insurer of the failure of the family to appear for the initial appointment within 5 days of discharge. If the infant misses the initial scheduled appointment and has not been seen by the pediatric provider within 14 days of discharge, the pediatric primary care provider should contact the CFSA Hotline at (202) 671-SAFE (7233) and a report of alleged medical neglect should be made.
7. The **Initial visit** shall be with a **licensed pediatric primary care provider** and should include:
 - a. A communication to the discharging facility to confirm the presence of the infant's arrival to the service and to clarify any discharging orders or recommendations shall be made. This can be done via secured email/FAX.
 - a. A preterm infant, who misses the initial scheduled appointment, should be a **HIGH ALERT** communication to the managed care organization or insurer's case manager/ social worker with attempt(s) to secure another appointment.
 - b. Once a **HIGH ALERT** communication to the managed care organization or insurer's case manager/social worker with attempt(s) to secure another pediatric primary care provider has been initiated, and the infant has not been seen by a pediatric provider after 14 days of a newly scheduled appointment, the CFSA Hotline should be contacted at (202) 671-SAFE (7233) and a report of alleged medical neglect should be made by the person attempting to secure a new appointment.
 - b. Review and documentation of relevant information from the inpatient maternal and infant records, in accordance with standard practice.
 - c. Verification of NHV agency contact information and plan of care to obtain feedback from NHV on all interval visits shall be made and documented.
 - d. Physical exam and assessment of weight, feeding adequacy, growth, jaundice, and any outstanding lab results (including the metabolic screen) and EPSDT visits in accordance with the periodicity schedule.
 - e. Documented communication of discharge-feeding plan to mother and/or father and/or legal guardian and need for additional/close follow up by NHV and pediatric primary care or specialist provider.
 - f. Referral to other professional specialists, from the pediatric primary care provider.
 - g. For infants utilizing other Durable Medical Equipment (DME), an assessment of indication for NHV and duration of monitoring should be reviewed. Specialty clinic should review NHV monitor logs and continued need for home apnea monitoring.

8. The Subsequent visit:

- a. These visits of a premature infant shall be based on best practices and established American Academy of Pediatric guidelines.
- b. Preterm infants should be monitored every two weeks or at the discretion of the pediatric primary care provider for the first four months following discharge **up to at least 40 week post menstrual age** especially, if they are on discharge medication(s)/ devices.
 - 1. Ideally, visits will be alternating weeks to that of the NHV.
- c. Immunization and periodicity schedules should be established;
 - 1. Include infants at risk for RSV during the subsequent RSV season.

» References:

1. American Academy of Pediatrics Committee on, F. and Newborn (2008). "Hospital discharge of the high-risk neonate." *Pediatrics* **122**(5): 1119-1126.
2. Multidisciplinary guidelines for the care of late preterm infants; Journal of Perinatology (2013) 33, S5-S22. The National Perinatal Association.
3. Dennis Z. Kuo, Robert E. Lyle, et al. Care System Redesign for Preterm Children After Discharge From the NICU PEDIATRICS Volume 139, number 4, April 2017; e20162969 [Epub ahead of print].
4. Sherman, MP, Ted Rosenkrantz et al. Follow-up of the NICU Patient- Medscape:<http://emedicine.medscape.com/article/1833812-overview#a3>; Updated: Jan 05, 2016.
5. Enlow E, Faherty LJ et al. **Perspectives of Low Socioeconomic Status Mothers of Premature Infants.** *Pediatrics*. 2017 Feb21. [Epub ahead of print].
6. Tubbs-Cooley, H.L., et al. (2016). "Testing a post-discharge nurse-led transitional home visit in acute care pediatrics: the Hospital-To-Home Outcomes (H2O) study protocol." *J Adv Nurs* 72(4): 915-925.
7. NICHQ.Org. | Toolkit for the Follow-up Care of the Premature Infant: <http://www.nichq.org/childrens-health/infant-health/resources/premature-infant-toolkit>.
8. Toolkit for the Follow-Up Care of the Premature Infant| AHRQ Health Care Innovations Exchange: <https://innovations.ahrq.gov/qualitytools/toolkit-follow-care-premature-infant>.
9. AHRQ- Hospital Medicine, Primary Care Physician Communication with Patients at or Soon After Discharge Significantly Reduces Medication Discrepancies 03/17/1410. [10.www.cdc.gov/vaccines/hcp/acip-recs/index.html](http://www.cdc.gov/vaccines/hcp/acip-recs/index.html).
10. <https://mpdc.dc.gov/page/dcs-child-restraint-law>.



» Marijuana Sub-Committee Work Group

During the review of cases, the IMRT was concerned with the use of substances, especially marijuana use. To that end, the IMRT decided to convene a sub-committee work group to devote time outside of the scheduled meetings to discuss the latest peer reviewed research, review the prevalence of marijuana usage in the cases reviewed and provide a forum for disseminating information. Seventeen volunteers met several times in 2018 to begin the early formation of this work.

The group looked at the impact that marijuana usage had on families in the District of Columbia. The group recommended having a 4 hour class which would be offered to the general public involving participants from federal and district agencies as well as national experts who have conducted studies on marijuana use and pregnancy. The subgroup viewed this as an opportunity to educate the IMRT and the public around marijuana use and the impact on the fetus and mother's. The work group looked at the impact of marijuana on infants related to mother's use and the effects on infants at delivery and post-delivery. The work group wanted a better understanding of the DC legislation from a programmatic viewpoint (legal versus safety) and the lessons learned when marijuana education is implemented. The work group also wanted to develop an initial approach to research and outcomes regarding infants that

are exposed to marijuana. The work group participants shared data and peer reviewed publications, which included articles from: The Official Journal of the American Academy of Pediatrics, 2013; The Colorado School of Public Health 2016; The American College of Obstetricians and Gynecologist 2017; The Official Journal of the American Medical Association; The Journal of Neurotoxicology and Teratology 201; The Journal of Drug and Alcohol Dependence 2018; U.S. National Institutes of Health's National Library of Medicine (NIH/NLM) 2014 and The Journal of Preventive Medicine 2017. The work group was very cognizant of the impact legalization and decriminalization had on not penalizing families, as well as the medical benefits attributed to marijuana use for pain, insomnia, nausea and anxiety.

The work group is still in the formative stages and is working toward addressing certain requirements when planning:

- » Collect data on marijuana use by caregivers in deaths classified undetermined and unsafe sleep environment fatalities.
- » To determine the number of scene investigations that had marijuana present and had caretakers admitting to marijuana use.
- » The workgroup inquired about the differences between street marijuana/bootleg marijuana and medical marijuana and want to understand usage and the therapeutic value, supporting the desire for more research on marijuana use and its impact and efficacy.

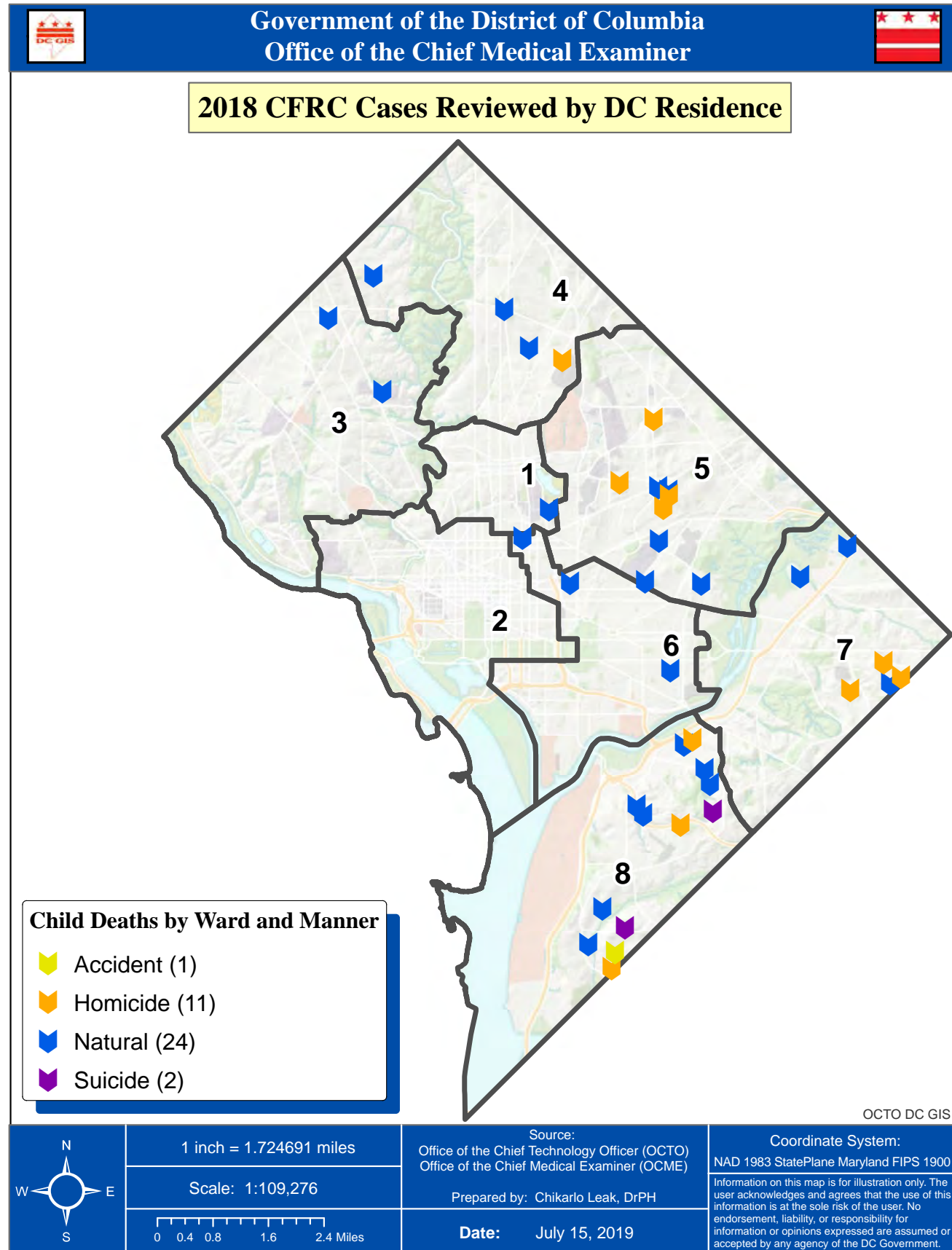
The work group was able to assess the need for questions to be addressed in tackling the use of marijuana as it relates to pre-pregnancy and post-pregnancy use. The following are some of the ideas discussed:

- » Is there data on whether the fetus and children are adversely impacted by a parent's marijuana use?
- » What happens with a family's psycho-social dysfunction and marijuana use and the impact on parenting?
- » What is the extent that marijuana use affects the health of mothers and infants?
- » More information on synthetic marijuana and K2 use.
- » Information on use during pregnancy and breastfeeding. The importance of knowing the education received on marijuana and its effects.
- » Importance of the committee to educate themselves on the impact of marijuana on parenting and the infant and mother's health.
- » The importance of health planning (staff) on pre, post-delivery education of mother's.
- » What is the perspective of the pregnant women using marijuana and what does a provider say to a woman who is using marijuana while pregnant or breast feeding?

The marijuana work group will continue to meet, share information and discuss trends and observations, as they move forward in the review of infant fatalities and develop appropriate recommendations to improve the outcomes for the District's youngest residents.

CHILD FATALITY REVIEW TEAM (CFRT) FINDINGS

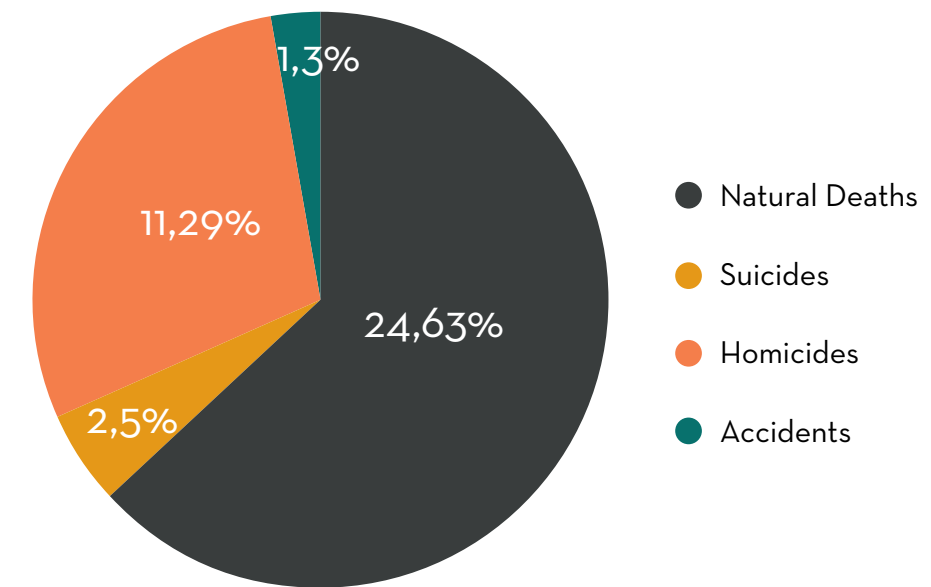




In 2018, the CFRT reviewed thirty-eight (38) cases involving children and youth whose deaths occurred in 2015, 2016, 2017 and 2018.

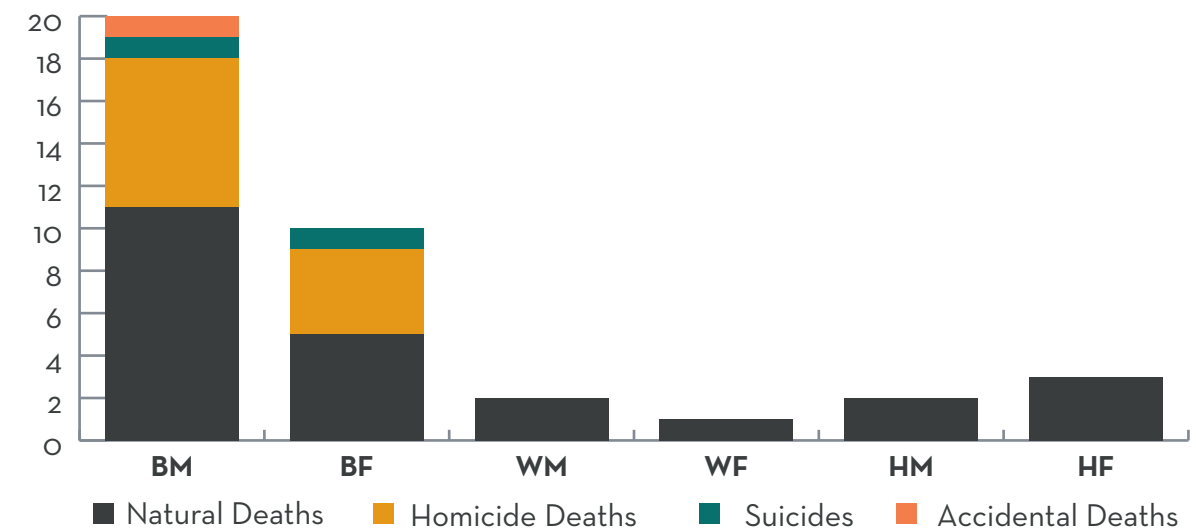
Many of the CFRT case reviews involved youth whose death was the result of natural causes (24, 63%). The CFRT also reviewed deaths of children and youth, who died of homicides, (11, 29%), two suicides (2, 5%) and one accident.

FIGURE 26 CFRT 2018 CASE REVIEWS



Thirty (30, 78%) of these cases involved Black/African American children and youth. Twenty (20, 53%) of the cases reviewed involved Black/African American males. Ten not 3 of the cases reviewed involved Black/African American females. Three (3, 8%) of the cases reviewed involved White males and females and five (5, 13%) cases involved Hispanic children and youth.

FIGURE 27 CFRT GENDER AND RACE



» CFRT Natural Deaths

TABLE 4: 2018 CFRT Natural Death Causes	
Cancer	5
Central Nervous System Disorders	5
Congenital Anomalies	7
Infection	4
Respiratory Disease	3
Total	24

The CFRC reviewed twenty-four cases involving the natural death of children and youth whose ages ranged from 1 to 16 years of age. The leading causes of natural deaths were those from congenital anomalies (7, 30%) – also known as birth defects that feature structural and functional defects identified during the pregnancy and at birth. The deaths of ten decedents were attributed to cancer or central nervous system disorders. The remaining decedents died due to respiratory disease and infections. Medical records reviewed indicated all of the decedents were insured and had access to primary care providers.

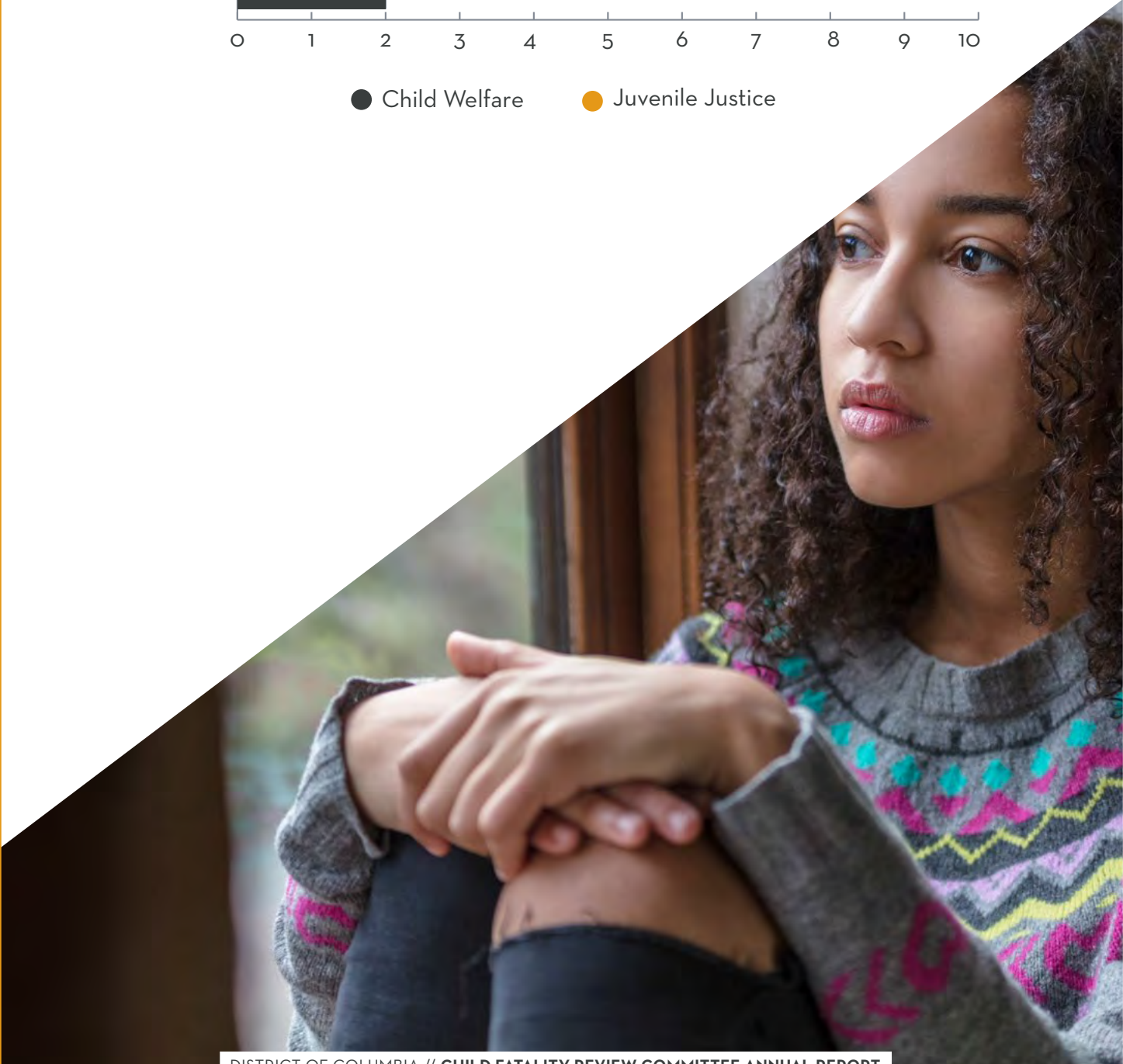
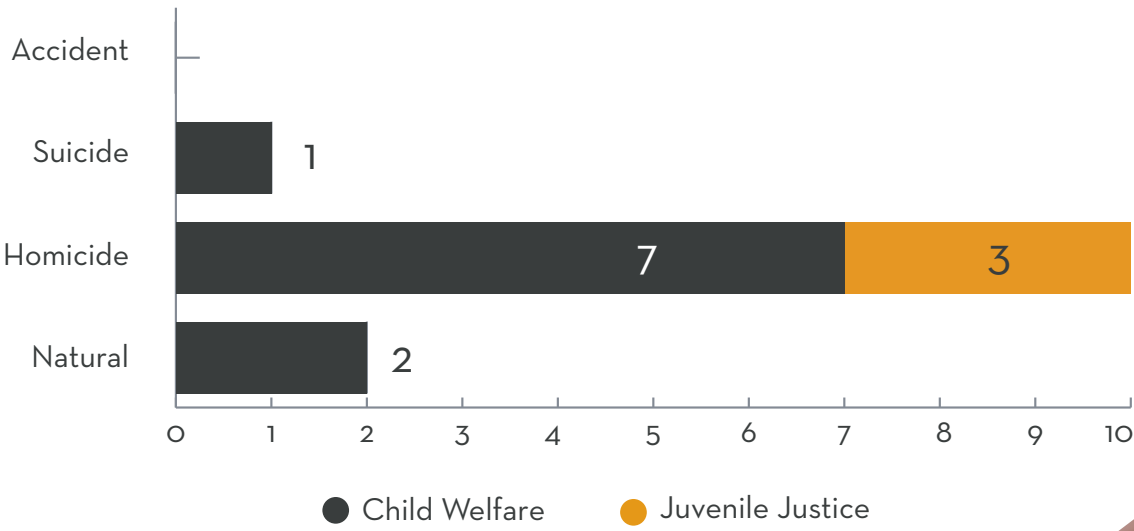
The CFRT discussed the need for the District of Columbia to address the needs of those children who are medically fragile. Medically fragile children are recognized as children whose medical needs require the ongoing medical care of a nurse, parental training, and assistance with all activities of daily living. With the lack of community based long-term care facilities for children, parents/caretakers are trained by skilled medical professionals to provide care for their children in the home setting. This may present as a challenge for families, particularly for those facing economic insecurities. Discussion of these cases led to recommendations that promote the multidisciplinary care coordination of medically fragile children who are recipients of Medicaid and involved with human services programs.

» CFRT Child Welfare and Juvenile Justice Deaths

The CFRC is mandated to review the deaths of infants, children and youth up to the age of 21 who were involved with child welfare or juvenile justice programs. As indicated in Figure 28, thirteen decedents were involved with either child welfare (10 cases) or juvenile justice programs (3 cases). Two of these decedents had involvement with both programs. Understanding the reasons why families were involved with child welfare programs and the adverse childhood experiences that led to the decedent’s involvement with juvenile justice services helps the CFRC formulate findings and recommendations for prevention.

This does not suggest a relationship between the decedent’s manner/cause of death and their involvement with child welfare or juvenile justice programs; however, this information suggests there is an opportunity for programs to recognize the indicators of child/youth fatalities amongst their client population to implement prevention activities that will lead to positive outcomes.

FIGURE 28 CHILD WELFARE AND JUVENILE JUSTICE CASE REVIEWS





CFRT HOMICIDE CASE REVIEWS

Homicides attributed to youth violence are the second most reviewed cases of the CFRC. Although issues surrounding public safety and access to guns are often discussed during CFRT meetings, the decedent’s social history provides key information that the District’s public safety, education and social services agencies can use collaboratively to address the needs of this population.

Table 5: Nationally Recognized Risk Factors Associated with Youth Homicides	
RISK FACTOR	CFRT CASE REVIEWS
Availability and Access to Guns	Seven of the eleven homicide decedent’s deaths were the result of gun violence.
Youth living in High Crime Neighborhoods	All of the homicide decedents resided in neighborhoods with known youth gang activity. Two decedents were victims of a violent crime leading to the death.
Youth involved in Criminal Activity	Two of the youth were involved with juvenile justice programs. One fatal incident resulted in the death of the victim and the perpetrator.
School Failure, Truancy and Violence	Six of the school aged decedents were truant. One of the decedents was involved in an ongoing school based dispute. None of the decedent’s aged 18 and over graduated high school.
Witnessing Violence	One of the decedents experienced domestic violence in the home environment. Two of the decedents were victims of fatal abuse.

The CFRT reviewed eleven homicide deaths (11, 29%) of District youth who succumbed to youth violence. Table 6 provides details of these deaths.

Table 6: CFRT Homicide Reviews	
DECEDENT Demographics	Cause of Death
1-year old AA Female	Multiple Blunt Force Injury
3 year old AA Female	Gunshot Wound of Chest
3 year old AA Male	Positional Asphyxia Associated with Complications of Remote Non-Accidental Blunt Head and Torso Trauma
16 year old AA Male	Gunshot Wound of the Head
17 year old AA Female	Gunshot Wound to the Head
17 year old AA Female	Stab Wound of Forearm
18 year old AA Male	Multiple gunshot Wounds
18 year old AA Male	Gunshot Wounds of Trunk and Gunshot wound of Extremity
18 year old AA Male	Gunshot Wound of Head
19 year old AA Male	Stab Wound to the Abdomen
20 year old AA Male	Gunshot Wound of Torso

As indicated in this table, most of the homicide deaths reviewed during this period was the result of gun violence (7, 63%). Two decedents each died of stab wounds and blunt force trauma. Decedents ranged from 1 to 20 years old, however it is noted that two decedents under the age of 3 died of fatal abuse. During CFRT case reviews, members discussed the shared adverse life experiences of these youth that are also nationally recognized risk factors for youth homicide victims as noted in Table 6.

Economic insecurity was the leading adverse life experience of all homicides during this period of review. All of the families met the household income threshold for combined federal assistance (TANF, Medicaid, Supplemental Nutritional Assistance Program, and housing assistance). Family child welfare (6, 55%) and juvenile justice involvement (2, 18%) and school disengagement (6, 55%) presented negative consequences for nine of these decedents.

School truancy continues to be a leading risk factor associated with homicide cases reviewed by the CFRT. Six of the homicide decedents between the ages of 17 and 20 years of age experienced school truancy. One of the homicide decedents between the ages of 18 and 20 graduated high school. Three of the homicide victims, aged 16 and 17, were on track to graduate from high school prior to their death. One of the decedents was college bound.

The decedents whose deaths were the result of fatal abuse (2, 18%) died of blunt force trauma. Both of these decedent’s families were involved with the District’s child welfare services prior to the fatal event. One decedent’s death was the result of children playing with a gun in the family home.

» CFRT Accidental Death Case Reviews

As shown in Table 7 , the CFRT reviewed one (1) accidental death case of a child.

Table 7 : CFRT 2017 Accidental Deaths	
DECEDENT DEMOGRAPHICS	CAUSE OF DEATH
6 year old AA Male	Multiple Blunt Force Injury

This death was the result of a motor vehicle accident. The District Government responded by immediately placing traffic calming measures in the community which faced a street frequented by children and their families.

» CFRT Suicide Case Reviews

The CFRT reviewed two cases of decedents whose death was attributed to suicide.

Table 8 : 2018 CFRT Suicide Case Reviews		
DECEDENT DEMOGRAPHICS	CAUSE OF DEATH	ASSOCIATED RISKS
18 year old AA Male	Gunshot Wound of Head	Social Isolation
12 year old AA Female	Asphyxia due to Ligature Hanging	Unresolved Grief

The CFRT suicide cases reviewed provided insight on the needs of youth possibly isolated due to their home school or private school settings. The CFRC developed recommendations that will address the needs of these children and youth to ensure there is a community network of services accessible to them regardless of their school setting.

Section 02

RECOMMENDATIONS AND AGENCY RESPONSES



» Child Fatality Review Committee Recommendations

During the 2018 operational year, the CFRC developed recommendations that were disseminated to District Government agencies and community based partners that address the need for improvements in systems and/or programs that will initiate positive outcomes for our children, youth and families. These recommendations were initially formulated by members at the closure of the case review, and formally adopted by the CFRC Recommendations Subcommittee. The CFRC Recommendations Subcommittee addresses each aspect of the recommendation, which includes the following: (1) the statement of need, (2) the beneficiary population and (3) how the implementation of the recommendation may impact the overall policies, practice, legal and budget of the receiving agency/community partner.

These eleven (11) recommendations were developed following the review of the 104 cases and adopted by the CFRC. These recommendations address the need for improvements in safe sleep education and training, the coordination of care for medically fragile children, defining mandated reporters of child abuse and neglect, improving the jurisdictional partnership with the state of Maryland, expansion of services for home schooled children and youth, and the utilization of advance technology to identify the causes of undetermined infant deaths.

RECOMMENDATION #1 CHILD AND FAMILY SERVICES AGENCY

The Child Fatality Review Committee recommends the Child and Family Services Agency should ensure there is comprehensive opportunity to share and receive information regarding District families involved with child welfare and augment or enforce services in accordance with the current border agreement shared with the state of Maryland.

AGENCY RESPONSE: THE CHILD AND FAMILY SERVICES AGENCY AGREES WITH THIS RECOMMENDATION

BEST PRACTICE: EXCHANGING INFORMATION BETWEEN JURISDICTIONS WHEN INDICATED

SPECIFIC ACTIONS PLANNED TOWARDS IMPLEMENTATION: The exchange of information between Maryland's child protection services agency and CFSA occurs on a routine basis. CFSA will contact Maryland's child protection agency with information about a DC family who was involved with CFSA and moved to Maryland. CFSA Principal Deputy Director and Maryland child welfare officials will meet on a quarterly basis to discuss a variety of agenda items including resolving issues related to exchange of information between jurisdictions. The quarterly cross jurisdictional meeting began occurring in the third quarter of 2018. CFSA will identify barriers to exchanging information and develop solutions.

RECOMMENDATION #2 CHILD AND FAMILY SERVICES AGENCY

The Child Fatality Review Committee recommends that medically fragile children involved with the Child and Family Services Agency should have coordinated skilled medical care that includes the collaboration of the Medicaid case manager, primary care provider and pharmacy to ensure the complex medical needs of the child are met.

AGENCY RESPONSE: THE CHILD AND FAMILY SERVICES AGENCY AGREES WITH THIS RECOMMENDATION

BEST PRACTICES: Coordination of medical care for children who enter foster care with a clear plan in place to address medical concerns. In-home families require consent from the birth parent for disclosure of health information and involvement in coordination of care efforts.

SPECIFIC ACTIONS PLANNED TOWARDS IMPLEMENTATION: CFSA has nurse case managers to case manage children with medical needs according to the referrals submitted by social workers. The nurse care managers manage children with complex medical needs and facilitate their care

coordination. Social workers can submit a nurse referral at any time throughout the life of a case, including at the point of case closure. This program has been implemented at CFSA.

EXPECTED OUTCOME: Coordination of medical care for children and youth in the child welfare system and medical needs met.

RECOMMENDATION #3 CHILD AND FAMILY SERVICES AGENCY

The Child and Family Services Agency should develop and implement a policy for children who remain in the home following a sibling's removal that addresses the supervision of the children remaining in the home.

AGENCY RESPONSE: THE CHILD AND FAMILY SERVICES AGENCY AGREES WITH THIS RECOMMENDATION

BEST PRACTICES: Social workers must individually assess safety and service needs for all children in the family, irrespective of whether the children are in foster care. Depending on the safety concerns or risk factors for the children remaining in the family home, social workers must follow clear criteria for determining whether ongoing case management of those children is necessary and clear guidelines for disengagement when appropriate, even while other children in the family may be in foster care.

SPECIFIC ACTIONS PLANNED TOWARDS IMPLEMENTATION: CFSA developed and issued Standards for Ongoing Case Management of Children at Home with a Sibling in Foster Care policy guidance in October 2018. Supervisors were trained on the policy and reinforced it with their staff members.

EXPECTED OUTCOMES: CFSA social workers will complete safety assessments of children who remain in the parent's home and respond accordingly based on assessment results (e.g., develop safety plan, intervention plan, ongoing case management, remove as necessary). Social workers (or other mandated reporters) who observe a safety issue for a child who is not receiving case management services, a report is to be made to the CFSA abuse and neglect hotline in accordance with District statute and Agency policy.

RECOMMENDATION #4 DC HEALTH AND THE DC HOSPITAL ASSOCIATION

DC Health shall promulgate regulations that require adherence by all DC hospitals, birth centers and birthing providers, to core competencies on standardized safe sleep education and feeding instructions to be communicated to caregivers prior to discharge.

AGENCY RESPONSE: YES, WITH MODIFICATION

DC Health agrees with the recommendation of the Child Fatality Review Committee and accepts this recommendation with minor modifications. DC Health supports standardizing the education and instructions parents and caregivers receive prior to discharge from a birthing facility, including providing evidence based guidance about safe sleep and infant feeding. This is well aligned with

our strategic framework to improve perinatal health outcomes, as it helps to ensure that every healthcare facility providing maternal and infant care has the tools and resources to practice evidence-based healthcare.

SPECIFIC ACTIONS PLANNED TOWARDS IMPLEMENTATION: Recently enacted format, the Community Health Omnibus Amendment Act of 2018 (DC Law 22-290), requires that “[e]ach hospital, birthing facility, and nurse-midwife shall provide to each parent comprehensive newborn education and a discharge form approved by the Department” of Health. The legislation additionally gives DC Health the authority to “develop and issue standards for post-partum education.” (See additional details below). DC Health is in the process of drafting regulations to support this law that became effective on April 11, 2019.

Title III. Comprehensive newborn screening, Sec. 302. Discharge standards (§ 7-858.03):

- (a) Each hospital, birthing facility, and nurse-midwife shall provide to each parent comprehensive newborn education and a discharge form approved by the Department with information regarding the newborn’s hospital course of treatment, including screenings, procedures, and other tests.
- (b) The Mayor shall develop and issue standards for post-partum education, including breastfeeding, family planning, safe sleep practices, tobacco exposure, vaccinations, car safety, basic newborn care, and the results and rationale for newborn screenings.
- (c) The Mayor shall establish the content of newborn discharge forms through rulemaking.

DC Health is currently reviewing all current birth hospital and birth center policy and procedures pertaining to newborn discharge practices.

EXPECTED OUTCOMES: Standardization of post-partum education and newborn discharge standards which include infant breastfeeding and safe sleep practices will aim to ensure that every healthcare facility providing maternal and infant care has the tools and resources to practice evidence-based healthcare. Additionally, every newborn will receive high-quality neonatal care in the hospital and outpatient setting. The time period to achieve this outcome is approximately 18 months. Draft regulations were completed in March 2019. Two indicator/milestones are (1) All birthing facilities will have documented postpartum education standards by March 2021 and (2) All birthing facilities will have documented newborn discharge standards by March 2021.

RECOMMENDATION #5 OFFICE ATTORNEY GENERAL IN COLLABORATION WITH THE OF THE CHILD AND FAMILY SERVICES AGENCY AND THE DC HOUSING AUTHORITY
The Child Fatality Review Committee recommends all inspectors (contracted or full time) with the DC Housing Authority should be added to the DC Statute as mandated reporters. As mandated reporters the DC Housing Authority inspectors should complete mandated reporter training and be required to report suspected child abuse and neglect to the Child and Family Services Agency hotline.

AGENCY RESPONSE: The Office of the Attorney General for the District of Columbia, through its Public Safety and Family Services Divisions, accepts this recommendation.

Best practices and actions planned for implementation of this recommendation are the following:

1. Request an amendment to the mandatory reporting statute to include DCHA inspectors as mandated reporters
2. DC City Council accepts OAG’s recommendation and changes the amends the statute to add DCHA inspectors to the list of mandated reports
3. Implement training program for DCHA’s inspectors about DC mandatory reporting statute and ways to identify children who may be at risk of being abused or neglected
4. Add the role of mandated reporter to all DCHA inspector’s job descriptions, so that this new group of mandated reporters understands their responsibility and the District’s expectations
5. DCHA inspectors put mandated reporting into practice

Specific actions taken to date towards implementation:

1. In July 2019, the Office of the Attorney General for the District of Columbia recommended to the DC City Council that the mandatory reporting statute be modified to include DCHA inspectors as mandated reporters

Expected outcomes:

1. DCHA inspectors will be required, by law, to report incidents of child abuse and/or neglect if seen in the course of their duties
2. DCHA inspectors will be trained to recognize signs of child abuse or neglect
3. DCHA inspectors will report instances of child abuse and/or neglect if they see evidence of it during the course of their duties
4. By expanding the pool of mandated reporters in the District of Columbia, more vulnerable children will be identified and protected

Measurable indicators/milestones:

1. Legislation is changed to include DCHA inspectors as mandated reporters
2. Training program is implemented for DCHA inspectors
3. Data of reports by DCHA inspectors is collected and evaluated quarterly

RECOMMENDATION # 6 OFFICE OF THE STATE SUPERINTENDENT OF EDUCATION
With the goal to improve its Home Schooling Program, the Office of the State Superintendent of Education should expand and codify this program, based upon nationally recognized best practices; to meet the needs of the growing number of District families engaged in homeschooling their children. The expansion should include:

- (1) The identification of certified curriculum(s) and nationally recognized standardized testing
- (2) Incorporation of social components to decrease instances of isolation,
- (3) a monitoring component that will track the academic progress and health/safety needs of homeschooled children,
- (4) Increase the budget of the District's Homeschooling Program within OSSE to include additional full-time employees and,
- (5) OSSE should reinstate an annual meeting or conference that provides information on the District's homeschooling program. This will also provide an opportunity for parents and homeschooled students to network within their community.

(1) OSSE SHOULD IDENTIFY CERTIFIED HOME SCHOOL CURRICULUM(S) AND NATIONALLY RECOGNIZED STANDARDIZED TESTING.

RESPONSE: NO, WITH EXPLANATION AND ALTERNATIVE RECOMMENDATION:

The Office of the State Superintendent of Education (OSSE) is currently working to update and enhance its infrastructure (i.e. policies, procedures, website and Homeschool Portal) related to the Homeschooling Program. As part of this process, OSSE is working to provide additional resources to homeschooling families through its webpage and Homeschool Portal. Among the resources provided will be information on standardized testing options through District of Columbia Public Schools (DCPS) for homeschooled students. Understanding standardized testing options, parents will be better informed to choose a curriculum that is well aligned with state standards and testing options, if they so choose. Matters of curriculum are generally left to the local level for public, private and charter schools. Accordingly, OSSE maintains that homeschooling parents should have the option to select the curriculum that works best for each family and its unique approach to education.

BEST PRACTICES: The level of oversight in homeschooling programs varies by state; however most states opt to provide parents with a high level of autonomy related to home instruction. Where direction is provided around matters such as curriculum, it is most often provided at the local level through local education agencies (LEAs) or other approved organized learning institutions (e.g. nonpublic school).

Specific Actions Planned towards Implementation: (1) Online homeschool portal is being updated with first round of updates scheduled to be completed in FY20. (2) Homeschool webpage has undergone several recent updates, with the next round scheduled to be completed at the beginning of FY20. This round of changes will include updates to the Frequently Asked Questions in order to make them more parent friendly and provide updates to testing information.

OSSE is currently working to update and enhance its infrastructure related to the Homeschooling Program. As part of this process, OSSE is working to provide additional resources to homeschooling families through its webpage and Homeschool Portal. Among the resources provided will be information on standardized testing options through DCPS for homeschooled students. Matters of curriculum

are left to the local level for public, private and charter schools. Accordingly, OSSE maintains that homeschooling parents should have the option to select the curriculum that works best for each family and its unique approach to education.

EXPECTED OUTCOMES: Parents will be connected with more resources and networks related to homeschooling. First round of portal upgrades completed (January 2020) and online frequently asked questions will be updated November 2019.

(2) INCORPORATION OF SOCIAL COMPONENT TO DECREASE INSTANCES OF ISOLATION:

RESPONSE: YES, WITH MODIFICATION

OSSE is currently working to develop opportunities for homeschool families to come together through mechanisms such as webinars and an annual homeschool summit. While the social aspect is not the only focus, hosting such initiatives will allow homeschooling families to network and collaborate with one another and provide a means for families to share best practices, lessons learned and various resources they have found useful or impractical in their homeschooling experience.

BEST PRACTICES: The level of oversight and involvement in individual homeschooling programs varies by state. In many cases, homeschooled students are offered opportunities to participate in athletics by local education agencies. No standard or best practice related to social activities offered at the State level has been identified.

SPECIFIC ACTIONS PLANNED TOWARDS IMPLEMENTATION: OSSE is in the process of updating its Homeschooling webpage to include additional resources for homeschooling families. OSSE is also investigating future programmatic options such as a summit or webinars for homeschooling families. OSSE is currently working to develop opportunities for homeschool families to come together through mechanisms such as webinars and an annual homeschool summit. Hosting such initiatives will allow homeschooling families to network and collaborate with one another and provide a means for families to share best practices, lessons learned and various resources they have found useful or impractical in their homeschooling experience.

EXPECTED OUTCOMES: Parents will be better informed regarding DC's homeschooling program and have increased opportunities for networking and collaboration with one another. An initial webinar will be released in the fall of 2020 and a Homeschool Summit will occur by the fall of 2021.

(3) A MONITORING COMPONENT THAT WILL TRACK THE ACADEMIC PROGRESS AND HEALTH/SAFETY NEEDS OF HOMESCHOOLED CHILDREN:

RESPONSE: YES WITH MODIFICATION

Pursuant 5-E DCMR 5206, OSSE conducts organized reviews of the education materials of randomly selected homeschooled students. In accordance with 5-E DCMR 5205, parents or guardians who choose to administer a homeschooling program are required to maintain a portfolio of homeschooling materials for each child, for at least one year. Each portfolio must include evidence of the child's current work, such as examples of the child's writings, worksheets, workbooks, creative materials, assessments, or any other materials demonstrating that the child is engaged in thorough and regular instruction in a range of subjects that include, but are not limited to language arts, mathematics, science, social studies, art, music, health, and physical education. In the event families are nonresponsive to OSSE's request for a portfolio review, OSSE has developed a protocol for notifying Child and Family Services

to further evaluate the child's health and safety status. OSSE will not maintain a separate monitoring component for tracking student health and safety.

BEST PRACTICES: The level of oversight and involvement in individual homeschooling programs varies by state, with most states requiring some form of academic review or certification to ensure sound instruction. In many cases, this certification is performed at the local level through local education agencies, tutors, private schools, or other independent establishments. Most states strive to provide a great deal of autonomy to homeschooling families. However, Illinois and Iowa have recently proposed wellness checks for homeschooled students; this proposal has been staunchly opposed by homeschooling families and advocates.

SPECIFIC ACTIONS TAKEN TO DATE TOWARDS IMPLEMENTATION: Pursuant 5-E DCMR 5206, OSSE conducts organized reviews of the education materials of randomly selected homeschooled students. In accordance with 5-E DCMR 5205, parents or guardians who choose to administer a homeschooling program are required to maintain a portfolio of homeschooling materials for each child, for at least one year. Each portfolio must include evidence of the child's current work, such as examples of the child's writings, worksheets, workbooks, creative materials, assessments, or any other materials demonstrating that the child is engaged in thorough and regular instruction in a range of subjects that include, but are not limited to language arts, mathematics, science, social studies, art, music, health, and physical education. In the event families are nonresponsive to OSSE's request for a portfolio review, OSSE has developed a protocol for notifying Child and Family Services to further evaluate the child's health and safety status.

(4) INCREASE THE BUDGET OF THE DISTRICT'S HOMESCHOOLING PROGRAM WITHIN OSSE TO INCLUDE ADDITIONAL FULL-TIME EMPLOYEES :

RESPONSE: NO, WITH EXPLANATION OF ALTERNATIVE RECOMMENDATION

OSSE's Division of Community Learning and School Support (CLASS), which currently houses the Homeschooling program, has recently hired administrative support that has been deployed to support the homeschooling program.

(5) OSSE SHOULD REINSTATE AN ANNUAL MEETING OR CONFERENCE THAT PROVIDES INFORMATION ON THE DISTRICT'S HOMESCHOOLING PROGRAM. THIS WILL ALSO PROVIDE AN OPPORTUNITY FOR PARENTS AND HOMESCHOOLED STUDENTS TO NETWORK WITHIN THEIR COMMUNITY.

RESPONSE: YES

The level of oversight and involvement in individual homeschooling programs varies by state, with many matters related to homeschooling occurring at the local level. However many states offer some form of technical assistance around the homeschool regulations (assuming it occurs at the state level) for their state.

BEST PRACTICES: The level of oversight and involvement in individual homeschooling programs varies by state, with many matters related to homeschooling occurring at the local level. However many states offer some form of technical assistance around the homeschool regulations (assuming it occurs at the state level) for their state.

SPECIFIC ACTIONS PLANNED TOWARDS IMPLEMENTATION: OSSE is in the process of updating its Homeschooling webpage to include additional resources for homeschooling families. OSSE is also investigating future programmatic options such as a summit or webinars for homeschooling families.

EXPECTED OUTCOMES: Parents will be better informed regarding DC's homeschooling program and have increased opportunities for networking and collaboration with one another. OSSE is planning a Homeschool Summit by the fall of 2021.

RECOMMENDATION #7 OFFICE OF THE STATE SUPERINTENDENT OF EDUCATION WITH THE COLLABORATION OF THE CHILD AND FAMILY SERVICES AGENCY

CFSA must develop and implement a policy to contact OSSE to verify the family has obtained permission to home school the child during the course of the CPS investigation prior to closing the investigation. OSSE must develop and implement a policy and protocol to ensure contact is made with CFSA within the established investigation closure timeframe.

AGENCY RESPONSE: YES, IN AGREEMENT

The Office of the State Superintendent of Education (OSSE) has developed a standard operating procedure for responding to written inquiries from the Child and Family Services agency by email within three (3) business days to verify that a family is verified for home instruction.

RECOMMENDATION #8 OFFICE OF THE CHIEF MEDICAL EXAMINER

The OCME shall complete post-mortem molecular and directed neuropathology testing as part of the autopsy process.

AGENCY RESPONSE: YES, IN AGREEMENT

SPECIFIC ACTIONS PLANNED TOWARDS IMPLEMENTATION: The Office of the Chief Medical Examiner (OCME) plans to identify a partner who can provide genetic testing for cases of Sudden Unexpected Infant Death in FY2020. Several meetings have been initiated with programs that provide this type of testing. The OCME is currently attempting to identify the best program to provide the testing.

EXPECTED OUTCOMES: Enrollment in a genetic testing protocol and development of Standard Operating Procedures will be achieved in FY2020.

RECOMMENDATION #9 OFFICE OF THE CHIEF MEDICAL EXAMINER WITH MULTIPLE AGENCY COLLABORATION

The Child Fatality Review Committee recommends that DC Health and the Office of the Chief Medical Examiner should collaborate to develop a District wide campaign to address and improve the safe sleep environment for infants. This collaboration will address the needs of families involved with DHS supportive housing, hospitals, birthing centers and community centers.

AGENCY RESPONSE: THE OFFICE OF THE CHIEF MEDICAL EXAMINER (OCME) ACCEPTS THIS RECOMMENDATION.

SPECIFIC ACTIONS PLANNED TOWARDS IMPLEMENTATION: OCME intends to work with listed partners during FY2020 and FY2021 to initiate public education campaign surrounding Safe Sleep. The OCME has been working with a federal fund to support the local campaign. It is not clear if we are going to be able to secure the funds. The OCME will use local funds to develop the campaign if necessary.

EXPECTED OUTCOMES: The OCME expects to reach families in Wards 5, 7, and 8 with outreach over the next 2 years. The OCME expects to achieve this by October 2020.

RECOMMENDATION #10 DEPARTMENT OF HUMAN SERVICES

The Department of Human Services' individual and family providers should ensure practices of safe sleep are incorporated into the training for all supportive housing services staff.

AGENCY RESPONSE: YES, WITH MODIFICATION

The Department of Human Services (DHS) should ensure that pregnant mothers and families with children under 12 months old that reside in shelters within the District of Columbia's Homeless Continuum of Care are educated on infant safe sleep practices.

DESCRIBE SPECIFIC ACTIONS PLANNED TOWARD IMPLEMENTATION:

The Department of Human Services will partner with the DC Department of Health to ensure that pregnant mothers and families with children under 12 months old, that reside in shelters within the District of Columbia's Homeless Continuum of Care, are educated on Safe-to-Sleep® practices. Safe-to-Sleep® practices emphasize actions that families and others can take to help babies sleep safely and reduce babies' risk of Sudden Infant Death Syndrome and other sleep-related causes of infant death.

RECOMMENDATION #11 DEPARTMENT OF HUMAN SERVICES WITH MULTIPLE AGENCY COLLABORATION

The Child Fatality Review Committee recommends a review of the Homeless Services Reform Act (HRSA) with DHS and the DC Interagency Council on Homelessness (ICH) to amend the legislation to address behavioral risk factors identified with families who utilize their services and require family involvement in case management services when one or more risk factors are present.

AGENCY RESPONSE: NO, WITH EXPLANATION OF ALTERNATIVE RECOMMENDATION

It is recommended the Committee receive an updated briefing on the District of Columbia's Homeless Continuum of Care by DHS or the District's Interagency Council on Homelessness (ICH), so that Committee members are provided with the current policy and programmatic levers used to increase families' engagement with the case management services provided by DHS in the shelter setting.

Additionally, it is recommended DHS bolster their case management practices by partnering with other District government agencies that are specifically charged with the health and well-being of children in the District.

DESCRIBE SPECIFIC ACTIONS PLANNED TOWARD IMPLEMENTATION:

The District of Columbia Homeless Continuum of Care is a comprehensive range of services provided by multiple District agencies to meet the needs of individuals and families who are homeless or at risk of homelessness. The District of Columbia Homeless Services Reform Act of 2005, as amended, (the Act) provides the statutory framework for how these needs shall be addressed. The Act requires that families residing in the shelter setting participate in case management services, and that these requirements be included in the signed agreement that each homeless shelter provider has with each family client. This 'agreement' is called Program Rules, which the Act requires DHS to review annually. A provider may terminate or suspend services, or transfer a client to another provider, if a client violates the Program Rules multiple times. For example, if a family repeatedly misses case management meetings or otherwise fails to participate in their case management plan, then the shelter provider could terminate or transfer services under the Act.

DHS, and through its entities contracted to deliver case management services to families, will continue to provide families with the wrap-around supports they need to stabilize their housing, so attention can be re-directed to the well-being of the children in the family. In support of this mission, when DHS or its contracted case management entities identify familial behaviors that may indicate risk to a child, a referral will be made to CFSA for assessment. Additionally, DHS will bolster its review of each homeless services provider's Program Rules, to confirm each Rule is clear about the case management partnership that must exist between the provider and family, and that it emphasizes the provider's commitment to collaborate with other supports, as appropriate, to underpin the family's overall well-being.



ACKNOWLEDGMENT

» MEETING ADJOURNED...

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

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



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