VIOLENCE FATALITY REVIEW COMMITTEE

2021 ANNUAL REPORT

Washington, DC

MISSION OF VFRC

To prevent deaths related to homicide and suicide; of adults aged 19 and older, in the District of Columbia. Through a multidisciplinary and comprehensive review of past cases of violent death fatalities; the VFRC will identify, evaluate, and make recommendations to improve community programs, and systems responsible for protecting and serving District residents.

This annual report is dedicated to those who lost their lives in the District of Columbia to homicide or suicide, their families, friends and the communities impacted by violence, who must balance the weight of grief with the hope for a safe future.

OFFICE OF THE CHIEF MEDICAL EXAMINER FATALITY REVIEW DIVISION STAFF

Jenna Beebe-Aryee, MSW
Fatality Review Program Manager

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PRESENTED TO

The Executive Office of the Mayor

The Council of the District of Columbia

The Citizens of the District of Columbia

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GREETINGS FROM THE CHIEF MEDICAL EXAMINER

Francisco J. Diaz, MD FCAP FASCP

Chief Medical Examiner
Office of the Chief Medical Examiner
Washington, D.C.

In 2021, the District of Columbia's Violence Fatality Review Committee (VFRC) met monthly to address systemic issues surrounding violent deaths through the review of 244 homicide and suicide cases.

Most of these violent deaths occurred in Wards 7 and 8, and more than half of the decedents were women and men of color. As the VFRC is unique in its examination of the violent deaths of adults, the true cost of lives lost for their families and communities is incomprehensible. The VFRC is dedicated in its advocacy for the eradication of violent deaths. The commitment of the VFRC's multidisciplinary mayoral appointees deserves our deepest gratitude.

We are pleased to present the 2021 VFRC annual report. This report contains data gathered from the VFRC's review of deaths that occurred between 2019 and 2020. It is our intention that this report will be used by the District of Columbia's public health and public safety agencies, as well as community organizations who work collaboratively with our residents most at-risk of succumbing to acts of violence.

Sincerely,

GREETINGS FROM THE
VIOLENCE FATALITY REVIEW COMMITTEE CHAIR

The District of Columbia's Violence Fatality Review Committee (VFRC), whose members were chosen by the Mayor to address the leading barriers to the prevention of acts of violence, have accepted this call to action.

Kenyatta Hazlewood, BSHS BSN MPH RN NE-BC
Trauma Program Director
Department of Surgery,
Division of Trauma
& Critical Care
Howard University Hospital

With 2020 being the inaugural year for VFRC's case reviews, COVID -19 presented its challenges. Three years in and we have focused on reducing these violent deaths by conducting case reviews of violent injures and suicides and then, informing stakeholders, and recommending evidence-based, practices, standards and programs. In 2021, the Committee saw an increase in violent injuries which included several District of Columbia youth. The VFRC also collaborated with the District's Child Fatality Review Committee (CFRC). This trailblazing collaboration has fostered communication among both human services and public safety agencies.

I am honored to be a part of the valiant effort to reduce violence in the District of Columbia. As we present the 2nd Violence Fatality Review Committee's Annual Report, it is our hope the information provided will be used by government agencies, hospitals, violence-focused organizations and community-based providers to prevent acts of violence. We hope that this report will help to inform community advocates and provoke an urgency for more robust violence prevention and reduction programs. We thank the VFRC members, and OCME staff for their commitment to the residents of the District of Columbia.

Sincerely,

Kenyatta Hazlewood

EXECUTIVE SUMMARY

The District of Columbia's Violence Fatality Review Committee (VFRC) is pleased to present its 2nd Annual Report. This Report covers data, discussions, and recommendations from the homicide and suicide cases reviewed by the VFRC in 2021.

The Violence Fatality Review Committee

The Violence Fatality Review Committee was established by §3042 of the Fatality Review Committee Amendment Act of 2018 and passed on September 5, 2018, as part of the FY2019 Budget Support Act (BSA). The VFRC was established to conduct retrospective reviews of circumstances leading to the violent deaths (homicides and suicides) of persons aged 19 and older, who were DC residents and those who died in the District regardless of place of residence.

GOALS of VFRC

- Reducing the number of preventable violent deaths, homicides and suicides.
- Identifying and evaluating improvements in policies, programs, trainings and systems that respond to these fatalities.
- Recommending systemic improvements to prevent and respond to homicides and suicides.
- Recommending policies for improved access to employment, healthcare, mental and behavioral health services, housing, and education programs; and
- Recommending training to improve the prevention of homicides and suicides and to identify risk factors and develop protective factors in the individual, family, and community response to violence.

The District of Columbia's model for violence prevention is based on a public health approach. This approach involves defining and measuring the problem, identifying the cause or risk factors, determining how to prevent the problem, and implementing effective strategies on a larger scale and evaluating the impact. Recognizing violence as a health issue is "founded on an understanding of violent behavior as arising from contextual, biological, environmental, systemic, and social stressors."[1] This approach focuses on prevention through addressing the known factors that increase or decrease the likelihood of violence. It is also a comprehensive way to help people, organizations, and systems understand how to prevent violence. Using a public health approach emphasizes input from broad multidisciplinary angles of sociology, psychology, health, social service, justice, policy, and the public sector.

1 Dahlberg LL, Mercy JA. History of Violence as A Public Health Problem. Virtual Mentor. 2009; 11:167-172.

VIOLENCE FATALITY **REVIEW COMMITTEE** 2021

VFRC MEMBER AGENCIES AND ORGANIZATIONS

- Community Wellness Ventures
- Court Services and Offender Supervision Agency
- DC Fire & Emergency Medical Services
- DC Health
- DC Housing Authority
- Department of Behavioral Health
- Department of Human Services
- George Washington University Hospital
- Hillcrest Children & Family Center
- Howard University Hospital
- Medstar Washington Hospital Center
- Metropolitan Police Department
- Office of the Attorney General
- Office of Gun Violence Prevention
- Office of Neighborhood Safety & Engagement
- Office of the Chief Medical Examiner
- Office of Victim Services and Justice Grants
- Residents of the District of Columbia
- Sibley Hospital
- Transformative Research and Applied Violence Intervention Lab
- United Medical Center
- United States Attorney's Office – Washington, DC

Key Data from 2021 Case Reviews

The findings presented in this report represent 244 violent deaths that occurred in 2019. These cases were reviewed by the VFRC between January 2021 and December 2021. The VFRC conducted full case reviews and statistical clustered reviews of the cases.[2]

Overall Demographics

- Of the total 244 violent deaths in the District, 61 (25 percent) were suicides and 183 (75 percent) were homicides.[3]
- Most homicides for 2019 occurred in Wards 7 and 8. *(Figure 1)*.
- Male decedents represented 88 percent of violent deaths, compared with 12 percent for females.
- The average age for victims of violent deaths was 28.6.
- Over fifty percent of homicides and suicides involved a firearm.
- Seventeen percent (17%) of DC residents who died by homicide or suicide, died outside the District. This population was 8 times more likely to die by a firearm and 7 times more likely to die in Maryland and by homicide.
- Most decedents who were undomiciled tended to be black (57%), male (86%) and die by blunt force trauma injuries (57%).
- Domestic violence cases comprised five percent (5%) of 2021 reviewed cases.

The Committee developed six recommendations that address community engagement, policy, system and program improvements and collaboration between the family of the decedent and District Government agencies.

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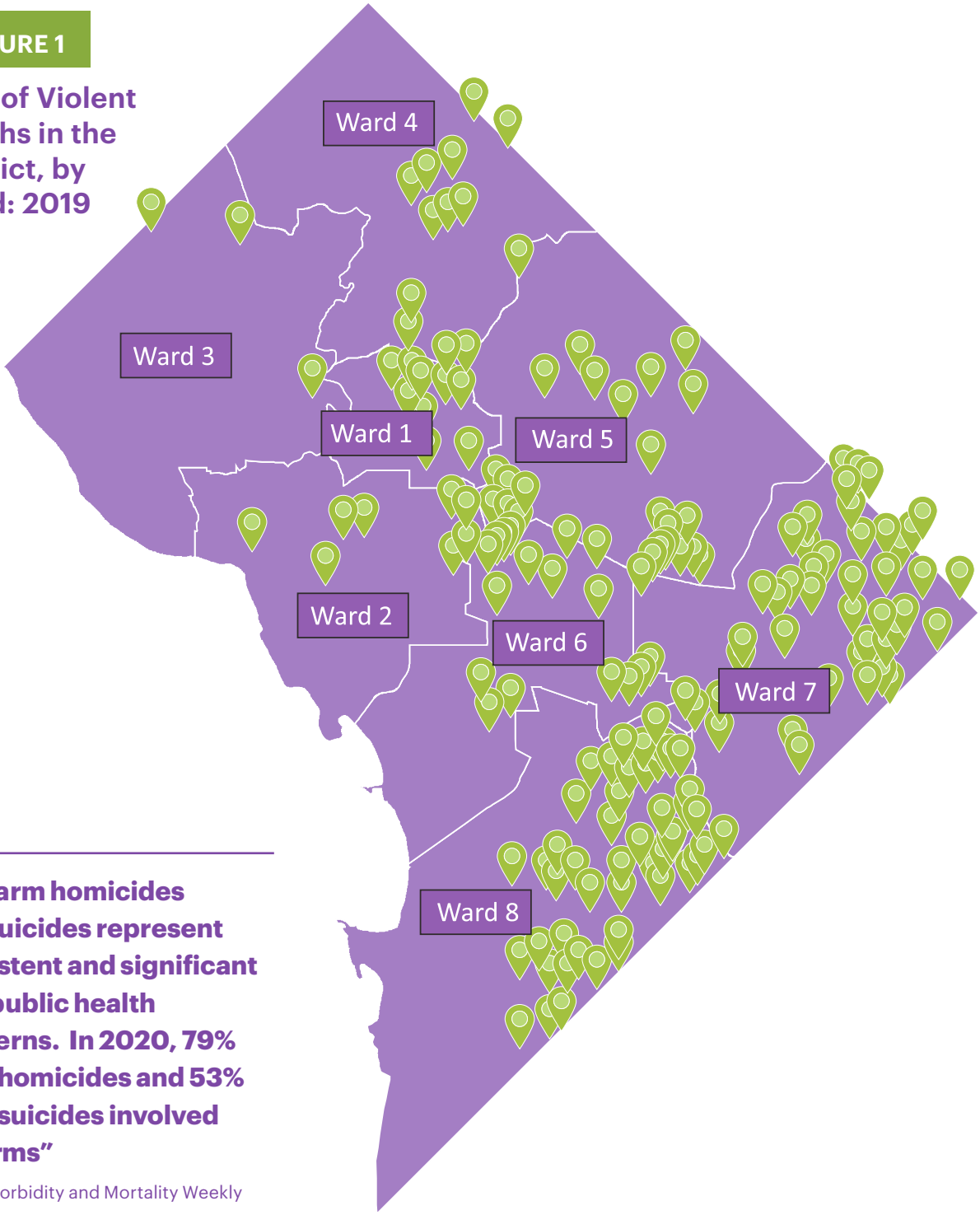
2 Full homicide case reviews were conducted for those decedents with a history of involvement with the Department of Corrections (DOC), Department of Youth Rehabilitative Services (DYRS), Court Services and Offender Supervision Agency (CSOSA), Law Enforcement and a history of previous injuries because of violence. Full suicide case reviews were conducted for those decedents with a history of involvement with the Department of Behavioral Health (DBH), Department of Human Services (DHS), Child and Family Services Agency (CFSA), Veteran's Administration, branches of military, those with a confirmed diagnosis of chronic depression and those who made a previous suicide attempt. Statistical reviews for homicide and suicide cases were administered if the decedent was not a District resident or if the decedent was a DC resident who died in a jurisdiction other than Washington, DC.

3 The total of homicides in the District documented by the Metropolitan Police Department (MPD) and the homicide cases supplied to and reviewed by the VFRC will not be the same. The data included in the VFRC population contains DC residents aged 19 and older and those adults died within the District but were not residents of the District. MPD data includes all persons, regardless of age who died in the District.

FIGURE 1

Map of Violent Deaths in the District, by Ward: 2019



"Firearm homicides and suicides represent persistent and significant U.S. public health concerns. In 2020, 79% of all homicides and 53% of all suicides involved firearms"

(CDC, Morbidity and Mortality Weekly Report 2022; 71:656-663)

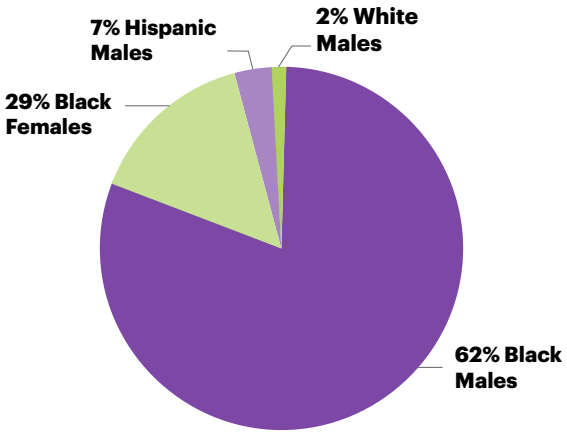
Source: https://georgetownvoice.com/2021/02/25/bowser-recognizes-gun-violence-as-health-crisis-launches-prevention-

AN OVERVIEW OF VIOLENCE IN THE DISTRICT

HOMICIDES

Violent deaths are a major concern in the United States, especially with recent increases in homicides and suicides. This is clearly felt in in communities of color and those with the lowest socio-economic statuses in the District of Columbia . In a city where Black Americans represent less than half of the population, they are disproportionately impacted by gun violence (Figure 2). According to the District of Columbia's Metropolitan Police Department data, 189 (95 percent) of the 198 homicide victims in 2020 were Black, and 160 of them were Black males.[4] While violence leaves a trail of preventable deaths, traumatized family, friends and communities, the ripple effects of the loss of human life is overwhelming.

FIGURE 2 **Race and Gender of VFRC 2019 Homicide Victims**



In February 2021, DC's Mayor, Muriel Bowser formally recognized and signed an executive order declaring gun violence to be a public health crisis in the city and announced a new "whole government" approach to combating the scourge. According to the District's Director of Gun Violence Prevention, Linda K. Harllee Harper, the goal is to ***"attack the root causes of gun violence before it occurs.... working one on one with the most impacted residents focusing on the circumstances that put people at high risk of engaging in or being victimized by violence."***[5] These circumstances include but are not limited to relationships, motivations, unemployment, lack of education, poverty, unstable housing, poor physical and mental health.

The District of Columbia's Violence Fatality Review Committee (VFRC) is one of the first in the United States to exclusively focus on adult decedents of homicides and suicides, using an extensive cross-sectional collaboration with an emphasis on public health. This allows agencies to be involved and held accountable while promoting wellness and opportunities for improvements in prevention programs.

Throughout the past several decades, the District of Columbia has experienced a steady increase in both homicide and suicide deaths. According to Everytown,[6] the rate of violent deaths by a firearm in the District of Columbia increased to 85 percent from 2011 to 2020, compared to a 33 percent increase nationwide. The rate of homicides by a firearm in the District increased to 92 percent compared to 70 percent increase nationwide.

4 https://mpdc.dc.gov/page/district-crime-data-glance
5 "DC mayor declares gun violence a 'public health crisis,' proposes new solutions" by Paul Duggan, Washington Post, February 17, 2021.
6 Everystat.org updated January 2022, CDC, Wonder, 2011-2020.

17X

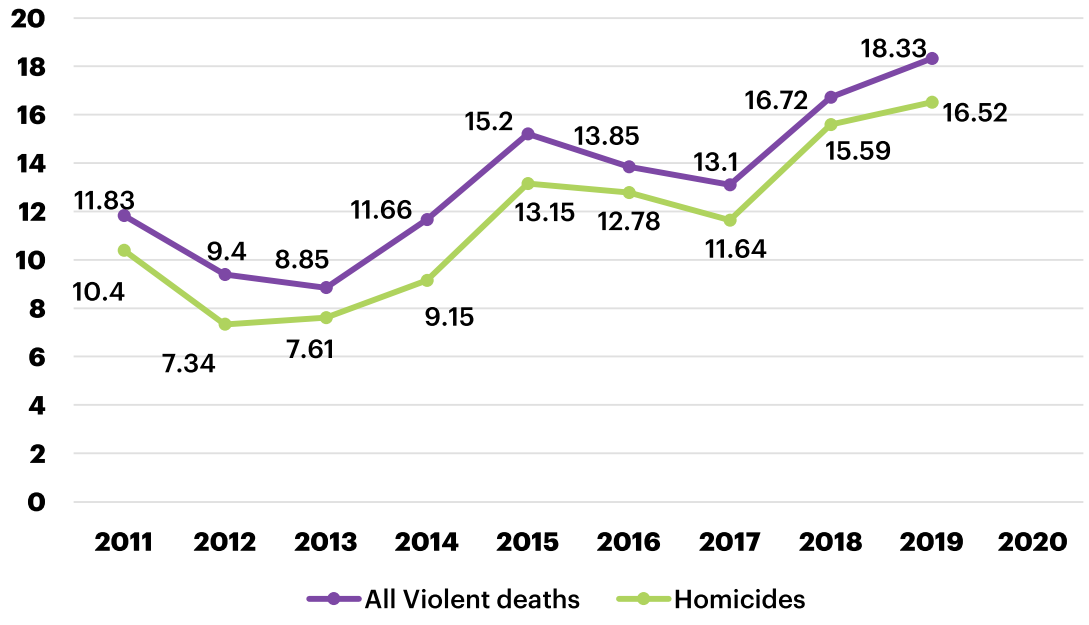
Black males were seventeen times more likely than black females to be victims of homicide.

81%

The majority (81%) of homicides in 2019 were committed with a firearm (135 of 166 cases).

Overall, suicides were more common among males.

FIGURE 3 Deaths per 100,000 People: 2011-2020



Source: CDC, Underlying Causes of Death, 2011-2020

SUICIDES

According to 2019 data from the National Violent Death Reporting System (NVDRS), the District of Columbia's suicide rate (per 100,000) was 6.7% in 2018 and remained steady for 2019.

The national suicide rate for males in 2019 was 23.3% -over two times greater than the suicide rate for males in the District of Columbia (10.6 percent). Although the District of Columbia has the lowest suicide rate compared with the United States, the District of Columbia's trend mirrors that of the United States.

- According to the Center for Disease Control and Prevention, the American Indian and Alaskan Native population have the highest rates of suicide followed by whites.
- Males have a suicide rate over three times higher when compared to females.
- Older males have higher rates of suicides, as observed among those ages sixty-five years and older. This group is followed by younger men between the ages of 45 to 54 years old.

THE DATA

This report examines the violent deaths, that occurred in 2019, reviewed by the VFRC in 2021. Various data sources for case reviews came from agency records and documents, publicly available data, community service resources and/or local service databases. Thirty individuals representing District Government agencies, residents, community service organizations, hospitals and universities participate as members on the VFRC. Case review discussions fostered data sharing among participants that resulted in a comprehensive understanding of the context of the decedent's life and what events and actions may have led up to the fatality. These discussions highlighted potential contributing factors to homicides and suicides, intervention implications and recommendations for systemic and program improvements.

THE REVIEW PROCESS

The case review process is retrospective. Information is gathered from the various District government agencies, community-based organizations, providers and the criminal investigation related to the case has been completed.
Once the Fatality Review Division (FRD) has received the quarterly list of decedents from DC Health, the fact gathering begins. The following items of information are examined:

- Demographic information for the decedent and perpetrator (i.e., age, race, gender, educational attainment, employment status, income level, etc.)
- Family dynamics
- Location of the fatal event
- Relationship of the parties involved in the fatal event
- Manner and Cause of death
- Community services requested, received, or refused by the decedent, perpetrator, and their families; and
- Circumstances leading to or involved with the death

When the decedent or his/her family had any involvement with District Government agencies and organizations, the following records (Table 1) are requested by the OCME Fatality Review Division staff. This information is then used to create the case review summary.

TABLE 1 Documentation & Records Available from DC Agencies & Organizations

Agencies & Organizations	Records Available
Chesapeake Regional Information System for our Patients (CRISP) and Hospitals	• Patient Medical Records • Prescribed Medication History • X-rays
Child & Family Services Agency (CFSA)	• Child Protective Services Reports of Abuse & Neglect • Foster Care Report • Office of Youth Engagement Reports (ages 14-21)
Court Services & Offender Supervision Agency for the District of Columbia (CSOSA)	• Adult Probation Records • Parole Supervision Records • Non-compliance Reports • Supervised Release Reports
Court Social Services (CSS)	• Juvenile Supervision & Probation Reports • GPS monitoring records
DC Health	• Birth Certificate • Death Certificate
DC Public Schools (DCPS) and Public Charter Schools	• Attendance Records • Report Cards • National Testing Scores • Individual Educational Plans (IEPs) • Truancy Reports • Discipline Reports
Department of Behavioral Health (DBH)	• Pre-Trial Services Assessments • Behavioral Health Reports • Post-Trial Services • Recovery Treatment Services • Referrals to community-based service providers
Department of Corrections (DOC)	• DC Jail Records • Correctional Treatment Facility Report • House Halfway Reports
Department of Disability Services (DDS)	• Outreach Service Reports • Service Provider Reports
Department of Healthcare Finance (DHCF)	• Medicaid Program Participation
Department of Human Services (DHS)	• TANF, SNAP, PASS Program Participation • Homeless/ Temporary Shelter Reports
Department of Youth Rehabilitation Services (DYRS)	• Case Management report • Case Plan for Placement & Rehab • Risk Management Tool • Mental Health/ Substance Abuse Assessment • Credible Messengers Reports
The District of Columbia Superior Court (DCSC)	• Warrants • Civil & Criminal Court Case documentation
Fire Emergency Medical System (DCFEMS)	• Ambulance Run Sheets • Fire Inspector Report
Hospitals and Community-based service providers	• Medical Records • Doctor's Notes • Prescription Records • X-rays, test results
Metropolitan Police Department (MPD)	• Arrest Records • Charging Document • PD-120 Death Report • PD-251 Officer's Report • Detective's Report • Victim Service Reports
Office of Attorney General (OAG)	• Juvenile Petitions • Restorative Justice Records • Diversion Program Records • Specialty Court Reports on Youth
Office of the Chief Medical Examiner (OCME)	• Autopsy Report • Scene Pictures • Toxicology Report • Investigative Report • Preliminary Death Certificate • Intake Forms & Property Forms
Office of Neighborhood Safety & Engagement (ONSE)	• Pathways Programs • Violence Intervention & Prevention Program • Family & Survivor Support Services • Violence Interrupter/ Credible Messenger Reports
Office of Unified Communications	• 911 call recordings
Pre-Trial Services (PSA)	• Records on the supervision of pre-trial defenders

"Enough is enough"
Chief Robert Contee III
Metropolitan Police Department

The case review for violent deaths includes examining the Social Determinants of Health (SDOH)[7], risk and protective factors[8] and Adverse Childhood Experiences (ACEs)[9] to help determine the decedent's life until the fatality. Homicide and suicide rates are closely associated with SDOH, risk and protective factors and ACEs as violence is a major contributor to life expectancy and provides a better understanding about the root causes of violent death. This is crucial for prevention intervention and postvention.

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7 According to Healthy People: 2030, the Social Determinants of Health (SDOH) are "the conditions in the environment where people are born, live, learn, work, play, worship and age that can support and affect health outcomes, quality of life outcomes, risks and disparities." SDOH is how your life conditions (background) influences your health outcomes.
8 Risk Factors are characteristics that increase the likelihood of experiencing violence, either as a victim or a perpetrator, but may or may not be a direct cause. Things that make it less likely that people will experience violence or that increase their resilience when they are faced with risk factors of violence are Protective factors.
9 Adverse Childhood Experiences investigates the impact of childhood traumas on the physical and mental health in adults.

CASE REVIEWS

HOMICIDES

The VFRC reviewed 118 homicide cases in 2021 of deaths that occurred in 2019, forty-eight percent (48%) of the total violent deaths that occurred in the District of Columbia in that year.

FIGURE 3 Gender, Decedents who died by Homicide, 2019

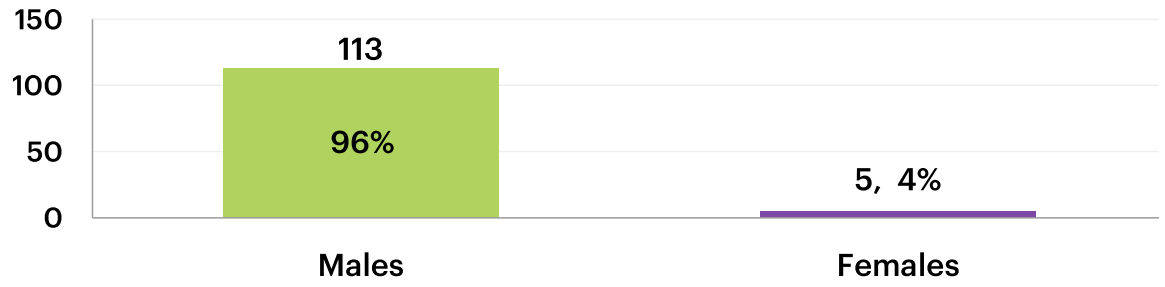
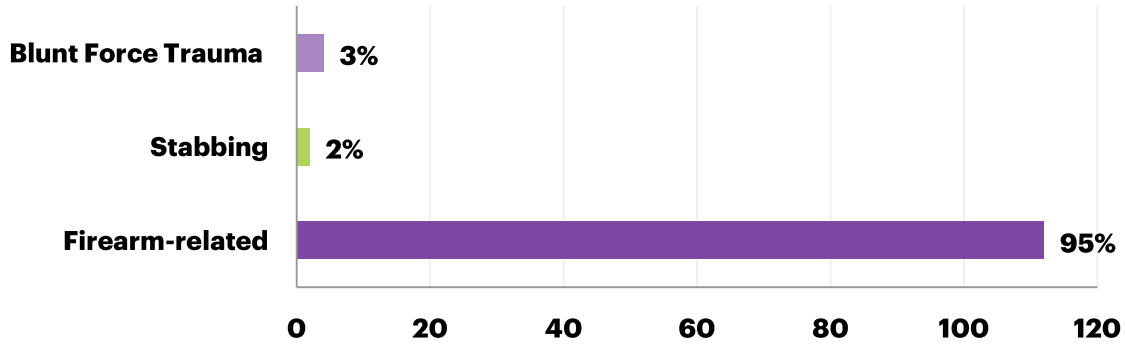


FIGURE 4 Cause of Death, Decedents who died by Homicide, 2019



RACE

FIGURE 5 Race, Decedents who died by Homicide, 2019

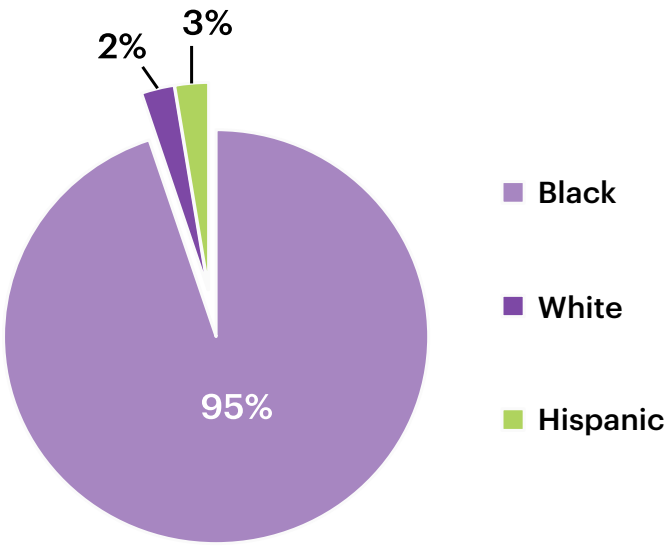
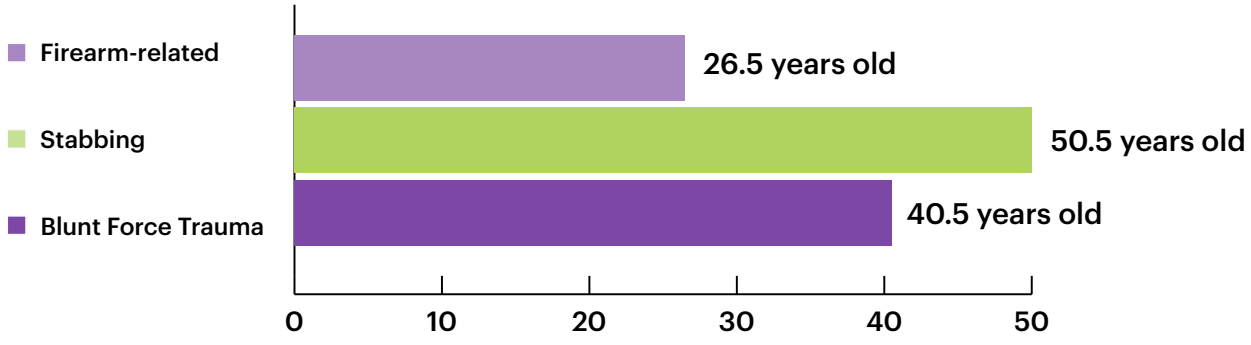


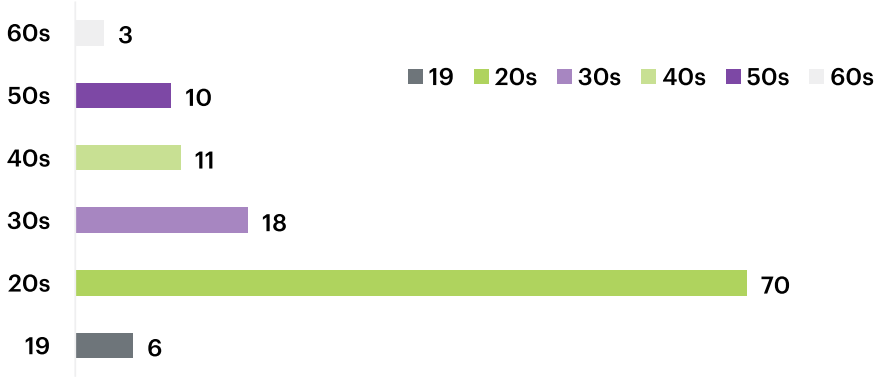
FIGURE 6 Average Age, Decedents who died by Homicide, 2019



Decedents of homicides caused by blunt force trauma and stabbings tended to be older than those who died by firearms. The average age for all homicide victims, regardless of cause of death, was 39.2 years old.

AGE

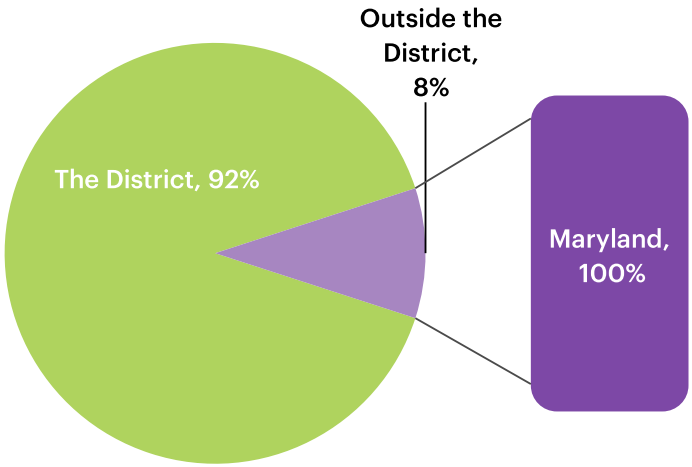
FIGURE 7 Age Breakdown, Decedents who died by Homicide, 2019



RESIDENCY BREAKDOWN BY STATE

FIGURE 8

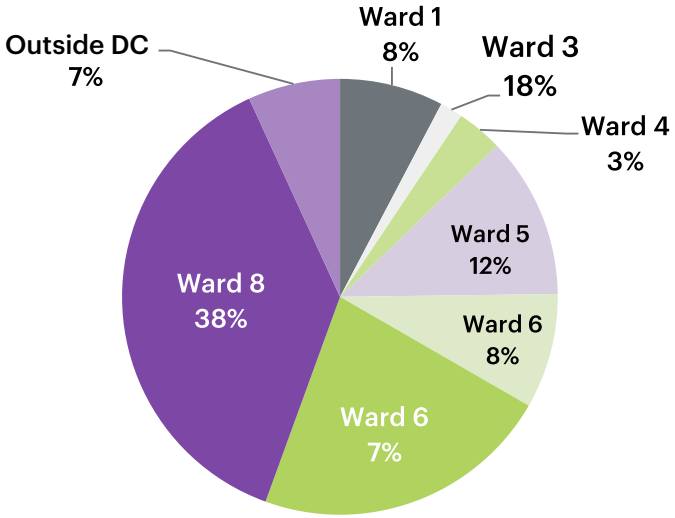
Residency Breakdown by percentage & state, Decedents who died by Homicide, 2019



WARDS

FIGURE 9

Ward of Residence of Decedents who died by Homicide, 2019



The majority of victims of homicide experienced risk factors of easy access to firearms (74%), being exposed to violence (61%), history of alcohol & drug abuse (58%), having a past criminal history (57%), and suffering from mental health issues (53%).

TABLE 2 Risk Factors for Victims of Homicide, 2019

Risk Factors	
Depression	Stressed
Involved in a local crew or gang	Involved in illicit activities
Experienced the death of a loved one	Poor conflict resolution skills
Mental health issues	Victim of previous violence
History of alcohol/ drug abuse	Financial insecurities
No/ poor compliance with taking medications	Low self esteem
Easy access to firearms	Exposed to violence
Homelessness	No mentoring systems
Past criminal history	Emotional abuse in family
Marital issues/ divorce	Physical abuse in family
Family history of violence	Sexual abuse in family
Did not graduate High School	Perpetrator of violence in the past

TABLE 3 Protective Factors for Victims of Homicide, 2019

Protective Factors
Participated in offered services and programs
Taking prescribed medications
Employed/ Retired
HS Graduate
Access to support services and interventions
Active with the Violence Interrupters/ Credible Messengers
Spiritually connected
Strong support systems
Living with Family

The protective factors for this population were not as numerous as the risk factors shown in Table 2. Almost fifty percent (49.2%) of homicide victims were high school graduates. This is lower than the national average for those aged 25 and over (88%).

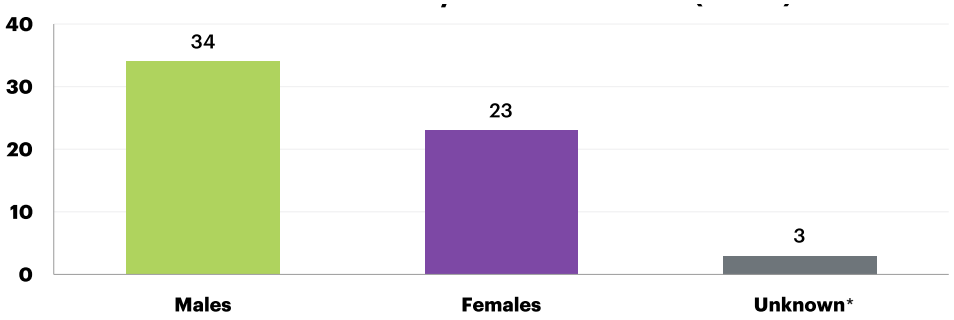
VFRC reviews documented eighty-five percent (85%) had access to support services and other interventions; however when victims of homicide were offered programs and/or services, only forty-one percent (41%) participated in them.

SUICIDES

GENDER

FIGURE 10

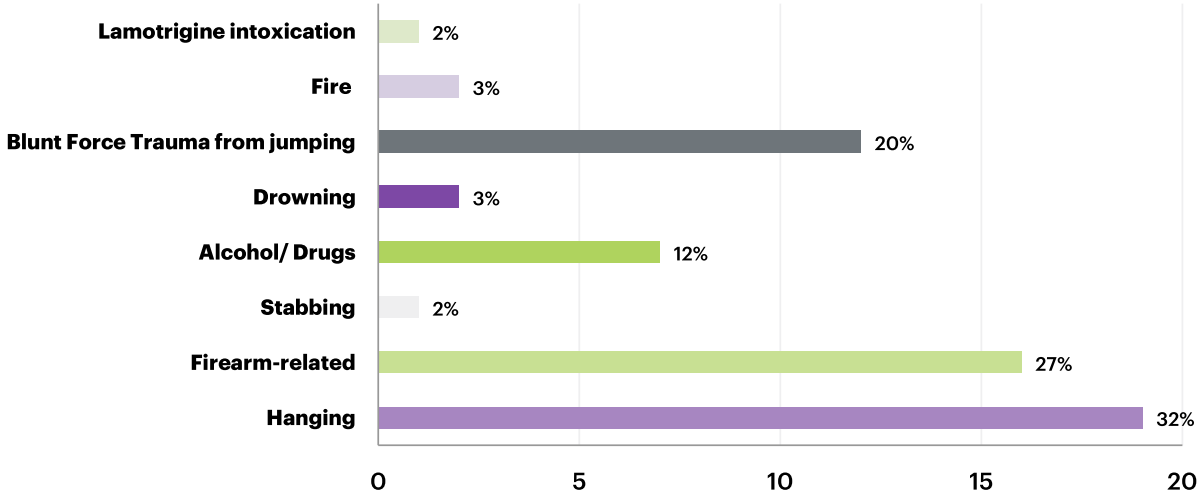
Gender, Decedents who died by Suicide, 2019



CAUSE OF DEATH

FIGURE 11

Cause of Death, Decedents who died by Suicide, 2019



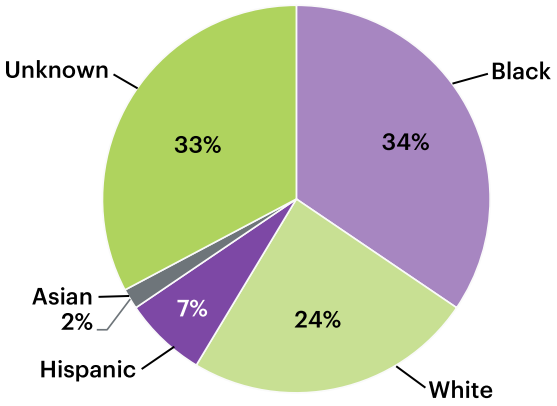
	Hanging	Firearm-related	Stabbing	Alcohol/ Drugs	Drowning	Blunt Force Trauma from jumping	Fire	Lamotrigine intoxication
Number of deaths	19	16	1	7	2	12	2	1

*Unidentifiable by DC Health records. Vital statistic records on these three decedents was not available from DC Health, because the decedents died outside of the District's jurisdiction

RACE

FIGURE 12

Race, Decedents who died by Suicide, 2019



AGE

FIGURE 13

Average Age & Cause of Death, Decendents that died by Suicide, 2019

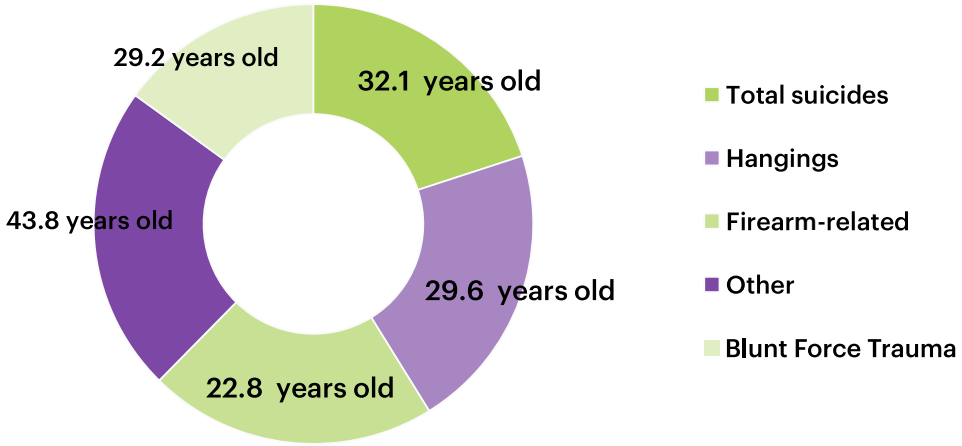


FIGURE 14 Age Breakdown, Decedents that died by Suicide, 2019

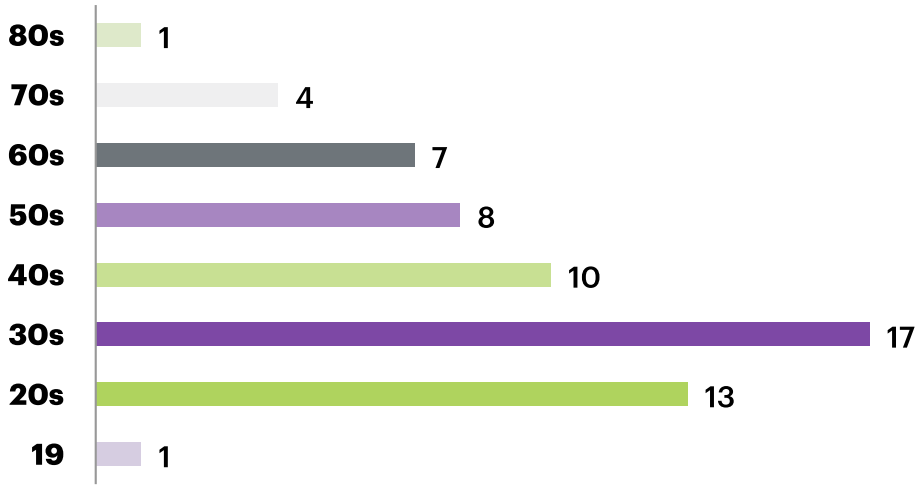
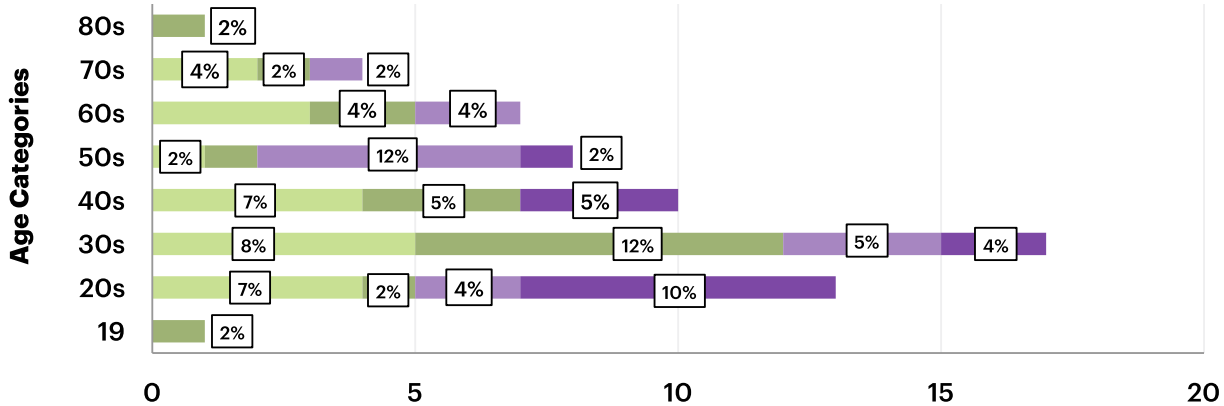


FIGURE 15 Age Breakdown & Cause of Death, Decedents who died by Suicide, 2019



	19	20s	30s	40s	50s	60s	70s	80s
Hanging	0	4	5	4	1	3	2	0
Firearm-related	1	1	7	3	1	2	1	1
Other	0	2	3	0	5	2	1	0
BFT	0	6	2	3	1	0	0	0

FIGURE 16

Residency by Breakdown by percentage & state, Decedents who died by Suicide, 2019

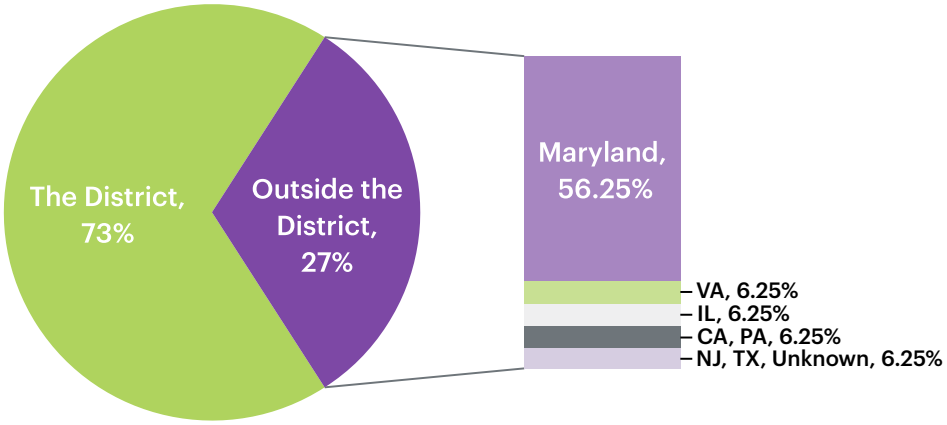


FIGURE 17

Ward of Residence of Decedents who died by Suicide, 2019

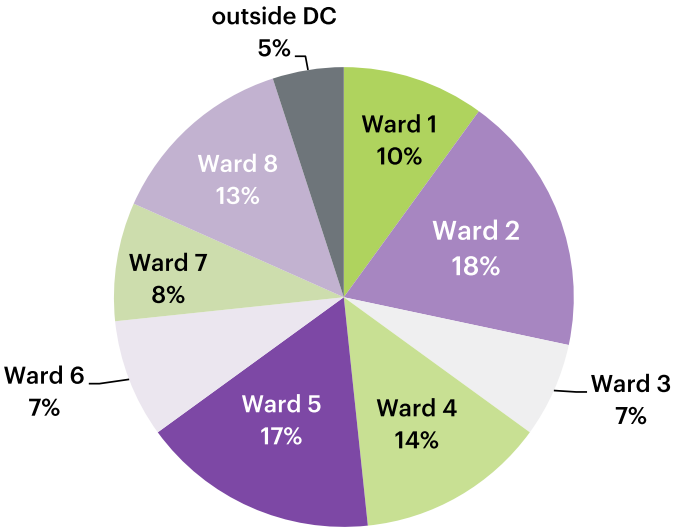


TABLE 4 Risk Factors for Victims of Suicide, 2019

Risk Factors	
Depression	Failed attempts to reconcile a relationship
Experienced a loss (relationship, job, economic, moved)	Poor conflict resolution skills
Ending/ break up of a romantic relationship	Refused help
Mental health issues	Financial insecurities
History of alcohol/ drug abuse	Suicidal ideation
No/ poor compliance with taking medications	Exposed to violence
Easy access to firearms	Hopelessness
Homelessness	Previous self-injury
Past criminal history	Feelings of Rejection
Marital issues/ divorce	Emotional abuse in family
Family history suicide	Physical abuse in family
Diagnosed with a terminal illness	Sexual abuse in family
Stressed	Low self esteem
Previous suicide attempts	

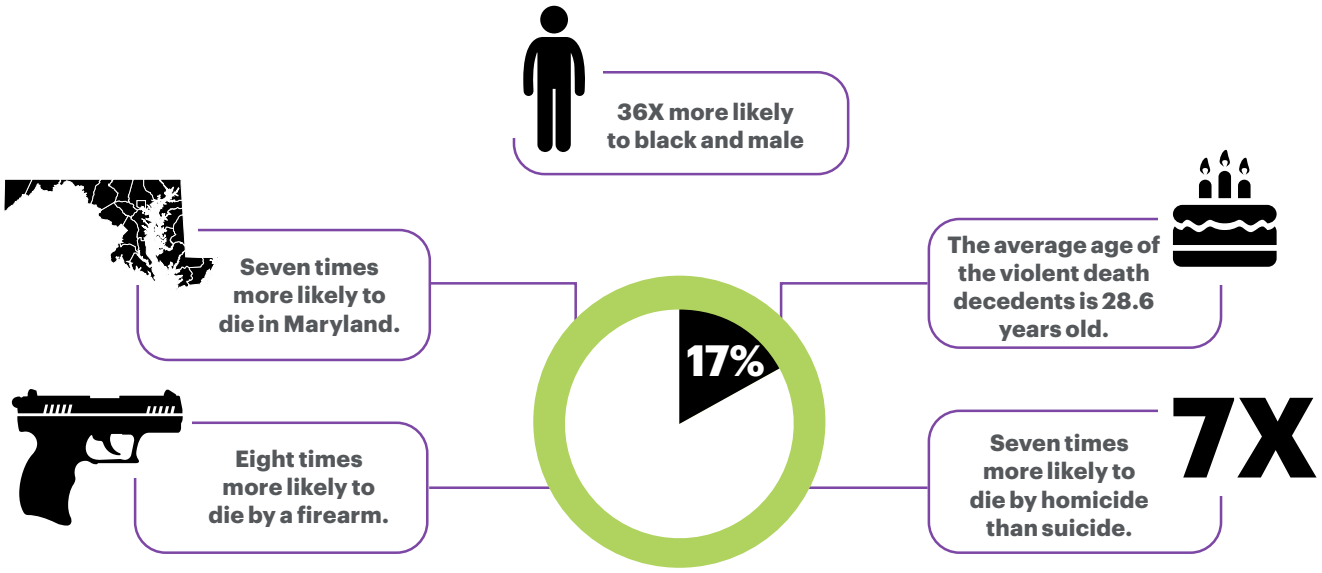
TABLE 5 Protective Factors for Victims of Suicide, 2019

Protective Factors
Sought professional help
Taking prescribed medications
Employed/ Retired
HS Graduate
Access to support services and interventions
Involved in counseling
Spiritually connected
Support systems
Living with Family

VIOLENT DEATHS OF RESIDENTS IN OTHER JURISDICTIONS

Of the 244 VFRC decedents, forty-one decedents (17%) were District residents were District residents who died in other jurisdictions outside of the District of Columbia.

FIGURE 18 Profile of Decedents in Other Jurisdictions

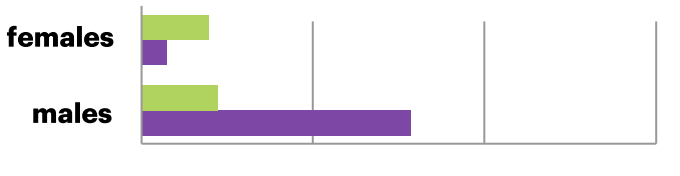


VIOLENT DEATHS OF NON-DC RESIDENTS

Of the 244 persons who died from violent deaths (homicides and suicides) in the District of Columbia, fifty-two (52) were non-DC residents. The following charts detail their demographic information:

FIGURE 19

Gender & Manner of Death, Non-DC Residents (2019)



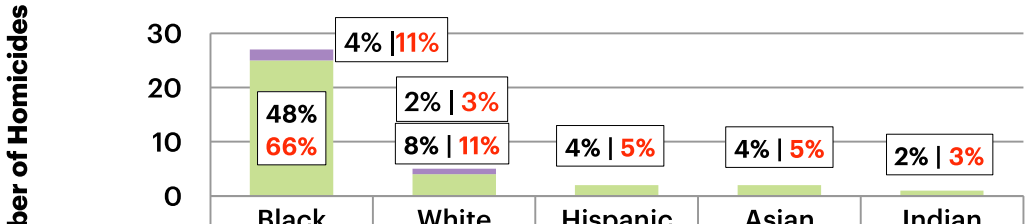
	males	females
Homicides	33	3
Suicides	8	7

Male decedents comprised 78.8% of the total non-DC resident population in 2019, followed by females at 19.2%. When broken down further by manner of death, non-DC residents who died in the District of Columbia by homicide were over eleven (11) times more likely to be male. Similarly with deaths by suicide for the same population, males were 1.14 time more likely to be victims when compared with their female counterparts, at 15% and 13%, respectively.

- Ninety-two percent of the population who died by homicide was comprised by males; compared with 8% of females.
- Seventy-eight percent of the population who died by suicide was comprised by males; compared with 21% of females.

FIGURE 20

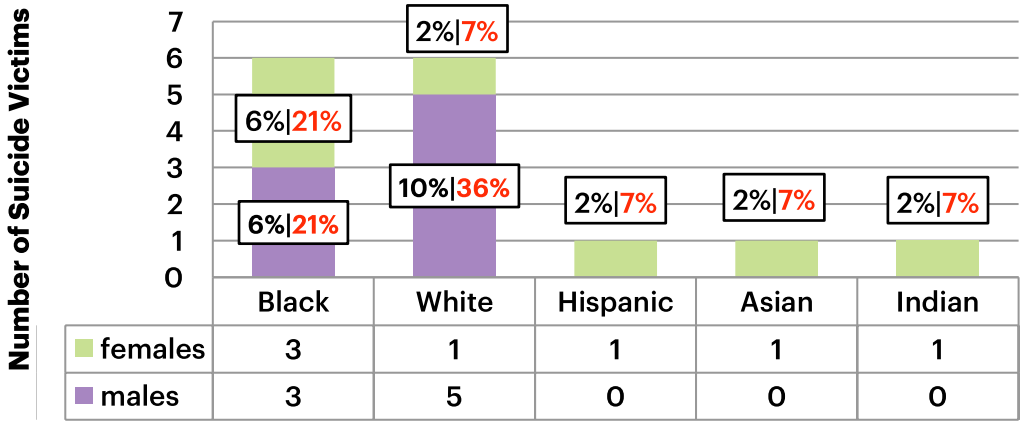
Homicides: Race, Gender & Manner of Death, Non-DC Residents (2019)



	Black	White	Hispanic	Asian	Indian
females	2	1	0	0	0
males	25	4	2	2	1

The Bold Percentage in black font is of the total population of non-DC residents (n=52).
The Percentage in red font is of the total homicide population of non-DC residents (n=38).

FIGURE 21 Suicides: Race, Gender & Manner of Death, Non-DC Residents (2019)

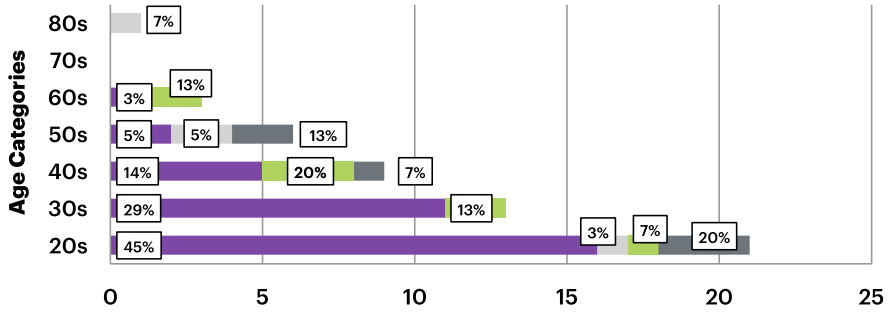


	Black	White	Hispanic	Asian	Indian
females	3	1	1	1	1
males	3	5	0	0	0

The Bold Percentage in black font is of the total population of non-DC residents (n=52).
The Percentage in red font is of the total suicide population of non-DC residents (n=14).

FIGURE 22 Age Breakdown & Manner of Death, Non-DC Residents (2019)

Figure 7: Age Breakdown & MOD, Non-DC Residents: 2019

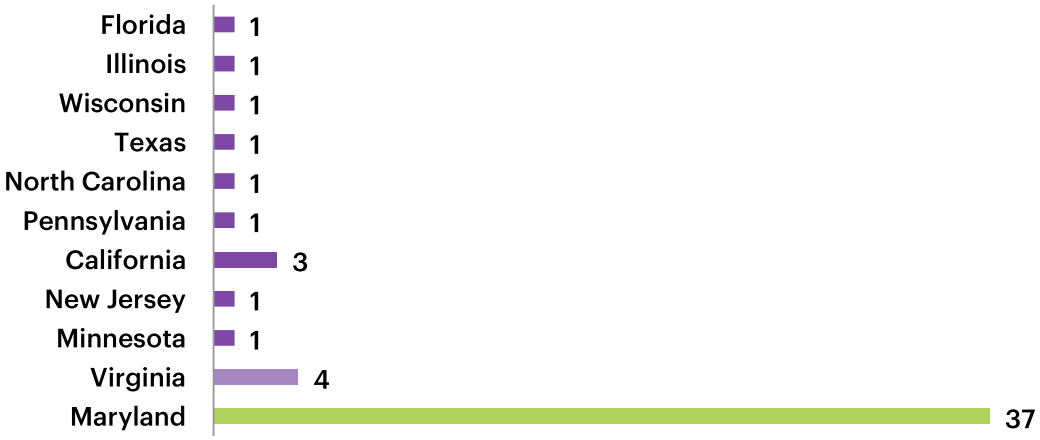


	20s	30s	40s	50s	60s	70s	80s
Homicide - males	16	11	5	2	1	0	0
Homicide - females	1	0	0	2	0	0	0
Suicide - males	1	2	3	0	2	0	0
Suicide - females	3	0	1	2	0	0	1

Percentages are based on the total homicide (n=38) or suicide (n=15) numbers for non-DC residents who died in the District.

FIGURE 23

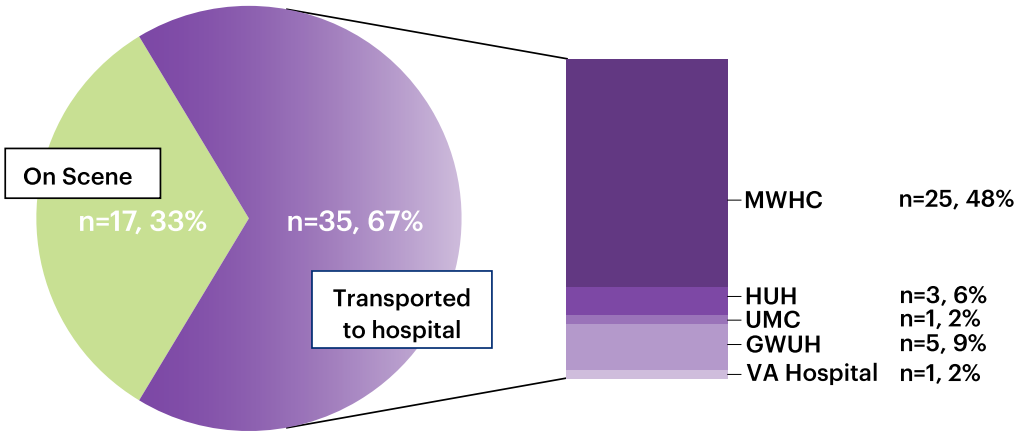
Residency, Non-DC Residents (2019)



Maryland residents compromised of decedents who were non-DC residents and died in the District at seventy-one percent; followed by Virginia (eight percent), California (six percent) and Florida, Illinois, Wisconsin, Texas, North Carolina, Pennsylvania, New Jersey & Minnesota at two percent.

FIGURE 24

Place of Death, Non-DC Residents (2019)



Thirty-three percent of non-DC Residents died on scene. Sixty-seven percent of non-DC Residents were taken to local hospitals for treatment. Forty-eight percent of decedents were transported to Medstar Washington Hospital Center (WHC), 9% of decedents were transported to the George Washington University Hospital (GWUH), 6% of decedents were transported to Howard University Hospital (HUH), and 2% of decedents were transported to United Medical Center (UMC) and the DC Veteran's Affairs Medical Center (VA Hospital) respectively. Of note, 90% of the Maryland resident decedents were transported to WHC.

PREVIOUS HISTORY

Suicide Decedents

- According to investigator interview notes with family members, ten (10) of the total number of non-DC residents who died by suicide in the District were dealing with mental health issues, however only four sought mental health treatment and received prescribed medications.
- Five decedents had previous suicide attempts.
- Records indicated that one family was left a suicide note via text message.
- Three decedents planned their suicides.
- All the decedents dealt with one or more of the following: unemployment, break ups with significant others, drug/alcohol addictions, gender identity disorder, financial problems, divorce, anxiety, OCD, stress, terminal disease, previous traumatic event(s), paranoid delusions, and the recent loss of a loved one.

PREVIOUS HISTORY

Homicide Decedents

- Four decedents were non-DC residents with involvement in the District of Columbia's criminal justice system.
- Three decedents were victims of random acts of violence.
- Two-thirds of the decedent's deaths stemmed from altercations, arguments and retaliatory incidents.
- One-third of the decedents tested positive for illicit drugs according to toxicology reports.

Those who were non-DC residents that died in the District were in DC for some of the following reasons[10]:

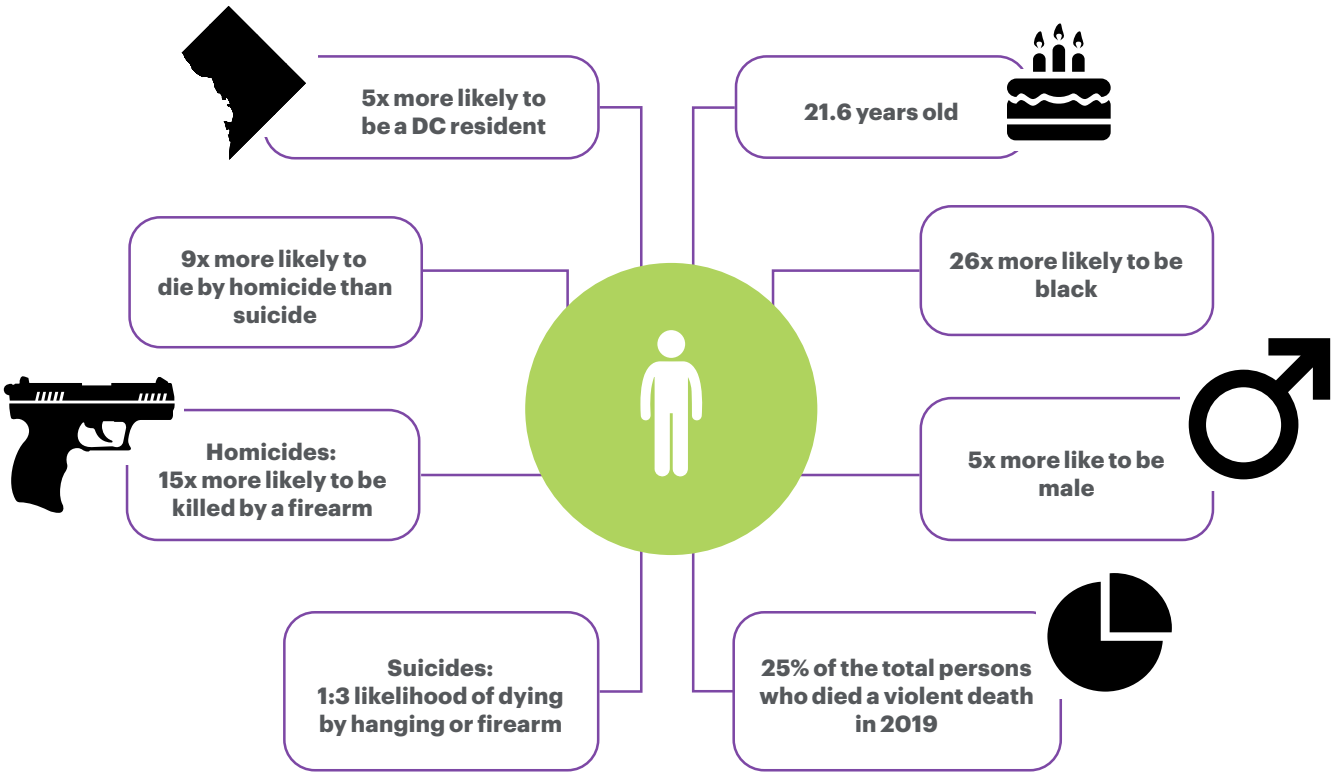
- In the military (n=2)
- Attending a college or university in the District (n=4)
- Worked in the District (n=5)
- Buying drugs in the District (n=4)
- Visiting friends or family (n=3); or
- On Vacation (n=2).

10 Not all records reviewed on non-DC residents provided information on the reason for the decedent being in Washington, DC.

THE EMERGING ADULT

Of the 244 decedents who died from violent deaths (homicides and suicides) in 2019, fifty-seven (57) were 19 to 24 years old. This population, often referred to as the "emerging adult",[11] had the highest rates of both violent offending and violent victimization.

FIGURE 25 Who is the "Emerging Adult"?



11 Emerging adulthood refers to a phase of the life span between late adolescence and early adulthood, as initially proposed by Jeffrey Arnett in a 2000 article from the American Psychologist. The term describes young adults who do not have children, do not live in their own home, and/or do not have sufficient income to become fully independent. Arnett suggests emerging adulthood is the distinct period between 18 and 25 years of age where young adults become more independent and explore various life possibilities.

The majority of the emerging adult population experienced the following risk factors: exposure to violence (88%),easy access to firearms (83%), alcohol & drug abuse (81%), associated with delinquent peers (74%), and resided in high crime areas (68%).

TABLE 6 Risk Factors Displayed Among Emerging Adult Homicide Victims

Risk Factors Present in Homicide Cases	Number of Cases*
Exposure to violence or conflict	50
Easy access to firearms	47
Alcohol & drug abuse	46
Associated with delinquent peers	42
Resided in high crime areas	39
Previous criminal history	38
History of aggressive behaviors	38
Relative in jail or killed to violence	36
High concentrations of poverty in area	36
Family dysfunction	29
Involved in gang/ crew activity	27
Did not obtain HS diploma/ GED	26
Lack of involvement in conventional activities	26
Poor/ low supervision	25
Unemployed	24
Mental health issues (diagnosed or per family)	23
No/ low involvement/ interest in school	21
Death/ loss	21
Low self-esteem	19
Diminished economic opportunities	12
Abuse in the family (witnessed, victim, perp)	4
Periods of homelessness	2

*The total number of cases for Emerging Adults was 57. The numbers represented in Table 2 refer to the number of decedents aged 19 to 24, who experienced that specific risk factor.

Over fifty percent (50%) of emerging adults had access to resources, services & programs, and had goals & aspirations.

TABLE 7 Protective Factors Displayed Among Emerging Adult Homicide Victims: 2019

Protective Factors Present in Homicide Cases	Number of Cases*
Access to resources, services & programs	35
Had goals/ aspirations	31
Employed (full-time)	27
HS graduate/ obtained GED	25
Supportive family & networks	24
Participated in DC Youth Summer Job Program	12
Connected with Violence Interrupters	12
Had mentors	10
Consistent parental presence	9
Positive memberships in peer groups	8

The fifty-one (51) Emerging Adult homicide decedents had several special circumstances:

- Fourteen (14) decedents were involved in shootings with multiple victims.
- Two decedents were involved in intimate partner violence.
- One decedent was a transgender female; this case was prosecuted as a hate crime.
- Two decedents were involved in court-supervised monitoring at the time of the fatal event.
- Forty percent of these homicides were solved and closed with the arrest and charges of suspects.
- In the cases where a motive was identified, seven (7) were neighborhood disputes (crew related); three (3) were retaliation, and eleven (11) were disputes over illicit drug transactions.

* The total number of cases for Emerging Adults was 57. The numbers represented in Table 3 refer to the number of decedents aged 19 to 24, who experienced that specific protective factor.

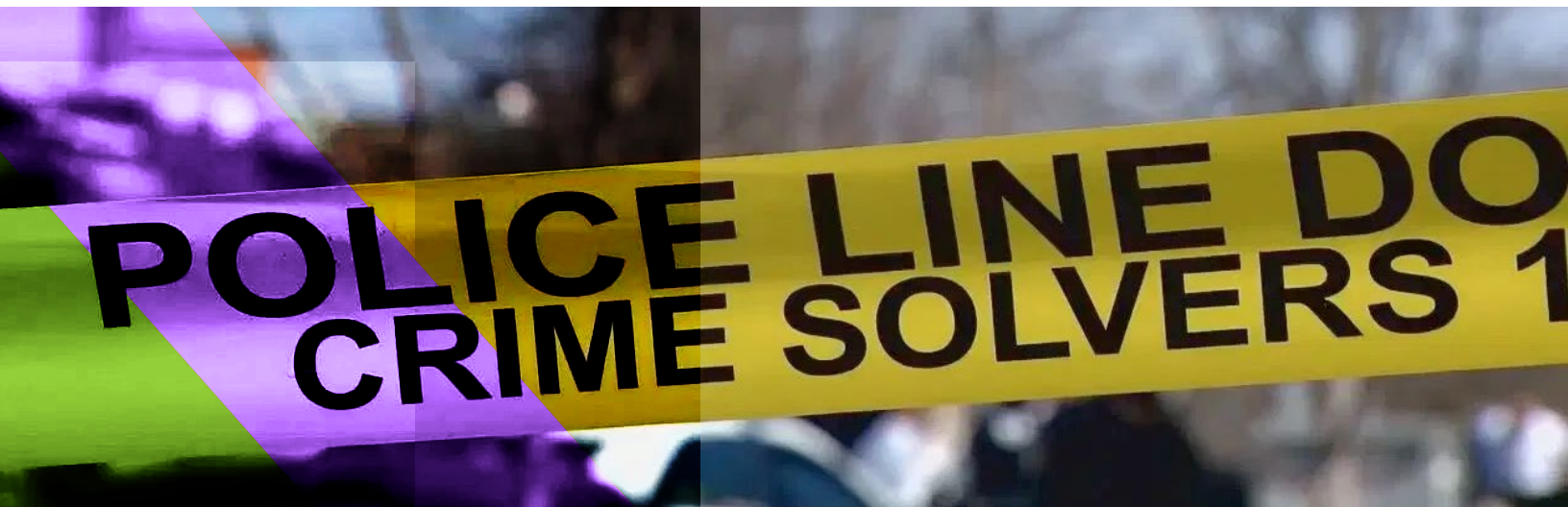
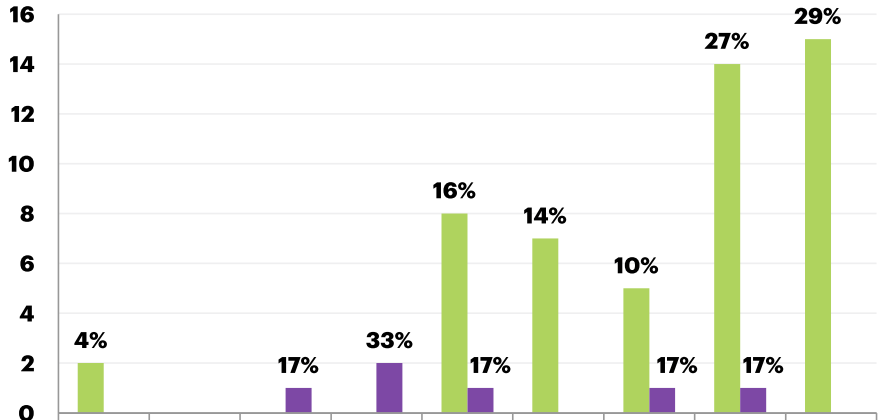


FIGURE 26

Ward Where Fatality Occurred by Manner of Death: 2019



	Ward 1	Ward 2	Ward 3	Ward 4	Ward 5	Ward 6	Ward 7	Ward 8	Died outside DC
homicide (N=51)	2	0	0	0	8	7	5	14	15
suicide (N=6)	0	0	1	2	1	0	1	1	0

Homicides

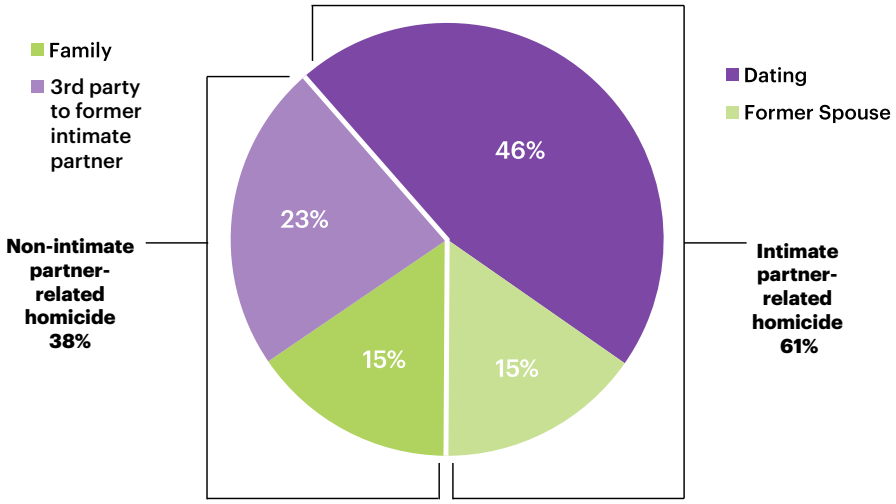
- Most of the emerging adult homicides occurred in Ward 8 (27%). There were no homicides in Wards 2, 3, or 4.
- 29% represented DC residents who died outside of the District.
- Of these decedents, most (88%) died in Maryland. 27% died at the scene of the fatal event and were taken to Baltimore for an autopsy. The remaining decedents were transported to Prince Georges Community Hospital from the scene of the fatal event.

Suicides

- There were no deaths by suicide for the emerging adult in Wards 1,2,6, or outside the District.
- One-third of the suicides committed by emerging adults occurred in Ward 4. The remaining suicides occurred in Ward 3, Ward 5, Ward 7, and Ward 8, where they comprised one-third of fatalities for those age 19-to-24 in 2019, followed by Wards 3, 5, 7, and 8 at 17%.

2019 DOMESTIC VIOLENCE CASE REVIEWS

FIGURE 27 Type of VFRC Domestic Violence-Related Homicides: 2019



Decedents whose deaths were associated with domestic violence comprised 5.3% (n=13) of the violent deaths in 2019.

FIGURE 28

Cause of Death, Domestic Violence Victims: 2019

FIGURE 29

Domestic Violence Victims by Race: 2019

FIGURE 30

Age Distributions for Domestic Violence Victims, 2019

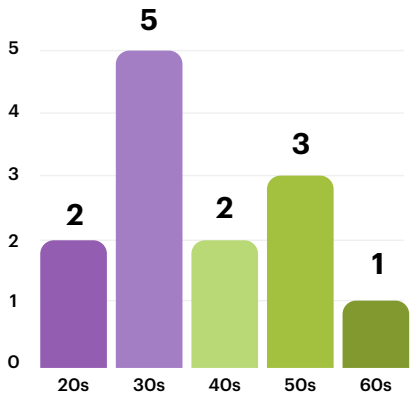


FIGURE 31

Gender, Domestic Violence Victims: 2019

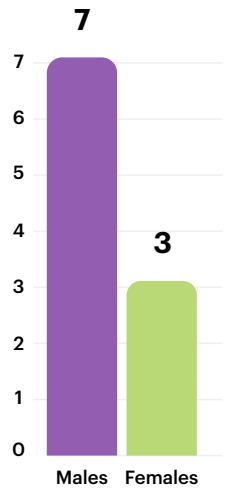
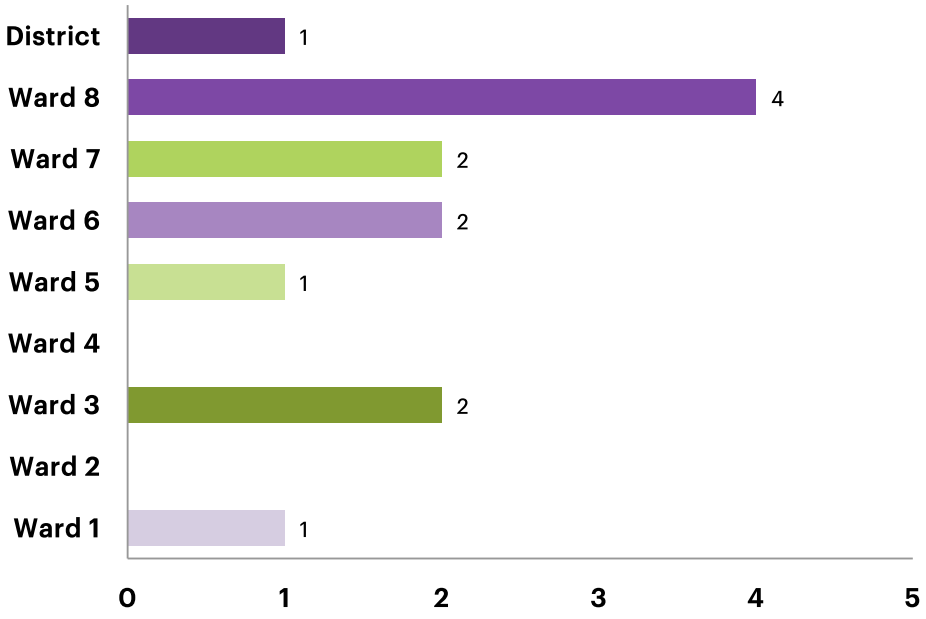


FIGURE 32

Domestic Violence-Related Homicides, 2019



Thirty-one percent (31%) of domestic violence homicides occurred in Ward 8, compared with 45% representing Ward 7, Ward 6 and Ward 3, and 23% percent for Ward 5, Ward 1, and jurisdictions outside of the District of Columbia. Ward 2 and Ward 4 had no domestic violence homicides in 2019.

RECOMMENDATIONS

The VFRC is continuing its discussion of several recommendations developed on behalf of the special population of individuals whose lives are impacted by violence. These pending recommendations will address the following areas of focus:

Area of Focus	Recommendations
Milestones & benchmarks for teens and young adults	Adolescents face many benchmarks and milestones during his time. For high school seniors these milestones include but are not limited to traditional events marking the culmination of their high school careers, prom, spring break, going to college, making new friends, breakups, being away from home for at the first time, getting a driver's license or their first job. These milestones promote positive adjustment by providing opportunities for adolescents to develop and build relationships outside of their families as they experience significant changes in their lives. Often these milestones, whether delayed, missed or on schedule, are accompanied by a range of emotions that can have a huge impact on the adolescents and their mental health. Teens need to be made aware that there are resources available to help them identify, understand and respond to signs of mental health issues and where to go for help when trying to navigate the new events or challenges they are facing.

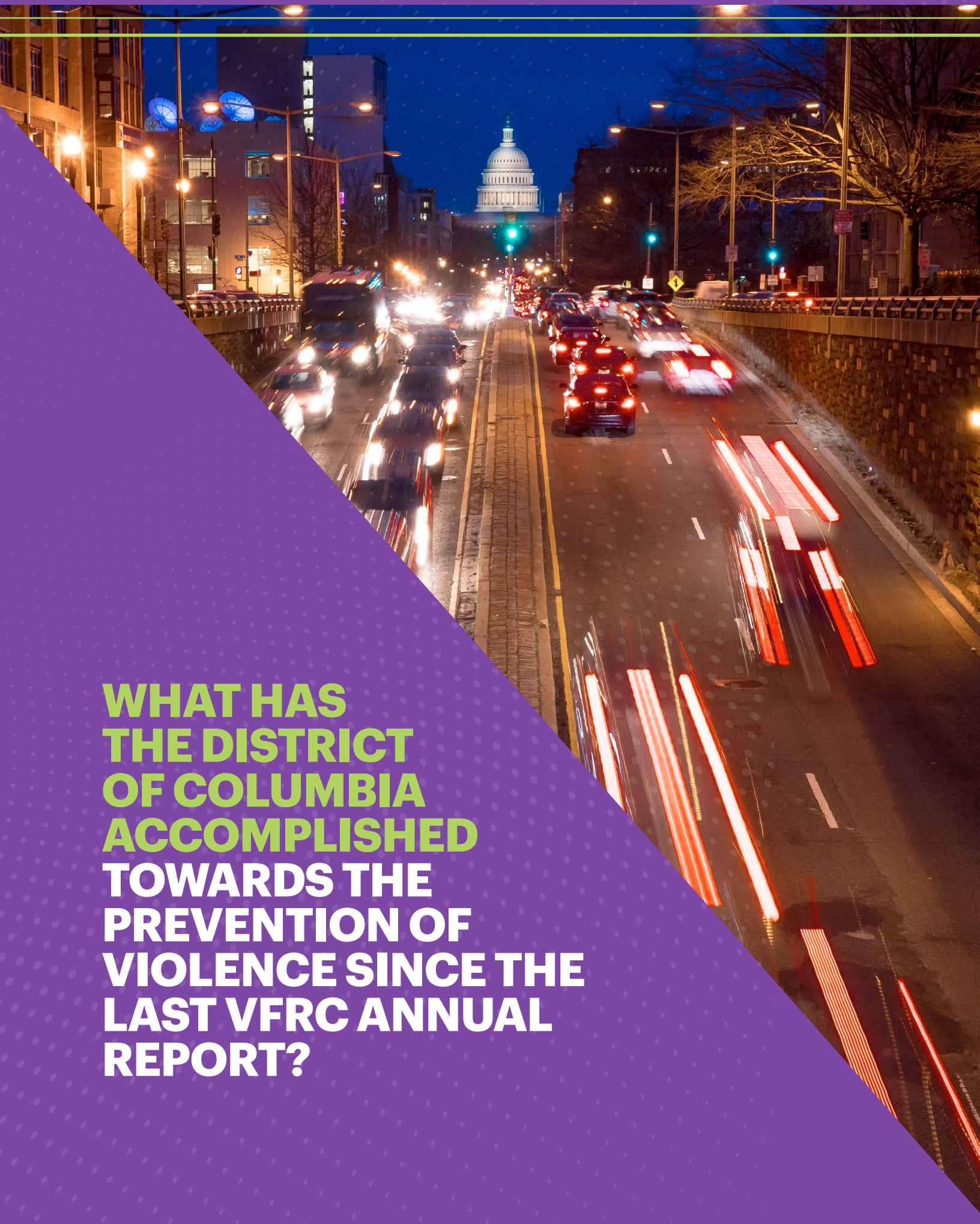
Area of Focus	Recommendations
Providing additional resources for the LBGTQIA population	• Invest in stable housing, supportive connections to caring adults, and access to mainstream services that will place homeless LGBTQIA populations on a path to long-term success. • Provide access to information and tools that LBGTQIA persons need to reduce high risk behaviors, make healthy decisions, and get medical & mental health treatment and care when necessary. • Examine the best practices of National organizations, created to help support and empower • Provide additional training, workshops and curriculum for educators, counselors, families and others involved with maintaining a safe and supportive environment for LGBTQIA persons. • Make it easier for persons to have access to community-based providers who have experience providing health services, including HIV/STD testing and counseling, and social and psychological services to LGBTQIA.

Area of Focus	Recommendations
Additional options for First-time gun offenders, other than entry into the Criminal Justice System	• Re-entry programs, specifically for juveniles and emerging adults, for populations screened as high risk for victimization and offending. • Funding will be made available for diversion programs and intensive developmentally appropriate wrap-around services for first time firearm offenders (i.e., those with possession charges) to include developing a cross-system inventory of services (to include government, community-based, federal and grant funded) available for this population. • Implement a "Gun Court" diversion program, like ones in Rochester, NY, Birmingham, AL, and Minneapolis, MN. • Offenders and their families must relate to wrap-around violence prevention and intervention services during detention and continuing post release.

"People also need to change the way they look at suicides and homicides. These are not just random acts, one-offs of violence that happen here & there. They are a preventable health problem that can be addressed by a comprehensive public health approach that includes decreasing access to the most lethal means to those most at risk."

DR. REBECCA CUNNINGHAM

Director of the University of Michigan Injury Prevention Center



WHAT HAS THE DISTRICT OF COLUMBIA ACCOMPLISHED TOWARDS THE PREVENTION OF VIOLENCE SINCE THE LAST VFRC ANNUAL REPORT?

GUN VIOLENCE PREVENTION COMMUNITY GRANTS

At a June 7, 2021, news conference, Mayor Bowser and the Director of the Office of Gun Violence Prevention announced $750,000 in community grants to individuals and local organizations to address gun violence in the District. Two types of grants - mini grants and large grants - were available:

- Mini grants, worth up to $5000, were geared towards individuals promoting public safety in their communities.
- Larger grants, up to $50,000, focused on small organizations seeking to create programs to help reduce gun violence in the District. Grant applications opened June 14 (for FY2021) on a rolling basis.

SUMMER 2021 CRIME PREVENTION INITIATIVE[12]

Since 2010, each summer the DC Metropolitan Police Department (MPD) identifies four to six areas where high density of violent crimes, specifically homicides and other gun-related incidents, occur. Throughout the summer months, MPD focuses all available resources, utilizes the latest technology, and calls upon partner agencies and organizations to assist in a coordinated effort to eliminate violent crime in these areas.

The six identified focus areas for the 2021 Summer Crime Prevention Initiative included:

- Potomac Gardens (First District)
- Rosedale/Carver-Langston (Fifth District)
- Greenway/Fort Dupont (Sixth District)
- Marshall Heights/Benning Ridge (Sixth District)
- Washington Highlands (Seventh District)
- Douglas/Shipley (Seventh District)

The Summer Crime Prevention Initiative occurs May 1-August 31 each year. Through focused prevention and strategic enforcement and the support of all partners in the criminal justice system, this program is designed to:

- Eliminate violent crime – specifically homicides
- Remove dangerous illegal guns from our neighborhood streets; and,
- Hold repeat violent offenders accountable

FALL 2021 CRIME PREVENTION INITIATIVE

The Fall Crime Prevention Initiative occurs October 1st to December 18th. It focuses all available DC Metropolitan Police Department resources and technology to eliminate violent crimes in the specified areas of:

- Columbia Heights (Third District)
- Brightwood Park (Fourth District)
- Benning (Sixth District)
- Historic Anacostia (Seventh District)
- Washington Highlands/Bellevue (Seventh District)

GUN VIOLENCE PREVENTION EMERGENCY OPERATIONS CENTER

In February 2021, with the launch of the Building Blocks DC initiative, the District of Columbia became the first jurisdiction to use an Emergency Operations Center model to coordinate violence reduction efforts between government agencies, non-profit partners, businesses and community-based organizations—focusing on the people and the places most likely to experience gun violence using a collaborative, whole-community, public health approach.

12 To learn more about MPD's Crime Prevention Initiatives, please visit mpdc.dc.gov/page/crime-prevention-initiatives.

Since February, the Gun Violence Prevention Emergency Operations Center has:

- Identified more than 67 Person-Based Service and Support resources from DC agencies that address employment, housing, substance use, mental health and family challenges,
- Completed Environmental Assessments of 151 Blocks and 49 Communities; and
- Offered 120 people employment opportunities through government and business partners.

ANALYZED 2020 VIOLENT CRIME DATA FOR DC

To identify the target blocks most likely to experience violence, particularly gun violence, the District of Columbia analyzed 2020 crime data for violent offenses and found that 151 blocks in 49 communities accounted for 41% of all gunshot-related crimes.

EXPANDING THE WORK OF THE VIOLENCE INTERRUPTERS & OTHER VIOLENCE PREVENTION PROGRAMS

On December 9, 2021, Mayor Muriel Bowser, announced a series of actions the District of Columbia is taking to expand violence prevention and intervention efforts, including expanding the work of the Office of Neighborhood Safety and Engagement (ONSE) into three new communities – Congress Park in Ward 8, Shaw in Ward 2, and Edgewood in Ward 5.[13] In addition to expanding into three new communities, ONSE is also creating a team of floating violence interrupters who will be able to respond to critical incidents and facilitate peacemaking efforts in areas of the city that are not currently designated as priority communities by the office. The office will also increase the number of violence interrupters serving existing priority communities. These expansions will ensure contracted ONSE violence interrupters are in 25 communities across seven of the District's eight wards and will increase the number of staff and contractors dedicated to life-saving violence intervention work to over eighty individuals.

13 https://thedcline.org/2021/12/09/press-release-mayor-bowser-expands-the-districts-gun-violence-prevention-and-intervention-efforts/

"There is no place where gun violence is acceptable in our city," said Mayor Bowser. ***"This is precisely why we are committed to making sure that we are investing in targeted programs and initiatives that protect our residents and bring resources to the communities that need it most."***

APPENDIX

Definitions

Adverse Childhood Experiences (ACEs) - Adverse childhood experiences encompass various forms of physical and emotional abuse, neglect, and household dysfunction experienced in childhood

Homicide - The killing of one human being by another human being

Homicide Rate - the result of dividing the number of homicides by the population of a jurisdiction.

Intervention – a strategy or approach that is intended to prevent an outcome or to alter the course of an existing condition (such as providing lithium for bipolar disorder or strengthening social support in a community). Warning Signs

Postvention – a strategy or approach implemented after a crisis or traumatic event has occurred.

Prevention – a strategy or approach that reduces the likelihood of risk of onset or delays the onset of adverse health problems or reduces the harm resulting from conditions or behaviors.

Protective factors – factors that make it less likely that individuals will develop a disorder; protective factors may encompass biological, psychological or social factors in the individual, family and environment.

Risk factors – those factors that make it more likely that individuals will develop a disorder; risk factors may encompass biological, psychological or social factors in the individual, family and environment.

Socio-Ecological Model - This model considers the complex interplay between individual, relationship, community, and societal factors. It allows us to understand the range of factors that put people at risk for violence or protect them from experiencing or perpetrating violence. The overlapping rings in the model illustrate how factors at one level influence factors at another level.

Suicidal act (also referred to as suicide attempt) – a potentially self-injurious behavior for which there is evidence that the person probably intended to kill himself or herself; a suicidal act may result in death, injuries, or no injuries.

Suicidal behavior – a spectrum of activities related to thoughts and behaviors that include suicidal thinking, suicide attempts, and completed suicide.

Suicidal ideation – self-reported thoughts of engaging in suicide-related behavior.

Suicidality – a term encompassing suicidal thoughts, ideation, plans, suicide attempts, and completed suicide.

Suicide – death from injury, poisoning, or suffocation where there is evidence that a self-inflicted act led to the person's death. Suicide attempt – a potentially self-injurious behavior with a nonfatal outcome, for which there is evidence that the person intended to kill himself or herself; a suicide attempt may or may not result in injuries.

Suicide Rate - the result of dividing the number of suicides by the population of a jurisdiction.

Violent Death - NVDRS defines a violent death as a death that results from the intentional use of physical force or power, threatened or actual, against oneself, another person, or a group or community.

ACKNOWLEDGMENTS

The Office of the Chief Medical Examiner wishes to acknowledge the dedication and unwavering support of the public servants, private agencies, violence prevention advocates & volunteers, community-based organizations, mental health & medical practitioners, and residents of the District of Columbia who serve as members of the District of Columbia's Violence Fatality Review Committee.

Through their act of courage and pursuit of the truth, the members meet monthly to examine the details surrounding violent deaths and the circumstances that may have contributed to a person's homicide or suicide. The members' unwavering commitment to improving the quality and lives of all residents of the District of Columbia through this process is admirable.

We would like to thank the members of the Committee for volunteering their time, support and dedication, while using their resources to achieve our common goal. We are grateful for your integrity and service to keep the residents of the District of Columbia safe.

We also want to thank the staff of OCME's Fatality Review Division for their hard work and due diligence to request & gather records, research & write case reviews & recommendations and facilitate the administrative needs for the meetings.

If you or someone you know may be considering suicide, contact the National Suicide Prevention Lifeline at 1-800-273-8255 (en espanol: 1-888-628-9454; deaf & hard of hearing: 1-800-799-4889) or the Crisis Text Line by texting "HOME" to 741741.

VIOLENCE FATALITY REVIEW COMMITTEE

2021 ANNUAL REPORT

Washington, DC

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