DISTRICT OF COLUMBIA

CHILD FATALITY REVIEW COMMITTEE ANNUAL REPORT

2017

DISTRICT OF COLUMBIA

CHILD FATALITY REVIEW COMMITTEE

2017 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

SEPTEMBER 2018

DISTRICT OF COLUMBIA
CHILD FATALITY REVIEW COMMITTEE
2017 ANNUAL REPORT

MISSION

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

CHILD FATALITY REVIEW COMMITTEE MEETING CO-CHAIRS

ROGER A. MITCHELL, JR., MD
CHIEF MEDICAL EXAMINER, OCME

CO-CHAIR, CHILD FATALITY REVIEW COMMITTEE

CYNTHIA G. WRIGHT, ESQ.
ASSISTANT US ATTORNEY - HOMICIDE SPECIAL VICTIMS UNIT, USA

CO-CHAIR, CHILD FATALITY REVIEW COMMITTEE

OFFICE OF THE CHIEF MEDICAL EXAMINER FATALITY REVIEW UNIT (2017)

JENNA BEEBE-ARYEE, MSW
FATALITY REVIEW PROGRAM MANAGER

TRACIE T. MARTIN, MSW
SENIOR FATALITY REVIEW PROGRAM SPECIALIST

JACQUELINE CORBIN-ARMSTRONG, MSW, MSM
FATALITY REVIEW PROGRAM SPECIALIST

ANDRE MULLINGS
OUTREACH SPECIALIST (GRANT)

TOYA BYRD
STAFF ASSISTANT

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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 welcomed six new community members. Their expertise in public health, child advocacy and residential life in the District of Columbia has enriched CFRC's discussions. Moreover, CFRC provided the new community members with the ability to become actively invested in the activities of the review process as well as promote improved and integrated public and private systems serving the District's children on safe sleep practices, care of our infants, and violence among our adolescents.

The CFRC is pleased to present its 22nd Annual Report covering mortality data from child/youth fatalities that were reviewed during calendar year 2017. This year, the committee reviewed 116 death cases: 3 from CY2014, 73 from CY2015, 39 from CY2016, and 1 from CY2017. This is a substantive increase compared to the 39 cases reviewed in 2016. The 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 while we work toward sustainable system change.

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

Yours in Truth and Service,

Roger A. Mitchell, Jr., MD

Chief Medical Examiner

District of Columbia Office of the Chief Medical Examiner

GREETINGS FROM THE CO-CHAIR

Throughout the last year, the Child Fatality Review Committee (CFRC) has improved the quality of our reports, provided influential recommendations to policymakers, and achieved tangible results for the District's children and infants.

The addition of new community members who provide a fresh perspective to our work coupled with improved attendance by our members has increased the vitality of the CFRC. One of the most productive moments this past year, was when our Committee identified an issue, reached out to a prominent medical provider who serves our community and educated them about helping to identify victims of child abuse and neglect. The provider responded positively and in turn, made efforts to educate their staff about how to identify victims of child abuse and neglect. We are encouraged to know that we are having a positive impact on improving the quality of life of all District residents by potentially saving the lives of many District children.

Additionally, we continue to provide valuable training opportunities to our committee members and the community. As a result, we have strengthened the esprit de corps of our direct service providers. The Committee is proud of our accomplishments. We welcome the opportunity to continue to collaborate on making even more progress in bettering the lives of children.

I am honored to serve on this Committee and have greatly benefited both personally and professionally, learning so much from other dedicated committee members. I am confident that this team will continue to make great strides in bettering the lives of the District's children in 2019.

Sincerely,

Cynthia G. Wright

Cynthia G. Wright, Esq.

Assistant U.S. Attorney.

DISTRICT OF COLUMBIA
CHILD FATALITY REVIEW COMMITTEE
2017 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 2017, members and meeting participants represented the following District Government agencies, medical providers, and community based organizations:

THE INFANT MORTALITY REVIEW TEAM (IMRT)

A DC MIDWIFE

CENTER FOR THE STUDY OF SOCIAL POLICY

CHILDREN'S NATIONAL MEDICAL CENTER

DC HEALTH

DEPARTMENT OF HEALTH CARE FINANCE

EVERMORE

MARCH OF DIMES

OFFICE OF THE CHIEF MEDICAL EXAMINER

OFFICE OF THE ATTORNEY GENERAL

OFFICE OF THE US ATTORNEY FOR THE DISTRICT OF COLUMBIA

METROPOLITAN POLICE DEPARTMENT

THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS

AMERIHEALTH CARITAS DC

CHILD AND FAMILY SERVICES AGENCY

DEPARTMENT OF BEHAVIORAL HEALTH

DC HOUSING AUTHORITY

DEPARTMENT OF HUMAN SERVICES

HOWARD UNIVERSITY HOSPITAL

NATIONAL INSTITUTES OF HEALTH-
CHILDREN'S HEALTH AND HUMAN DEVELOPMENT

PROVIDENCE HOSPITAL

TRUSTED HEALTH PLAN

THE CHILD FATALITY REVIEW TEAM (CFRT)

The CFRT convenes on the 3rd Thursday of each month. In 2017, 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 OF BEHAVIOR HEALTH
- DEPARTMENT OF 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

The death of an infant, child or youth resident of the District of Columbia initiates a call to action. Community residents, government employees and advocates of the District's most vulnerable population convenes monthly to answer the question "What, if anything, could have been done to prevent this death?"

The District's child fatality review process is the only legislatively established mechanism within the city 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 and improve the quality of life for all residents.

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

EXECUTIVE SUMMARY

The District of Columbia Child Fatality Review Committee is pleased to present its 22nd Annual Report. This Report covers data from 116 infant, children and youth fatality cases reviewed by the CFRC during meetings held in 2017.

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 services[1] 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. Most important, Committee membership includes community members representing the District of Columbia's Wards. 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.

The CFRC reviews cases based on criteria set forth in the legislation. This annual report summarizes data collected from 116 infant, child and youth fatalities that met the criteria for case review and were pending a review. These cases represent a subset of fatalities that occurred in 2014, 2015, 2016, and 2017 but do not represent statewide data[2].

This report is comprised of two sections:

» Section 1

Summary of Team Findings - This section provides the reader with 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 and the agency's responses.

1 None of the deaths reviewed by the CFRC in 2017 met the criteria for review due to the decedent's involvement with intellectual and disability services.

2 For statewide estimates of birth outcomes, including prematurity, low birth weight and infant mortality, please see the 2014 Infant Mortality Report at dchealth.dc.gov

KEY CHILD FATALITY REVIEW DATA FINDINGS

DECEDENT DEMOGRAPHICS

The age of the 116 decedent cases reviewed by the CFRC in 2017 ranged from birth to 22 years of age. Select demographic information is bulleted below:

- Eighty-five percent (85%, 99 cases reviewed) of the decedents were infants.
- Seventy-four percent (74%, 85 cases reviewed) of the decedents were Black or African American.
- Eighty percent (80%, 92 cases reviewed) of the decedents died of natural causes.
- Three percent (3%, 3) of cases reviewed were of decedents who died in 2014.
- Sixty-three percent (63%, 73) of cases reviewed were of decedents who died in 2015.
- Thirty-four percent (34%, 39) of cases reviewed were of decedents who died in 2016.
- One percent (1%, 1) of cases reviewed was of decedents who died in 2017.

MANNERS OF DEATH

Natural Deaths

The CFRC reviewed ninety-two (92) natural cases involving infants. Among the natural death case reviews, fifty-five percent (55%, 64 cases) involved infants who died of causes related to premature birth.

Homicide

The CFRC reviewed ten (10) fatalities of decedents whose deaths resulted from acts of violence. These decedents were between the ages of 3 months and 22 years old.

Accidental

The CFRC reviewed five (5) accidental deaths resulting from choking on food (3 cases), drowning (1 case), and a car accident (1 case).

Undetermined

The CFRC reviewed seven (7) undetermined deaths. Six (6) of these cases involved infants whose sleep environment was identified as a risk factor in the death.

Suicide

The CFRC reviewed two (2) suicide cases of African American male youth.

» Child Fatality Review Committee Community Engagement Grant

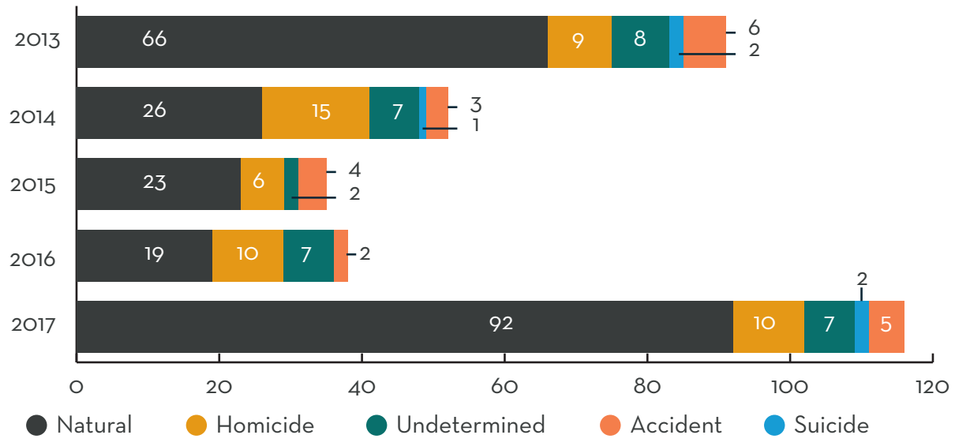
In FY2017, the OCME continued its receipt of grant funds in the amount of $119,000 from the Office of Victims Services and Justice Grants (OVSJG) for the CFRC to engage in community outreach and provide training to CFRC members on trends and themes identified through case reviews or on topics of interest in an effort to further facilitate the CFRC's work. This grant provided continued funding for an Outreach Program Specialist who was tasked to directly interact with District residents, community leaders, advocates and public agency leaders. This collaboration created the platform to share and address the issues identified in the annual report, as well as trends the Committee believed to be vitally important. Training for members on violence, trauma and healing and an in-depth look into gun violence was provided. As the CFRC benefited greatly from the grant, it continues to become a leading voice in the prevention of child deaths. (See Appendix 1 for more details).

» Child Fatality Review Committee - Total Case Reviews

The Child Fatality Review Committee 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 the deaths of infants, children and youth who were residents of the District of Columbia. Due to the vulnerability of this population, each team is charged with evaluating government-based systems that provided services to families prior to or at the time of the death.

Since 2013, the CFRC has reviewed 332 deaths of infants, children and youth (as indicated in Figure 1). Most of the cases reviewed involved infants and children who died of natural causes (227, 68%) and victims of homicide (50, 15%). Additionally, infant and child deaths were due to undetermined cases (31, 9%), accidents (20, 6%) and suicides (5, 2%).

FIGURE 1: TOTAL CFRC CASE REVIEWS 2013-2017



During the case review meetings, each CFRC team considers adverse environmental factors that have impacted the lives of the District's infants, children and youth. These issues often become relevant in cases involving premature births, youth homicides, and the sudden unexpected death of an infant.

Since 2013, the CFRC teams reviewed 129 deaths involving premature births, 40 youth homicides and 27 cases involving the unsafe sleep environment of infants and medically fragile children.

CFRC 2017 CASE REVIEWS MANNERS OF DEATH IN CHILDREN

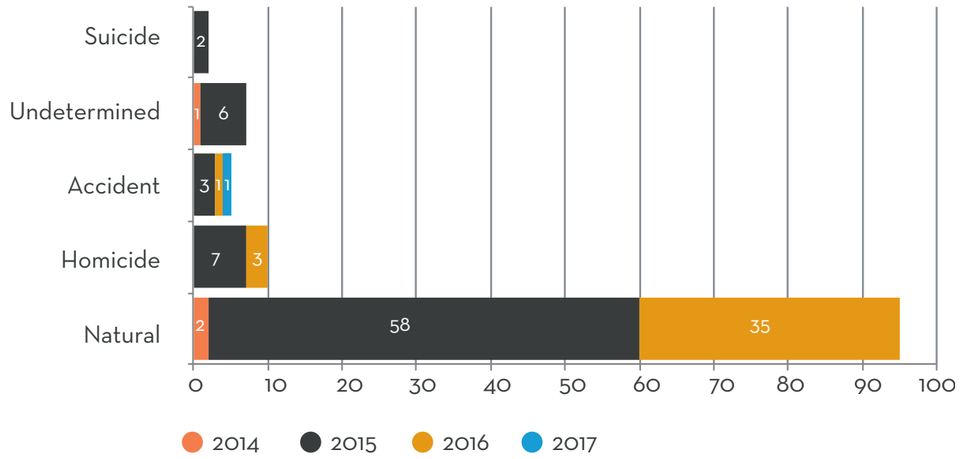
TABLE 1: MANNERS OF DEATH OF INFANTS AND CHILDREN REVIEWED IN 2017(N= 116)

CFRC 2017 MANNERS OF DEATH	CFRC ANNUAL REPORT DEFINITION
Natural 92 cases reviews (80%)	Deaths caused by the natural disease process[3], including prematurity and not an accident or violence
Homicide 10 cases reviews (8%)	The deliberate and unlawful killing of a person by another person
Undetermined 7 Cases reviewed (6%)	Following a thorough medical and legal investigation, a conclusive manner of death is not determined
Accident 5 Cases reviewed (4%)	Deaths caused unintentionally rather than by natural causes, suicide, or murder
Suicide 2 Cases reviewed (2%)	Deaths caused by self-inflicted behavior with the intent to die as a result

3 Of note, although the death may be the result of a natural disease process, some may have been preventable

Eighty percent (80%) of the cases reviewed by the CFRC involved the natural death of infants. The remaining twenty percent (20%) of cases reviewed involved homicides, accidental deaths and suicides of children and youth.

FIGURE 2: 2017 CASE REVIEWS BY DECEDENT YEAR OF DEATH



In 2017, the Committee reviewed 116 cases of child deaths that occurred in 2014, 2015, 2016 and 2017. CFRC legislation permits the Committee to establish the manner in which it selects cases for review. The Committee may conduct a multidisciplinary review of individual fatalities; multidisciplinary review of clusters of fatalities identified by special category or characteristic; statistical reviews of fatalities; or any combination of such approaches. In keeping with previous years, for this review period, the IMRT chose to conduct 17 multi-disciplinary full case reviews of individual infant fatalities and 82 statistical case reviews of infants who died of natural causes.

The multidisciplinary full case review process provided the IMRT with records from multiple agency sources and was conducted on decedents who may have been born premature, but lived for over 30 days. The statistical reviews were conducted utilizing information obtained only from vital records- birth and death certificates. These reviews were high in number and the decedents they focused on were born premature, lived for less than 30 days and were never discharged from the hospital. Information compiled from the reviews is included in Section I: Summary of Team Findings and does not represent statewide data.

1

SUMMARY OF TEAM FINDINGS

» Infant Mortality Review Team Natural Death Statistical Review Findings

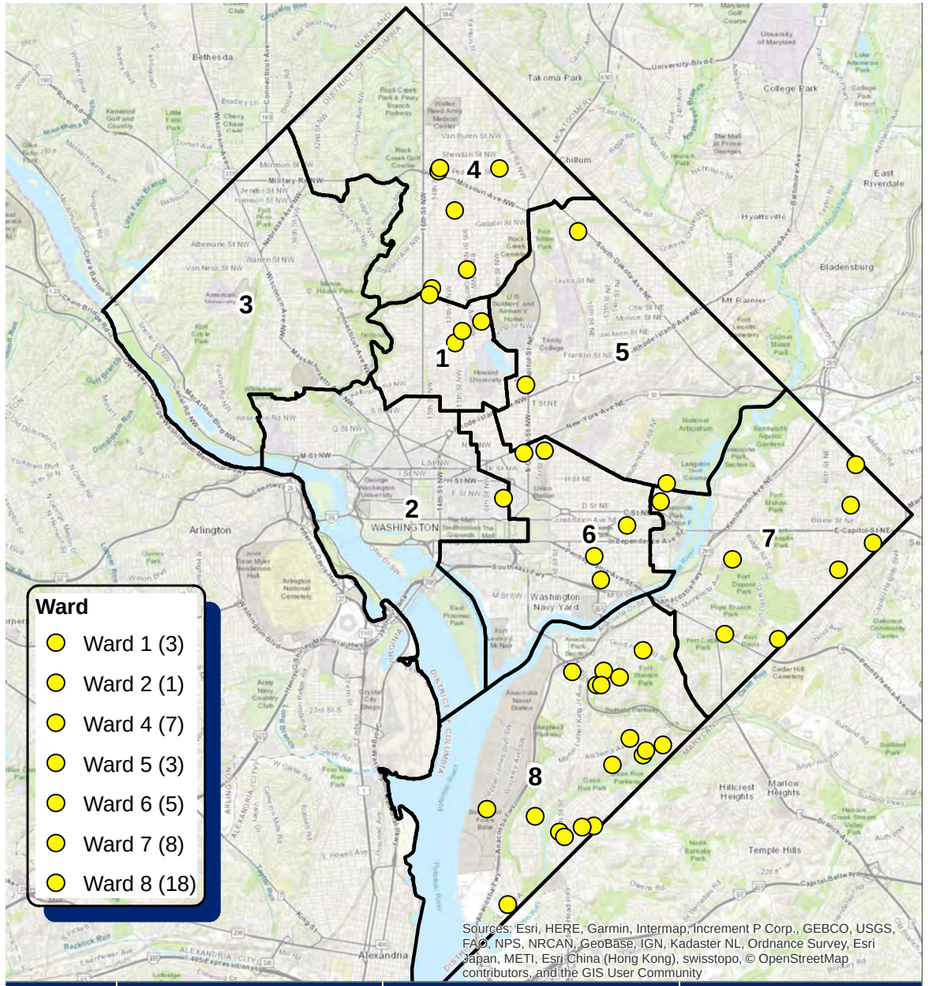
In 2017, the IMRT conducted a statistical review of 82 infants who met the criteria for review and who died of natural causes. These infant deaths were due primarily to disorders of newborns related to short gestation and low birth weight, followed by cardiovascular disorders or other respiratory conditions originating in the perinatal period. The results of the statistical reviews are provided in accordance with the year of the infant's death. These infants lived up to a matter of minutes, hours and 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 DC Health (DOH) Vital Statistics- Certificate of Live Birth and Certificate of Death.[4]

4 This information is not statewide data. For statewide estimates of birth outcomes, including prematurity, low birth weight and infant mortality, please see the 2014 Infant Mortality Report at dchealth.dc.gov.

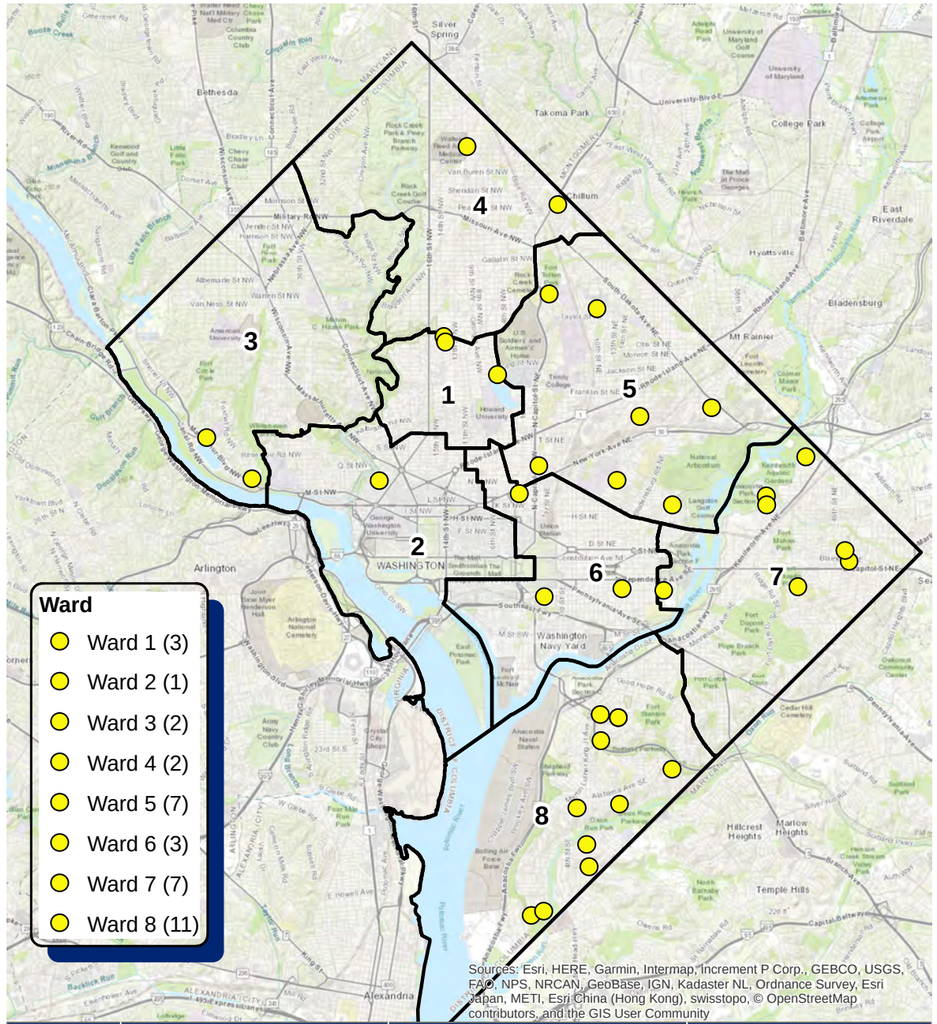
MOST COMMON CHARACTERISTICS OF MOMS

- I am a 30 year old Black resident of Ward 8. I have my high school diploma. I have barriers to prenatal care 50% of the time.
- My risk factors include: previous Cesarean section, hypertension (prior to pregnancy) previous pre-term birth and diabetes (prior to pregnancy)

2017 IMRT STATISTICAL REVIEW CASES (NATURAL CASES, 2015)



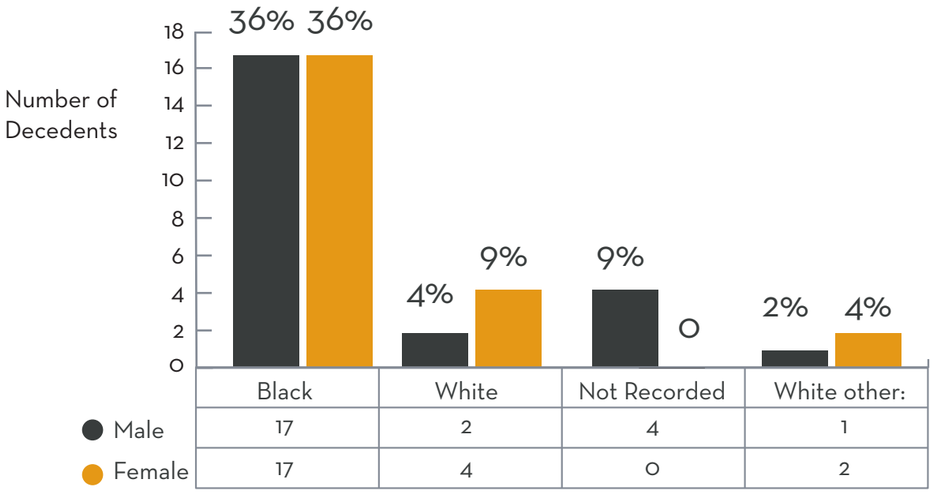
2017 IMRT STATISTICAL REVIEW (NATURAL CASES, 2016)



STATISTICAL REVIEWS- 2015 AND 2016 DECEDENT INFORMATION

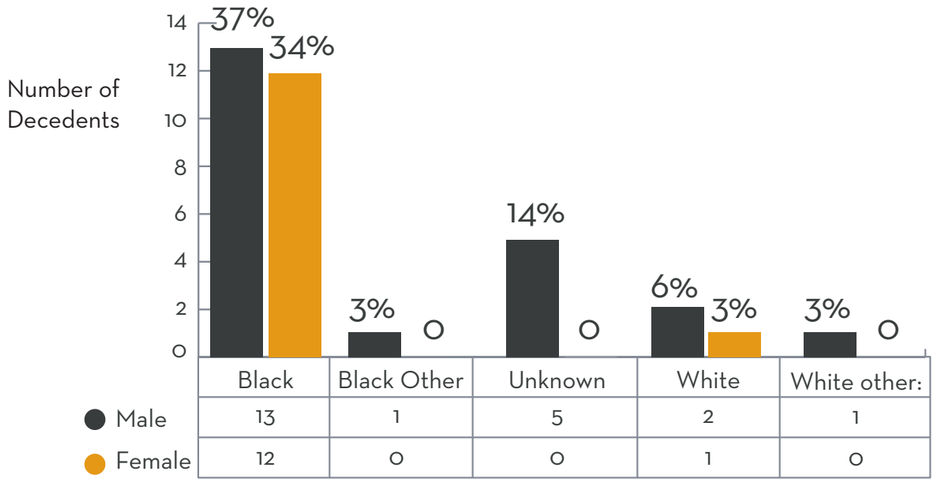
There were fifty-one percent (51%, n=24) of male and forty-nine percent (49%, n=23) of female decedents included in the statistical review that died in 2015 and sixty-three percent (63%, n=22) of male and thirty-seven percent (37%, n=13) of female decedents included in the statistical review that died in 2016. Of these, seventy-two percent (72%) of decedents who died in 2015 and seventy-one percent (71%) of decedents who died in 2016 were Black residents of Ward 8. Eighty-one percent (81%) of decedents who died in 2015 were Singleton pregnancies with thirteen percent (13%) being Twins and two percent (2%) being Quadruplets. Eighty-six percent (86%) of the decedents who died in 2016 were Singleton pregnancies with fourteen-percent (14%) being Twins. Forty-three percent (43%) of decedents who died in 2015 lived between 1-27 days with an average of eight (8) days lived. Fifty-four percent (54%) of decedents who died in 2016 lived between 1-26 days with an average of ten days lived.

FIGURE 3: 2015 IMR DECEDENT GENDER AND RACE



	Black	White	Not Recorded	White other:
Male	17	2	4	1
Female	17	4	0	2

FIGURE 4: 2016 IMR DECEDENT GENDER AND RACE



	Black	Black Other	Unknown	White	White other:
Male	13	1	5	2	1
Female	12	0	0	1	0

FIGURE 5: 2015 IMR DECEDENT-BIRTH PLURALITY

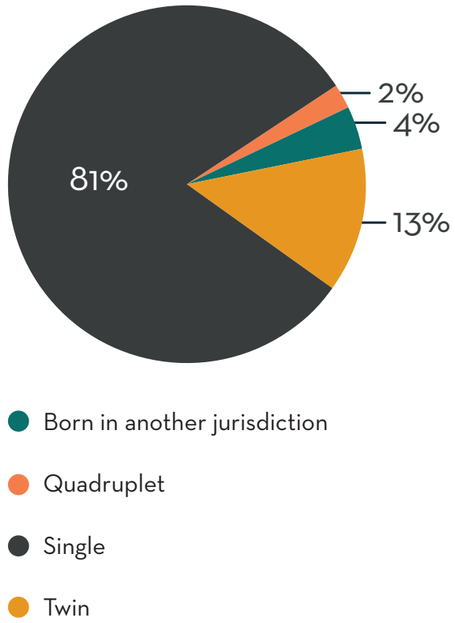
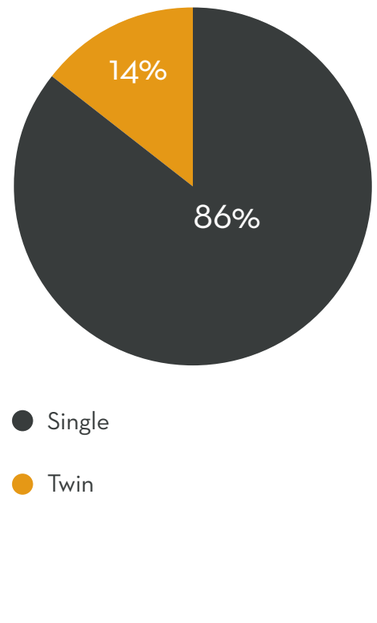
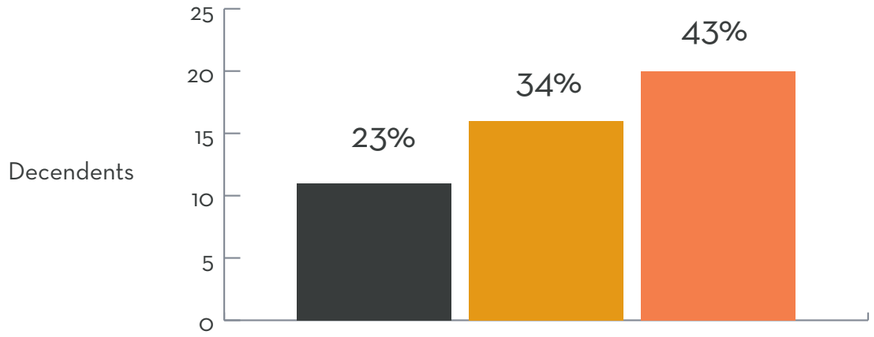


FIGURE 6: 2016 IMR DECEDENT-BIRTH PLURALITY



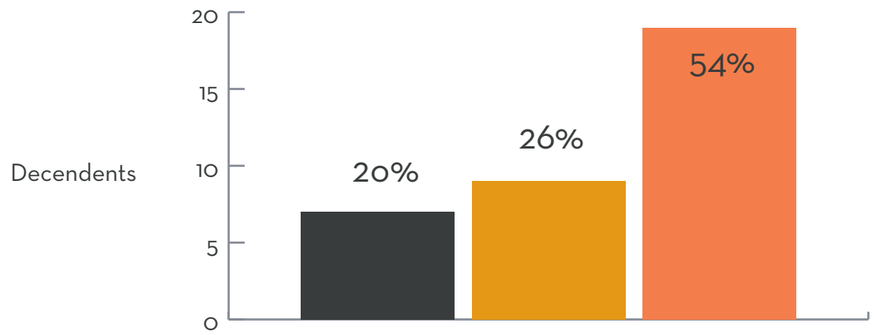
Data disclaimer: This data represents only a subset of child and infant deaths and is not intended to be a full representation of Maternal and Infant Health in the District of Columbia. For annual statistics on Maternal and Infant Health, please refer to DC Health publications at dchealth.dc.gov

FIGURE 7: 2015 IMR DECEDENT AGES (MINUTES, HOURS AND DAYS) AT BIRTH



	Number of Decedents
Minutes (btw 4-35 min)	11
Hours (1-5 hours)	16
Days (btw 1-27 days)	20

FIGURE 8: 2016 IMR DECEDENT AGES (MINUTES, HOURS AND DAYS) AT BIRTH



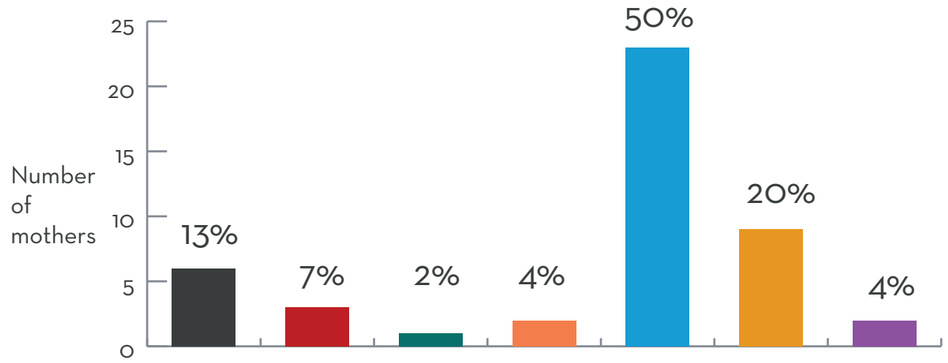
	Number of Decedents
Minutes (btw 1-37 min)	7
Hours (1-22 hours)	9
Days (btw 1-26 days)	19

Data disclaimer: This data represents only a subset of child and infant deaths and is not intended to be a full representation of Maternal and Infant Health in the District of Columbia. For annual statistics on Maternal and Infant Health, please refer to DC Health publications at dchealth.dc.gov

For cases reviewed of decedents who died in 2015, sixty-nine percent (69%) of their births occurred during the second trimester with an average gestational age of 22 weeks. For decedents who died in 2016, sixty-three (63%) of their births occurred during the second trimester with an average gestational age of 22 weeks.

Fifty percent (50%) of mothers of decedents whose cases were reviewed and who died in 2015 and sixty-eight percent (68%) of mothers of decedents who died in 2016 attended "regularly" scheduled prenatal appointments. The IMRT discussed the use of the word "regularly" related to prenatal care visits as it gave the wrong impression as to the interval of care received. It was suggested to group visits by gestational week for example, 1st visit received by 8th week of gestation, in order to determine whether the care provided was optimal. Because this review was solely based on birth and death certificate data, prenatal care records were not available for review, thus the manner by which the mothers care was supplemented or altered to prevent the death of the decedent or provide adequate care throughout the pregnancy was unknown.

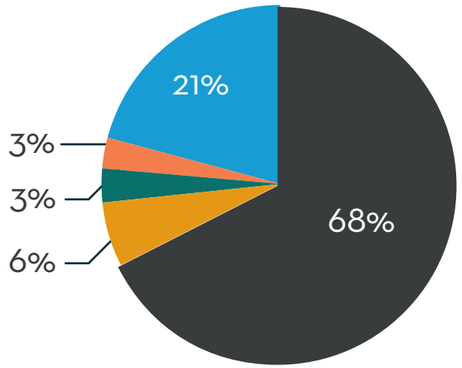
FIGURE 9: 2015 IMR TOTAL NUMBER OF PRENATAL VISITS



	Late entry	1st visit at 3 mos	1st visit at 4 mos	1st visit at 6 mos	Regularly scheduled	Not recorded	Out of Jurisdiction
Number of mothers	6	3	1	1	23	9	2

Data disclaimer: This data represents only a subset of child and infant deaths and is not intended to be a full representation of Maternal and Infant Health in the District of Columbia. For annual statistics on Maternal and Infant Health, please refer to DC Health publications at dchealth.dc.gov

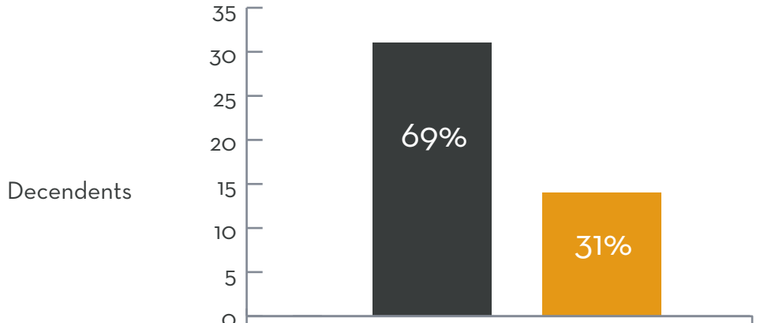
FIGURE 10: 2016 IMR TOTAL NUMBER OF PRENATAL VISITS



The IMRT discussed the fact that there are a high number of decedents dying in the 2nd trimester of extreme prematurity and suggested that Progesterone should be considered and introduced. The IMRT was interested in learning further about whether mothers qualified for Progesterone and are offered and utilize it? It was also realized that insurance companies play an important role in the utilization of Progesterone and whether they cover its use. This impacts a mother's decision to utilize it and its ability to decrease her risk of a premature birth. Although this information was not captured in the vital statistics information reviewed it will be considered for future reviews.

Of the cases reviewed, the majority of decedents, who died in both 2015 and 2016, fell into the Low Birth Weight category with 84-86% of decedents weighing 2,500 grams or less. Of the low birth weight decedents, 76-83% of them weighed less than 1,000 grams and fell into the Extremely Low Birth Weight category as the average weight of these decedents was 522-530 grams.

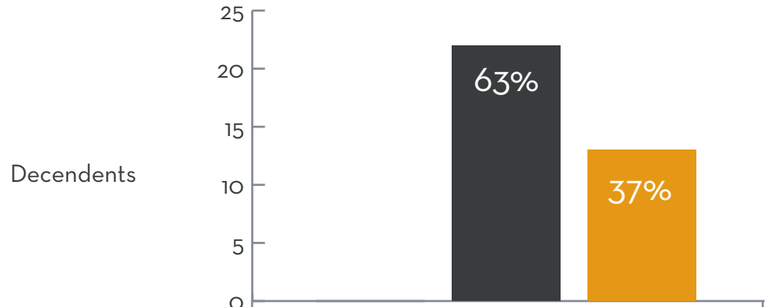
FIGURE 11: 2015 IMR DECEDENT GESTATIONAL AGE AT BIRTH



	Number of Decedents
First Trimester (1-13 weeks)	0
Second Trimester (14-26 weeks)	31
Third Trimester (27-40 weeks)	14

Data disclaimer: This data represents only a subset of child and infant deaths and is not intended to be a full representation of Maternal and Infant Health in the District of Columbia. For annual statistics on Maternal and Infant Health, please refer to DC Health publications at dchealth.dc.gov

FIGURE 12: 2016 IMR DECEDENT GESTATIONAL AGE AT BIRTH



	Number of Decedents
First Trimester (1-13 weeks)	0
Second Trimester (14-26 weeks)	22
Third Trimester (27-40 weeks)	13

FIGURE 13: 2015 IMR DECEDENT BIRTH WEIGHT

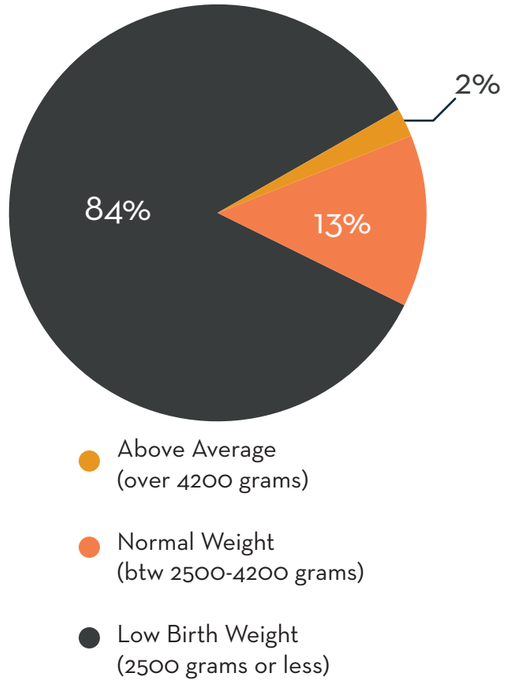


FIGURE 14: 2016 IMR DECEDENT BIRTH WEIGHT

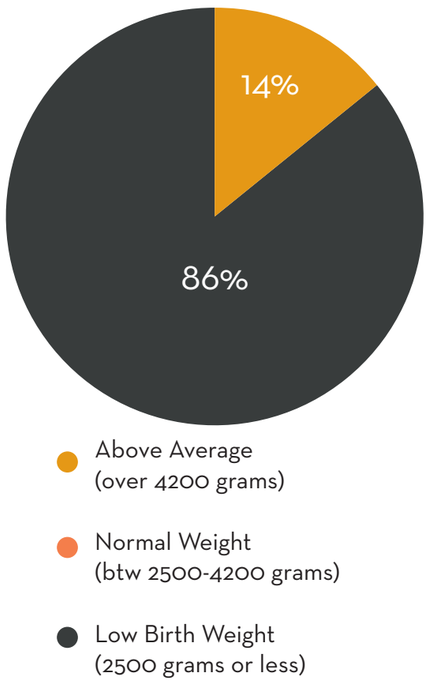


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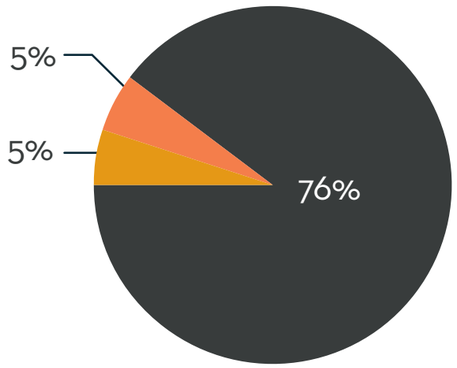
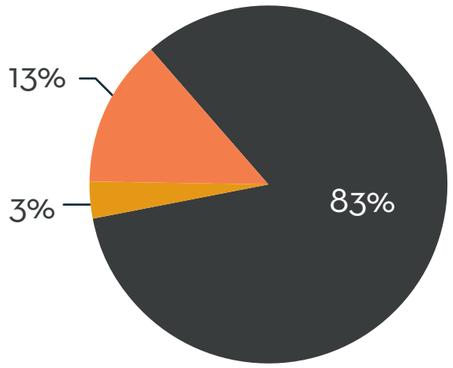
FIGURE 15: 2015 IMR DECEDENT LOW BIRTH WEIGHT DETAILS



- Moderately Low Birth Weight (1500 - 2499 grams)
- Very Low Birth Weight (1500 grams or less)
- Extremely Low Birth Weight (1000 grams or less)

FIGURE 16: 2016 IMR DECEDENT LOW BIRTH WEIGHT DETAILS



- Moderately Low Birth Weight (1,500 - 2,499 grams)
- Very Low Birth Weight (1,500 grams or less)
- Extremely Low Birth Weight (1,000 grams or less)

Of the cases reviewed, those decedents who died in 2015 and who were born in the above average birth weight category (over 4,200 grams) were of a gestational age of 39 weeks. There were no decedents who died in 2016 who were born in the above average birth weight category. Those decedents who died in 2015 and were born with a normal birth weight (between 2,500 – 4,200 grams) were of a gestational age range of 35-40 weeks and had an average gestation of 38 weeks. Those decedents who died in 2016 and were born with a normal birth weight were third trimester births of a gestational age range of 35-40 weeks and had an average gestation of 38 weeks.

Those decedents who died in 2015 and were born with a moderately low birth weight (1,500 – 2,499 grams) were of a gestational age range of 36-37 weeks and had an average gestation of 36.5 weeks. There was only one decedent in the review who died in 2016 and was born with a moderately low birth weight that had a gestational age of 33 weeks and weighed 1,928 grams. Those decedents who died in 2015 and were born in the very low birth weight category (1,500 grams or less) were of a gestational age range of 27-29 weeks and had an average gestation of 28 weeks. Those decedents who died in 2016 and were born in the very low birth weight category were of a gestational age range of 27-29 weeks and had an average gestation of 28 weeks.

And, decedents who died in 2015 and were born with an extremely low birth weight (less than 1,000 grams) were of a gestational age range of 16-29 weeks and had an average gestation of 22.5 weeks. Those decedents who died in 2016 and were born with an extremely low birth weight were of a gestational age range of 15-39 weeks and had an average gestation of 23 weeks.

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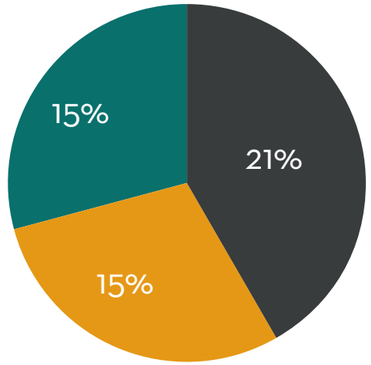
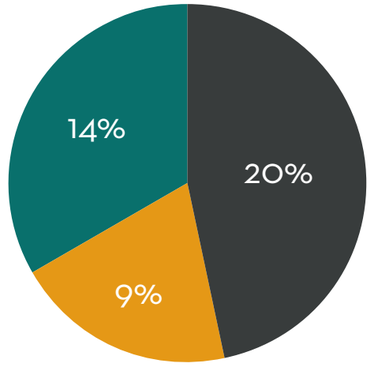
FIGURE 17: 2015 IMR DECEDENT-TOP THREE CONDITIONS LEADING TO CAUSE OF DEATH



- Extreme Prematurity
- Premature rupture of membranes
- Preterm Labor

FIGURE 18: 2016 IMR DECEDENT-TOP THREE CONDITIONS LEADING TO CAUSE OF DEATH



- Extreme Prematurity
- Premature rupture of membranes
- Preterm Labor

As identified in the cases reviewed, the most immediate causes of death of decedents who died in 2015 were due to disorders of newborns related to short gestation and low birth weight, followed by cardiovascular disorders originating in the perinatal period. The third most frequent immediate cause of death was the result of pregnancies with inconclusive fetal viability. The top conditions leading to the cause of death were extreme prematurity, preterm rupture of membranes and preterm labor.

The most immediate cause of death of decedents who died in 2016 was also due to disorders of newborns related to short gestation and low birth weight, followed by other respiratory conditions originating in the perinatal period. The third most frequent cause of death was hypoxic ischemic encephalopathy and sepsis with acute organ dysfunction was the fourth highest cause of death.

Of the cases reviewed, extreme prematurity was the top condition leading to the cause of death for decedents who died in 2015 and in 2016. Premature rupture of membranes and preterm labor were equal contributors to the leading causes of death.

A large number, sixty-six percent (66%) of cases reviewed of decedents who died in 2015, were delivered by spontaneous vaginal delivery and thirty percent (30%) were delivered by Cesarean section. Similarly, sixty-six percent (66%) of decedents who died in 2016 were

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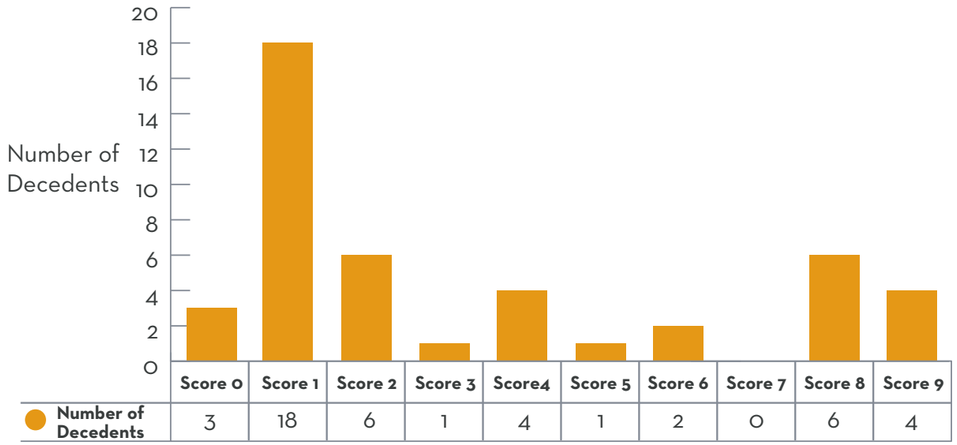
delivered by spontaneous vaginal delivery and thirty-four percent (34%) of decedents were delivered by Cesarean section.

Forty percent (40%) of decedents who died in 2015 had an Apgar score of one (1) at one minute and thirty percent (30%) of decedents had an Apgar score of one (1) at five minutes, although, forty-seven percent (47%) of decedent scores at five minutes were not recorded.

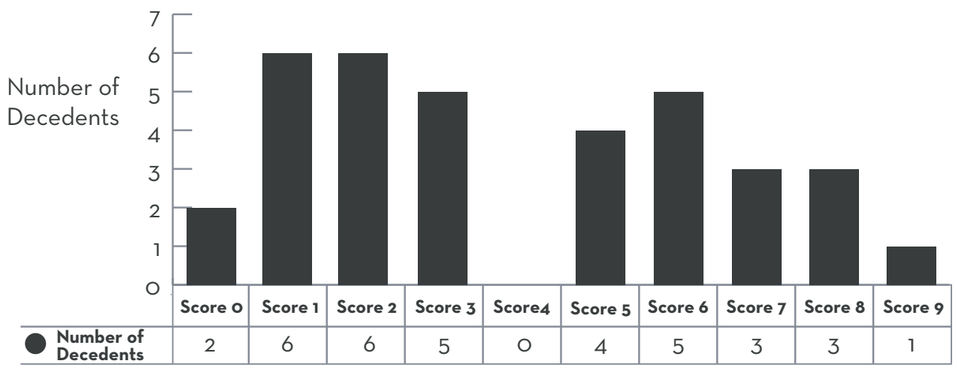
Thirty-four percent (34%) of decedents who died in 2016 had an Apgar score of one or two at one (1) minute and twenty-eight percent 28% of decedents had an Apgar score of 3 or 6 at one (1) minute. The majority of the decedent's scores either did not change or deteriorated and did not improve at five (5) minutes resulting in forty percent 40% of scores not being reported and twenty-three percent 23% of decedents receiving a score of zero (0) at five minutes.

FIGURE 19: 2015 IMR DECEDENT APGAR SCORE AT 1 MINUTE



	Score 0	Score 1	Score 2	Score 3	Score4	Score 5	Score 6	Score 7	Score 8	Score 9
Number of Decedents	3	18	6	1	4	1	2	0	6	4

FIGURE 20: 2016 IMR DECEDENT APGAR SCORE AT 1 MINUTE



	Score 0	Score 1	Score 2	Score 3	Score4	Score 5	Score 6	Score 7	Score 8	Score 9
Number of Decedents	2	6	6	5	0	4	5	3	3	1

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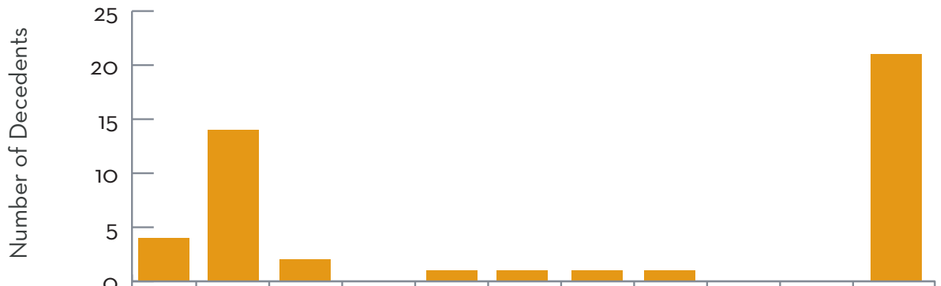
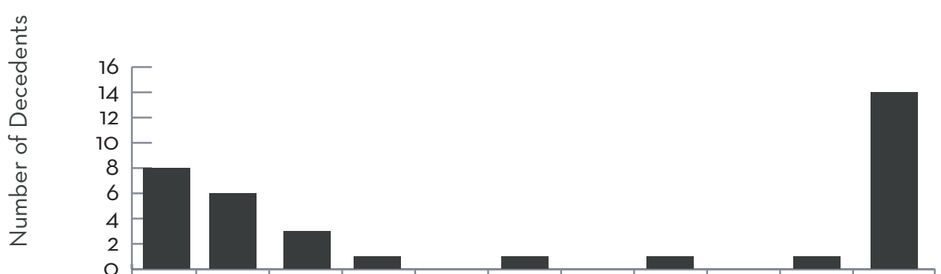
FIGURE 21: 2015 IMR DECEDENT APGAR SCORE AT 5 MINUTES



	Score 0	Score 1	Score 2	Score 3	Score 4	Score 5	Score 6	Score 7	Score 8	Score 9	Not recorded
Number of Decedents	4	14	2	0	1	1	1	1	0	0	21

FIGURE 22: 2016 IMR DECEDENT APGAR SCORE AT 5 MINUTES



	Score 0	Score 1	Score 2	Score 3	Score 4	Score 5	Score 6	Score 7	Score 8	Score 9	Not recorded
Number of Decedents	8	6	3	1	0	1	0	1	0	1	14

Of the cases reviewed, seventy-two percent (72%) of decedents who died in 2015 and sixty-six percent (66%) of decedents who died in 2016 were not breastfed at the time of discharge as most of the decedents were not discharged from the hospital or did not leave the labor and delivery unit. Thirteen percent (13%) of decedents who died in 2015 and thirty-one percent (31%) of decedents who died in 2016 were breastfed at the time of discharge; most having moved to the NICU. Eleven percent (11%) of decedents who died in 2015 and three percent (3%) of decedents who died in 2016 did not have any information recorded in this section on the certificate of live birth.

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FIGURE 23: 2015 IMR DECEDENTS- BREASTFED AT DISCHARGE

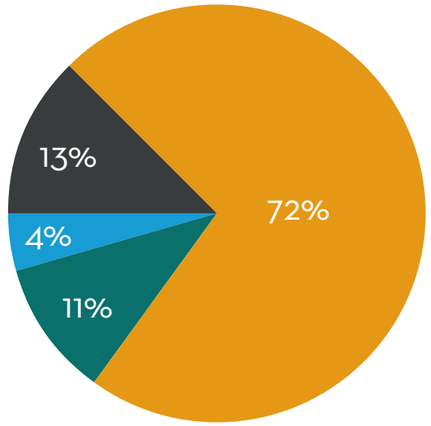
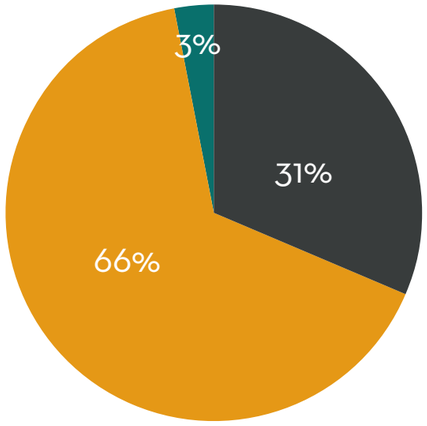


FIGURE 24: 2016 IMR DECEDENTS- BREASTFED AT DISCHARGE



STATISTICAL REVIEWS- 2015 AND 2016 MATERNAL INFORMATION AND RISK FACTORS

Fifty percent (50%) of mothers whose infants' cases were reviewed and who died in 2015 were between 25-34 years of age at the time of the decedent's birth with an average age of 29 years old. Twenty-nine percent (29%) of mothers whose infants died in 2016 were between 25-30 years of age at the time of the decedent's birth and twenty-four percent (24%) of mothers were between the ages of 36-40 years of age with an average age of 38 years. The average age of all mothers whose infants died in 2016 was 30 years old.

Seventy-three percent (73%) of the mothers whose infants died in 2015 and seventy-six percent (76%) of mothers whose infants died in 2016 were disproportionately Black.

FIGURE 25: 2015 IMR MATERNAL AGE

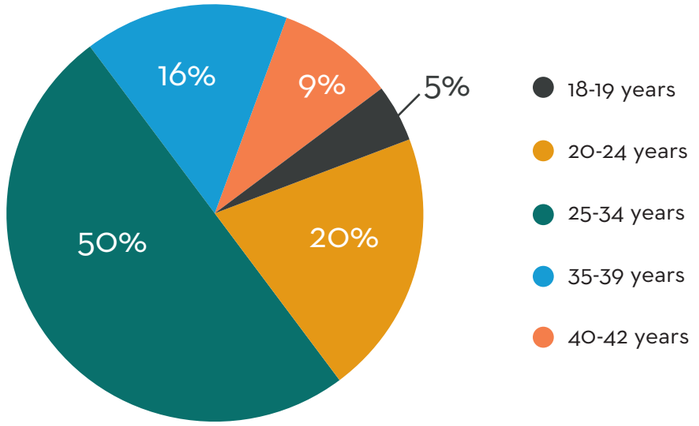


FIGURE 26: 2016 IMR MATERNAL AGE

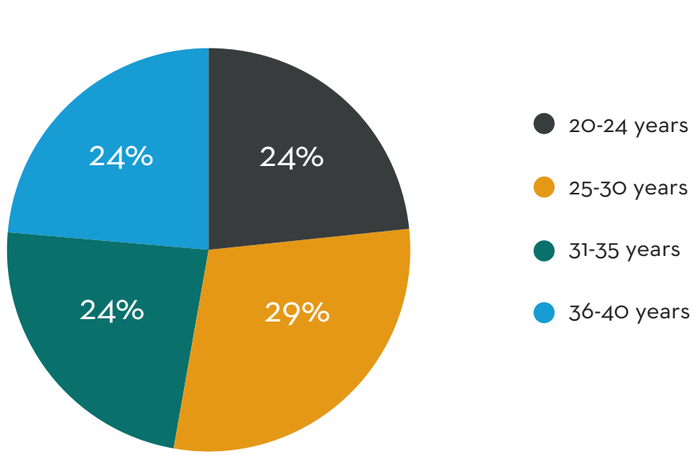


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FIGURE 27: 2015 IMR MATERNAL RACE

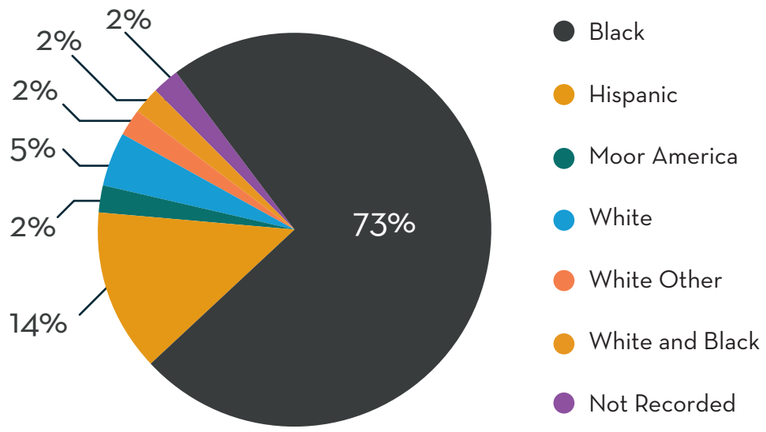
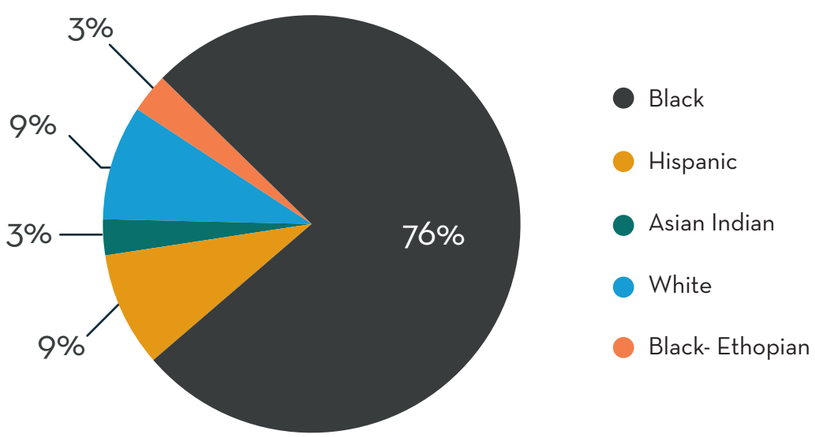


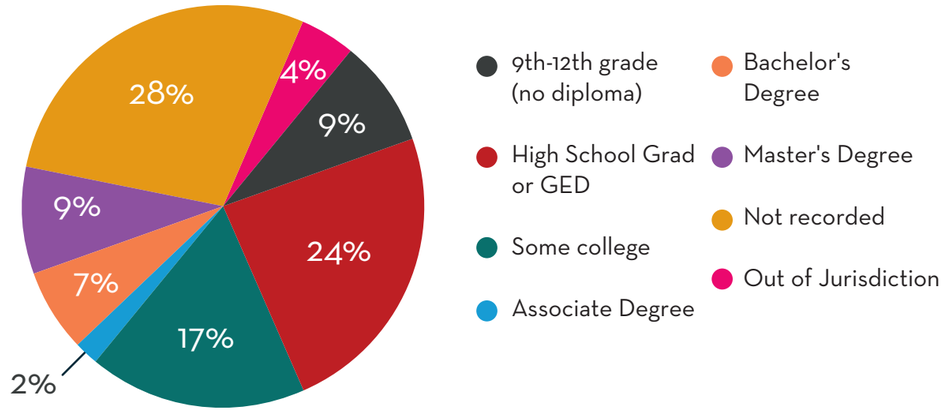
FIGURE 28: 2016 IMR MATERNAL RACE



Case reviews identified that fifty-nine percent (59%) of mothers whose infants died in 2015 completed their high school education with fifteen percent (15%) combined completing either a Bachelor's or Master's Degree. Seventy-seven percent (77%) of mothers were not married or in a registered domestic partnership at the time the child was conceived, at the time of birth, or at any time between conception and giving birth. Fifty percent (50%) of mothers received prenatal care[5] and sixty-one percent (61%) of mothers were enrolled in DC Medicaid.

Seventy-one percent (71%) of mothers whose infants died in 2016 completed their high school education with twenty-one (21%) combined completing a Bachelor's, Master's or Doctoral Degree. Seventy-one percent (71%) of mothers were not married or in a registered domestic partnership at the time the child was conceived, at the time of birth, or at any time between conception and giving birth. Sixty-eight percent (68%) of mothers received prenatal care[6] and fifty-three percent (53%) of mothers were enrolled in DC Medicaid.

FIGURE 29: 2015 IMR MATERNAL EDUCATION STATUS



5 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.

6 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.

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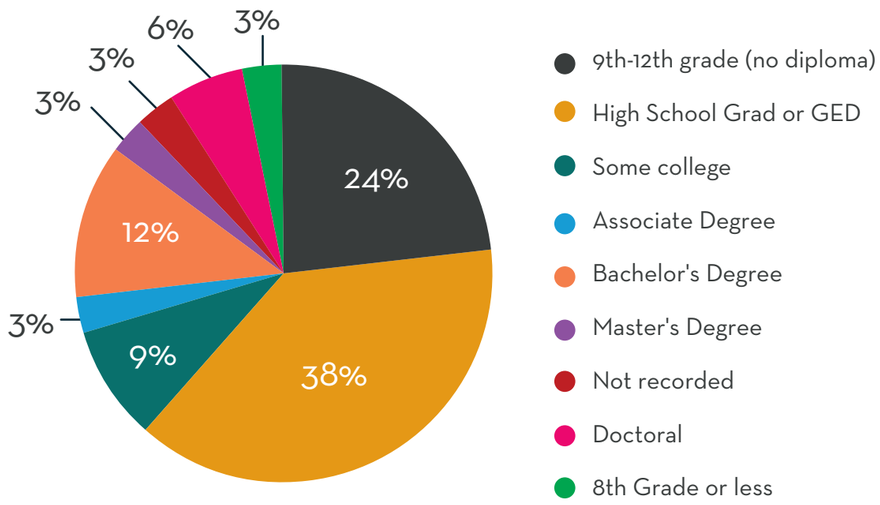
FIGURE 30: 2016 IMR MATERNAL EDUCATION STATUS



Of the cases reviewed, the average maternal height for mothers of decedents who died in 2015 was five feet four inches tall with an average pre-pregnancy weight of 170 pounds and BMI of 29.2. The average maternal weight at delivery was 189 pounds with a BMI of 32.4 and an average weight gain of 16 pounds. Thirty-nine percent (39%) of mothers did not have any previous live births. The number of previous live births ranged from 0-9. There were forty-one percent (41%) of mothers who did not have any other living children. The number of other living children ranged from 0-9. Eighty-nine percent (89%) of mothers had not experienced a child fatality and fifty percent (50%) of mothers reported experiencing no previous induced losses or ectopic pregnancies. The number of previous pregnancy losses of such ranged from 0-5.

The average maternal height for mothers of decedents who died in 2016 was also five feet four inches tall with an average pre-pregnancy weight of 169 pounds and BMI of 29.0. Forty-one percent (41%) of mothers did not have any previous live births or any other living children. Thirty-two percent (32%) of mothers had given birth to two (2) children previously and six percent (6%) of mothers had given birth to three (3) children previously. Six percent (6%) of mothers respectively gave birth to four (4) children previously and three percent (3%) of mothers gave birth to eight (8) children previously. Ninety-two percent (92%) of mothers did not have any deceased children and eight percent (8%) of mothers had one (1) deceased child. Fifty percent (50%) of mothers reported experiencing no previous induced losses or ectopic pregnancies. The number of previous pregnancy losses of such ranged from 0-5.

Risk Factors

Of the cases reviewed, the greatest number of pregnancy risk factors for mothers of decedents who died in 2015 as listed on the certificate of live birth was in the "other previous poor pregnancy outcome" category. Other risk factors included previous Caesarean delivery, hypertension and diabetes (prior to pregnancy). Ninety-eight percent (98%) of mothers did not have any infections present or treated during their pregnancy and two percent (2%) had a diagnosis of HIV. Additionally, 100% of mothers did not experience any maternal morbidity per the certificate of live birth.

Of the cases reviewed, the greatest number of pregnancy risk factors for mothers of decedents who died in 2016 as listed on the certificate of live birth was also in the "other previous poor pregnancy outcome" category. Other risk factors included previous Caesarean delivery, and previous preterm birth. Eighty-two percent (82%) of mothers did not have any infections present or treated during their pregnancy and three percent (3%) had a diagnosis of Chlamydia. Additionally, 100% of mothers did not experience any maternal morbidity per the certificate of live birth.

TABLE 2 : 2015 MATERNAL PREGNANCY RISK FACTORS

Pregnancy Risk Factors	Number of Affected Mothers
Other previous poor pregnancy outcomes	14
None	13
Previous cesarean delivery x 2	4
Hypertension- pregnancy (chronic)	3
Previous preterm birth plus other previous poor pregnancy outcomes	3
Previous preterm birth	2
Out of Jurisdiction (information not available)	2
Diabetes (prior to pregnancy)	1
Diabetes plus other poor outcome	1
Hypertension (gestational) plus other previous poor pregnancy outcome and previous cesarean delivery	1
Hypertension- pregnancy (chronic) plus Eclampsia and IVF	1
Previous preterm birth plus previous cesarean delivery and IVF	1

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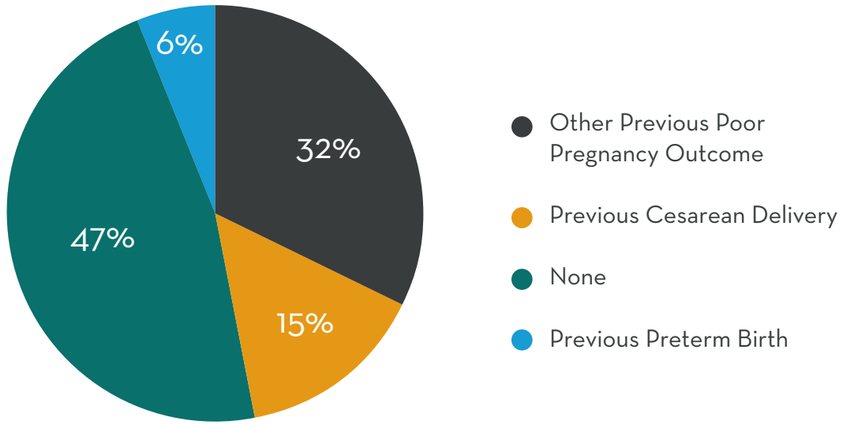
FIGURE 31: 2016 MATERNAL PREGNANCY RISK FACTORS



Thirty-three percent (33%) of mothers of decedents who died in 2015 did not exhibit any characteristics of labor and delivery. The administration of steroids for fetal lung maturation was the most frequently reported characteristic of labor and delivery and accounted for seventeen percent (17%) of mothers.

Fifty-three percent (53%) of mothers of decedents who died in 2016 did not exhibit any characteristics of labor and delivery. The epidural or spinal anesthesia during labor was the most frequently reported characteristic of labor and delivery and accounted for twenty-four percent (24%) of mothers.

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TABLE 3: 2015 Maternal Characteristics of Labor and Delivery

Characteristics of Labor and Delivery	Number of Affected Mothers
None	15
Steroids for fetal lung maturation received by mother prior to delivery	8
Antibiotics received by mother during labor	6
Epidural or spinal anesthesia during labor	6
Induction of labor	4
Augmentation of labor	2
Out of Jurisdiction	2
Cord presentation	1
Moderate/heavy meconium staining of amniotic fluid	1
Clinical chorioamnionitis diagnosed during labor or maternal temperature greater or equal to 38 degrees C	1

TABLE 4: 2016 Maternal Characteristics of Labor and Delivery

Characteristics of Labor and Delivery	Number of Affected Mothers
None	18
Steroids for fetal lung maturation received by mother prior to delivery	3
General	1
Epidural or spinal anesthesia during labor	8
Induction of labor	2
Non-vertex Presentation	1
Trisomy 18	1

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STATISTICAL REVIEWS- 2015 AND 2016 PATERNAL INFORMATION

The average age of fathers of decedents who died in 2015 was 32 years old with fifty-seven percent (57%) of fathers being Black. Seventy-five percent (75%) of fathers graduated from high school with nineteen percent (19%) earning a Master's or Doctoral/Professional Degree.

The average age of fathers of decedents who died in 2016 was 32 years old with fifty-nine percent (59%) of fathers being Black. Eighty-two percent (82%) of fathers graduated from high school with five percent (5%) earning a Master's or Doctoral/Professional Degree.

FIGURE 32: 2015 IMR PATERNAL AGE

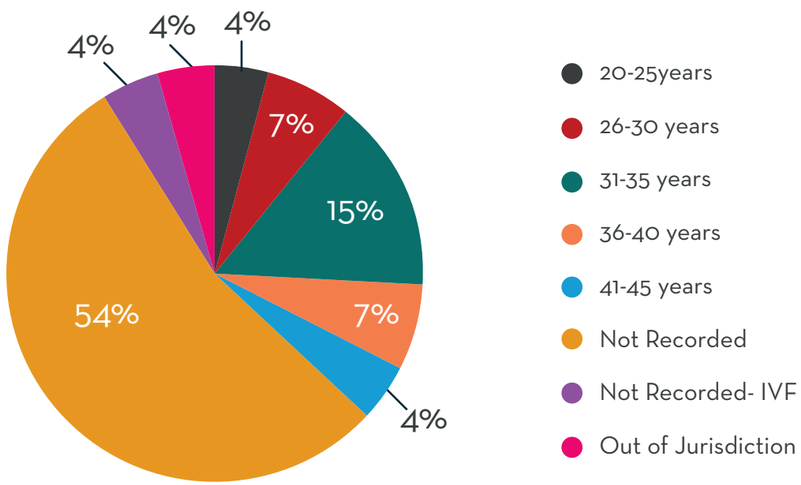

FIGURE 33: 2016 IMR PATERNAL AGE

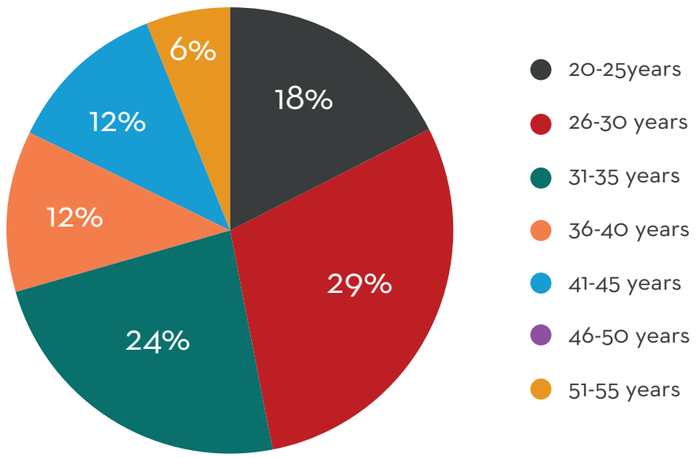

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FIGURE 34: 2015 IMR PATERNAL RACE

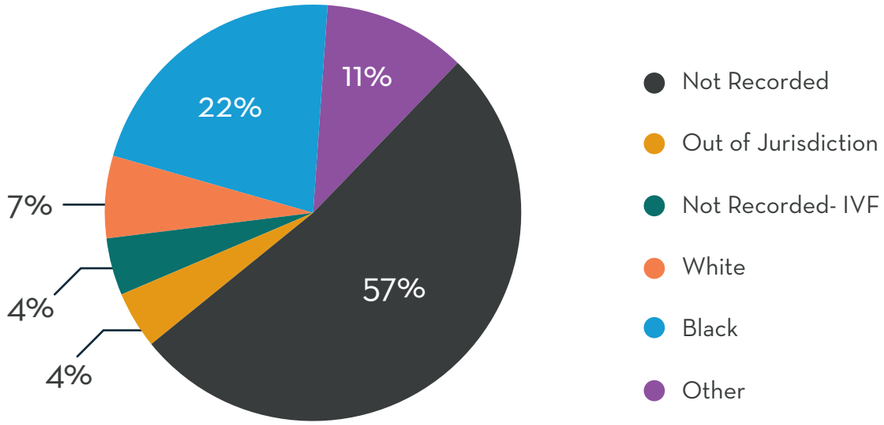

FIGURE 35: 2016 IMR PATERNAL RACE

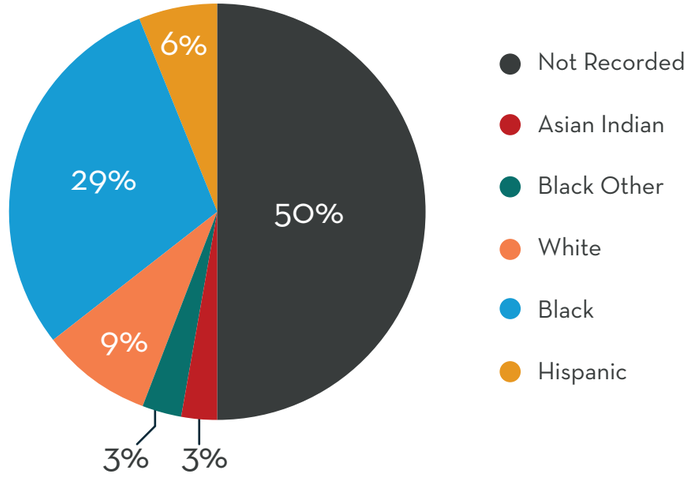

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FIGURE 36: 2015 PATERNAL EDUCATION STATUS

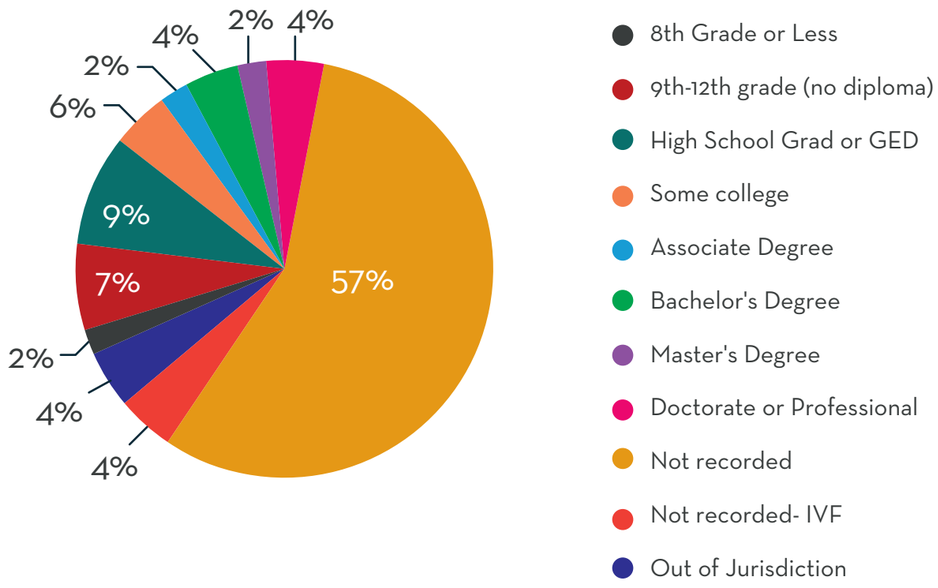
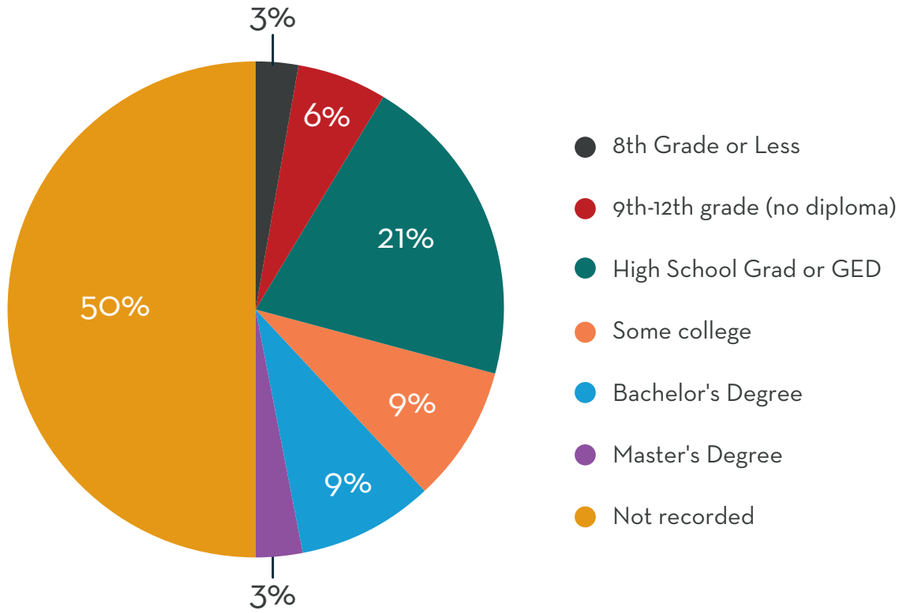


FIGURE 37: 2016 PATERNAL EDUCATION STATUS



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2016 DECEDENT FOCUSED STATISTICAL REVIEW

During the review of decedents who died in 2016, IMRT meeting participants requested further details of those decedents born during the third trimester as these decedents were considered the most viable and their death was thought to be generally more preventable than in other trimesters.

Of the decedent cases reviewed who died in 2016; there were thirteen cases that fell into the third trimester birth category. The majority, sixty-nine percent (69%), of decedents was Black, fifteen percent (15%) were White and eight percent (8%) were identified as White Other (of Hispanic origin) or Black and American Indian. Over half, sixty-two percent (62%) of decedents were male and thirty-eight percent (38%) of decedents were female. Decedent weights varied with the lowest weights closer to the early third trimester gestation and highest weights closer to the later third trimester gestational ages. The lowest birth weight was 369 grams and highest weight was 3,005 grams with an average birth weight of 1,769 grams. This average birth weight is in the moderately low birth weight category by definition.

The top most frequent causes of death by theme for the decedents born in the third trimester were attributed to twenty-three percent (23%) other respiratory conditions originating in the perinatal period and twenty-three percent (23%) due to Hypoxic ischemic encephalopathy. The other various conditions leading to the cause of death were mostly attributed to issues of prematurity. The average APGAR score for these decedents was 5 at one (1) minute with the lowest score being 0 and highest score of 9. Fifty-four percent (54%) of decedents did not have a score recorded at 5 minutes. The average APGAR score at five (5) minutes was 2.

Characteristics of Labor and Delivery revealed thirty-eight percent (38%) of mothers received an epidural or spinal anesthesia during labor. Thirty-one percent (31%) were administrated steroids for fetal lung maturation and fifteen-percent (15%) of mothers received antibiotics during labor. Seventy-seven percent (77%) of decedents did not experience any congenital anomalies. Of those cases with congenital anomalies noted, all decedents were 35 weeks gestation or greater. Such congenital anomalies included Club feet, congenital diaphragmatic hernia and Hypoplastic left heart.

Thirty-one percent (31%) of mothers in this category did not have any pregnancy risk factors noted. Thirty-one percent (31%) had experienced other previous poor pregnancy outcomes. Several mothers were noted to have had a previous cesarean delivery prior to the current pregnancy. Fifty-four percent (54%) of mothers underwent a cesarean section with no trial of labor attempted. Forty-six percent (46%) of mother's gave birth via vaginal/ spontaneous delivery.

Ninety-two percent (92%) of decedent cases had abnormal conditions of the newborn indicated on the certificate of live birth. Such conditions included ninety-two percent (92%) of decedents requiring admission to the NICU with an additional twenty-three percent (23%) requiring assisted ventilation and thirty-one percent (31%) requiring antibiotics to be administered for suspected neonatal sepsis.

Thirty-eight percent (38%) of mothers did not experience any other previous pregnancy outcomes to include spontaneous or induced loses or ectopic pregnancy. Thirty-eight percent (38%) of mothers experienced one prior loss, one mother experienced three prior losses and one mother experienced five previous loses. Sixty-nine percent (69%) of mothers giving birth in the third trimester were receiving regularly scheduled prenatal care. Because this review

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was solely based on birth and death certificate data, prenatal care records were not available thus the manner by which the mothers care was supplemented or altered to prevent the death of the decedent was unknown.

Fifteen percent (15%) of mother's received their first prenatal care visit during the 6th month of their pregnancy and their babies were born at 39 weeks of gestation. One died due to Neonatal hypertension with contributing conditions of pulmonary hypoplasia and a congenital diaphragmatic hernia. The other decedent died as the result of other respiratory conditions originating in the perinatal period with contributing conditions of neonatal encephalopathy of an unknown etiology.

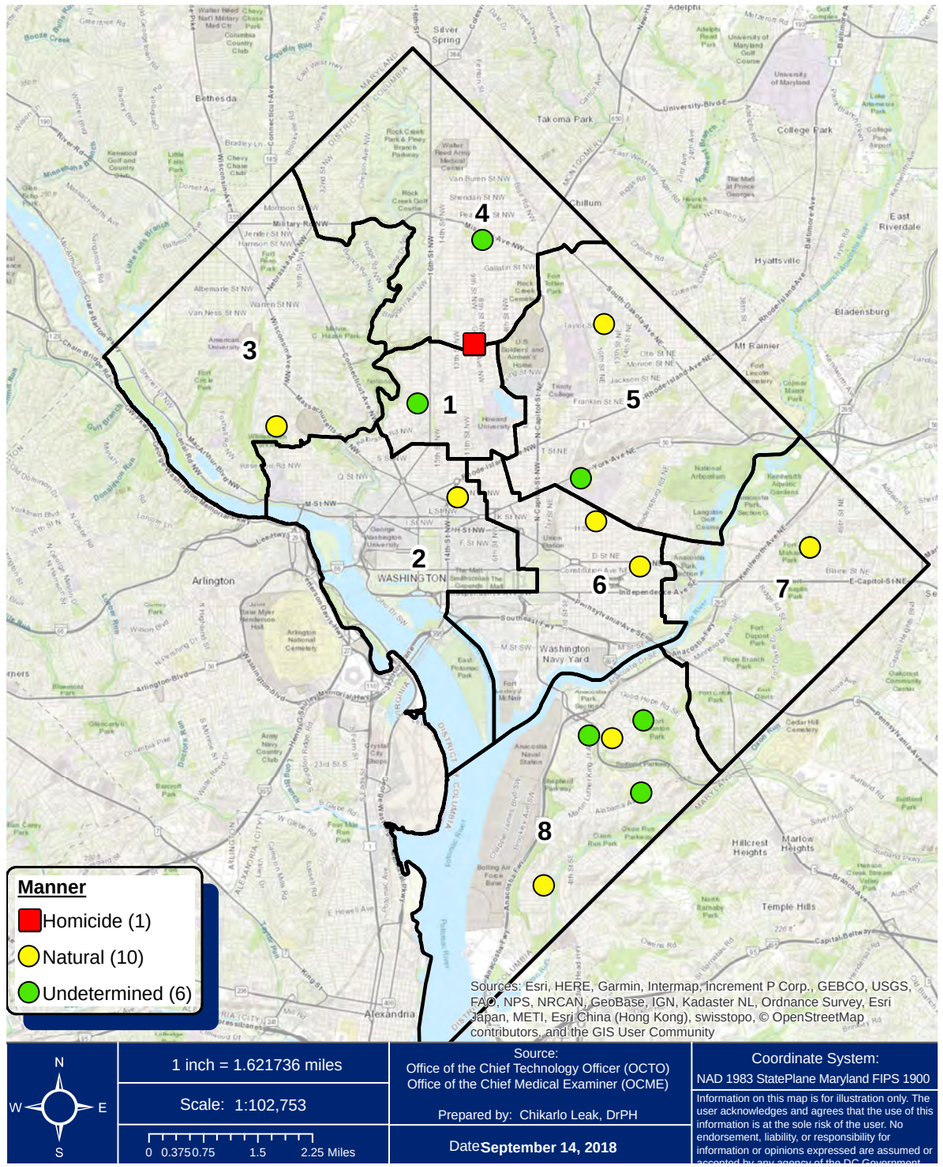
The average age of the mothers who gave birth during the third trimester was 31 years old with the youngest mother being 21 years old and oldest mother being 40 years old.

INFANT MORTALITY REVIEW TEAM MULTIDISCIPLINARY FULL CASE REVIEW FINDINGS

MOST COMMON CHARACTERISTICS OF MOMS

- I am 29 years old
- I reside in Ward 4
- I used marijuana during my pregnancy
- I am single
- I have DC Medicaid
- I did attend prenatal care
- My baby was premature at 27.1 weeks gestation
- My baby weighed 1302 grams
- My pregnancy risk factors included: twin gestation, STI's, high blood pressure, obesity and chorioamnionitis

2017 IMR CASES BY DC RESIDENCE



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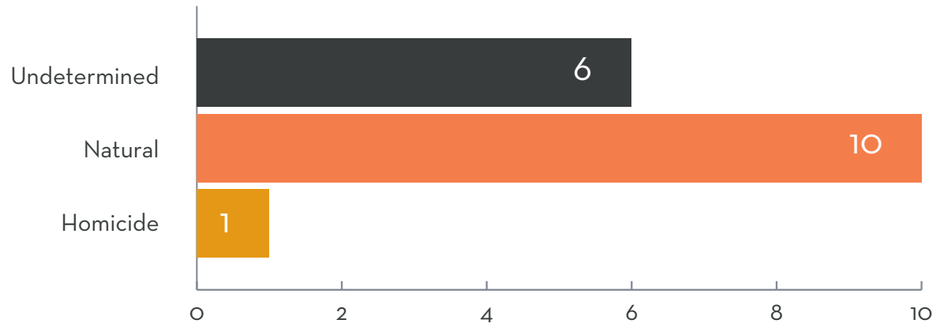
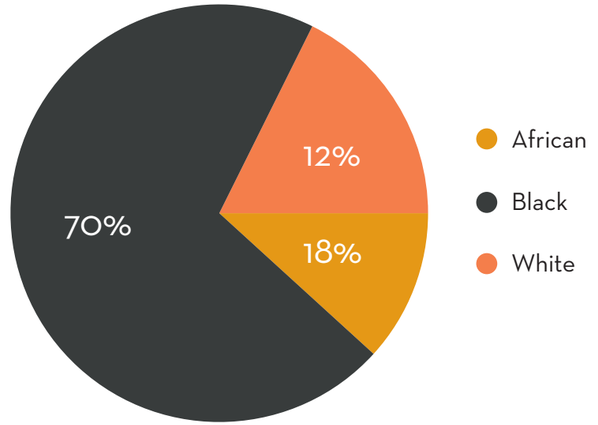
During the 2017 review year, the IMRT conducted full multidisciplinary reviews of 17 cases involving infants (<365 days old). Most of these decedents died of natural deaths (10, 59%) and undetermined deaths (6, 35%). One decedent's death was the result of fatal abuse homicide.

FIGURE 38: IMRT MANNER OF DEATHS



Seventy percent (70%, 12) of the IMRT decedents in these reviews were Black, twelve percent (12%,2) were African and eighteen percent (18%, 3) were white.

FIGURE 39: IMRT DECEDENT ETHNICITY



The average gestational age of decedents whose cases were reviewed in a full multidisciplinary manner was 27.1 weeks and the median gestational age was 25 weeks. The average weight for decedents was 1302 grams (2 pounds, 14 ounces) and the median weight was 842 grams (1 pound, 14 ounces). Severe prematurity where the decedent's gestational age was < 25 weeks was identified as a cause of death in fifty percent (50%, 9) of the cases.

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TABLE 5: IMRT Case Reviews Causes Of Death	
Causes Of Death	Number Of Cases Reviewed
Natural Cases	
Complications Of Prematurity	8
Congenital Malformation	2
Undetermined Deaths	
Sudden Unexplained Death In Infancy/ Bed Sharing	5
Intoxication/Poisoning	1
Homicide	
Multiple Blunt Force Injuries	1
Total	**17**

As indicated in Figure 40, eleven decedents (11, 67%) were born during the second trimester. The second trimester, which occurs between weeks 14 and 27 of the pregnancy, is a period of significant development for the infant. According to the American College of Obstetricians and Gynecologists, the delivery of infants prior to 23 weeks of gestation usually results in a neonatal death. Infants that survive, which is rare, experience significant morbidity issues. For this reason, mitigating risks for preterm birth is key in reducing infant mortality. This includes optimizing women's health before pregnancy and providing early and continuous care.

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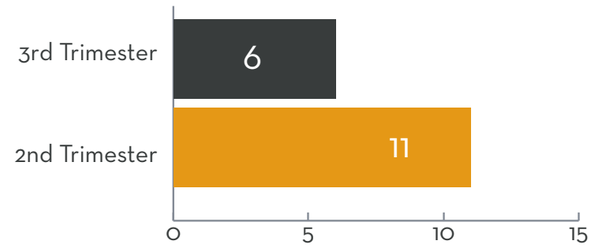
FIGURE 40: IMRT DECEDENT GESTATIONAL AGES



Maternal Risks

In forty-four percent (44%, 8) of the multidisciplinary cases reviewed, obesity was identified as a maternal risk factor. Being overweight is defined as having a body mass index (BMI) of 25-29.9. Obesity is defined as having a BMI of 30 or greater (American College of Obstetricians and Gynecologists-ACOG). During the review of cases, the IMRT identified hypertension, obesity and diabetes as comorbid conditions affecting the outcomes for the decedent and mother; recommending that obesity and BMI should be tracked in health records and vigorously addressed by health providers during annual physical examinations of all women of child bearing age. Obesity during pregnancy puts mothers at risk of several serious health problems to include: Gestational Diabetes, Preeclampsia and Sleep Apnea. Obesity during pregnancy increases the risk to the fetus and can lead to the following problems: pregnancy loss, birth defects, problematic diagnostic fetal testing, macrosomia, preterm birth and still birth.[7] The lack of documented information relating to the weight of the mother, concerning obesity and BMI, was identified in nineteen percent (19%, 3) of the cases.

Other risk factors included mothers having an infection which was identified in twenty-two percent of cases (22%, 4) where the mothers had chorioamnionitis[8]. Two mothers were twin gestation and two mothers had a shortened cervix. Four cases revealed the mothers had hypertension.

Twenty-eight percent, (28%, 5) of the cases reviewed had minimal or no documented prenatal care at the time of delivery. The IMRT discussed evaluating whether barriers to accessing care were evident for the mothers. Empirical evidence also suggested licensed peer navigator and consumer driven groups could be successful in supporting prenatal care by providing education and addressing other health and emotional related issues. The IMRT discussed the need to conduct research concerning the use of group prenatal care. Existing models combine three major components of care (health assessment, education and support) into a unified program within a group setting. The IMRT supports further developments from stakeholder groups who can provide this model of care to mother's in the District without cost.

7 https://www.acog.org/Patients/FAQs/Obesity-and-Pregnancy

8 Chorioamnionitis or intraamniotic infection is an acute inflammation of the membranes and chorion of the placenta, typically due to ascending polymicrobial bacterial infection in the setting of membrane rupture. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3008318/

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Studies have examined factors influencing late entry into prenatal care by race/ethnicity and insurance payer. Optimal prenatal care included initiation before the 14th week of gestation. Beginning care in the first trimester provided an opportunity for sonographic pregnancy dating or confirmation with best accuracy, which could later prove critical for management of preterm labor, maternal or fetal complications, or prolonged pregnancy.

IMRT DISCUSSION OF PLACENTAL PATHOLOGY

As a result of several case reviews trending poor neonatal outcomes, the IMRT identified the need to include placental pathology information when conducting reviews to better explain these occurrences and assist in the development of recommendations for further prevention. The IMRT conducted a survey in June 2017 of nine health institutions in Washington, D.C. where decedents were born to assess under what circumstances placental pathology was completed at the time of delivery. The survey revealed a lack of standardized procedures among the labor and delivery institutions that were contacted. Six institutions completed placental pathologies on location, and three sent the tissue samples to another local facility. Complete pathologic evaluation of the placenta provides valuable information for perinatal care for the obstetrician, neonatologist, pediatrician, and family. The histopathology of the placenta can answer specific questions about in utero insults, give insight into management of subsequent pregnancies and provide an assessment of the newborn risk. Despite the advantages of placental pathologic examination, it remains an under-utilized part of perinatal medicine.[9] This stems from a historically under-taught part of surgical and autopsy pathology resulting in inadequate reporting. (US National Library of Medicine National Institutes of Health).

The analysis illuminated the disparity among institutions when requesting a pathological review: Four institutions completed an analysis on all placentas obtained, three completed an analysis if a mother's labor does not progress or there was a question concerning the outcome of the delivery, one institution only completed pathology when requested by the obstetrician and one institution did not provide any information.

IMRT DISCUSSION OF STEROID USE IN PREGNANCY

The use of antenatal steroid therapy is common in pregnancy. In early pregnancy, steroids may be used in women for the treatment of recurrent miscarriage or fetal abnormalities such as congenital adrenal hyperplasia. In mid-late pregnancy, the antenatal administration of corticosteroids to expectant mothers to support fetal lung maturity in anticipation of preterm birth is one of the most important advances in perinatal medicine. The widespread uptake of this therapy is due to a compelling body of evidence demonstrating improved neonatal outcomes following antenatal corticosteroid exposure. The IMRT discussed the importance of tracking the offering of steroid treatment when indicated, when in the gestational period treatment is offered and the outcomes when steroid treatment is used. This analysis will assist in addressing educational and treatment trends and identify gaps in services for child bearing district residents who are eligible when clinically indicated in obtaining antenatal steroid therapy.

9 https://www.ncbi.nlm.nih.gov/pubmed/16753764

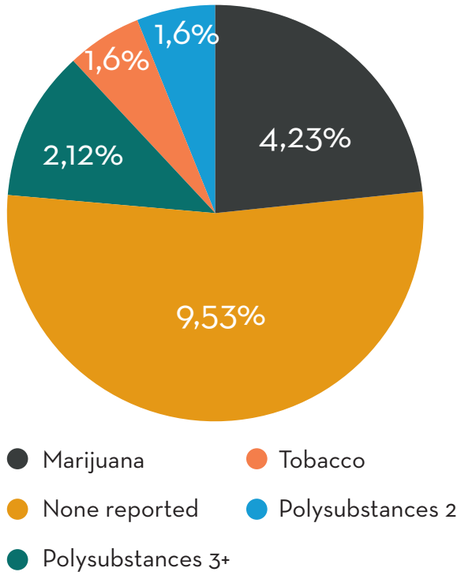
IMRT DISCUSSION OF MATERNAL INTERVIEWS

The IMRT continues to support the development of a maternal interview process to assist in validating the mother's view of how she reached certain conclusions in her decision making while pregnant as well as gain further insight into her perspective on factor's influencing the infant's death. The IMRT/OCME, in collaboration with DC Health, took steps to develop a maternal interview process by researching best practices from other states, drafting an interview series of questions and a maternal interviewer position description. The maternal interview process will assist in obtaining vital information from mothers in order to provide information from the family's perspective on ways in which the system could have assisted in the prevention of an infant's death. This information will also supplement data not already captured through the vital statistics process. Additional work to finalize the process will continue in calendar year 2018.

» Social Determinants Of Health

The mental and social well-being of the pregnant mother is recognized as an important component of the overall health of the pregnancy. The statistical case reviews included information as listed on the birth and death certificates but did not include full case records that would reveal any applicable social determinants of health. Economic insecurity, unaddressed mental health diagnoses, domestic violence and mandated involvement with government systems were social determinants observed by the IMRT during these multidisciplinary discussions. These social determinants of health – conditions in which we are born and live that shape our daily lives – may adversely affect healthy outcomes for infants and their families.

FIGURE 41 : MATERNAL SUBSTANCE ABUSE



Forty-seven percent (47%, 8) of mothers used one or more substances that were toxic to the decedent's physical health in utero. Abused substances include marijuana, PCP, alcohol, and cigarettes. Two (2) infants tested positive for THC, the principal psychoactive ingredient of cannabis. The National Institutes of Health indicates a risk associated with substance abuse in pregnancy includes infant withdrawal symptoms that may interfere with the further development of the fetus. The IMRT discussed the impact of re-examining the conditions under which child welfare agencies should become involved in positive toxicology or exposure screens for mothers and infants and that further research should be conducted on the "nexus" for treatment and intervention, especially when mother's had positive toxicology screens and the infants tested negative.

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The IMRT discussed researching resources that address normalizing the receipt of mental health services as a way to provide support to mothers and families who may have the need for mental health support, but do not feel comfortable accessing services. Improving mental health literacy is an important consideration when promoting expedient and effective treatment seeking for psychological disorders.10 During the IMRT reviews, the team observed that limited or no information was documented in the medical, prenatal or antenatal records indicating a screen for maternal or postpartum depression was completed or discussed with the decedent's mother.

Economic insecurity and its ensuing stress can exacerbate pre-existing medical and mental health conditions. Fifty-nine percent (59%, 10) of decedents and their families met the income qualifications to receive Medicaid and Temporary Assistance to Needy Families (TANF). Two (2) decedents with complex medical needs and their families also experienced homelessness. Thirty-five percent (35%, 6) of the families received benefits through the Supplemental Nutritional Assistance Program (SNAP). The inability to have reliable food resources available for a family can impact the mental and prenatal health of the mother and infant.

Although eighty-eight percent (88%, 15) of the cases reviewed indicated no documented domestic violence incidences, the IMRT noted the information was obtained through self-reporting versus hospital or criminal record documentation. The IMRT postulated the information may not be accurate, and discussed additional ways to capture data on domestic violence in all forms; physical, verbal and mental. Data from the National Institutes of Health reveals poor pregnant women are disproportionately exposed to violence which reduces newborn health. Although violence doesn't directly cause poverty, repetitive trauma leads to issues with social functioning, educational attainment and impacts economic success. The IMRT will continue to address the role that violence plays in maternal and infant health and poverty.

10 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4755316/

IMRT DISCUSSION OF CHILD WELFARE INVOLVEMENT

During the review of cases, the IMRT discussed the importance of judicial oversight for some in-home child protective services cases. The IMRT recommended the Child and Family Services Agency (CFSA) should evaluate the need to revise their policy on voluntary services for in-home cases and implement a stronger consultative model for determining when they should use "community papering[11]" to secure judicial oversight of a case; especially in cases where clients have declined service participation. The IMRT also observed that there was a disconnected feedback loop to ensure families referred for voluntary child welfare services actively engaged in the services. Cases for families in which there is a determined high or intensive safety concern or risk should not be closed without documented evidence that a referral linkage has occurred and the family accepted the need for services and engaged with the service provider. This applies to investigations, family assessments and in-home services cases. It was determined that policy improvement on the collaboration between agencies when referrals are made was vital to the safety and health of the children and families that are at highest risk.

11 Child welfare defines community papering as a petition being filed in Family Court that initiates a child abuse or neglect case when an emergency removal by the child welfare agency has not occurred. In some community papering situations, court intervention is requested even though the child remains in the home with the parent or parents.

IMRT DISCUSSION OF DISCHARGE PLANNING FROM HOSPITALS

Finally, the IMRT recognized the importance of discharge planning, protocols and tools for preterm infants who required lengthy birth hospitalizations. These infants remain at increased risk for morbidity and mortality following discharge from the hospital's 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. The IMRT recommended the facilitation of a comprehensive discharge planning process to minimize the risk of morbidity and mortality. The IMRT recognized the importance of shared information and resources to facilitate the coordination of care of premature infants and improve outcomes. The IMRT believes improvement in the quality and continuity of follow-up care for premature infants after hospital discharge is paramount.

» UNDETERMINED INFANT DEATHS

Unsafe sleep environment was a contributing factor in the cause of death in twenty-eight percent (28%, 5) of the cases reviewed. The IMRT observed that the messaging and training geared to safe sleep environments should account for communication style and be socialized with multi-generational caregivers as most infants are mobile moving from home to home (resident to resident). Although resources to address safe sleep were in place and operationalized from a provider/system standpoint, the practice of ensuring the child slept in a safe sleep environment by the decedent's parents was not followed. The IMRT encourages the District agencies associated with ensuring education and provision of safe sleep equipment to conduct an assessment of the efficacy of safe sleep trainings and determine what additional reinforcement measures can be implemented to ensure parental behavioral choices related to safe sleep are optimal.

In October 2017, IMRT participants including Dr. Roger Mitchell, Jr. and Cynthia Wright, Co-Chairs engaged in a Safe Sleep Symposium in Ward 8 to provide education and information to residents highlighting the risk of unsafe sleep environments and bed-sharing with infants. Approximately, 100 residents participated in the robust discussion around the dangers of bed-sharing, SUID and the implications of the lack of prenatal care received.

HOMICIDE DEATH AND CASE DISCUSSION

The IMRT recognized an opportunity to further engage with the community providers around the need for them to internally audit their records in cases involving potential child abuse. In the homicide case reviewed, it was noted in the record that subconjunctival hemorrhages were observed in the decedent during a well-child visit. The record did not reveal that the treating facility acknowledged this as a potential risk factor and indicator of child abuse.

The Chair of the CFRC penned a letter to the treating facility to inform them of the fatality and team concerns and requested their review of the case and to report back whether they identified any findings or took any corrective action. The IMRT also inquired about the facilities processes for mandated reporting of child abuse and neglect.

The IMRT received a response from the treating facility expressing thanks and indicated they were reviewing their protocols and processes for mandated reporting. The IMRT offered to further engage the provider and provide additional follow-up as to their findings and any additional trainings they would be implementing to their staff. The IMRT agreed to adopt this forward leaning approach with other providers in future cases.

CFRT HOMICIDE **CASE REVIEWS**

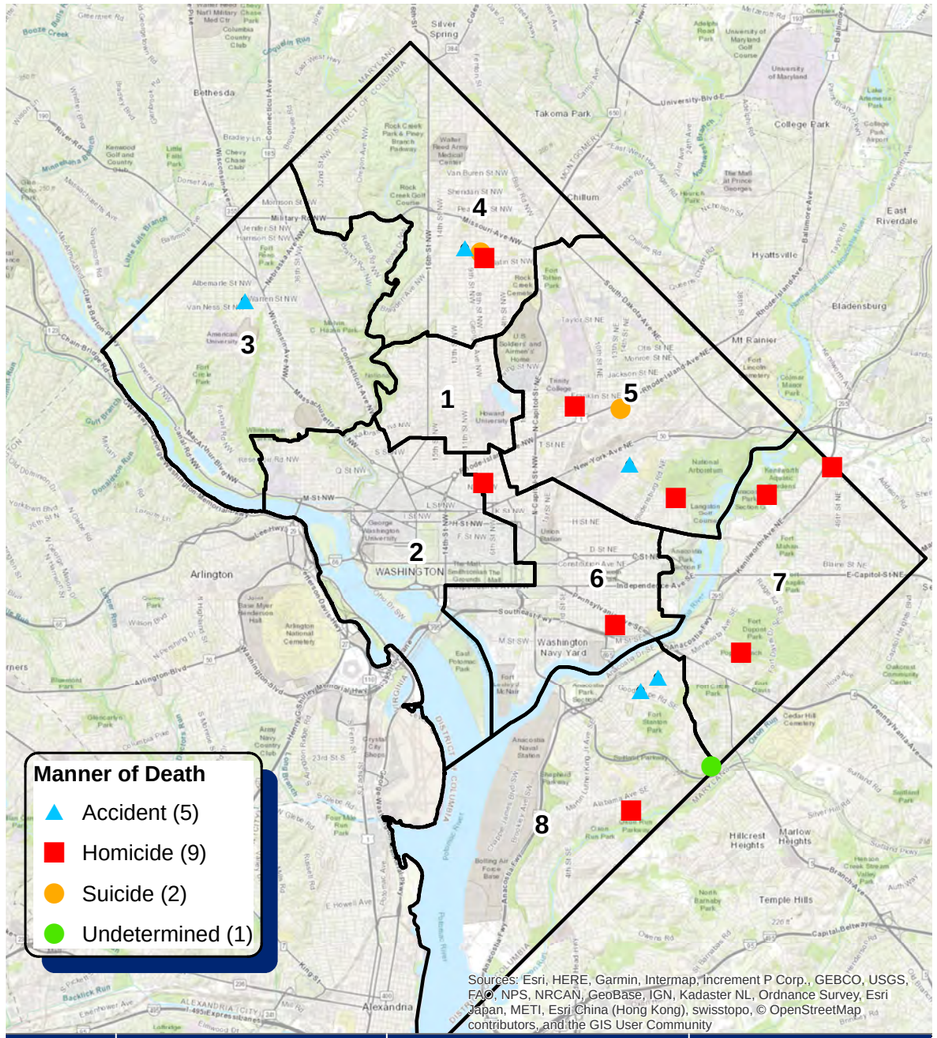
MOST COMMON CHARACTERISTICS OF CFRT DECEDENTS

- I am an 18-year-old Black male. I didn't finish high school and I am unemployed. I have been involved with juvenile justice and my family has received public assistance for several years.

CHILD FATALITY REVIEW TEAM MULTIDISCIPLINARY FULL CASE REVIEW FINDINGS

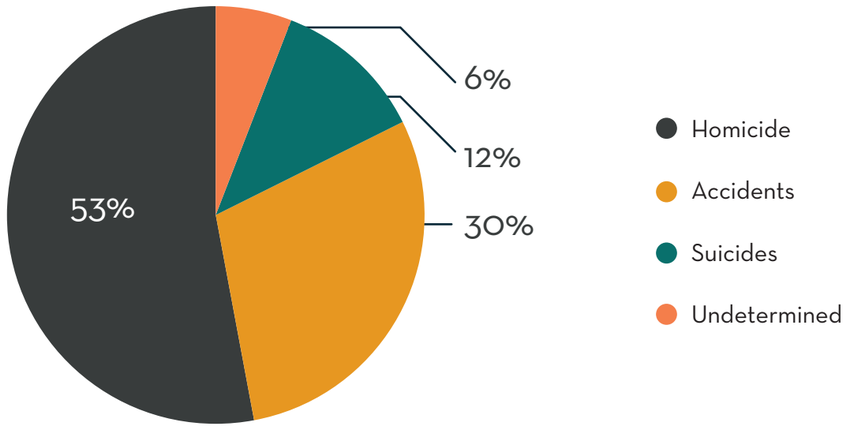
In 2017, the CFRT reviewed seventeen (17) cases involving children and youth whose deaths occurred in 2015, 2016 and 2017.

2017 CFRC CASES REVIEWED BY DC RESIDENCE



Most of the CFRT case reviews involved youth whose death was the result of homicide (9, 53%). The CFRT also reviewed deaths of children and youth who died of accidents (5, 30%), suicides (2, 12%) and one (1) case of a child whose manner of death was undetermined.

FIGURE 42: CFRT 2017 DECEDENT MANNER OF DEATHS



Eighty-eight percent (15, 88%) of these cases involved Black/African American children and youth. Seventy-six percent (13, 76%) of the cases reviewed involved Black/African American males. Two (2, 12%) of the cases reviewed involved Black/African American females. Two (2, 12%) of the cases reviewed involved Hispanic children and youth.

FIGURE 43: 2017 CFRT RACE AND GENDER BY MANNER OF DEATH

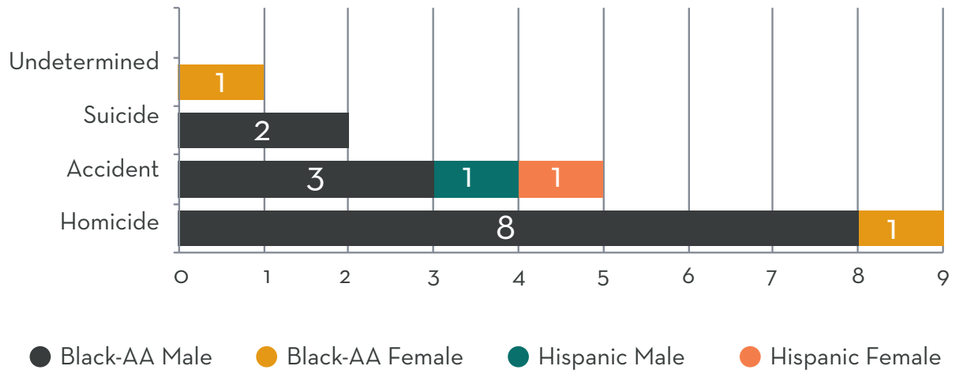
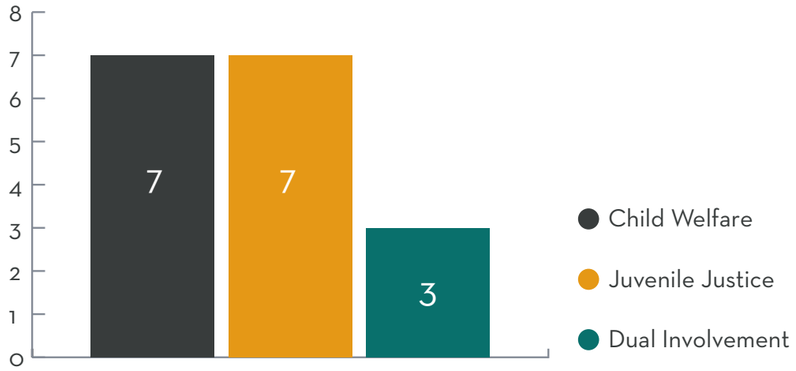
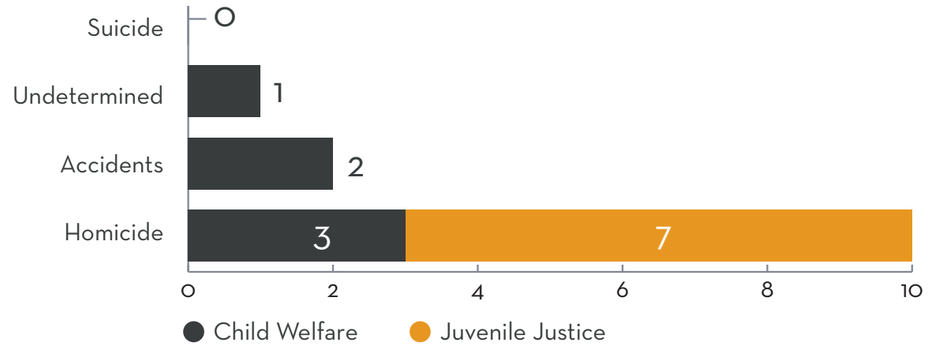


FIGURE 44: CFRT DECEDENT CHILD WELFARE AND JUVENILE JUSTICE INVOVLEMENT



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 44 seven (7, 41%) decedents each were involved with child welfare or juvenile justice programs. Three decedents (3, 18%) had dual involvement with both programs. Understanding the reasons why families are involved with child welfare programs and the adverse childhood experiences that may lead to the decedent's involvement with juvenile justice services leads to the CFRC's formulation of findings and recommendations for prevention.

FIGURE 45: DECEDENT INVOVLEMENT WITH CHILD WELFARE AND JUVENILE JUSTICE BY MANNER OF DEATH



Ten (10, 59%) of the decedents whose manner of death was homicide were involved with child welfare and juvenile justice services. Two (2, 12%) decedents died of accidental causes, and one (1) decedent's manner of death was undetermined. This does not suggest a relationship between the decedent's manner of death and program involvement, however it does suggest that 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.

Homicides that are 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 6: Nationally Recognized Risk Factors associated with Youth Violence Homicides (Review, 2005)

Risk Factor	CFRT Case Reviews
Availability and Access to Guns	Six (6) decedents died due to gun violence.
Youth living in High Crime Neighborhoods	All of the decedents resided in neighborhoods with high incidents of criminal activity.
Youth involved in Criminal Activity	Seven (7) decedents were involved with juvenile justice. Two (2) of these decedents had pending adult criminal offenses.
School Failure, Truancy and Violence	Six (6) decedents experienced school failure and truancy. One (1) youth was successfully referred to the Persons in Need of Supervision (PINS) program and one (1) youth was referred to the Parent and Adolescent Support Services (PASS).
Witnessing Violence	One (1) decedent was exposed to domestic violence in the home. One (1) decedent experienced the death of an older sibling to youth violence.

The CFRT reviewed nine homicide deaths (9, 53%) of District youth who succumbed to youth violence. Table 7 provides details of these deaths.

TABLE 7: CFRT HOMICIDE REVIEWS

DECEDENT DEMOGRAPHICS	CAUSE OF DEATH
22-year-old [12] Black-AA male	Multiple Sharp Force Injuries of the Torso
20-year-old Black-AA Male	Gunshot Wound of the Chest
19-year-old Black-AA Male	Gunshot Wound of the Chest
18-year-old Black-AA/Male	Multiple Gunshot Wounds
18-year-old Black-AA/Male	Multiple Stab Wounds
16-year-old Black-AA/Female	Gunshot Wound of the Head and Lower Extremity
15-year-old Black-AA/Male	Sharp Force Injuries
15-year-old Black-AA/Male	Gunshot Wound of Chest
15-year-old Black-AA/Male	Gunshot Wound of Chest

12 This decedent was committed to the Department of Youth Rehabilitation Services (DYRS). Their commitment ended on their 21st birthday and was within a year of the death. The CFRC reviews the deaths of decedents who are known to the juvenile justice system within 2 years of the fatal event.

As indicated in this table, most of the CFRT homicide decedent's deaths were the result of gun violence (6, 35%). The remaining three (3) homicide decedents died due to sharp force injuries/ stab wounds. Decedents ranged from 15 to 22 years old. 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.

Economic insecurity was the leading adverse life experience as all homicide decedents met the household income threshold for combined federal assistance (TANF, Medicaid, Supplemental Nutritional Assistance Program, and housing assistance). Juvenile justice involvement and disengagement presented negative consequences for seven (7) of these decedents (63%). Two (2) youth involved with juvenile justice programs were involved with the adult criminal justice system. These youth were also disengaged from school. None of the decedents ages 18 and older completed high school or alternative education programs. Records further indicated none of the youth ages 18 and older were employed. School records indicated school truancy impacted the school-based special education services as required of two (2) decedents. Two of the homicide decedents were on target to graduate from high school immediately prior to their deaths.

The CFRT discussed truancy intervention strategies the DCPS Response-to-Intervention (RTI) program addresses. Corrective measures are taken to address the student's poor school attendance prior to the student's referral for court intervention. On a case-by-case basis, the CFRT learned that the District of Columbia Public Schools (DCPS) referral notification process to the Office of the Attorney General (OAG) does not necessarily insure the court will intervene to mandate the student's school attendance. The CFRT will continue to track issues related to the student's referral process for court intervention, as the documentation of the attendance and prevention efforts is paramount to secure the court's intervention.

Youth involved with the Department of Youth Rehabilitative Services (DYRS) will be working with Credible Messengers who will help to de-escalate crisis through conflict resolution strategies within their community. To help curb the incidence of absconding youth, DYRS has improved youth's access to community based mental health services and supports. Youth may experience trauma and exhibit behaviors that may lead to over prescribing psychotropic medications. DYRS had implemented a program that allows medical interns to work through cycles at DYRS; giving future medical professionals the opportunity to work with youth and learn the effects of trauma amongst this population.

To help improve educational outcomes for adjudicated youth, the Office of the State Superintendent of Education (OSSE) has executed Memorandums of Agreements with multiple youth servicing agencies to support youth with disabilities who receive special education services. Also, implementation plans for Restorative Justice models to address conflicts among youth has been approved for the public schools.

» CFRT Accidental Death Case Reviews

As shown in Table 8, the CFRT reviewed five (5) accidental death cases of children between the ages of 1 to 9 years old.

TABLE 8: CFRT 2017 ACCIDENTAL DEATHS

DECEDENT DEMOGRAPHICS	CAUSE OF DEATH
1-year-old Hispanic Male	Choking
3 – year- old Black-AA/ Male	Choking
7-year-old Black-AA/ Male	Drowning
8- year old Black-AA Male	Multiple Blunt Force Injuries (Motor Vehicle Accident)
9-year-old Hispanic Female	Asphyxia due to Upper Airway Obstruction due to Food Bolus

During the CFRT's review of accidental death cases, members discussed the need to provide the community with information on the risks associated with choking in young children. The FRU Outreach Specialist discussed the risks associated with accidental deaths during community based forums throughout the District of Columbia. The CFRT also developed a recommendation that will address training needs for licensed providers caring for young children in homes and facilities throughout the District of Columbia.

CFRT Suicide Case Reviews

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

TABLE 9 : 2017 CFRT SUICIDE CASE REVIEWS

DECEDENT DEMOGRAPHICS	CAUSE OF DEATH	ASSOCIATED RISKS
16-year old Black-AA/Male	Drowning Complicated by the Combined Effects of Methylphenidate and Fluoxetine	Previous suicidal ideation Documented Substance Abuse Treatment Previous Psychiatric Hospitalizations
17-year old Black-AA/Male	Gunshot Wound of the Head	None Identified

As indicated in Table 9, suicide deaths may occur following substantial mental health intervention or no history of mental health treatment. The Center for Disease Control reports "suicide is a serious public health issue that has negative social and economic consequences" (National Center for Injury Prevention and Control, 2017). During the suicide case reviews, members learned that suicide prevention outreach is provided through Children's National Medical Center, and the Department of Behavioral Health's Crisis Hotline. Team physicians indicated there is no known interaction between psychotropic medications (such as medications for ADHD) and marijuana, however youth should remain drug free. The CFRT will continue to track findings of incidents where polysubstance abuse is indicated as a contributing cause of death.

CFRT Undetermined Case Review

The CFRT reviewed one (1) case in which the cause of death was undetermined:

TABLE 10 : 2017 CFRT UNDETERMINED CASE REVIEWS

DECEDENT DEMOGRAPHICS	CAUSE OF DEATH	ASSOCIATED RISKS
9-year old Black-AA/Female	Positional Asphyxia in a Setting of Spastic Quadriplegia due to Anoxic Encephalopathy due to Blunt Force Injuries of the Head	Medically Fragile Child Family history of child neglect Unsafe Sleep Environment

The CFRT's discussion of this case surrounded the unique and challenging needs of families caring for homebound children with multiple global developmental delays. Parents and/or caretakers have to learn how to secure and manage medical appointments, durable medical equipment and in-home health providers. For families with burdensome socio-economic needs, navigating the needs for a medically fragile child may present its own difficulties.

CFRC Decedents Known To Child Welfare

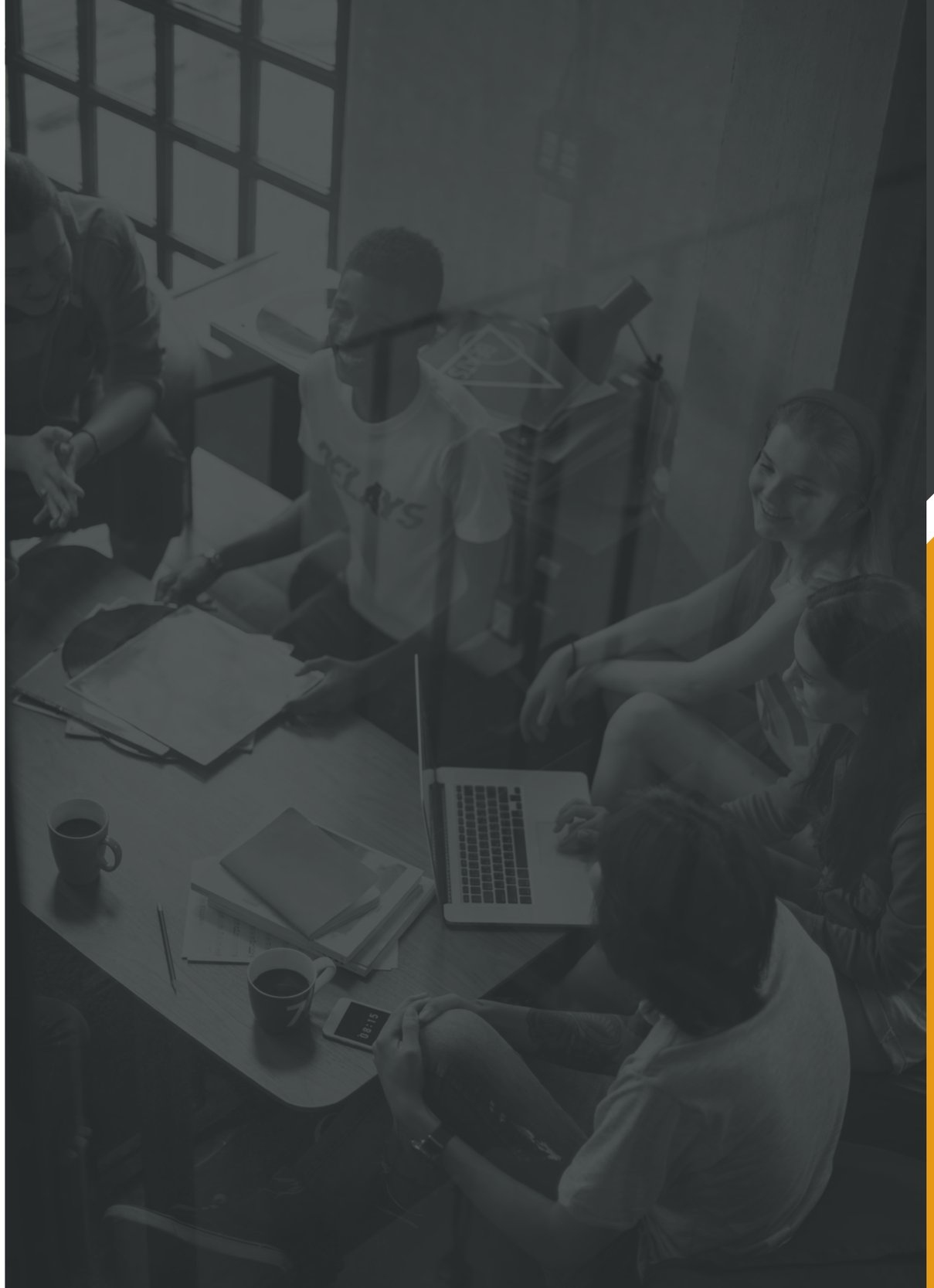
The CFRC is mandated to review the fatalities of children and youth known to the District of Columbia's child welfare and juvenile justice programs. Children and youth involved in these systems of care often interact with multiple publicly funded providers (e.g. mental health, education, or community resources). Documentation related to this system of care provides the Committee with the opportunity to learn how systems collaborated to improve outcomes for this at-risk population. Children and youth with child welfare and juvenile justice involvement are at risk particularly due to their adverse life experiences (CDC-Kaiser ACE Study, 2016). Such adverse life experiences – which may include child maltreatment, exposure to violence, substance /alcohol exposure and abuse, and poor educational outcomes – may have lasting negative effects on the overall health and social outcomes of children and youth. As the ACE study concludes, the key to improving outcomes for this vulnerable population is to prevent their exposure to adverse life experiences.

During the 2017 review year, the CFRT reviewed seven (7, 41%) cases involving children and youth who were known to the District's child welfare agency within four years of the fatal event. CFRT members discussed the needs of families with multiple interactions with child welfare and barriers to supportive community based services.

CFRT Juvenile Justice Decedents

TABLE 11: CFRC Juvenile Justice Decedents		
Decedent Demographic	Cause of Death/Motive	Risks/Adverse Life Experiences
16-year-old Black AA Female	Gunshot Wound/ Unintended Victim	Economic Insecurity School Truancy
15-year-old Black AA/Male	Sharp Force Injuries/ Dispute	Economic Insecurity School Truancy
18-year-old Black- AA/Male	Gunshot Wound/ Unknown	Economic Insecurity Special Education Needs History of Child Neglect
18-year-old Black-AA/Male	Gunshot Wound/ Neighborhood Dispute	Economic Insecurity School Truancy Family Safety Concerns
19-year-old Black-AA Male	Gunshot Wound/ Neighborhood Dispute	Economic Insecurity School Truancy History of Child Neglect Special Education Needs
20-year-old Black-AA Male	Gunshot Wound/ Dispute	Economic Insecurity School Truancy Adult Criminal Involvement
22-year-old Black-AA Male	Sharp Force Injuries/ Unknown	Economic Insecurity Adult Criminal Involvement Documented Substance Abuse History Unresolved Mental Health School Truancy

The CFRT reviewed seven (7) cases of youth involved with the District's juvenile justice system. As indicated in Table 11, each youth experienced a number of adverse life experiences prior to and during their involvement with juvenile justice services. All of these decedents, six (6) males and one (1) female were Black-African American, were homicide victims. Economic insecurity (7 cases) and school truancy (6 cases) were the leading adverse life experiences observed in juvenile justice case reviews. Two (2) decedents' families were co-involved with child welfare services.



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COMMITTEE RECOMMENDATIONS AND AGENCY RESPONSES

The following are recommendations developed by the Child Fatality Review Committee and submitted to the following agencies: Child and Family Services Agency (CFSA), Department of Behavioral Health (DBH) , DC Health and the Office of the State Superintendent of Education (OSSE). These recommendations address the need for improvements in daycare licensing, discharge protocols, bereavement support and investigations of child neglect and abuse.

» Recommendation for the Office of the State Superintendent of Education (OSSE)

RECOMMENDATION:
The Office of the State Superintendent of Education will require each licensed day care facility and providers to have an emergency plan that includes training based upon national standards.

AGENCY RESPONSE: No, with explanation and alternative recommendation

OSSE has regulations in place that require all child development facilities to have emergency preparedness and response plans in place (5-A DCMR § 148 effective Dec. 2016). Training on emergency preparation and response planning is also required annually (5-A DCMR § 139.7). OSSE procured a contractor to provide the required training to all child development facility staff by September 30, 2017 and will continue to provide this training for providers at no cost through FY18. The aforementioned information was shared with the CFRC on May 18, 2017, during a committee meeting.

While we appreciate the concerns raised by the committee, at this time we feel confident that our current requirements ensure that child development providers are aware of the actions and steps they should take during an emergency. No further actions will be taken at this time.

Recommendation for DC Health (DOH)

RECOMMENDATION:
DC Health should partner with local hospitals serving the pediatric population to ensure that hospitals create, maintain and monitor implementation of discharge protocols for high risk infants. This will assist in the transition from the in-patient hospital setting to the community provider setting. The Chief Medical Examiner agreed to present this information to the DC Hospital Association.

AGENCY RESPONSE: Agree with Modifications

Hospitals in the District of Columbia should have discharge policies in place that include the documentation of pertinent medical information in the form of a discharge summary, an identified primary care provider, and a mechanism to ensure delivery of the summary to this outpatient provider. Discharge policies along with best practices for implementation at hospitals, birthing facilities and in nurse midwifery groups are beneficial for all infants born in the District of Columbia.

The Department of Health (DC Health) implements a comprehensive approach to improving and protecting perinatal health in the District (attached). Strategies applicable to this CFRC recommendation to improve perinatal health include ensuring that every newborn receives high quality neonatal care in the hospital and outpatient setting; and that every health care facility providing maternal and infant care has the tools and resources to practice evidence based health care and to document QI/QA activities. DC Health agrees that discharge protocols should be in place and we maintain that this is a benefit to all babies born in the District. There is expert consensus that such protocols provide for better transition of care and decrease readmission rates.[13] Additionally, the Joint Commission mandates basic minimum standards for discharge summaries that can be built upon to best meet the needs of District residents.

Establishment of discharge standards includes institution of policy and protocols, technical assistance, accountability and continuous quality improvement. DC Health supports the establishment of policy to ensure every woman who delivers in the District and every baby born in the District receives the highest standard of care. Policy should include mechanisms to improve continuity of care from the inpatient to outpatient setting through discharge protocols, a mandate of primary care provider identification prior to discharge and mechanisms to directly relay pertinent information. DC Health provides hospitals technical assistance in the form of educational presentations, face-to-face meetings, and teleconferences to support and promote safety and quality in healthcare delivery for patients receiving hospital services in in the District of Columbia.

13 Gonçalves-Bradley DC, L. N. (2016). Discharge planning from hospital. Cochrane Database Syst Rev.(1). doi:10.1002/14651858

In FY 18, Mayor Bowser announced a new legislative proposal called the Better Access for Babies to Integrated Equitable Services (B.A.B.I.E.S.) Act of 2018, known as the BABIES bill. The BABIES bill includes four key provisions to reinforce the goal of providing high-quality services for pregnant women, mothers and newborns:

1. Annual report card for birthing facilities by 2020 to help ensure that every pregnant woman who delivers in the District and every baby born in DC receives the highest standard of care.
2. Perinatal and infant health advisory committee of DC-based subject matter experts to review existing needs, identify emerging issues and make recommendations to safeguard newborns.
3. DC Health will partner with two birthing facilities to find the most effective ways to identify and treat women at-risk for preterm birth and reduce the number of babies born too early in DC by the use of 17P.
4. Annual report on baby-friendly government buildings to assess the availability and accessibility of breastfeeding support, such as lactation rooms, for employees and visitors.

Specific to this recommendation, this bill requires each hospital, birthing facility, and nurse midwife to provide comprehensive newborn education to parents and a discharge form approved by the DC Health with information regarding the newborn's hospital course, screenings, procedures, and other tests. It institutes mayoral authority to develop and issue standards for post-partum education, including breastfeeding, family planning, safe sleep practices, tobacco exposure, vaccinations, car safety, basic newborn care, and results and rationale for newborn screenings. The bill also establishes a Perinatal and Infant Health Advisory committee to review the discharge protocols of each facility. The bill was introduced on March 22, 2018, and the hearing is scheduled for July 11, 2018.

DC Health implements its comprehensive approach to improving and protecting perinatal health, by working with key stakeholders to promote health and remove barriers to receiving quality care. In the absence of legislation, DC Health has existing mechanisms through which perinatal health strategies can be imparted to hospitals. The Health Regulation and Licensing Administration (HRLA) provides support in the form of quarterly reports about various methodologies, a help desk for support for hospitals, and a quarterly newsletter that highlights best practices for health providers. Additionally, DC Health continues to explore the use of health information technology and systems such as the Chesapeake Regional Information System for Patients (CRISP) continuity of care processes and how they can be utilized for discharge quality improvement in the neonatal setting. We continue to partner with the Department of Health Care Finance on the development of the State Medicaid Health IT Plan on support for transitions of care, one of the four areas prioritized to improve connection and navigation in the District.

EXPECTED OUTCOMES ARE:

- Improved transition of care practices through established discharge standards and protocols for contacting outpatient providers for all newborns born in the District.
- District parents will be better equipped upon discharge to care for their families through standardization of comprehensive newborn education, post-partum education, including breastfeeding, family planning, safe sleep practices, tobacco exposure, vaccinations, car safety, basic newborn care, and results and rationale for newborn screenings.
- Increased birthing facility and hospital accountability through implementation of an annual facility report card.
- Increased oversight of best practices implementation through a Perinatal and Infant Health Advisory Committee responsible for making comprehensive recommendations to the city regarding improving perinatal health and assuring access to quality perinatal health services.

» Recommendation for the Department of Behavioral Health (DBH)

RECOMMENDATION:
The Department of Behavioral Health (DBH) should consider creating a position under the auspices of a family advocate who will assist families and caretakers who lost a child with their connection to bereavement services. The DBH should develop a full cadre of bereavement supportive services that allows for timely access to services beyond that which is currently available.

AGENCY RESPONSE: No, with explanation and alternative recommendation

The Department of Behavioral Health (DBH) provides behavioral health services through the Mental Health Rehabilitative Services (MHRS) and the Substance Abuse Rehabilitation Services (ASARS) programs which do not have specific grief and loss services. Attached is list of services offered through MHRS and ASARS.

Currently, DBH has knowledge of one provider with clinicians trained in grief and loss and offer three (3) child and youth trauma evidence-based practice models Child Parent Psychotherapy – Family Violence (CPP-FV), Trauma Focused – Cognitive Behavior Therapy (TF-CBT) and Trauma System Therapy (TST) within network that can support children and families that have experienced grief and loss. System wide information on therapists with specific grief and loss training and expertise is not currently available to DBH.

Additionally, District residents with private insurance coverage would have to go through their respective insurance companies to access bereavement or grief and loss services.

The DBH will consider utilization of existing staff within the Consumer and Family Affairs Administration to serve as a family advocate who will assist families and caretakers who lost a child with their connection to bereavement services.

When a caregiver's grief-related thoughts, behaviors, or feelings are extremely distressing, unrelenting, or incite concern, therapeutic services by a qualified mental health provider is recommended. Therapeutic services that address effective coping skills and management of symptoms with techniques such as relaxation or meditation are beneficial. A referral for assessment at a behavioral health provider might help the caregiver find different ways to maintain healthy connections with the deceased through memory, reflection and ritual. In addition to individual therapy, group therapy can be helpful for those who find solace in the reciprocal sharing of thoughts and feelings. Similarly, family therapy may be suitable for a family whose members are struggling to adapt to the loss of a child.

Specific action planned towards implementation:

- DBH to develop a protocol for response to caregivers who suffer the loss of a child within 30 days.
- Educate the DBH access helpline on this protocol.
- Inform the DBH provider network of the protocol

The DBH will accept "the Department Behavioral Health (DBH) should consider creating a position under the auspices of a family advocate who will assist families and caretakers who lost a child with their connection to bereavement services." Within the Consumer and Family Affairs Administration, the current position of the DBH Resiliency Specialist and the family peer specialist will take on the responsibility of connecting children and caregivers to available bereavement services in the District.

The DBH is a member of the Community Stabilization Response for the District of Columbia and provide evidenced based practices within network of providers. The Department is also in the developmental phase of a Peer Operating Center staffed with recovery coaches and peer providers that can also support families experiencing grief and loss providing a warm handoff to behavioral health services.

Expected Outcomes Include and measurable milestones are as follows:

- DBH Resiliency Specialist will contact caregiver within 48-72 hours of the notice of loss.
- Caregivers dealing with grief and loss of a child will be supported upon notice and linked to a DBH or other behavioral health provider within 1 week of traumatic event as clinically appropriate.
- Caregiver will have first service within 2 week of linkage to behavioral health provider.

Indicator/milestones:

1. Completion of the protocol and educate internal DBH staff.
2. Inform DBH provider network
3. Implement protocol

Indicator/milestones: Track the number of individuals referred to Resiliency Specialist (monthly, quarterly and annually)

Indicator/milestones: Number of individuals linked and received bereavement services. (ongoing, quarterly)

» Recommendations for the Child and Family Services Agency (CFSA)

RECOMMENDATION #1

The Child and Family Services Agency should consistently implement its policy on community papering to ensure judicial oversight in cases where the safety/well-being of the child are at risk and the families declined to participate in voluntary services.

AGENCY RESPONSE – Agree

CFSA accepts this recommendation and will continue to use the Community Papering process as necessary for that smaller percentage of families where the additional oversight of the court is warranted to achieve progress to a safe resolution for the family and the facts meet the legal standard to bring the case to court.

RECOMMENDATION #2

The Child and Family Services Agency should continue to provide supportive services to its' front line social work staff and improve their access to existing programs that promote well-being.

AGENCY RESPONSE – No, with explanation and alternative recommendation

CFSA does not accept this recommendation and requests that it be deleted as it falls outside the scope of responsibility of this Committee. CFSA does not understand the correlation between well-being services to front line social workers and the impact on child fatalities in the District. CFSA acknowledges that employee well-being is important and the Agency has made it a priority. However, CFSA does not see the direct connection as to how these services will reduce the likelihood of child fatalities. Further, CFSA has a robust wellness program offered to staff that includes a meditation room, fitness and health classes, counseling and intervention post exposure to traumatic events.

RECOMMENDATION #3

The Child and Family Services Agency should strengthen the agency's entry services policy and practice to ensure families with multiple referrals to Child Protective Services receive an intensive historical review. The intended result is that service intervention will be designed to prevent further reoccurrence of maltreatment.

AGENCY RESPONSE – Yes with modification

CFSA accepts this recommendation with a recommended modification. Current CFSA policy provides for review of families with multiple referrals to the agency. The existing 4+ staffing review policy ensures that in instances where four or more reports are received, with the most recent being in the past 12 months, an additional review is conducted by the worker and supervisor. This review is intended to ensure that a full assessment of the family, including case history and a review of interventions, is conducted. This review is held within 15 days of the new referral being accepted to ensure that if a different strategy is needed that it is put in place early in the process.

Additionally, CFSA also has the Review Evaluation and Direct (R.E.D.) team meetings on each accepted referral where a multi-disciplinary team consisting of social workers, nurses, and attorneys review each referral.

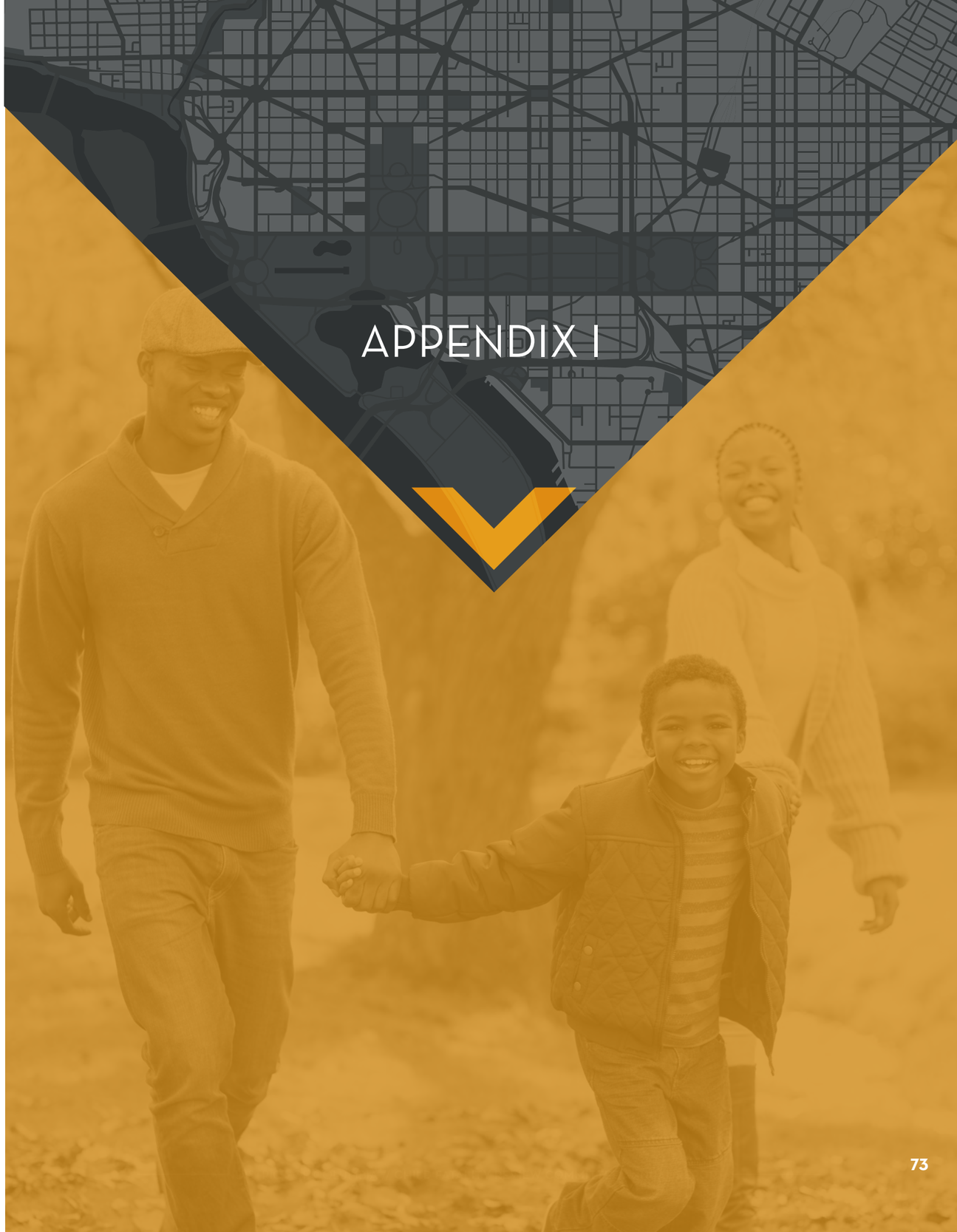
GLOSSARY OF TERMS

GESTATIONAL DIABETES is diabetes that is first diagnosed during pregnancy. This condition can increase the risk of having a cesarean delivery. Women who have had gestational diabetes also have a higher risk of having diabetes in the future, as do their children. Obese women are screened for gestational diabetes early in pregnancy and also may be screened later in pregnancy as well.

PREECLAMPSIA is a high blood pressure disorder that can occur during pregnancy or after pregnancy. It is a serious illness that affects a woman's entire body. The kidneys and liver may fail. Preeclampsia can lead to seizures, a condition called eclampsia. In rare cases, stroke can occur. Severe cases need emergency treatment to avoid these complications. The baby may need to be delivered early.

MACROSOMIA In this condition, the baby is larger than normal. This can increase the risk of the baby being injured during birth. For example, the baby's shoulder can become stuck during delivery. Macrosomia also increases the risk of cesarean delivery. Infants born with too much body fat have a greater chance of being obese later in life.

SLEEP APNEA is a condition in which a person stops breathing for short periods during sleep. Sleep apnea is associated with obesity. During pregnancy, sleep apnea not only can cause fatigue but also increases the risk of high blood pressure, preeclampsia, eclampsia, and heart and lung disorders



CHILD FATALITY REVIEW COMMITTEE
STATUS OF GRANT FUNDING

In FY2017, the OCME was awarded a $119,000 grant from the Office of Victims Services and Justice Grants (OVSJG) for the CFRC to engage in community outreach and provide training to CFRC members on trends and themes identified through case reviews or on topics of interest to the Committee in an effort to further facilitate the Committee's work.

This project further enhanced the Committee's efforts to improve outcomes of the District's most vulnerable residents and is a strategic tenant within the Committee's spectrum of advocacy activities.

The OCME Outreach Program Specialist continued his work in the community forming direct relationships with community organizations and District residents with a particular focus on interactions with youth. He spent a considerable amount of time with youth who frequented the Malcolm X Recreation Center, located in Ward 8. Many youth shared information with the Outreach Program Specialist on what they believed was needed in their community- namely sustainable wage earning jobs, recreational or other types of fun activities, a safe place to be in and more people to listen to them.

The Outreach Program Specialist continued participation in a communication strategy between the US Attorney's Office, the FBI and other community organizations around heroin and the opioid epidemic and how it was affecting the community. The Outreach Program Specialist continued strengthening networks and sharing information about the CFRC in the community and continued to spread the message of the role of Safe Sleep for infants.

One of the Outreach Program Specialist's other critical tasks was to identify national speakers to present to the CFRC on identified risk factors of the population of decedents reviewed by the Committee. Training was provided to CFRC members on youth violence, violence intervention initiatives, bereavement, aftermath of violence and solutions for healing and preventing further victims of violence and retaliation. Dr. Joseph Richardson, Jr., Ph.D. presented on "Invisible Wounds: Violence, Trauma and Healing among Violently Injured Young Black Men". In his presentation, Dr. Richardson addressed patient outcomes among victims of violent injury, their caregivers and stakeholders in violence intervention initiatives, and addressed topics of violence and trauma, incarceration as a social determinant of health, the Black Male Life Course and health risk behaviors and parenting strategies for low-income Black male youth.

Training was also provided by Taylonn Murphy, Sr., founder of the Tayshana "Chicken" Murphy Foundation who presented on "Both Sides of the Gun: An In-depth Look into Gun Violence". This presentation addressed feelings and viewpoints from the victim's family, the perpetrator's family, bereavement services, aftermath and solutions for healing and preventing further victims of violence. Mr. Murphy presented ways in which New York City (West Harlem) was able to curtail homicides from occurring for over a 1 year period and developed ways in which members of the community began to heal and hold each other accountable to ensure no further homicides would occur.

The CFRC benefited greatly from the grant resources provided and it is hoped that with continued funding, the Committee will continue to be recognized as a leading voice in the prevention of child deaths

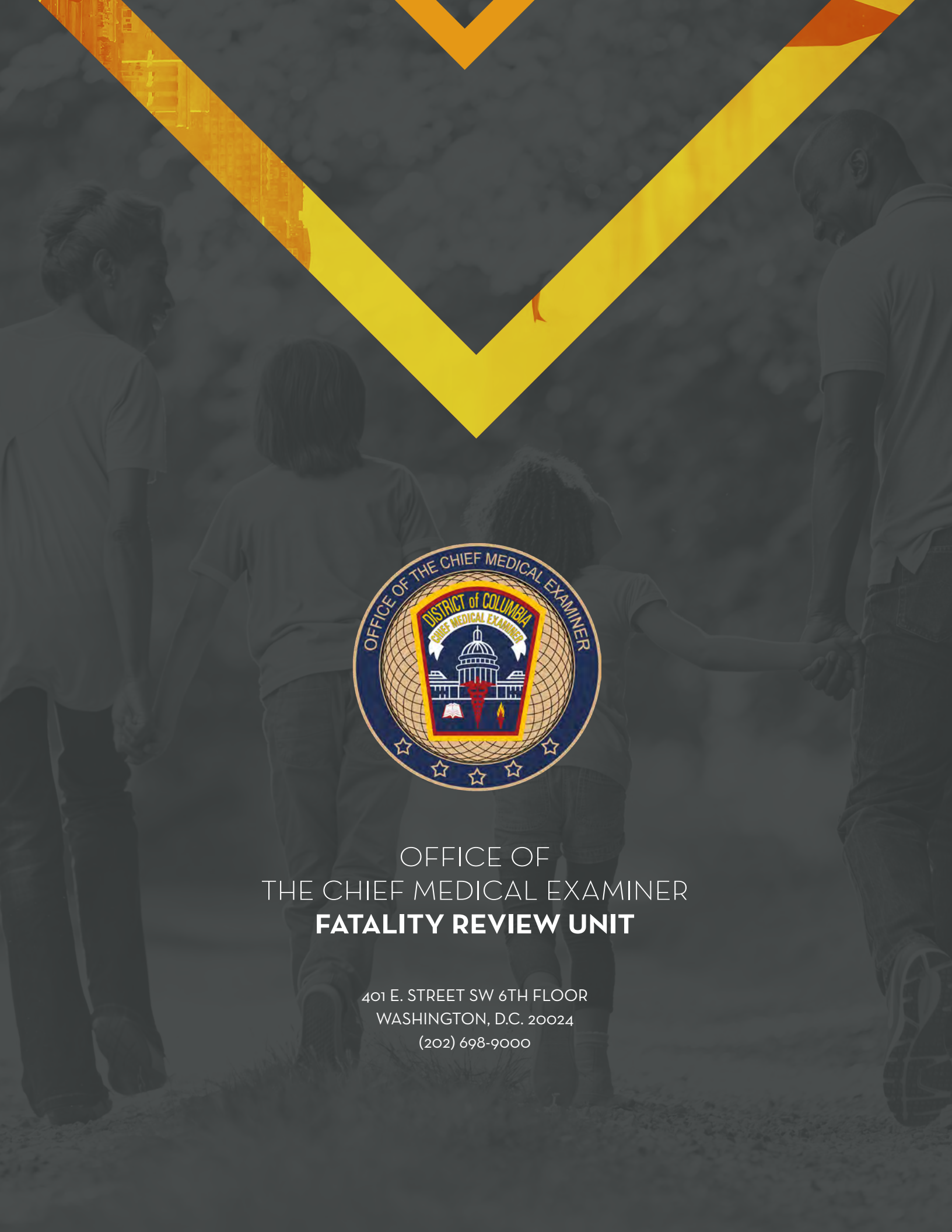
ACKNOWLEDGMENT

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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