District of Columbia
Child Fatality Review Committee

2012 Annual Report

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District of Columbia Government

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DISTRICT OF COLUMBIA
CHILD FATALITY REVIEW COMMITTEE

2012 ANNUAL REPORT

MISSION:

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

PRESENTED TO:

The Honorable Vincent Gray, Mayor, District of Columbia

The Council of the District of Columbia

MARCH 2014

District of Columbia
Child Fatality Review Committee

Dedication

This Annual Report is dedicated to the memory of the children and youth who continue to lose their lives 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 the District's children, we can succeed in positively affecting the future of other District of Columbia children by reducing the number of preventable deaths and promoting quality of life for all residents.

Table of Contents

EXECUTIVE SUMMARY

The District of Columbia Child Fatality Review Committee (CFRC) is pleased to present its 17th Annual Report. This Report covers data from 109 child/youth fatality cases reviewed by the Child Fatality Review Committee in 2012.

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). The 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 or committed to the District. The primary goals of the District's child death review process are to: 1) identify risk reduction, prevention and system improvement factors, and (2) recommend strategies to reduce the number of preventable child deaths and/or improve the quality of life of District residents. The primary agencies that report child deaths to the Committee are: the Department of Health (DOH), the Office of the Chief Medical Examiner (OCME), the Child and Family Service Agency (CFSA), the Department of Youth Rehabilitation Services (DYRS), and the Metropolitan Police Department (MPD).

KEY CHILD FATALITY REVIEW DATA FINDINGS

DECEDENT DEMOGRAPHICS

The age of the decedents reviewed by the CFRC in 2012 ranged from birth to 22 years of age.

- Sixty-three percent (N=69) of the decedents were infants.
- Eighty-seven percent of the decedents (N=95) were black.
- Fifty-nine percent (N=64) of the decedents were males.

MANNERS OF DEATH

Natural Deaths

In 2012, the Committee reviewed 73 natural cases involving infants, children and youth. The majority of these cases , 86% (N=63) were infants.

Homicide

The Committee reviewed 24 fatalities of children and youth whose deaths were the result of violent acts. Of these, two infants and one child were victims of fatal abuse.

Accidental Deaths

The Committee reviewed 5 accidental deaths involving infants and children. The circumstances leading to these accidental deaths were as follows: motor vehicle accidents (3); fire (1) and drug toxcicity(1).

Undetermined Deaths

The Committee reviewed seven infant/child fatalities in which the manner of death was classified as Undetermined.

CFRC 2012 Recommendations

The following were recommendations developed by the Child Fatality Review Committee to address the need for improvements in systems and/or program initiatives to improve outcomes for children and families in the District of Columbia.

Area of Focus	Recommendation	Response
District Government Policy and Practice	The Child and Family Services Agency should develop and implement a protocol to address issues related to poor living conditions found in publicly funded housing (e.g. mold, poor air quality) that may present health risk to the home's residents. The Child and Family Services agency should provide all agencies with a review of the Mandated Reporter Law for child abuse and neglect to ensure that employees and their contractors are aware and adhere to this statute to ensure the safety of children residing in publicly funded housing programs.	**Disagreed with Explanation** **See Page 25**
Dual Agency Policy and Practice	The Office of the State Superintendent for Education and the District of Columbia Fire and Emergency Medical Services Department should collaborate to disseminate information about fire safety and prevention to children and youth attending District of Columbia Public and Charter Schools.	**Agreed** **See Page 27**
Agency Policy and Practice	The Department of Behavioral Health (formerly the Department on Mental Health) should identify and disseminate information regarding community based mental health providers that support children, and youth struggling with gender identity. Providers that can provide awareness and support to parents and caretakers of children and youth should also be identified.	**Agreed** **See Page 27**
Agency Policy and Practice	The Metropolitan Police Department should provide information regarding domestic violence and child abuse to parents involved in domestic disputes. The information should contain information for parents on how to recognize perpetrators of domestic violence and early stages of child abuse in toddler and young children.	**Agreed** **See Page 28**
Agency Policy and Practice	The Department on Youth Rehabilitative Services should outline and comply with established aftercare protocols to ensure discharge plans for committed youth are developed prior to their discharge from treatment and adult correction facilities, implemented and tracked for compliance. This may require the development of protocols and training for direct service staff and supervisors.	**Agreed with Modifications** **See Page 28**

INTRODUCTION

The District's child fatality review process is the only formally established mechanism within the District for tracking child/youth fatalities, assessing the circumstances surrounding their deaths and evaluating associated risk factors. This process assists in identifying family and community strengths, as well as deficiencies and improvements needed in service delivery systems to better address the needs of children and families served. It is an opportunity for self-evaluation, through a multi-agency, multidisciplinary approach. As such, it provides a wealth of information regarding ways to enhance services and systems in an effort to reduce the number of preventable deaths and improve the quality of children and youth's lives.

The Child Fatality Review Committee (CFRC) is divided into two teams; the Infant Mortality Review Team reviews the deaths of District infants from birth through 12 months. The Child Fatality Review Team reviews the death of District children ages 1 through 18 years, and youth older than 18 who were known to child welfare and juvenile justice programs. When a child dies in the District, the Committee is notified through several established sources. Once notified, the Committee staff obtains copies of the decedent's birth and death certificates, copies of records from the medical examiner, police, hospitals and other major child and family-serving agencies. Records are reviewed, and a summary is developed for presentation during the monthly case review meetings.

In accordance with DC Official Code §4-1371.04 et. seq, Committee membership is multidisciplinary, representing public and private child and family service agencies and programs, and includes, community members representing the District of Columbia's Wards. ***All fatality review meetings are confidential.*** Committee members seek to identify shortfalls related to the services and interventions provided to the child and/or family. More importantly, the Committee also indicates potential system improvements and makes recommendations for the prevention of deaths.

This annual report summarizes data collected from 109 child and youth fatalities reported to and reviewed by the Committee during calendar year 2012. The statute mandates an Annual Report be published reflecting the work of the Committee during the year of review.

Section I: Summary of Case Findings: This section summarizes decedent's demographics and the causes and manners of death.

Section II: Summary of Child Welfare and Juvenile Justice Decedents: This section summarizes decedent's demographics and the causes of death for CFRC decedents known to child welfare and the juvenile justice system.

Section III: Recommendations: This section contains the Committee's recommendations and the agency responses.

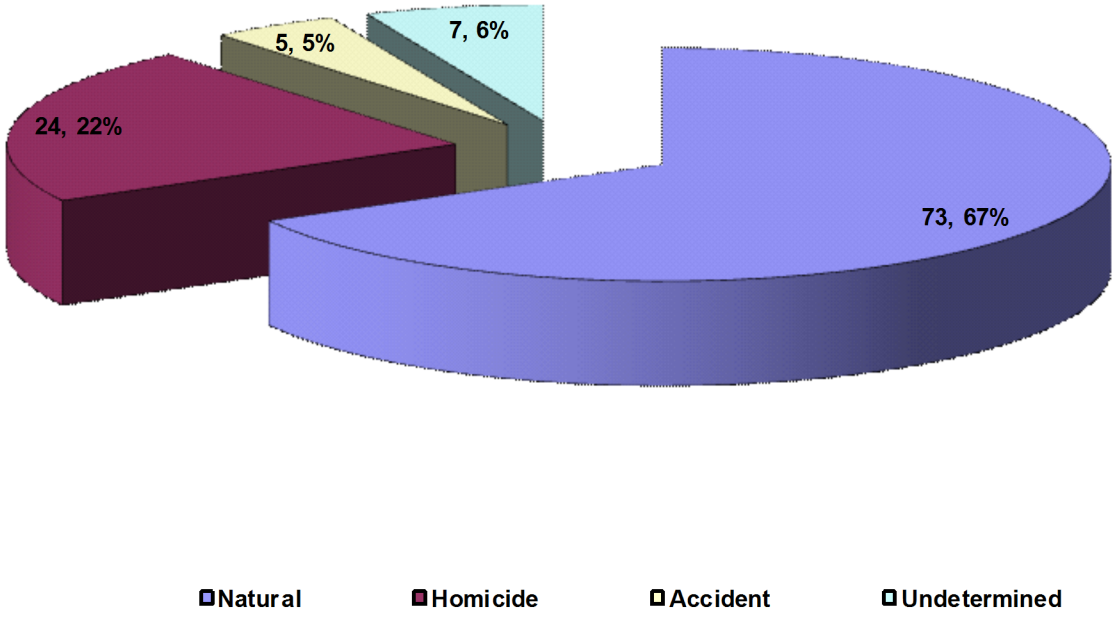
SECTION I: SUMMARY OF CASE FINDINGS

MANNER OF DEATH OF CASES REVIEWED BY THE CFRC IN 2012

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

In 2012, the Committee reviewed data associated with 109 infants, children, and youth deaths. Seventy-three of these deaths (67%) involved infants, children and youth who died of natural causes and twenty-four (22%) were infants, children and youth whose deaths were the result of a homicidal act. Of the remaining fatalities reviewed, seven deaths were classified as Undetermined, and five as Accidents.

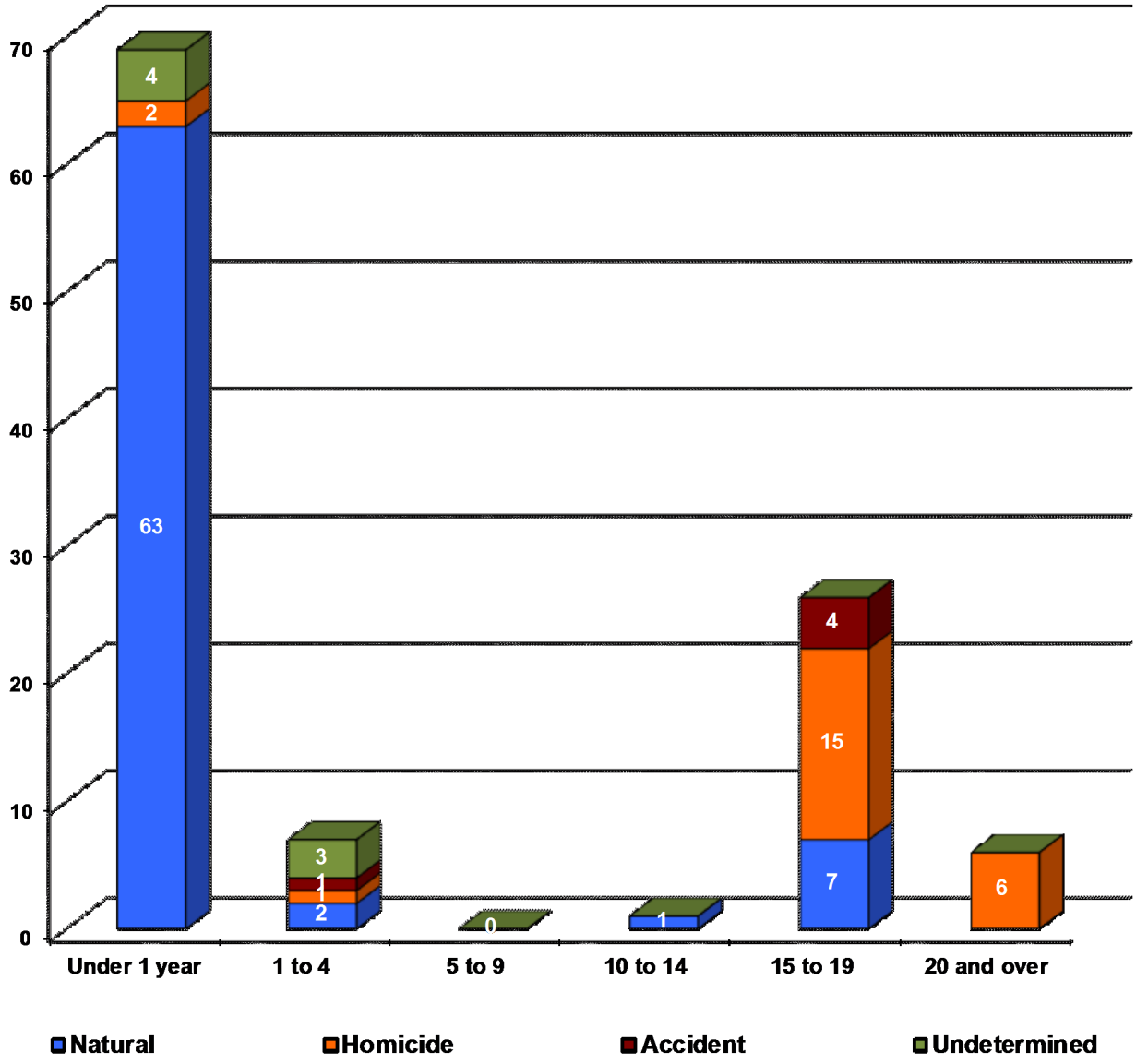
Figure 1: 2012 CFRC Decedents Manner of Death



DECEDENT DEMOGRAPHICS BY MANNER OF DEATH

During the 2012 review year, the CFRC reviewed the fatalities of decedents whose ages ranged from birth to 22 years old. The majority of the cases reviewed involved infants (N=69) and youth between the ages of 15 and 19 years old (N=26).

Figure 2: 2012 CFRC Decedent Age by Manner of Death
N=109



Race and Gender by Manner of Death

As Figure 3 illustrates, Black children and youth represented 87% (N=95) of the total CFRC decedent cases reviewed in 2012. Black children and youth had the highest percentage of representation in all manners of death.

Figure 3: Decedent Race by Manner of Death N=109

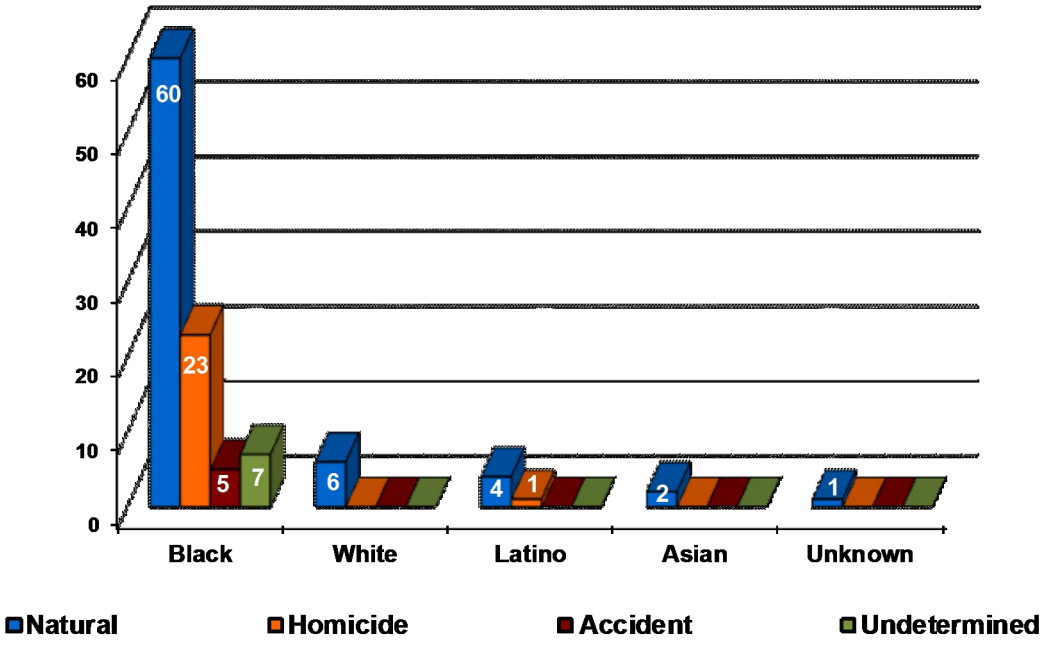
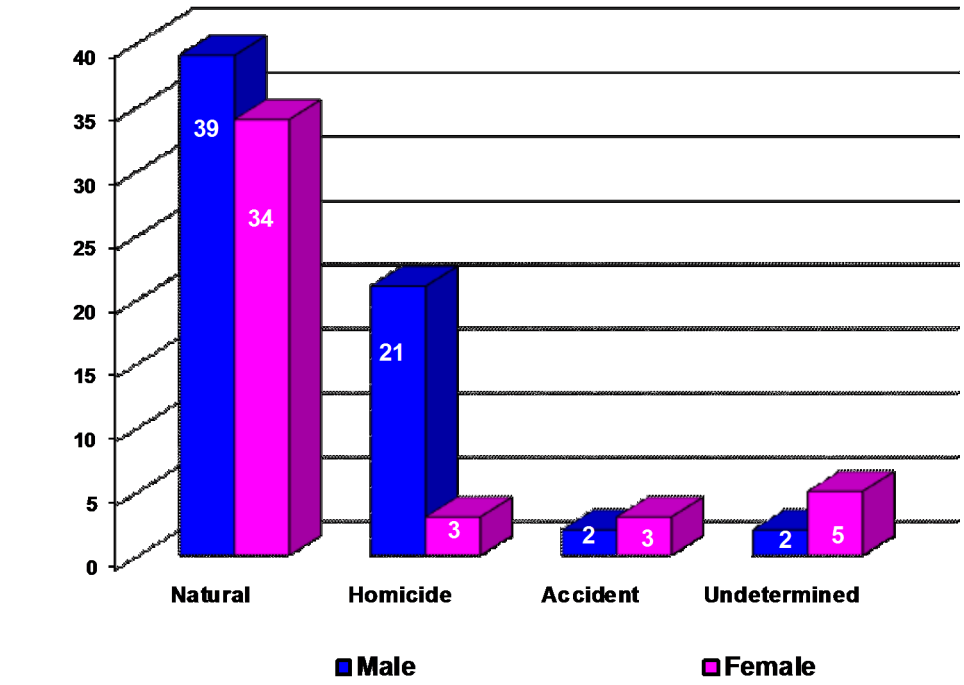


Figure 4: Decedent Gender by Manner of Death N=109



Decedents' Ward of Residency by Manner of Death

The Ward of residency is primarily determined by information contained on the death certificates and other supporting documentation (i.e., child welfare, public assistance records/databases, etc.). Of the cases reviewed in 2012, Ward 8 had the greatest number of child and youth fatalities with 27% (N=29), Ward 5 had the second largest number with 18% (N=20), and Ward 4 was third with 16% (N=17).

Figure 5: 2012 CFRC Decedent Ward of Residency

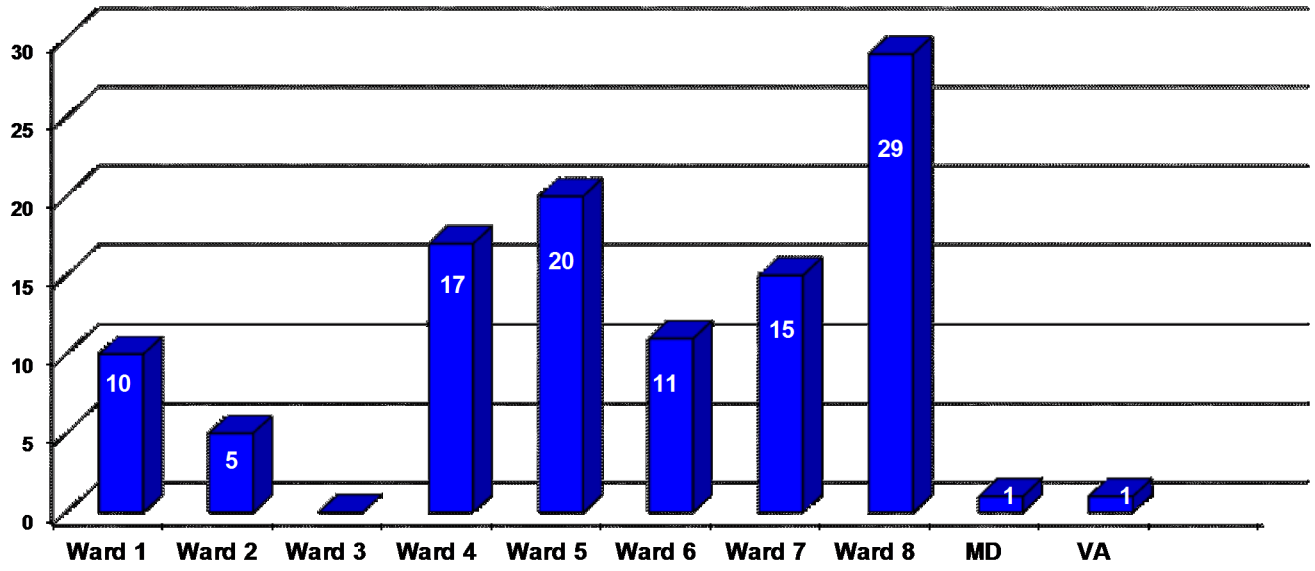
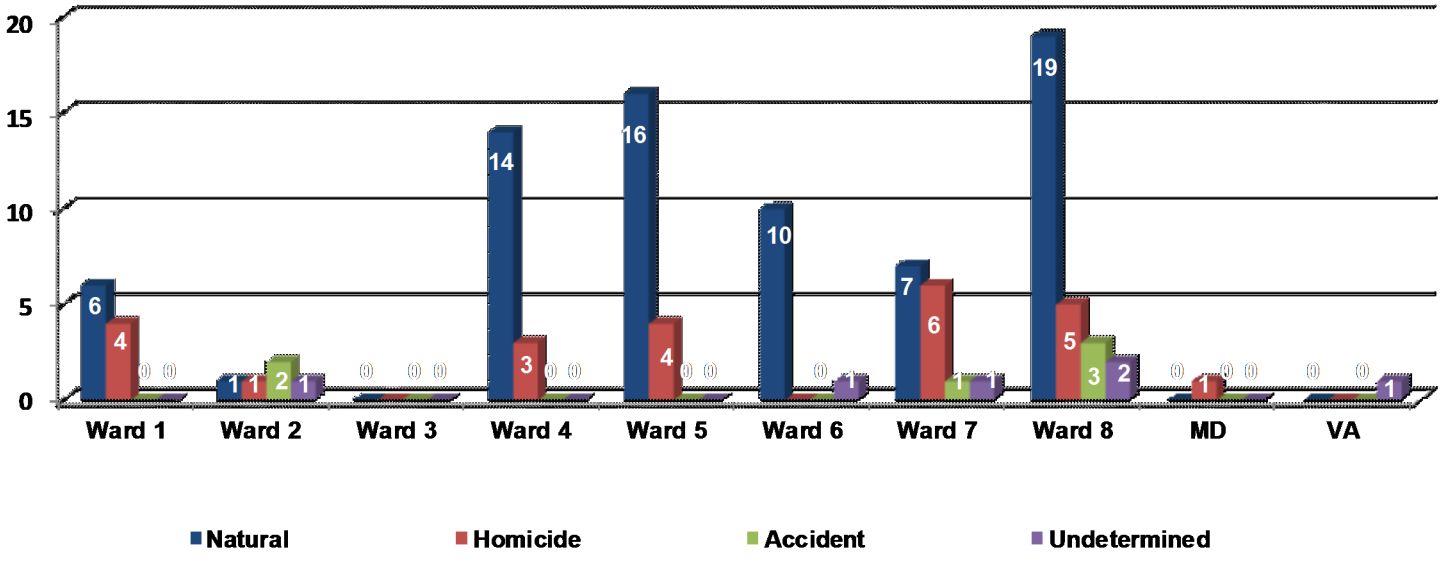


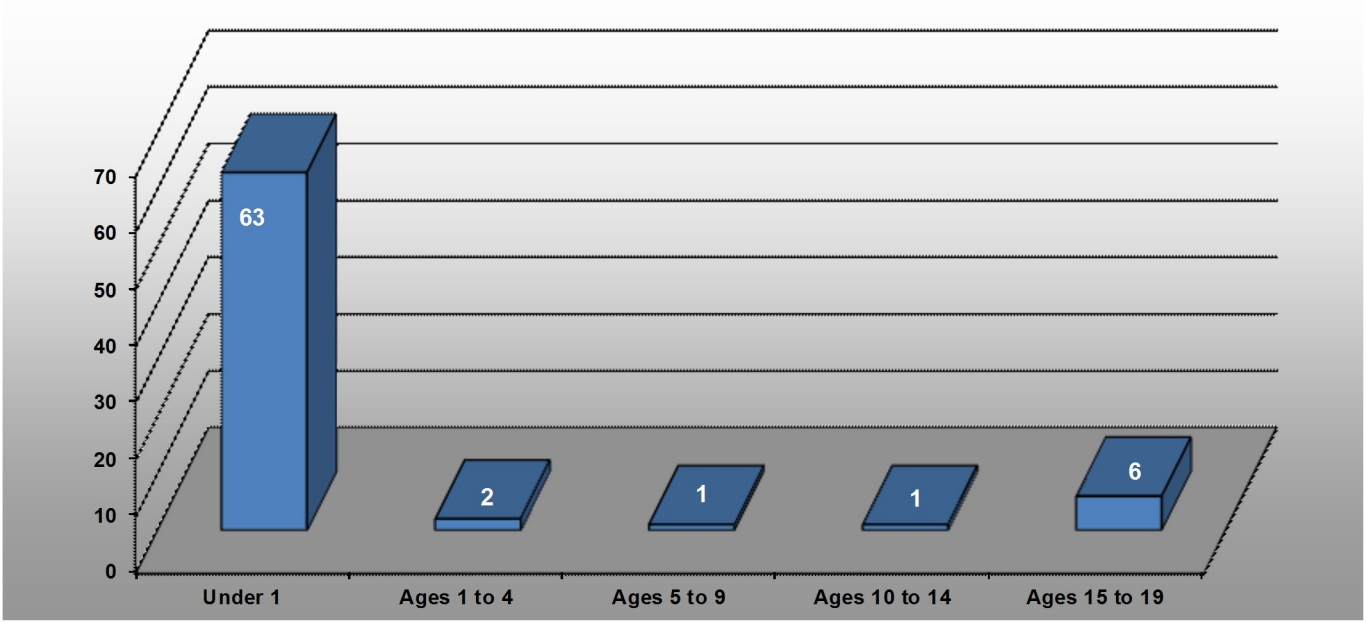
Figure 6: Decedent Ward by Manner of Death

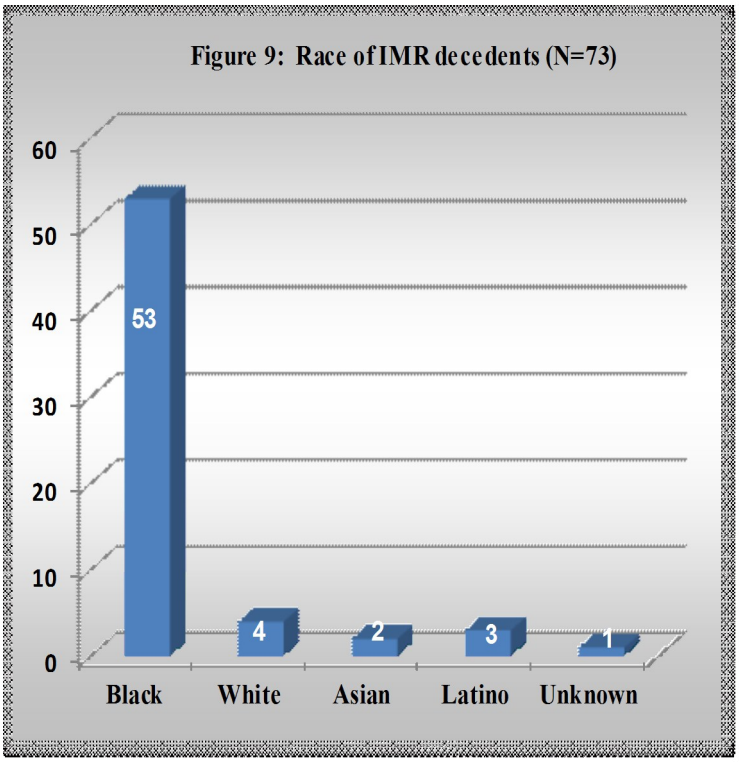


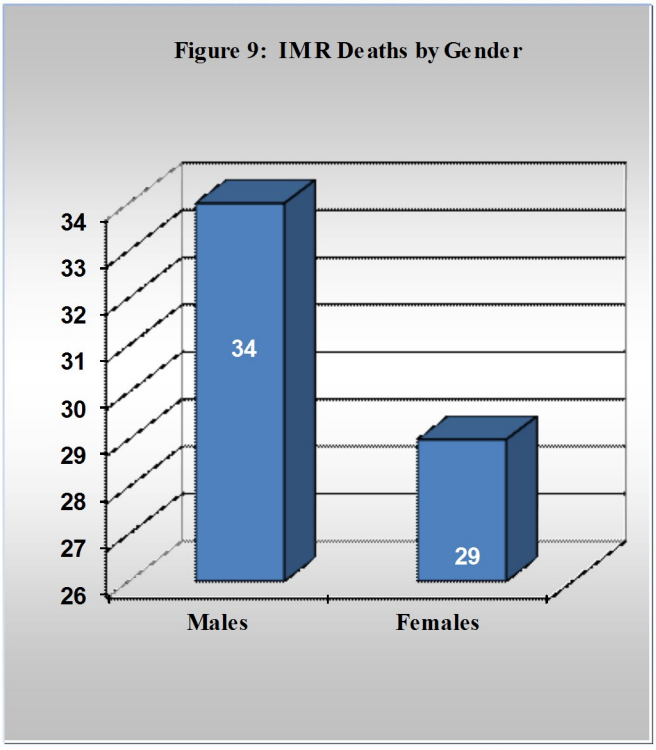
Natural Deaths

In 2012, the Committee reviewed 73 cases involving infants, children and youth whose death resulted from pre-existing conditions or underlying medical conditions. The majority of these cases , 86% (N=63) involved infants whose cases were reviewed by the Infant Mortality Review Team (IMR). The majority of the infants in this category were Black males.

Figure 7: Age of Natural Decedents (N=73))







Deaths Related to Premature Births

The Infant Mortality Review Team (IMR) reviewed the fatalities of 63 infants. Forty-four (70%) of these infants died as a result of premature birth. The following are risk factors associated with the premature births as reviewed by the IMR Team:

Maternal Risk Factors

Prenatal Care

The IMR Team did not review preconception data but focused on timeliness of the initial prenatal visit and subsequent routine visits. Based on these two parameters, the IMR Team concluded that *inadequate prenatal care was a risk factor in 16 of the 44 premature infant deaths reviewed.*

Adequate prenatal care is associated with lower risks of maternal as well as infant deaths. Routine prenatal care visits will include an initial visit in the 1st trimester (gestation week 1 to week 12)

- Prenatal care visit once every 4 weeks until the 28th week
- Prenatal care visit once every 2 weeks until the 36th week
- After the 36th week, a prenatal care visit should occur once a week until delivery

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

Inadequate prenatal care is associated with premature births. This includes late entry into prenatal care with no visit during the first trimester, and missed prenatal visits throughout the course of the pregnancy. Also, the mother's non-compliance with prescribed medications, recommended procedures and diet also places the unborn infant at risk for premature birth.

Premature Rupture of Membranes (PROM)

Of the 44 total premature infant cases reviewed, 22 presented with premature rupture of membranes. Premature rupture of membranes refers to a patient who is beyond 37 weeks gestation and has presented with rupture of membranes (ROM) prior to the onset of labor before 37 completed weeks of gestational age and prior to the onset of labor is a cause of prematurity. A specific cause for this anomaly has not been established though infection is thought to be the underlying factor.

Deaths Related to Premature Births

Maternal Risk Factors continued

Chorioamnionitis
A diagnosis of Chorioamnionitis was made in 25 of the 44 premature birth cases reviewed. Of these cases, 6 had either a history or a current diagnosis of sexually transmitted disease. Chorioamnionitis is defined as an inflammation of the chorion and amnion, membranes that surround the fetus. Chorioamnionitis is usually associated with bacterial infection which may be passed on to the fetus causing sepsis.

Incompetent Cervix
Cervical incompetence was present in 26 of the 44 premature infant cases reviewed. This is a medical condition in which a pregnant woman's cervix begins to dilate (widen) and efface (thin) before her pregnancy has reached term with resultant expulsion of the fetus.

Obesity
Maternal Obesity was a recognized risk factor in 17 of the 44 premature infant cases. Several studies report a negative impact of excessive maternal weight on the outcome of a pregnancy.

Infant Risk Factors

The infant risk factors evaluated by the IMR Team were gestational age and birth weight, and congenital anomalies. The following information was gathered from medical records provided in 44 of the premature infant cases reviewed by the IMR team.

Gestational age and birth weight
The American Academy of Pediatrics defines a preterm birth as "any delivery, regardless of birth weight that occurs before 37 completed weeks from the first day of the last menstrual period." It further divides and classifies preterm birth as:

- Extreme prematurity, birth before 24 weeks
- Moderate prematurity, birth between 24 to 33 weeks,
- Late prematurity, birth between 34 to 36 weeks.

Birth weight is also an important factor in the survival of premature infants, especially when the weight is below the range 700 to 1000g (1.9 to 2.32 lbs.). As illustrated in Tables 1 and 2, twenty-eight of the infants whose deaths were reviewed fell in the category of extreme prematurity (gestational age: 17 to 24 weeks) and 16 were in the category of moderate to late prematurity (gestational age: 24 to 36 weeks). Twenty-one infants weighed between 100 to 500g (3.52oz to 1lb 1.63oz); 16 weighed 501 to 1000g, (1lb 1.67oz to 2lbs 3.2 oz.); and 7 weighed 1001 to 4000g (2lbs 3.30oz to 8lbs 13.09oz).

Deaths Related to Premature Births

Infant Risk Factors

Table 1 IMR Premature Infants	
Level of Prematurity	**Number of Infants**
Extreme	28
Moderate to Late	16
Total	44

Table 2 IMR Decedent Weight	
Weight	**Number of infants**
100-500g	21
501-1000g	16
1001-4000g	7
Total	44

Congenital Anomalies

Congenital anomalies including genetic/chromosomal disorders, such as Potter's Syndrome and Congenital Heart Disease, were present in 3 infants of the infant cases reviewed.

Other Risk Factors

Table 3 identifies other risk factors observed in 28 of the 44 premature infant cases reviewed by the IMR Team. Sexually transmitted diseases, and smoking were other risk factors associated with the premature birth of the infant in cases reviewed by the IMR team in 2012.

Table 3 Other Risk Factors	
Risk Factor	**# of cases**
Sexually Transmitted Diseases	11
Illicit Drug Use	5
Family History of Involvement with Child Welfare	4
Alcohol Use	2
Smoking	6

Natural Deaths

Other Causes of Death in Infancy

Nineteen of the infants whose case was reviewed by the IMR Team in 2012 died of natural causes not associated with premature birth. The leading cause of death among these infants was congenital anomaly (N=13).

TABLE 4

Other Natural Causes of Death in CFRC Infants

Cause of Death	Number of Deaths
Congenital Anomaly	13
Infectious Disease	5
Failure to Thrive	1
Total	**19**

Natural Causes of Death in Children and Youth

As indicated in Table 5, 14% (10) of the Natural death cases reviewed by the Committee were of children and youth between the ages of 4 and 19. The leading cause of death among these decedents was congenital anomaly (4) followed by disorders of the central nervous system (2).

TABLE 5

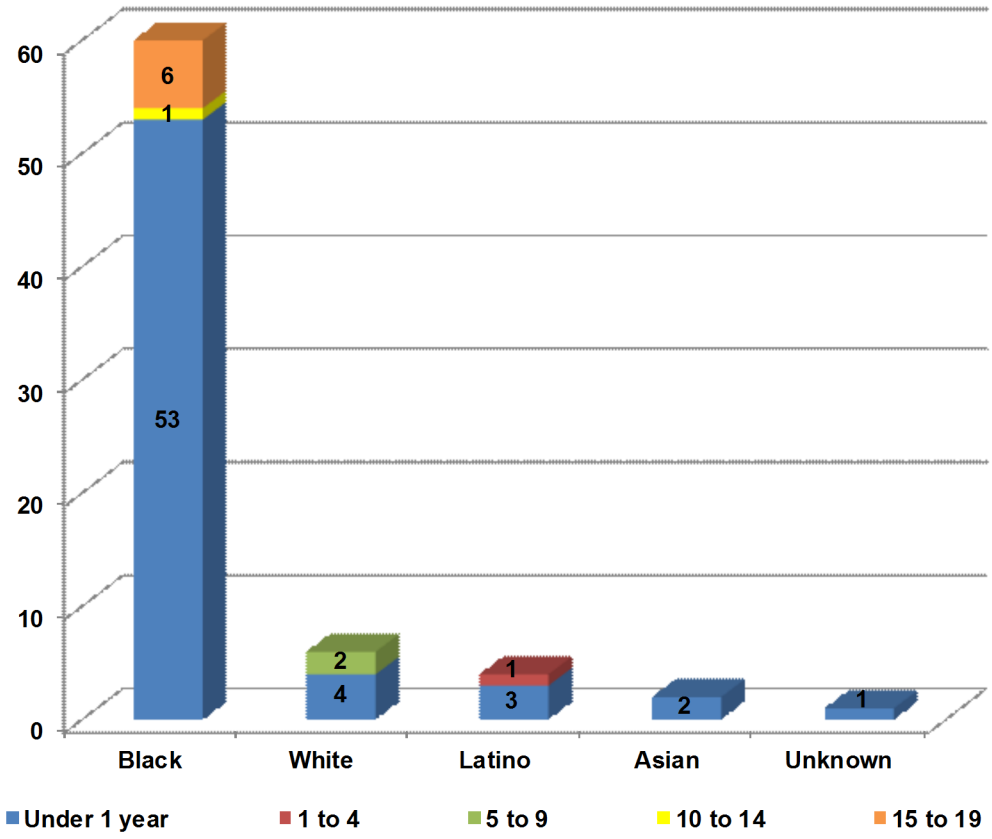
Natural Causes of Death in Children and Youth

Cause of Death	Number of Deaths
Cancer	1
Infectious Disease	1
Congenital Anomaly	4
Central Nervous System (Brain)	2
Complication of Pregnancy	1
Connective Tissue Disease	1
Total	**10**

Age and Race of Decedents—Natural Child Fatalities

Of the 73 Natural deaths reviewed by the Committee in 2012, 82% (60) of the deaths involved Black children, 8% (6) White children, and 5% (4) Latino and 3% (2) Asian The race of one decedent is unknown.

Figure 10: 2012 CFRC Natural Death Race and Age



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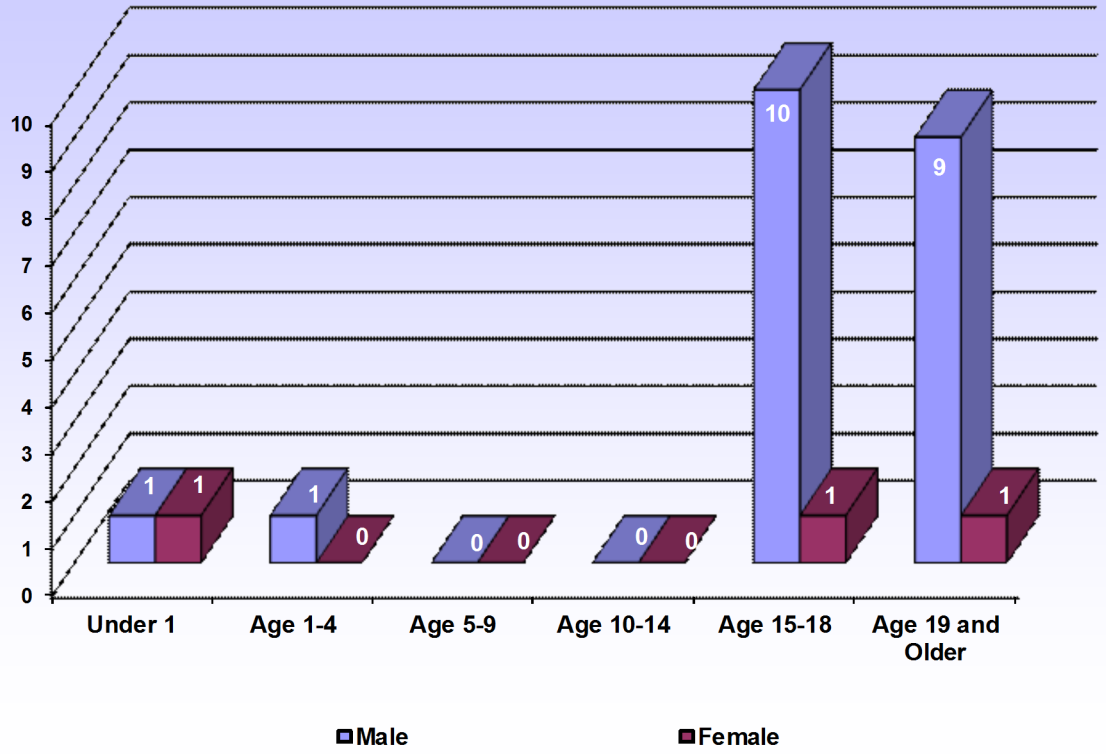
Homicides

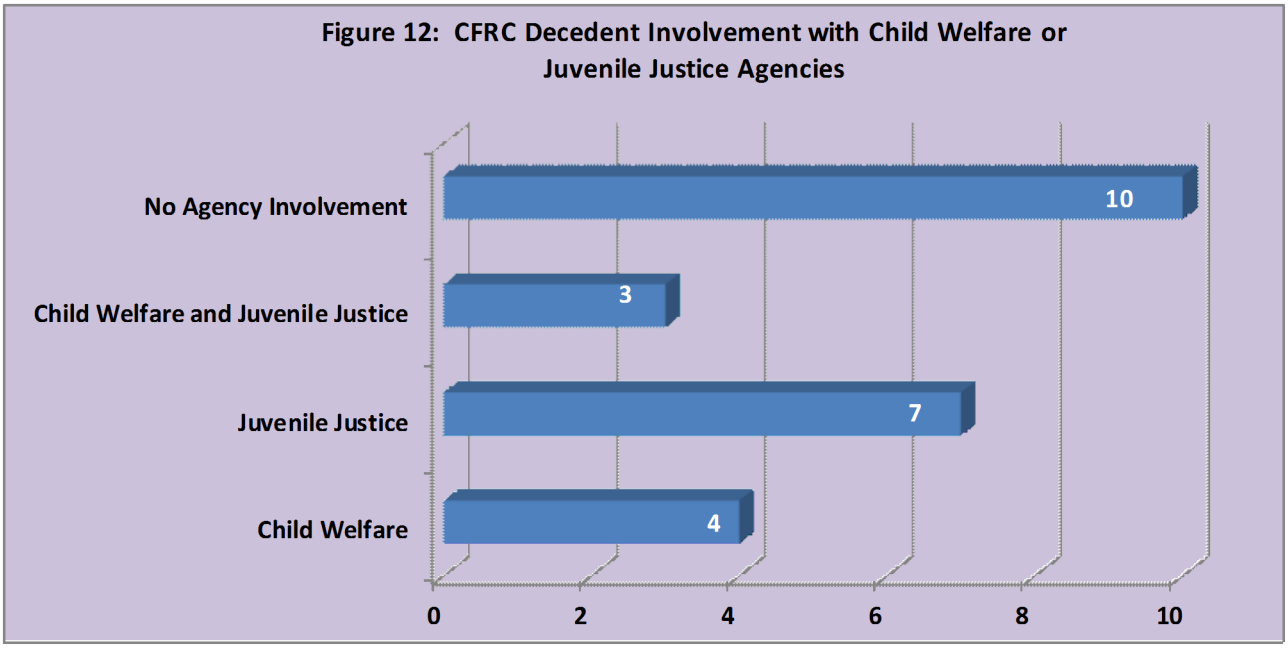
Twenty-four (22%) of the 109 cases reviewed by the Committee were Homicides. The Committee utilizes the following categories to describe the fatal events of child homicide victims:

- ***Youth Violence Homicides*** are cases involving juvenile victims and are usually associated with criminal activity, arguments, or retaliation.
- ***Fatal Child Abuse and Neglect*** occur at the hands of a parent, legal custodian or person responsible for the child's care at the time of the fatal incident.
- ***Other Child Homicides*** are the result of an act of violence by a perpetrator who is not the parent/caretaker of the child.

Figure 11: Age and Gender of CFRC Homicide Victims N=24



The majority of homicide cases reviewed by the Committee in 2012 were youth violence victims between the ages 15 to 22 years (88%, 21). Twenty of the decedents died as a result of gunshot wounds, one died due to stab wounds. The three youngest homicide victims died as a result of fatal abuse and parental neglect. Twenty-three of the youth homicide victims were Black. The remaining decedent was Latino.



One of the Committee's mandates is to review the fatalities of children who were involved with child welfare or juvenile justice programs. As illustrated in Figure 12, 42% (N=10) of the twenty-four homicide victims were not known either program. Seven (29%) of the homicide victims were known to juvenile justice programs, and four (17%) were known to child welfare. Three of the decedents were known to both child welfare and juvenile justice programs.

Fatal Child Abuse

Three of the twenty-four Homicide fatalities reviewed in 2012 were the result of fatal child abuse:

- None of the decedents were known to child welfare agencies or were participants in the District's early child care programs.
- Two of the fatal child abuse victims died as a result of Blunt Force Injuries. One victim died due to Hyperthermia resulting from parental neglect.

Causes of Homicides

Gunshot wounds continue to be the leading cause of death among CFRC decedents. Twenty of the homicide cases reviewed by the CFRC in 2012 involved youth killed due to gun violence. All of these youth were between the ages of 15 and 22 years old. All of the victims were Black, and two were female. One decedent died as a result of a stab wound. Table 6 depicts the causes of death among the CFRC Homicide cases reviewed in 2012.

Causes of Death for CFRC Homicides

TABLE 6—Causes of Death of CFRC Homicide Victims		
Method	**Fatal Child Abuse**	**Youth Violence**
Gunshot Wounds	**0**	**20**
Stab Wounds	**0**	**1**
Blunt Force	**2**	**0**
Parental Neglect	**1**	**0**
Total	**3**	**21**

Education Outcomes for School Aged Homicide Victims

In the District of Columbia, children between the ages of 5 and 17 are required to attend school. During the review of youth homicide cases, the CFRC finds issues related to truancy to be a leading risk factor in these homicides. In the District of Columbia, Truancy is defined as the accumulation of ten unexcused absences from school. When school aged youth are truant from school, they are less likely to receive school based services, or graduate. Of the homicide cases reviewed by the Committee in 2012, nine of the homicide victims were school aged. Among the homicide cases reviewed by the Committee only two of the school aged homicide victims were attending school. School records indicate three of the truant school aged youth were required to receive special education services in the school setting. Of the remaining twelve youth homicide victims who were between the ages of 19 and 22, only two graduated from high school. Of these two, one youth was attending college at the time of the fatal event. Figures 13, 14 and 15 illustrates these findings.

Education Outcomes for School Aged Homicide Victims

Figure 13: School Aged Homicide Victims
School Attendance (N=9)

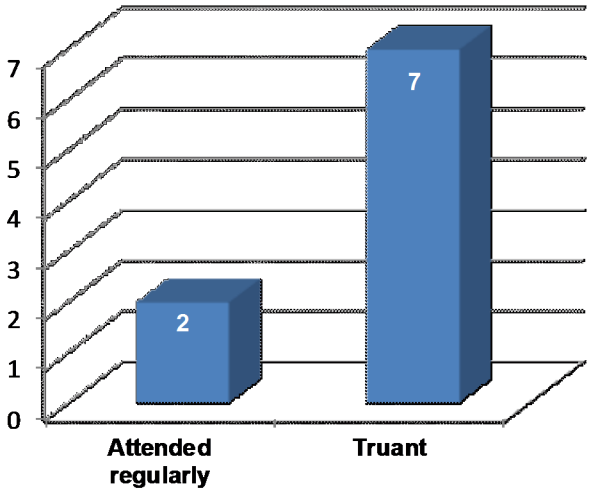


Figure 14: Older Youth Graduates (N=12)

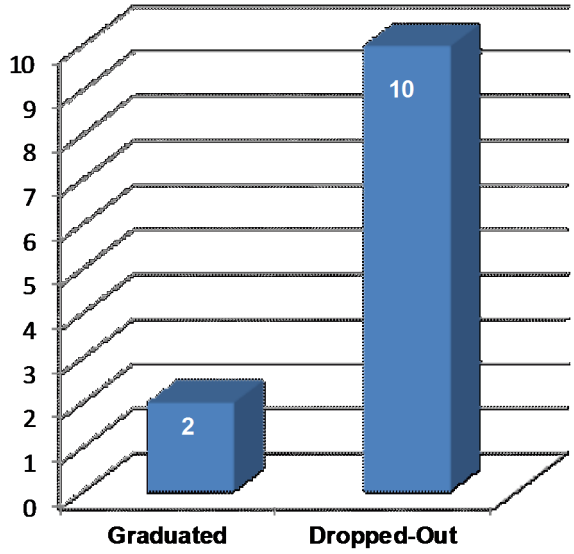
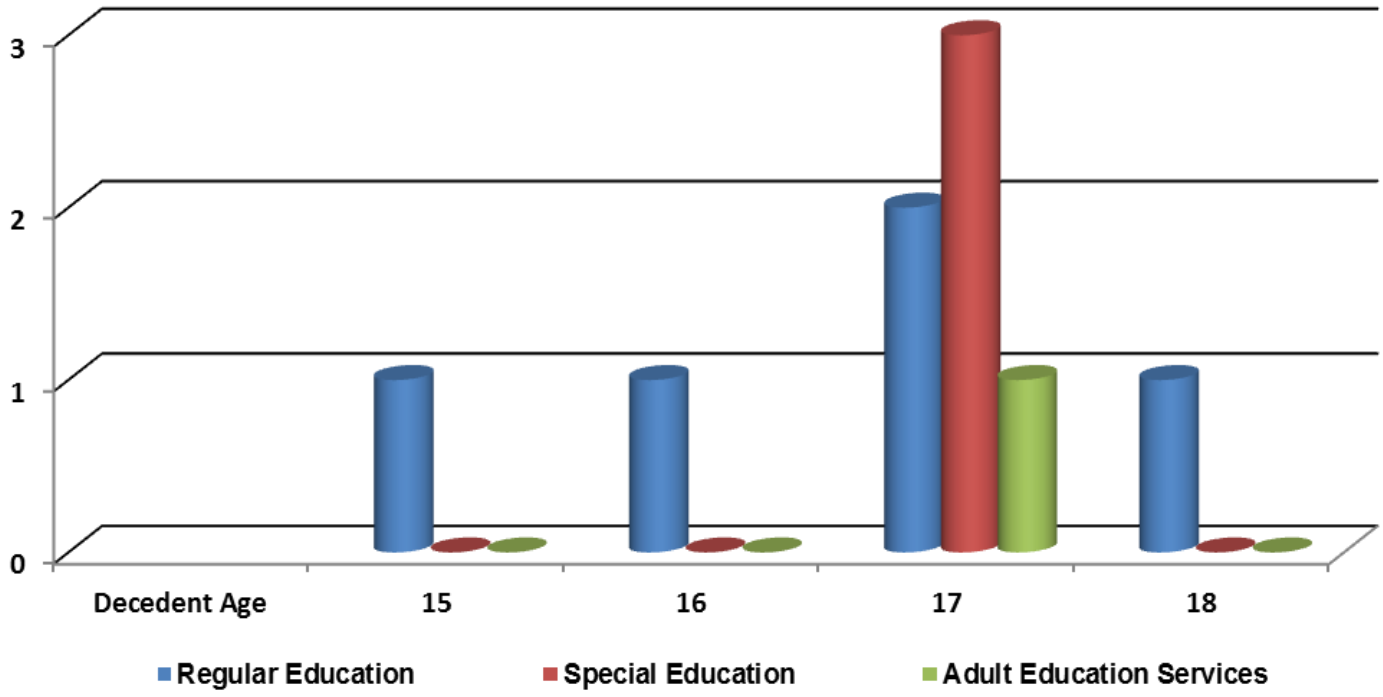


Figure 15: School Aged Decedent Education Needs (N= 9)



ACCIDENTAL DEATHS

In 2012, the Committee reviewed five child fatalities resulting from accidental events.

- The ages of the 2012 accidental death victims ranged from 1 month to 7 years.
- All five decedents in this category were Black.
- Three decedents were female, and two were male.
- Alcohol and illicit drugs were contributing factors in the three motor vehicle accident deaths.

The following tables provide details regarding the accident related child fatalities reviewed by the CFRC in 2012:

TABLE 7	
CFRC Accidental Deaths	
Fire	**1**
Motor Vehicle Accident	**3**
Mixed Drug Toxicity	**1**
Total	**5**

TABLE 8: Fire Related Fatality				
AGE/RACE/ GENDER	***Time of Injury***	***Ward of Residence***	***Place of Incident***	***Contributing Factors***
2 yo/Black/Female	1:57 AM	7	Prince Georges County, MD	Electric Stove Malfunction

TABLE 9: MIXED DRUG TOXCITIY

AGE/RACE/ GENDER	Place of Injury	Ward of Residence/ Location of Fatal Incident	Contributing Factors #1	Contributing Factor #2
19/Black/ Male	Family Home	6/6	Chronic Medical Condition	Improper Intake of Prescription Medications

TABLE 10: TRANSPORTATION RELATED ACCIDENTS

AGE/ RACE/ GENDER	Time of Injury	Ward of Residence/ Location of Fatal Incident	Type of Victim	Type of Vehicle	Contributing Factor #1	Contributing Factor #2
16/Black/ Female	4:25 AM	8/8	Driver	Automobile	Alcohol and Illicit Drug use	Unlicensed Driver Speed
17/Black/ Female	4:25AM	8/8	Passenger	Automobile	Illicit Drug Use	Trapped in Vehicle
18/Black/ Male	5:02 AM	8/8	Passenger	Automobile	Alcohol and Illicit Drug Use	Stolen Vehicle

UNDETERMINED DEATHS

In 2012, the deaths of seven infants and children reviewed by the CFRC had an Undetermined manner of death. Four of these case reviews indicated the deaths were sudden, unexpected, or unexplained, and a definitive cause of death remained elusive despite the thorough forensic death investigation and examination and are identified as SUDI cases. In these four cases reviewed by the CFRC, the death occurred after the infant was placed to sleep. Risk factors associated with SUDI cases associated with the infants sleep environment include (1) infants sharing a bed with others, (2) infants placed to sleep in an adult bed, (3) infants placed on their stomachs (supine) to sleep, and (4) infants placed to sleep on pillows or in environments with excessive bedding. The CFRC developed the *Position Statement: Safe Sleep for Infants* (see Appendix A) to address the sleep environment of infants as it relates to sudden unexplained infant deaths. Table 11 provides details related to the infant's sleep environment and other issues observed in CFRC SUDI case reviews.

TABLE 11: FINDINGS OF SUDI FATALITY REVIEWS

Age/Race/ Gender	*Ward of Residence*	*Birth Outcome*	*Sleep Environment*	*Other Medical and Environmental Issues*
15 months/ Black/Male	8	Healthy Full Term	Infant sleeping with parents	Infant's Hypoxic Brain Injury Placed in adult bed with Infant
7 months/Black/ Male	7	Healthy Full Term	Infant placed in adult bed	Gastroesophageal Reflux Disease/ indigestion/constipation
5 months 25 days/Black/ Female	2	Preterm birth 27 weeks gestation	Infant placed supine on pillow	Gastroesophageal Reflux Disease// formula intolerance Adult smoking in the home Inexperienced caregiver
2 months	8	Preterm 36 weeks gestation	Prone sleep position placed on pillow	Adult smoking in the home

Undetermined Deaths and Associated Risk Factors

Three cases reviewed by the CFRC had an Undetermined manner of death. Table 12 provides details of these cases as well as risk factors identified by the CFRC.

TABLE 12: FINDINGS OF OTHER UNDETERMINED FATALITIES

Age/Race/ Gender	*Ward of Residence*	*Cause of Death*	*Risk Factors*
18 month/ Black/Male	8	Global Hypoxic Ischemic Encephalopathy of Unknown Etiology	Medically Fragile
4 year/Black/ Male	6	Thermal Injuries including Soot Inhalation and Cutaneous Burns	Unsupervised Child
28 days/ Black/ Female	Father resided in DC/Mother resided in VA	Complications of Respiratory Distress Treated with Mechanical Ventilation Following Pre-Term Cesarean Section due to Maternal Hypertension	Medically Fragile

SECTION II:

SUMMARY OF CHILD WELFARE AND JUVENILE JUSTICE DECEDENTS

CFRC Decedents known to Child Welfare Programs

In accordance with District law, the CFRC is mandated to review the fatalities of children and youth known to the District's child welfare agency within four years of the fatal event. Of the 109 cases reviewed by the Committee in 2012, 13% (N=14) of the children and youth were involved with the District's child welfare within four years of the fatal event. The leading manner of death among these victims is Homicide 50% (N=7) followed by Natural deaths 49% (N=4). The majority of child welfare cases reviewed by the Committee in 2012 involved youth aged 15 and over 79% (N=11).

Figure 16: CFRC Decedents known to Child Welfare Age by Manner of Death (N= 14)

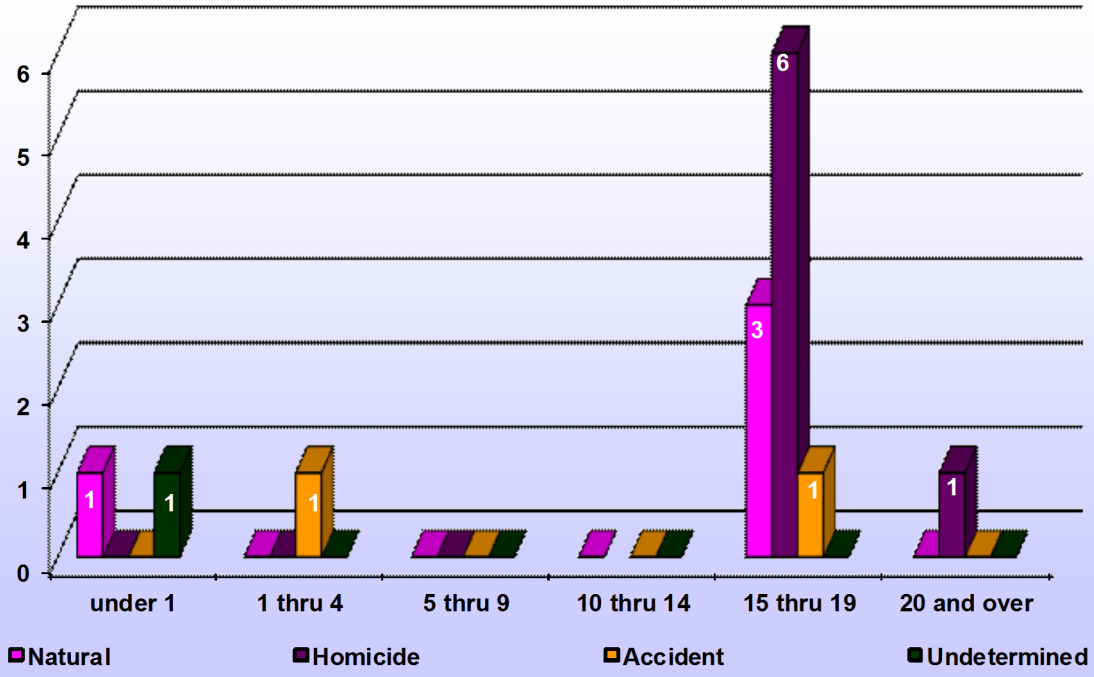
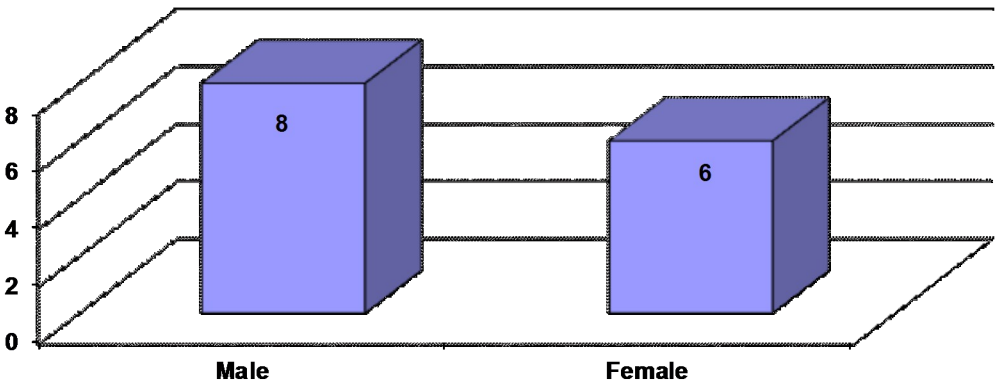


Figure 17: 2012 CFRC Decedents known to Child Welfare Gender (N=14)



CFRC Decedents known to Juvenile Justice Programs

The CFRC is mandated to review the deaths of youth who were involved with the District's juvenile justice program within two years of the fatal event. In 2012, eleven of the CFRC cases reviewed met this criteria. All of these decedents, who were between the ages of 17 and 22 years old, were Black males. Four decedents were known to both juvenile justice and child welfare programs. Ten of the eleven decedents were victims of homicide. The remaining decedent's death was determined to be accidental.

Figure 19: 2012 CFRC Decedents Known to Juvenile Justice Programs Age (N=11)

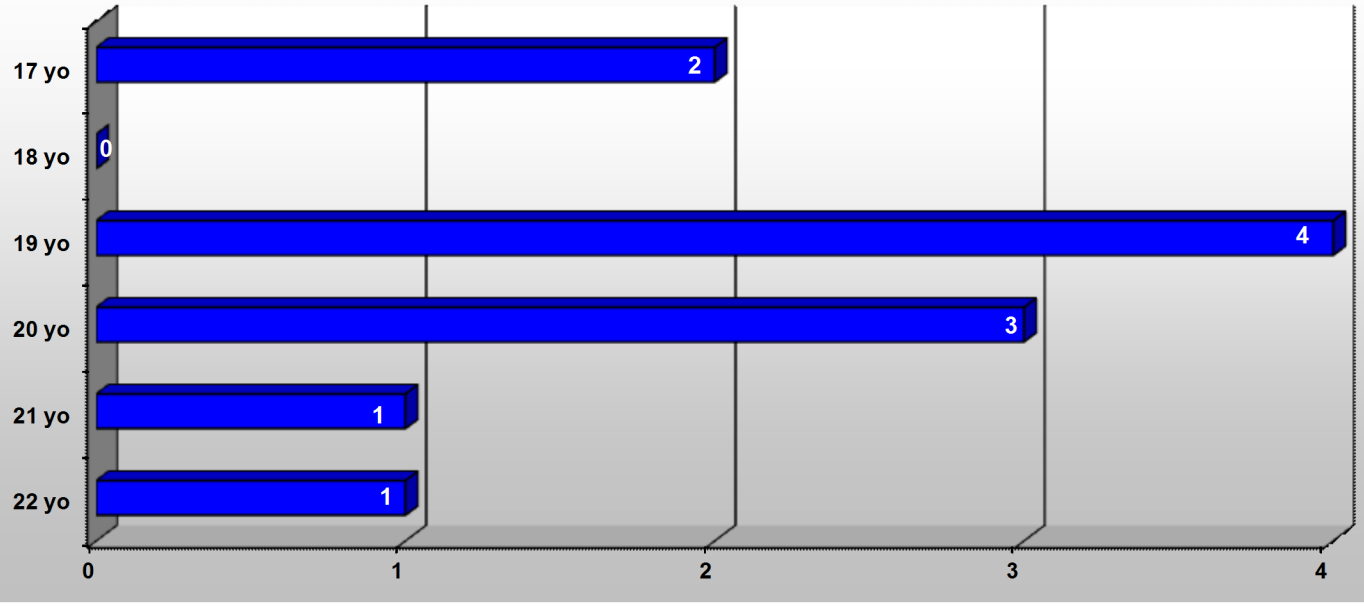
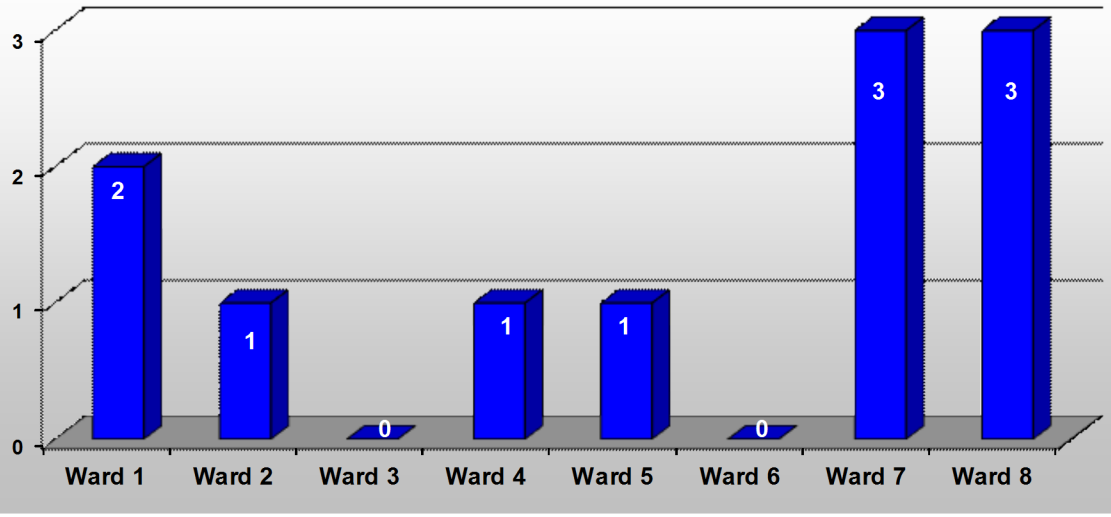


Figure 20: 2012 CFRC Decedents knwn to Juvenile Justice Programs Ward of Residency (N=11)



Dual District Agency Involvement

Of the cases reviewed by the Committee in 2012, four of the decedents were known to both juvenile justice and child welfare programs prior to the fatal event. All of these youth were victims of homicide, and all were Black males.

Fatality reviews of decedents known to child welfare and juvenile justice programs provide the most comprehensive information with regards to the decedents personal and family history prior to the fatal event. As a result of the comprehensive record review of government and community based programs the Committee noted the effect of social issues on outcomes for children and youth. In cases involving youth, school truancy, decedent substance abuse and financial/housing problems were leading issues affecting outcomes for youth who were involved with government programs.

TABLE 14

Social Issues Observed in Cases Where Decedents were known to Both Child Welfare and Juvenile Justice

Social Issues	Number of Cases
Decedent Substance Abuse	4
Decedent Mental Health Problems	4
School Truancy	3
Parental Substance Abuse	3
Financial and/or Housing Problems	4

SECTION III:

RECOMMENDATIONS

CFRC RECOMMENDATIONS

The leading goal of the District of Columbia's Child fatality Review Team is to develop recommendations that will prevent those child fatalities that are preventable and improve outcomes for the District's most vulnerable residents. During the monthly case review meetings, Committee members discuss issues surrounding the decedent's involvement with District Government and community based agencies and develop recommendations. The recommendations are then discussed by the CFRC Recommendations Subcommittee who address the feasibility of each recommendation, formally adopt recommendations and assign agency responsibility. Agencies review the recommendations and submit their response within 30 days. In 2012, the following recommendations were adopted by the CFRC Recommendations Subcommittee to address issues related to domestic violence, fire prevention education, child welfare investigations. community based mental health services, and youth committed to juvenile justice programs.

Recommendation to the Child and Family Services Agency (CFSA):

The Child and Family Services Agency should develop and implement a protocol to address issues related to poor living conditions found in publicly funded housing (e.g. mold, poor air quality) that may present health risk to the home's residents. The Child and Family Services agency should provide all agencies with a review of the Mandated Reporter Law for child abuse and neglect to ensure that employees and their contractors are aware and adhere to this statute to ensure the safety of children residing in publicly funded housing programs.

Response: Disagreed with explanation for alternative recommendation. The Child and Family Services Agency (CFSA) is committed to promoting the safety, well-being and permanency of children and families in the District of Columbia. To this end, the Agency ensures that a fully staffed Child Protective Services (CPS) Administration includes professionally trained investigators who respond within federally and locally mandated timeframes to all Hotline-screened and accepted reports of child abuse and/or neglect. As part of the investigative process, CPS investigators engage and assess the family for safety and risk factors that may be negatively impacting the children, including home environment. CPS also teams with internal and external professionals to ensure the most applicable, child-focused, family-centered disposition possible. Community services are provided for families with an allegation where removal is unnecessary; to prevent removals and to address the identified needs of the child and family, as well as to address the presenting and underlying issues that lead to the initial maltreatment allegations. CFSA further provides services to reduce the risk of future maltreatment. All investigative procedures require detailed and consistent compliance with federal and District regulations. In addition, all CPS employees are mandated to fulfill and reinforce the Agency's mission and are committed to exemplary child protective service standards in the District of Columbia. CFSA has developed and implemented Hotline and Investigation Policies that outline the requirements for each process. The Agency has further implemented the Hotline Procedural Operations Manual (HPOM) and Investigative Procedural Operations Manual (IPOM), which provides Hotline and Investigative social workers with detailed, step-by-step guidance on how to respond to and investigate the various reports on child abuse and neglect that CFSA receives daily, including information on best practices for each.

CFRC RECOMMENDATIONS

If children are removed from their home, the family is assigned an ongoing social worker who ensures the ultimate safety and well-being of the child(ren) while in foster care and additionally provides services and support to biological families with the intent to ameliorate the safety concerns in order for the child(ren) to be returned. To do so, the ongoing social worker conducts regular family assessments, in consultation with other team members, to continually assess for safety, risks, needs and strengths during every visit, from initial contact to case closure, and they must document assessment findings in FACES. During each visit with the children (whether in home or in a foster home) the social worker is responsible for assessing safety by meeting with the child outside the presence of the caregiver. They shall assess the risk and safety factors in children's home, school, neighborhood, and other homes where they spend significant time to ensure maltreatment does not occur. As mandated reporters, social workers are required to report any safety concerns that may arise to the Hotline. Social workers also continuously report findings to their supervisors to work in consultation around ensuring that any entity involved with the family is made aware of observations or occurrences where safety is compromised and/or risk is identified. The Child and Family Services Agency includes on the website a link that provides a list, according to District law, of individuals who are Mandated Reporters. That list includes Public Housing Resident Managers. This link also provides another website for free on-line mandated reporter training.

Currently, the CFSA front line staff undergoes extensive initial training provided via CFSA Child Welfare Training Academy. In this training curriculum, social workers learn how to assess for unhealthy living conditions (aka deplorable conditions) that could affect the health and well-being of a child. Social workers are trained to overall assess routinely the home environment. If not deemed safe, and if the family is living in public housing, for example, than those hazardous conditions are elevated to the appropriate entity who will address them within DC Government (e.g. DCRA, DCHA, DOE, and/or DOH).

CFRC RECOMMENDATIONS

Recommendation for the District of Columbia Fire and Emergency Medical Services (DCFEMS) in collaboration with the Office of the State Superintendent for Education (OSSE):

The Office of the State Superintendent for Education and the District of Columbia Fire and Emergency Medical Services Department should collaborate to disseminate information about fire safety and prevention to children and youth attending District of Columbia Public and Charter Schools.

Response: Agreed. DCFEMS has partnered with OSSE by using their quarterly newsletter to advertise and introduce, in the first edition of each month, two valuable fire safety education programs that we offer. The OSSE newsletter is distributed to DCPS and DC Public Charter School staff and faculty. The programs that DCFEMS advertise are "Safety Smart About Fire" and "Safety Smart Science (Understanding fire)". School teachers and administrators now have the opportunity to request these programs offered to be presented in their classroom setting for Grades K-3 and Grades 4-8 to help reinforce their students learning and understanding in the area of fire safety and fire science. Also, teachers now have an identified contact person in DCFEMS to assistance with facilitating their request. These programs are available for immediate presentation.

Recommendation for the Department of Behavioral Health (Formally the Department of Mental Health) :

The Department of Behavioral Health should identify and disseminate information regarding community based mental health providers that support children, and youth struggling with gender identity. Providers that can provide awareness and support to parents and caretakers of children and youth should also be identified.

Response: Agreed. The community should have the necessary knowledge and awareness of providers who have expertise in and can address the unique issues of specific target populations including GLBTQ youth. Professionals who provide mental health services and support to youth should be aware of the unique concerns of youth who identify as GLBTQ including stigma, depression, family/peer-related stressors, anxiety, and suicidality. Specific action plans for implementation include :

- A community mental health resource guide will be made available by the Department of Mental Health (DMH); this resource guide will include a listing of DMH provider agencies (with clinicians) including GLTBQ agencies who have experience providing mental health services to youth who identify as GLBTQ as well as information and resources for community-based agencies that provide services/supports to this population (expected completion date: September, 2014)
- In March 2013, DMH hired a Social Marketing Coordinator to increase community-based education around mental health.
- Current and ongoing social marketing/community education efforts will consistently include a focus on the mental health needs of youth who identify as GLBTQ as a special population.

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CFRC RECOMMENDATIONS

Recommendation for the Metropolitan Police Department (MPD)

The Metropolitan Police Department should provide information regarding domestic violence and child abuse to parents involved in domestic disputes. The information should contain information for parents on how to recognize perpetrators of domestic violence and early stages of child abuse in toddler and young children.

Response: Agreed. According to Metropolitan Police Department General Order 309.06 (Child Abuse and Neglect), dated November 18, 2010, the following procedures are in place:

- Members on the scene of an Intra-Family ("Domestic Violence") Offense shall handle the incident in accordance with GO-OPS-304.11 (Intra-Family Offenses).
- Members shall contact CFSA's 24-hour Hotline at (202) 671-SAFE (7233) when a child has been exposed to domestic violence. NOTE: Exposure to domestic violence in the home may impact a child's safety and well-being. Exposure is a more inclusive term that goes beyond "witnessing," and can include watching or hearing the violent incident, direct involvement (e.g., trying to intervene), or experiencing the buildup of tension to the violence or experiencing the aftermath of an assault (e.g., seeing bruises or observing maternal depression).
- Members shall contact YID when a child has been exposed to domestic violence.
- Members shall note the time CFSA and YID were notified, the name of the person identified and indicate this information on the Intrafamily offense report.

The Metropolitan Police Department is in the process of finalizing the updates to General Order 304.11 (Intrafamily Offenses) with the same language. This order should be in effect before the end of the fiscal year. The MPD has also made a brochure titled "The Effect of Domestic Violence on Children in the Home". This brochure is available in hardcopy or online at http://mpdc.dc.gov/node/202262. This brochure is a guide to getting educated and getting help. It has resource information and signs of domestic violence.

Recommendation for the Department on Youth Rehabilitative Services (DYRS)

The Department on Youth Rehabilitative Services should outline and comply with established aftercare protocols to ensure discharge plans for committed youth are developed prior to their discharge from treatment and adult correction facilities, implemented and tracked for compliance. This may require the development of protocols and training for direct service staff and supervisors.

Response: Agreed with Modifications. DYRS believes youth thrive in the least restrictive environment consistent with public safety. As such there are several methods employed in order to ensure placing youth in a Residential Treatment Center is the last resort. The Residential Review Committee is comprised of management reviewing cases on a weekly basis in order to determine whether all services and attempts have been exhausted in the District of Columbia first prior to placement in addition to the preparation of a youth's return. Services are extended to the entire family through the use of family engagement and the DYRS District of Columbia Youth Link Program.

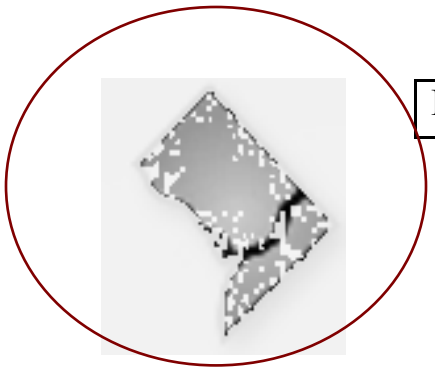
CFRC RECOMMENDATIONS

Response from DYRS continued:

With regards to implementation, the Case Management Manual Version V will be updated to include further detailed steps of youth preparation and linkages to services prior to a youth's return by June 2014. In addition DYRS will be transitioning to the use of the FamCare database which allows for a more comprehensive plan to be outlined, tickler systems for essential data missing and extensive review of a youth's entire case. As an outcome, DYRS expects increased accountability and efficiency as it relates to preparing for a youth's return from RTC's through the use of FamCare and the updated Case Management Manual.

APPENDICES

APPENDIX A



DISTRICT OF COLUMBIA CHILD FATALITY REVIEW COMMITTEE

POSITION STATEMENT: SAFE SLEEP FOR INFANTS

The District's Child Fatality Review Committee in collaboration with other District child/family serving agencies is charged with the responsibility of reducing the number of preventable child/infant deaths and improving the quality of life for District residents. This goal is accomplished through conducting retrospective reviews of child deaths, assessing services and systems involved with these families and making recommendations for systemic improvements and improved public education. The DC CFRC initiated a Prevention Subcommittee to assess trends and risk factors associated with infant who died due to Sudden Unexpected Death in Infants (SUDI) and other related causes; and to develop prevention strategies and recommendations to reduce the number of related deaths. As a result of the work of the Prevention Subcommittee, the DC CFRC has developed a position statement on infant and child safe sleep environments. It is the hope of the DC CFRC that this statement will be adopted by the District government agencies that serve children, youth and families; or may be used as a guide to address the prevalence of SUDI in the District by promoting improved policies, practices, resources and education.

Consistent with other states, the Center for Disease Control, American Academy of Pediatrics, and other national organizations, the DC CFRC supports promoting safe sleep practices and safe sleep environments as a primary means of reducing the number of preventable infant deaths from SUDI. The DC CFRC makes the following recommendations on sleep environments and practices as well as general health practices to help reduce the number of preventable infant deaths and to reinforce researched best practices for safe sleep of infants.

Bed Sharing and Co-Sleeping

The DC CFRC accepts the following distinctions in the definitions of bed-sharing and co-sleeping and encourages all public and private child/family servicing agencies to incorporate these definitions in relevant policies and practices:

- Bed-sharing refers to a sleeping arrangement in which the infant shares the same sleep surface with the parent, caregiver or sibling.

- Co-sleeping refers to a sleeping arrangement in which the infant is sleeping in the same room, however not sleeping in the same bed as the parent, caregiver, or sibling. Placing the infant's bassinet or crib within arm's reach of the parent's bed promotes bonding and breast feeding.

Sleep Position:

- Infants should be placed in a supine position (on their backs) to sleep for naps or at night. Side sleeping is not as safe as supine and is not advised.

- Infants should be given time on their tummies when awake and supervised by a responsible adult or caregiver.

- Parents should reinforce with relatives and other temporary caregivers the importance of always placing infants on their backs when sleep.

Sleep Environment

- Infants should be placed to sleep preferably in a safety-approved crib or bassinet with a firm mattress, using a well fitting sheet made for the crib/bassinet.

- Parents should maintain the home and especially the infant's sleep area free of cigarette smoke.

- Infants should not be placed on adult beds to sleep as they are more at risk of suffocation from several hidden hazards, such as entrapment between the bed and wall, bed frame, headboard or footboard, and falls from adult beds onto piles of clothing, plastic bags or other soft materials; and adults may roll over onto the infant while sleeping. Securing an infant on an adult bed with pillows also places the infant at risk for suffocation.

- Infants should never be placed to sleep on soft surfaces or objects, such as foam, cushions, pillows, sheepskins, sofas, chairs, waterbeds or air mattresses.

- Infants sleep environment should be free of toys or other soft bedding and loose objects, such as blankets or comforters, stuffed animals and bumper pads, since they could cover the infant's head or face.

- The infants sleep environment should be free of unsafe items, such as plastic sheets, plastic bags, strings, cords or ropes.

- The safest place for an infant to sleep is in the same room with a parent or caregiver but on a separate sleep surface (crib, or bassinet), not sharing space with another child/infant or adult. The same room allows the parent to be able supervise and bond with the infant, and also makes breastfeeding more convenient.

- Infants should sleep in a room that is kept between 68 and 72 degrees.

- Infants should not be over bundled and should be placed in a garment such as a sleeper or sleep sack to ensure the infant's head and face do not get covered by a blanket.

Scholarly research, as well as DC CFRC data confirm that bed-sharing can be unsafe for infants. Adults and siblings can accidentally roll onto an infant while sleeping. However, in the event that parents choose to bed-share based on their own personal decision and cultural beliefs, the DC CFRC recommends that the following information be provided to parents, in addition to the above recommendations on health practices, sleep position and sleep environment:

- An infant should not be allowed to sleep with another infant or child on the same sleep surface (crib, mattress, etc)
- An infant should never sleep with an adult if:
    1. The adult/caregiver sleeps on soft bedding, such as sofas, waterbeds, bean bag, air mattresses etc.
    2. The adult/caregiver or others in the household smoke
    3. The adult/caregiver is under the influence of drugs, alcohol or other medications that can cause drowsiness or incoherent thinking
    4. The adult/caregiver is excessively tired or sick
    5. The adult/caregiver is angry or upset
    6. The caregiver is obese

The DC CFRC supports the concept of educating parents and prospective infant caregivers on safe sleep environments and position. Education should be provided through the course of routine pre-conceptual and prenatal health care, and should continue through the first year of the infant's life. Physicians, discharge planners, social workers, and other direct service providers serving women of child bearing years, relatives and caregivers, should maximize their efforts and opportunities to offer education and support to encourage right decision making to reduce the risk of SUDI. Public education is essential, and should be designed to target not only parents, but infant caregivers (fathers, paramours, and extended family members).

XLVI. CHILD FATALITY REVIEW COMMITTEE

Sec. 4601. Short title.

This act may be cited as the "Child Fatality Review Committee Establishment Act of 2001".

Sec. 4602. Definitions.

For the purposes of this title, the term:

(1) "Child" means an individual who is 18 years of age or younger, or up to 21 years of age if the child is a committed ward of the child welfare, mental retardation and developmental disabilities, or juvenile systems of the District of Columbia.

(2) "Committee" means the Child Fatality Review Committee.

Sec. 4603. Establishment and Purpose.

(a) There is established, as part of the District of Columbia government, a Child Fatality Review Committee. Facilities and other administrative support may be provided in a specific department or through the Committee, as determined by the Mayor.

(b) The Committee shall:

Identify and characterize the scope and nature of child deaths in the jurisdiction, particularly those that are violent, accidental, unexpected or unexp1ained;

(2) Examine past events and circumstances surrounding child deaths by reviewing the records and other pertinent documents of public and private agencies responsible for serving families and children, investigating deaths, or treating children in an effort to reduce the number of preventable child fatalities and shall give special attention to child deaths that may have been caused by abuse, negligence, or other form of maltreatment;

(3) Develop and revise as necessary operating rules and procedures for the review of child deaths, including identification of cases to be reviewed, coordination among the agencies and professionals involved, and improvement of the identification, data collection, and record keeping of the causes of child death;

(4) Recommend systemic improvements to promote improved and integrated public and private systems serving families and children;

(5) Recommend components for prevention and education programs; and

(6) Recommend training to improve the investigation of child deaths.

Sec. 4604. Composition of the Child Fatality Review Committee.

(a) The Mayor shall appoint a minimum of one representative from appropriate programs providing services to children within the following public agencies:

(1) Department of Human Services;
(2) Department of Health;
(3) Office of the Chief Medical Examiner;
(4) Child and Family Services Agency;
(5) Metropolitan Police Department;
(6) Fire and Emergency Medical Services Department,
(7) D.C. Public Schools;
(8) Department of Housing and Community Development; and
(9) Office of Corporation Counsel

(b) The Mayor shall appoint, or request the designation of, members from federal, judicial, and private agencies and the general public who are knowledgeable in child development, maternal and child health, child abuse and neglect, prevention, intervention, treatment or research, with due consideration given to representation of ethnic or racial minorities and to geographic areas of the District of Columbia. The appointments shall include representatives from the following:

(1) Superior Court of the District of Columbia;
(2) Office of the United States Attorney for the District of Columbia;
(3) District of Columbia hospitals where children are born or treated;
(4) College or university schools of social work, and
(5) Mayor's Committee on Child Abuse and Neglect.

(c) The Mayor, with the advice and consent of the Council, shall appoint 8 community representatives, none of whom shall be employees of the District of Columbia.

(d) Governmental appointees shall serve at the will of the Mayor, or of the federal or serve for 3-year terms.

(e) Vacancies in membership shall be filled in the same manner in which the original appointment was made.

(f) The Committee shall select co-chairs according to rules set forth by the Committee.

(g) The Committee shall establish quorum and other procedural requirements, as it considers necessary.

Sec. 4605. Criteria for case review.

(a) The Committee shall be responsible for reviewing the deaths of children who were residents of the District of Columbia and of such children who, or whose families, at the time of death, or at any point during the 2 years prior to the child's death, were known to the child welfare, juvenile justice, or mental retardation or developmental disabilities systems of the District of Columbia.

(b) The Committee may review the deaths of nonresidents if the death is determined to be accidental or unexpected and occur within the District.

(c) The Committee shall establish, by regulation, the manner of review of cases, including use of the following approaches:

(1) Multidisciplinary review of individual fatalities;

(2) Multidisciplinary review of clusters of fatalities identified by special category or characteristic;

(3) Statistical reviews of fatalities; or

(4) Any combination of such approaches.

(d) The Committee shall establish 2 review teams to conduct its review of child fatalities. The Infant Mortality Review Team shall review the deaths of children under the age of one year and the Child Fatality Review Team shall review the deaths of children over the age of one year. Each team may include designated public officials with responsibilities for child and juvenile welfare from each of the agencies and entities listed in section 4604.

(e) Full multidisciplinary/multi-agency reviews shall be conducted, at a minimum on the following fatalities:

(1) Those children known to the juvenile justice system;

(2) Those children who are known to the mental retardation/developmental disabilities system;

(3) Those children for which there is or has been a report of child abuse or neglect concerning the child's family;

(4) Those children who were under the jurisdiction of the Superior Court of the District of Columbia (including protective service. foster care, and adoption cases);

(5) Those children who for some other reason, were wards of the District and

(6) Medical Examiner Office cases.

Sec. 4606. Access to Information.

(a) Notwithstanding any other provision of law, immediately upon the request of the Committee and as necessary to carry out the Committee's purpose and duties, the Committee shall be provided, without cost and without authorization of the persons to whom the information or records relate, access to:

(1) All information and records of any District of Columbia agency, or their contractors, including, but not limited to, birth and death certificates, law enforcement investigation data, unexpurgated juvenile and adult arrest records, mental retardation and developmental disabilities records, medical examiner investigation data and autopsy reports, parole and probation information and records, school records, and information records of social services, housing, and health agencies that provided services to the child, the child's family, or an alleged perpetrator of abuse which led to the death of the child.

(2) All information and records (including information on prenatal care) of any private health-care providers located in the District of Columbia, including providers of mental health services who provided services to the deceased child, the deceased child's family, or the alleged perpetrator of abuse which led to the death of the child.

(3) All information and records of any private child welfare agency, educational facility or institution, or child care provider doing business in the District of Columbia who provided services to the deceased child, the deceased child's immediate family, or the alleged perpetrator of abuse or neglect which led to the death of the child.

(4) 1nfomation made confidential by section 20 of the Vital Records Act of 1981, effective October 8, 1981 (D.C. Law 4-34; D.C. Official Code § 7-219); section 512 of the Mentally Retarded Citizens Constitutional Rights and Dignity Act of 1978, effective March 3. 1979 (D.C. Law 2-137; D.C. Official Code § 7-1305.12); section 302 of the District of Columbia Mental Health Information Act of 1978, effective March 3, 1979 (D.C. Law 2-136; D.C. Official Code § 7-1203.02); section 203 of the Prevention of Child Abuse and Neglect Act of 1977, effective September 23, 1977 (D.C. Law 2-22; D.C. Official Code § 4-1302.03); section 306 of the Prevention of Child Abuse and Neglect Act of 1977, effective October 18, 1979 (DC Law 3-29; D.C. Official Code § 4-1303.06); section 28of the Hea1th Maintenance Organization Act of 1996, effective April 9, 1997 (D.C. Law 11-235; D.C. Official Code § 31- 3426); and D.C. Official Code §§ 16-2331, 16-2332, 16-2333, and 16-2335.

(b) The Committee shall have the authority to seek information from entities and agencies outside the District of Columbia by any legal means.

(c) Notwithstanding subsection (a) (l) of this section, information and records concerning a current law enforcement investigation may be withheld, as the discretion of the investigating authority, if disclosure of the information would compromise a criminal investigation.

(d) If information or records are withheld under subsection (c) of this section, a report on the status of the investigation shall be submitted to the Committee every 3 months until the earliest of the following events occurs:

(1) The investigation is concluded;

(2) The investigating authority determines that providing the information will no longer compromise the investigation; or

(3) The information or records are provided to the Committee.

(e) All records and information obtained by the Committee pursuant to subsections (a) and (b) of this section pertaining to the deceased child or any other individual shall be destroyed following the preparation of the final Committee report. All additional information concerning a review, except statistical data, shall be destroyed by the Committee one year after publication of the Committee's annual report.

Sec. 4607. Subpoena Power.

(a) When necessary for the discharge of its duties, the Committee shall have the authority to issue subpoenas to compel witnesses to appear and testify and to produce books, papers, correspondence, memoranda, documents, or other relevant records.

(b) Except as provided in subsection (c) of this section, subpoenas shall be served personally upon the witness or his or her designated agent, not less than 5 business days before the date the witness must appear or the documents must be produced, by one of the following methods, which may be attempted concurrently or successively:

(1) By a special process server, at least l8 years of age, designated by the Committee from among the staff of the Committee or any of the offices or organizations represented on the Committee; provided, that the special process server is not directly involved in the investigation; or

(2) By a special process server, at least 18 years of age, engaged by the Committee.

(c) If, after a reasonable attempt, personal service on a witness or witness' agent cannot be obtained, a special process server identified in subsection (b) of this section may serve a subpoena by registered or certified mail not less than 8 business days before the date the witness must appear or the documents must be produced.

(d) If a witness who has been personally summoned neglects or refuses to obey the subpoena issued pursuant to subsection (a) of this section, the Committee may report that fact to the Superior Court of the District of Columbia and the court may compel obedience to the subpoena to the same extent as witnesses may be compelled to obey the subpoenas of the court.

Sec. 4608. Confidentiality of Proceedings.

(a) Proceedings of the Committee shall be closed to the public and shall not be subject to section 742 of the District of Columbia Home Rule Act, approved December 24, 1973 (87 Stat. 831; D.C. Official Code § 1-207.42), when the Committee is discussing cases of individual child deaths or where the identity of any person, other than a person who has consented to be identified, can be ascertained. Persons other than Committee members who attend any Committee meeting which pursuant to this section, is not open to the public, shall not disclose what occurred at the meeting to anyone who was not in attendance, except insofar as disclosure is necessary for that person to comply with a request for information from the Committee. Committee members who attend meetings not open to the public shall not disclose what occurred with anyone who was not in attendance (except other Committee members), except insofar as disclosure is necessary to carry out the duties of the Committee. Any party who discloses information pursuant to this subsection shall take all reasonable steps to ensure that the information disclosed, and the person to whom the information is disclosed, are as limited as possible.

(b) Members of the Committee, persons attending a Committee meeting, and persons who present information to the Committee may not be required to disclose, in any administrative civil, or criminal proceeding, information presented at or opinions formed as a result of a Committee meeting, except that nothing in this subsection may be construed as preventing a person from providing information to another review committee specifically authorized to obtain such information in its investigation of a child death, the disclosure of information obtained independently of the Committee, or the disclosure of information which is public information.

(c) Information identifying a deceased child, a member of the child's immediate family, the guardian or caretaker of the child, or an alleged or suspected perpetrator of abuse or neglect upon the child, may not be disclosed publicly.

(d) Information identifying District of Columbia government employees or private health-care providers, social service agencies, and educational, housing, and child-care provider may not be disclosed publicly.

(e) Information and records which are the subject of this section may be disclosed upon a determination made in accordance with rules and procedures established by the Mayor.

Sec. 4609. Confidentiality of Information.

(a) All information and records generated by the Committee, including statistical compilations and reports, and all information and records acquired by, and in the possession of the Committee are confidential.

(b) Except as permitted by this section, information and records of the Committee shall not be disclosed voluntarily, pursuant to a subpoena, in response to a request for discovery in any adjudicative proceeding, or in response to a request made under Title II of the District of Columbia Administrative Procedure Act, effective March 29, 1977 (D.C. Law 1-96; D.C. Official Code § 2-531 el seg.), nor shall it be introduced into evidence in any administrative, civil, or criminal proceeding.

(c) Committee information and records may be disclosed only as necessary to carry out the Committee's duties and purposes. The information and records may be disclosed by the Committee to another child fatality review committee if the other committee is governed by confidentiality provisions which afford the same or greater protections as those provided in this title.

(d) Information and records presented to a Committee team during a child fatality review shall not be immune from subpoena or discovery, or prohibited from being introduced into evidence, solely because the information and records were presented to a team during a child death review, if the information and records have been obtained through other sources.

(e) Statistical compilations and reports of the Committee that contain information that would reveal the identity of any person, other than a person who has consented to be identified, are not public records or information, and are subject to the prohibitions contained in subsection (a) of this section.

(f) The Committee shall compile an Annual Report of Findings and Recommendations, which shall be made available to the Mayor, the Council, and the public, and shall be presented to the Council at a public hearing.

(g) Findings and recommendations on child fatalities defined in section 4605(e) shall be available to the public on request.

(h) At the direction of the Mayor and for good cause, special findings and recommendations pertaining to other specific child fatalities may be disclosed to the public.

(i) Nothing shall be disclosed in any report of findings and recommendations that would likely endanger the life, safety, or physical or emotional well-being of a child, or the life or safety of any other person, or which may compromise the integrity of a Mayor's investigation, a civil or criminal investigation, or a judicial proceeding.

(j) If the Mayor or the Committee denies access to specific information based on this section, the requesting entity may seek disclosure of the information through the Superior Court of the District of Columbia. The name or any other information identifying the person or entity who referred the child to the Department of Human Services or the Metropolitan Police Department shall not be released to the public.

(k) The Mayor shall promulgate rules implementing the provisions of sections 4607 and 4608. The rules shall require that a subordinate agency director to whom a recommendation is directed by the Committee shall respond in writing within 30 days of the issuance of the report containing the recommendations.

(l) The policy recommendations to a particular agency authorized by this section shall be incorporated into the annual performance plans and reports required by Title XIV A of the District of Columbia Government Comprehensive Merit Personnel Act of 1978, effective May 16, 1995 (D.C. Law 11-16; D.C. Official Code § 1-614.11 et seq.).

Sec.4610. Immunity from liability for providing information to Committee.

Any health-care provider or any other person or institution providing information to the Committee pursuant to this act shall have immunity from liability, administrative, civil, or of the information.

Sec. 4611. Unlawful Disclosure of Information; Penalties.

Whoever discloses, receives, makes use of, or knowingly permits the use of information concerning a deceased child or other person in violation of this act shall be subject to a fine of not more than $1,000. Violations of this act shall be prosecuted by the Corporation Counselor his or her designee in the name of the District of Columbia. Subject to the availability of an appropriation for this purpose, any fines collected pursuant to this section shall be used by the Committee to fund its activities.

Sec. 4612. Persons Required to Make Reports; Procedure.

(a) Notwithstanding, but in addition to, the provisions of any law, including D.C. Official Code § 14-307 and the District of Columbia Mental Health Information Act of 1978, effective March 3, 1979 (D.C. Law 2-136; D.C. Official Code § 7-1201.01 et seq.), any person or official specified in subsection (b) of this section who has knowledge of the death of a child who died in the District of Columbia, or a ward of the District of Columbia who died outside the District of Columbia shall as soon as practicable but in any event within 5 business days report the death or cause to have a report of the death made to the Registrar of Vital Records.

(b) Persons required to report child deaths pursuant to subsection (a) of this section shall include every physician, psychologist, medical examiner, dentist, chiropractor, qualified mental retardation professional, registered nurse, licensed practical nurse, person involved in the care and treatment of patients, health professional licensed pursuant to the District of Columbia Health Occupations Revision Act of 1985, effective March 25, 1986 (D.C. Law'6-99; D.C. Official Code § 3-1201.01 et seq.),law-enforcement officer, school official, teacher; social service worker, day care worker, mental health professional, funeral director, undertaker, and embalmer. The Mayor shall issue rules and procedures governing the nature and contents of such reports.

(c) Any other person may report a child death to the Registrar of Vital Records.

(d) The Registrar of Vital Records shall accept the report of a death of a child and shall notify the Committee of the death within 5 business days of receiving the report.

(e) Nothing in this section shall affect other reporting requirements under District law.

Sec.4613. Immunity from Liability for Making Reports.

Any person, hospital, or institution participating in good faith in the making of a report pu~t to this act shall have immunity from liability, administrative, civil, and criminal, that might otherwise be incurred or imposed with respect to the making of the report. The same immunity shall extend to participation in any judicial proceeding involving the report. In all administrative, civil, or criminal proceedings concerning the child or resulting from the report, there shall be a rebuttable presumption that the maker of the report acted in good faith.

Sec. 4614. Failure to Make Report.

Any person required to make a report under section 4612 who willfully fails to make the report shall be fined not more than $100 or imprisoned for not more than 30 days, or both. Violations of section 4612 shall be prosecuted by the Corporation Counsel of the District of Columbia, or his or her agent, in the name of the District of Columbia.

Sec.4615. Section 20 of the Vital Records Act of 1981, effective October 8, 1981 (D.C. Law 4-34; D.C. Official Code § 7-219), is amended by adding a new subsection (d) to read as follows:

"(d) Notwithstanding the provisions of this section, the Registrar shall provide reports of deaths of children 18 years of age or younger who either received or were eligible to receive certificates of live birth, as defined by section 2(9), to the Child Fatality Review Committee pursuant to section 4612 of the Child Fatality Review Committee Establishment Act of 2001, passed on 2nd reading on June 5, 2001 (Enrolled version of Bill 14-144)". .

Sec. 4616. Section 302 of the District of Columbia Mental Health Information Act of 1978, effective March 3, 1979 (D.C. Law 2-136; D.C. Official Code § 7-1203.02), is amended by striking the period at the end and inserting the phrase ", including section 4612 of the Child Fatality Review Committee Establishment Act of 2001, passed on 2nd reading on June 5, 2001 (Emol1ed version of Bill 14-144)." in its place.

Sec. 4617. Section 203 (a) of the Prevention of Child Abuse and Neglect Act of 1971, effective September 23, 1977 (D.C. Law 2-22; D.C. Official Code § 4-1302.03(a)), is amended as follows:

(a) Paragraph (6) is amended by striking the word "and" at the end.

(b) Paragraph (7) is amended by striking the period at the end and inserting the phrase "; and" in its place.

(c) A new paragraph (8) is added to read as follows:

"(8) The Child Fatality Review Committee, for the purpose of examining past events and circumstances surrounding child deaths in the District of Columbia and deaths of children-who were either residences or wards of the District of Columbia in an effort to reduce the number of preventable child deaths, especially those deaths attributable to chi1d abuse and neglect and other forms of maltreatment. The Child Fatality Review Committee shall be granted, upon request, access to information contained in the tiles maintained on any deceased child or on the parent, guardian, custodian, kinship caregiver, day-to-day caregiver, relative/godparent caregiver, or sibling of a deceased child.".

Sec.4618. Section 306(a) of the Prevention of Child Abuse and Neglect Act of 1977, effective October 18, 1979 (D.C. Law 3-29; D.C. Official Code § 4-1203.06 (a)), is amended by striking the period at the end and inserting the phrase, ", or the investigation or review of child fatalities by representatives of the Child Fatality Review Committee, established pursuant to section 4603 of the Child Fatality Review Committee Establishment Act of 2001, passed on 2nd reading on June 5, 2001 (Enrolled version of Bill 14-144)." in its place.

Sec. 4619. The Fiscal Year 2001 Budget Support Act of 2000, effective October 19, 2000 (D.C. Law 13-172; 47 OCR 6308), is amended as follows:

(a) Section 2905 is amended by adding new subsections (c) and (d) to read as follows:

“(c) The CME shall inform the Registrar of Vital Records of all deaths of children 18 years of age or younger as soon as practicable, but in any event within 5 business days.

“(d) The CME or his or her designee, shall attend all reviews of child deaths by the Child Fatality Review Committee. The CME shall coordinate with the Child Fatality Review Committee in its investigations of child deaths."

(b) Section 2906(b X2) is amended by adding the phrase "for' infants one year of age and younger" before the semicolon.

(c) Section 29J3(b) is amended by striking the word "official" and inserting the phrase "official, and the Child Fatality Review Committee when necessary for the discharge of its official duties" in its place.

Sec. 4620. Title 16 of the District of Columbia Official Code is amended as follows:

(a) Section 16-311 is amended by adding after the phrase "promoted and protected." the sentence “Such records and papers shall, upon written application to the court, be unsealed and provided to the child Fatality Review committee for inspection if the adoptee is deceased and inspection of the records and papers is necessary for the discharge of the Committee’s official duties.”

(b) Section 16-2331(b) is amended as follows:

(1) Paragraph (8) is amended by striking the word "and" at the end.

(2) Paragraph (9) is amended by striking the period and inserting the phrase” and” in its place.

(3) A new paragraph (10) is added to read as follows:

"(10) The Child Fatality Review Committee for the purposes of examining past events and circumstances surrounding deaths of children in the District of Columbia or of children who are either residents or wards of the District of Columbia, or for the discharge of its official duties”.

(c) Section 16-2332(b) is amended as follows:

(1) Paragraph (4) is amended by striking the word "and" at the end.

(2) Paragraph (5) is amended by striking the period at the end and inserting a semicolon in its place.

(3) Paragraph (6) is amended by striking the period at the end and inserting the phrase “; and” in its place.

(4) A new paragraph (7) is added to read as follows:

"(7) The Child Fatality Review Committee for the purposes of examining past events and circumstances surrounding deaths of children in the District of Columbia or of, children who are either residents or wards of the District of Columbia. or for the discharge of its official duties.".

(d) Section 16-2333(b) is amended as follows:

(1) Paragraph (6) is amended by striking the word "and" at the end.

(2) Paragraph (7) is amended by striking the word "and" at the end.

(3) Paragraph (8) is amended by striking the period at the end and inserting the phrase "; and" in its place.

(4) A new paragraph (9) is added to read as follows:

"(9) The Child Fatality Review Committee when necessary for the discharge of its official duties.".

(e) Section 16-2335(d) is amended by adding after the phrase "in the records to" the phrase "the Child Fatality Review Committee, where necessary for the discharge of its official duties, and".

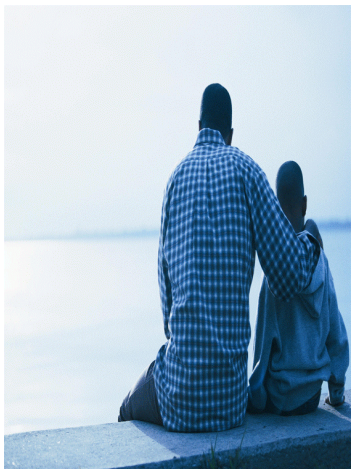
Sec. 4621. Fiscal Impact Statement.

The Fiscal Year 2002 Budget and Financial Plan provides $296,000 in local funds to support the Child Fatality Review Committee.

Acknowledgement

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 live 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 your time, giving of your resources, support and dedication to achieving our common goal. A special thanks is extended to the community volunteers who continue to serve the citizens of the District throughout every aspect of the child fatality review process.



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