District of Columbia
Child Fatality Review Committee
2003 ANNUAL REPORT

Government of the District of Columbia
Anthony A. Williams, Mayor

Robert Bobb
Interim Deputy Mayor for Public Safety and Justice

Marie-Lydie Y. Pierre-Louis, Acting Chief Medical Examiner
Office of the Chief Medical Examiner

some of significant and wide-ranging issues that are addressed through CFRC reviews and recommendations:

- Establish a policy that requires age appropriate youth known to public service programs with a diagnosis of a mental health or other disability to be referred to Rehabilitation Services Administration (RSA) for eligibility determination and linkage/provision of a range of services to include education, vocational assessment/training and independent living.
- Ensure that youth released from the District's juvenile detention facility have an enforceable transition educational plan that is age and level appropriate.
- Continue to expand mental health services to ensure that all District schools and parents have access to school-based and/or community-based services to ensure that children/youth's mental health needs are immediately and appropriately addressed.
- Assess the problem associated with youth of compulsory school age dropping out of school and develop/expand educational alternatives when regular school is not possible or appropriate.
- Ensure that youth who come before the courts for juvenile offenses are referred for appropriate assessments and assistance prior to cases being dismissed.
- Include obesity as a high risk factor for prenatal care and treatment and develop strategies to provide better care to these patients.
- Establish stricter guidelines and monitoring practices for community residential facilities related to safety, supervision and social work practice, for teen mothers and children known to the District's child welfare system.
- Address the following quality of care issues at the only remaining hospital in the southeast quadrant of the city to ensure optimum newborn and obstetrical care:
  - Develop/implement standards for providing social service intervention prior to a mother's discharge. At a minimum, psychosocial, safety assessments and discharge planning should be provided to all teens, at-risk mothers and infants discharged from the neonatal nursery. Assessment and planning should include parent education and newborn health care.
  - Revisit or address standards/process for referring appropriate families to the existing nurse home visitation program.
- Establish a practice of making referrals for appropriate community-based medical and social services assistance/support, when women at risk of pre-term labor are discharged from emergency room visits with pregnancy complications.
- Improve the current system of monitoring the time it takes emergency medical services to arrive on the scene following 911 calls and evaluate the apparent flaws with the Computer Aided Dispatch (CAD) system.
- Educate mandatory reporters (hospital staff, obstetricians, pediatricians, etc.) about the new law and reporting requirements for drug-exposed infants and infants born to mothers who test positive for illegal drugs.

DISTRICT OF COLUMBIA
CHILD FATALITY REVIEW COMMITTEE

2003 ANNUAL REPORT

MISSION:

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

PRESENTED TO:

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

December 2004

DEDICATION

In keeping with the tradition of the Child Fatality Review Committee, this Annual Report is dedicated to the memory of the children/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 children by reducing the number of preventable deaths and improving the quality of their lives.

EXECUTIVE SUMMARY

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

Margaret Meade

The District of Columbia Child Fatality Review Committee (CFRC) is pleased to present its tenth Annual Report. This Report covers data that resulted from reviews of 133 fatalities from calendar year 2003.

Key Child Fatality Review Findings

Total Number of Child/Youth Fatalities

- The 133 fatalities reviewed to the Committed from 2003 represents a 33% decrease in the total number of CFRC child deaths identified between 1999 and 2003.
- The largest decrease occurred between 1999 and 2000 (n = 43, or 22%) and the smallest decrease was between calendar years 2002 and 2003 (n = 6, or 4%)

Decedent Demographics

- The ages of the 2003 decedents ranged from birth to 25 years.
- The largest population of child fatalities was children under the age of one year (n = 68, or 51%). The second largest population was youth over the age of 14 years (n = 45, 34%)
- Consistent with previous years, the majority of the decedents were Black/African American (116, or 87%).
- Also consistent with previous years data, males continued to dominate the child/youth fatality population. There were 85 (64%) male deaths compared to 48 females.
- The majority of the decedents were residents of Wards Seven and Eight. There were 32 children/youth from these Wards who died in 2003.

Manners of Death

Natural Deaths

- A review of death certificates indicates that the majority of District children/youth continue to die from natural causes during the 2003 calendar year. There were a total of 79 natural deaths. As with previous years, children under the age of one year accounted for 76% of 2003 natural child deaths and the majority of these deaths were associated with prematurity, low birth weight and congenital anomalies.
- There were eight 2003 infant deaths attributed to Sudden Infant Death Syndrome.

Violence Related Deaths

Death certificates attributed 41 fatalities from 2004 to violence related causes. This included 38 homicides and three suicides.

Homicides

- Fatal Abuse/Neglect – There were three child deaths during 2003 where the causes were associated with parental/caretaker abuse and neglect compared to seven in 2002. The children who died from fatal abuse/neglect in 2003 ranged in age from five months to two years.
- Youth Violence – Youth violence continued to be the primary cause of child/youth homicides. In 2003, there were 35 youth who died from violent acts that included gunshot and stab wounds. Youth in this category were between 15 and 22 years of age. They were primarily Black/African American (97%) and male (91%).

Suicides

The number of suicide youth deaths increased from one in 1999 through 2002 to three in 2003. The ages of these youth ranged from 11 to 15 years.

Unintentional Injuries

Accidental or unintentional injuries increased slightly in 2003. There were eight unintentional deaths in calendar year 2003 compared to seven in 2002. The causes of accidental deaths in all age groups were:

- 7 Motor Vehicle Accidents, and
- 1 Asphyxia.

Undetermined, Unknown and Pending

- There were four deaths where the manner was "undetermined". In three of these cases the cause was also undetermined, however, in one case the cause was determined to be "Sudden Unexpected Infant Death with Co-sleeping and Inappropriate Bedding".
- The cause/manner of death is unknown for one District infant. This child died in another state and CFRC was unable to obtain a copy of the death certificate.
- In 2003, there were no fatalities where the cause and manner of death remained pending. This is a tremendous accomplishment for the District and is representative of the hard work and continuous improvements that are occurring in the Office of the Chief Medical Examiner.

Top CFRC Recommendations from Calendar Years 2003

Key factors considered during case reviews are the identification of contributing factors, systemic issues/gaps and strategies/recommendations for preventing child deaths and improving the quality of the lives of the District residents. As membership is broad, covering multiple public, private and community organizations, recommendations are also wide-ranging. Each case yields recommendations that include improving policies and practices, expanding programs and resources and furthering public outreach efforts. A listing of the most critical recommendations with a status of implementation efforts is provided as part of the Appendices (see Appendix A). However, the following recommendations are provided as a sample of

INTRODUCTION

The Child Fatality Review Committee (CFRC) is a citywide effort that is authorized by District statute (see Appendix B: Child Fatality Review Committee Establishment Act of 2001, DC Law 14-028). The Committee was established for the purpose of conducting retrospective examinations of the circumstances that contributed to the deaths of infants, children and youth who were residents or wards of the District. Identifying risk reduction, prevention and system improvements factors; recommending strategies to reduce the number of preventable child deaths; and improving the quality of residents' lives are the primary goals of the District's child death review process (see Appendix C: Summary of CFRC Goals, Objectives and Operating Process). The Committee focuses on using information gained from fatality reviews as a means of understanding the following:

- The manner in which District children are dying and patterns/trends associated with preventable child deaths;
- The type of services/interventions and resources needed by families;
- The appropriateness of current child/family-focused policies, legislation and practices; and
- The changes required for ensuring a city-wide continuum of care for children and families and for the protection of our children.

The 2003 Annual Report summarizes data collected from reviews conducted on infant, child and youth fatalities that occurred during calendar year 2003. It also highlights some of the contributory factors and recommendations identified by the District's Child Fatality Review Committee. The Committee identified the deaths of 133 children/youth from calendar year 2003, from birth through 25 years of age. These children died from a multitude of causes including extreme prematurity, congenital anomalies, diseases, homicide, suicide and unintentional injuries. Additionally, because the 2001 and 2002 Annual Report (issued January 2004) presented preliminary data for calendar year 2002, the 2003 Annual Report also provides an update of child death data from that year. The updated 2002 data (see Appendix A) includes nine additional fatalities that were identified by CFRC, bringing the total number of deaths to 139.

The child death review processes are intended to assist 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, multi-disciplinary approach. This process can provide 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's lives.

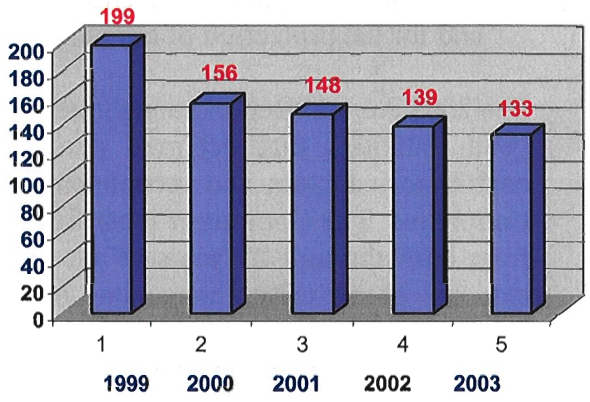
2003 Case Review Findings

Information presented in CFRC annual reports is raw data which results from the Committee case review process and should not be used as the only tool for measuring true changes in child deaths in the District. This information should be evaluated within the context of other statistical measures, such as the changes in the District's adult and child populations, as well as trends in resident demographics, including racial distribution and economic status. These elements are critical to understanding the overall trends and patterns that are consistently occurring in the child death population. Coupled with other data measures, CFRC data are designed to benefit agencies in determining patterns in family characteristics and needs; and in formulating strategies that may assist in improving programs and services to District residents, i.e., changes in funding and resources and policy/legislative needs.

Summary of All Child/Youth Fatalities

Through the implementation of a consistent CFRC case review criterion (revised in 1998), over the past five years (1999 through 2003), there has been a steady decrease in the number of child fatalities identified by the Committee.

Figure 1: Total Fatalities (1999 through 2003)



- In 2003, there were 133 deaths identified by the Committee as meeting the criteria for review.
- As depicted in Figure 1, since calendar year 1999, there has been a 33% decrease in the total number of CFRC child deaths, with the largest decrease occurring between 1999 and 2000 (n = 43 or 22%) and the smallest decrease occurring between calendar years 2002 and 2003 (n = 6, or 4%).
- The greatest decrease in child deaths occurred in the infant population. Between 2002 and 2003, there was a 15% decrease in the number of infants identified. Over the past five years, there has been an overall decrease of 41% (n = 47) in this population.

Description of Decedent Population

This section of the Annual Report covers demographic characteristics of the 133 decedents identified as meeting the CFRC criteria from the 2003 calendar year. Data are provided in various forms of comparison within a variety of characteristic categories (i.e., age, sex, race), manners/causes of death and case types. Despite the fact that child fatalities occurred in all District communities, the number and types varied a great deal among different segments of the population. These demographic differences represent very real needs among different groups and should be used to better inform policy makers and service providers to ensure more targeted and appropriate services for District residents.

Ages of Decedents

- The ages of the 133 decedents ranged from birth through 25 years[1].
- As with previous years, the two largest categories of child deaths reviewed from 2003 included infants (under the age of one year) and youth over 14 years of age. Similar to 2001 and 2002, combined fatalities of these two age categories represented 85% of the total 2003 population (n = 113).
- Although the number of infant deaths continued to decrease during 2003, this population remained the largest group of CFRC fatalities. Of the 133 CFRC fatalities, 68 (51%) of the children fell into this category, while still representing a 15% decrease from the same population in 2002 (n = 80) and a 13% decrease from 2001 infant deaths (n = 78). The 2003 infant population included 43 neonates (birth through 27 days); 29 (67%) of these children died during their first day of life. Twenty-five infants were post-neonates (28 days up to one year).
- Forty-five, or 34% of the 2003 fatalities were of youth over the age of 14 years. This population of youth fatalities included thirty-six decedents 15 through 20 years of age and nine decedents who were 21 years or older.
- The remaining 20 decedents were between the ages of one through 14 years of age, with the largest category being children between eleven and fourteen years (n = 8) and the smallest between 5 and 10 years of age.

Figure 2: Age of Decedents - 2003

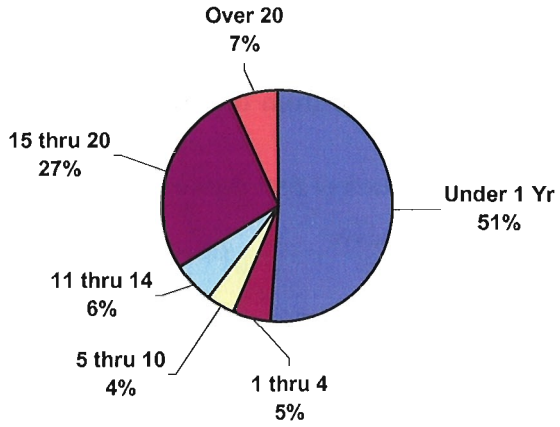
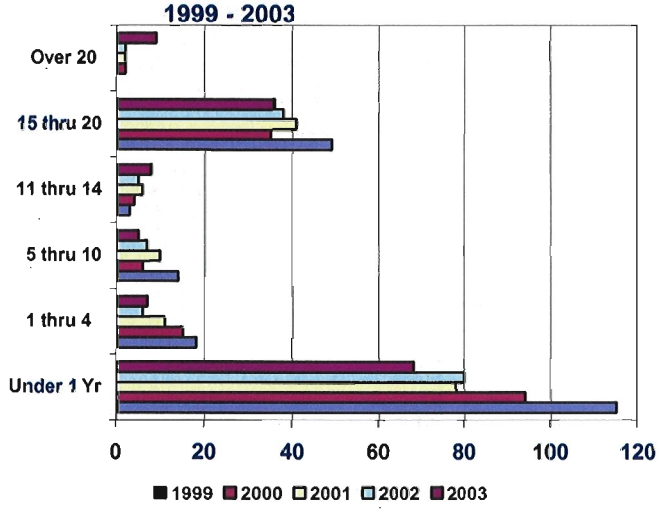


Figure 3: Age of Decedents - Comparison Data 1999 - 2003



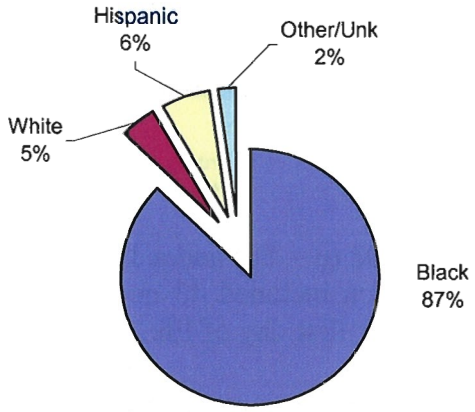
Decedent Age Comparison Data

When comparing the ages of decedents over a five-year period (1999 – 2003) several trends become apparent. Figure 3 illustrates the differences in two major age populations of child deaths. It also depicts the fact that while numbers of deaths have fluctuated in all age categories, the degree of fluctuation has been greater with the infant deaths. Infant deaths have always represented the largest percentage of child deaths; however, the number of deaths in this age group has the most significant downward trend (41% from 1999 to 2003), with a small increase occurring only between the 2001 and 2002 calendar

[1] Based on established CFRC definitions for child welfare and juvenile justice fatalities, the District's review process can include decedents through the age of 25 years.

years. Deaths of older youth (over 15 years of age) have represented the second largest fatality population. Although, there has been an overall decrease of eight percent between 1999 and 2003 in this population, the most significant decrease (n = 12, or 24%) occurred between calendar years 1999 and 2000. Unlike previous years, the number of youth over 20 years of age increased significantly during 2003. There were 9 decedents in this age category in 2003, representing a 400% increase from the two youth in the same age category for calendar years 2000, 2001 and 2002.

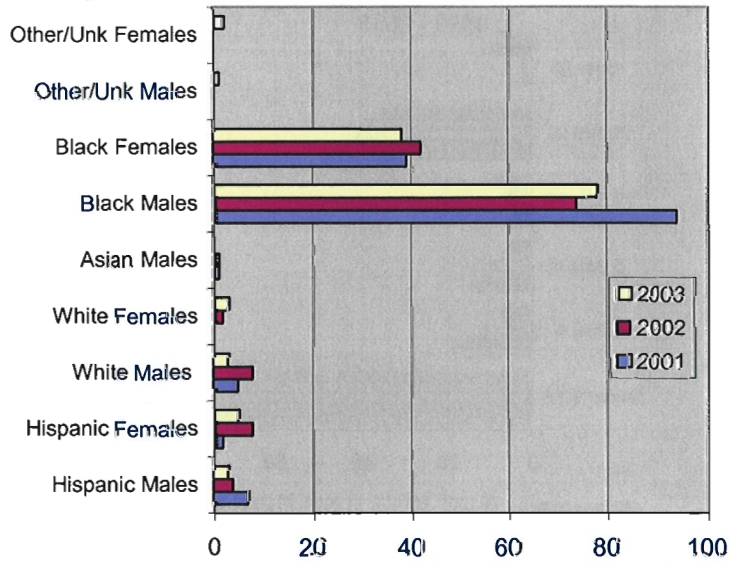
Figure 4: Race of 2003 Decedents



Race and Gender of Decedents

Black children/youth continued to make up the majority of the District's CFRC fatalities. The disproportionate representation of Blacks among the child death population continues to be a glaring trend and Committee concern. Although data indicate a change over the past five years in the racial composition of the District population (57% decrease in Black/African American children)[2] and the CFRC child death population (33% decrease), this racial change is not significantly reflected in the child death numbers. In 2003, Black/African American decedents continued to dominate the child death population (n = 116, or 87%). Despite the overall decrease in the number of 2003 deaths, racial data indicate that the number of Black/African American child/youth deaths in 2003 remained the same as the number who died in 2002 (n = 116). Between 1999 and 2003 calendar years, Blacks/African American children/ youth represented between 83 and 89% of CFRC deaths. Also consistent with other CFRC years, Hispanic and White children have consistently represented the second and third leading child death populations.

Figure 5: Gender/Race of Decedents - Comparison Data (2000 - 2003)



Similarly, male children/youth have continued to be over-represented in the fatality data. In 2003, there were 85 males (64%) and 48 females. Figure 5 illustrates the vast disparity in children/youth deaths among Black/ African American males within the District.

- In 2003, 78 Black/African American males met the CFRC criteria. Thirty-seven (47%) of these deaths involved children under the age of one year

[2] DC Kids Count reports a change in the number of Black/African American children between the ages of birth to 18 from 81,300 in 1997 to 35,240 in 2002 (57% decrease).

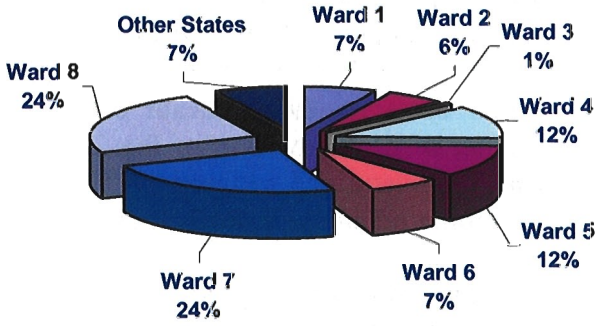
(infants) and 33 (42%) were 15 years of age or older. The overall average age of Black/African American male decedents was nine years, however, the average age of decedents under one year of age was 12 days and the average age of youth 15 years and older was 18 years. Although the leading cause of death for Black/African American males was natural (n = 40, or 51%), 41% (n = 32) died from homicides associated with youth violence. Fifty-four percent (n = 42) of all African American male decedents were residents of Wards Seven and Eight.

- Black/African American females represented the second leading gender/racial group among 2003 decedents (n =38). Although, the majority (n = 23, or 61%) of this population was infants, the overall average age was five years. The leading cause of death was natural (n = 29, or 76%) followed by homicide (n = 5, or 13%). Fifty percent of the decedents were residents of Wards Seven and Eight.
- There were eight deaths of Hispanic children/youth referred to CFRC from calendar year 2003. Over half of these decedents (n = 5) were under the age of one year and the average age was five years. Seven children/youth died from natural causes and one died from homicide. Half of the decedents were residents of Ward Four.
- Six 2003 deaths were of White children/youth. The average age was eleven years with the youngest being four months and the oldest 18 years. The causes of deaths included three natural, one suicide, one accident and one undetermined.
- Included in the 2003 data were the deaths of a two-year old East Indian child, and one infant decedent whose race is unknown.

District Ward of Decedents

Residency of decedents is determined based on the review of various documents and records, including the birth and death certificates. In many cases there is conflicting information relating to the address of the decedent and/or the family member with whom he/she resided. Therefore, in an effort to ensure consistency in reporting, the decedent's state of residency and the Ward within the District are determined based on the address documented on the death certificate.

Figure 6: Ward of Residency - 2003 Data



In 2003, nine (7%) of the 133 decedents were residents of or residing in the state of Maryland. These children/youth were known to either the child welfare and/or juvenile justice system and were either committed to the District at the time of their deaths or were placed through these programs in out-of state facilities and, as such met the CFRC definition for fatality review. As illustrated in Figure 6, consistent with previous years, the majority of the 2003 decedents were residents of Wards Seven and Eight. Equal numbers of decedents resided in these Wards (n = 32, or 24% each). These Wards were followed by Wards Four and Five with 16 child/youth deaths each, and Wards One and Six with nine fatalities each. Also consistent with previous years, Ward Three continued to have the smallest number of

deaths during calendar year 2003 with one percent (n = 2) of the 2003 deaths being residents from this Ward.

"2003 Natural Fatality"

A 19-year old female came to the hospital with presenting complaint of uterine contractions and spotting. Upon assessment the cervix was determined to be fully effaced/dilated with bulging membranes. Based on sonogram the mother was determined to be 23 weeks gestation. Her vital signs were taken and she was transported to the delivery suite for imminent delivery. Labor advanced and she had a non-spontaneous delivery later that evening. The infant's birth weight was 605 grams and APGAR scores were 1 at one minute and 2 at 5 minutes. Condition at birth was noted as extreme prematurity, fused eyelids, no activity, no respiratory effort. The infant was considered to be non-viable and no extensive resuscitation was initiated. She was transported to NICU, placed in a warmer and monitored for vital signs. She had diminished heartbeat and was pronounced dead approximately 15 minutes after birth. The mother's history was negative for drugs, alcohol, cigarettes and a voluntary interrupted pregnancy in 2002. She had 6 prenatal visits at a neighborhood health clinic during her 2003 pregnancy.

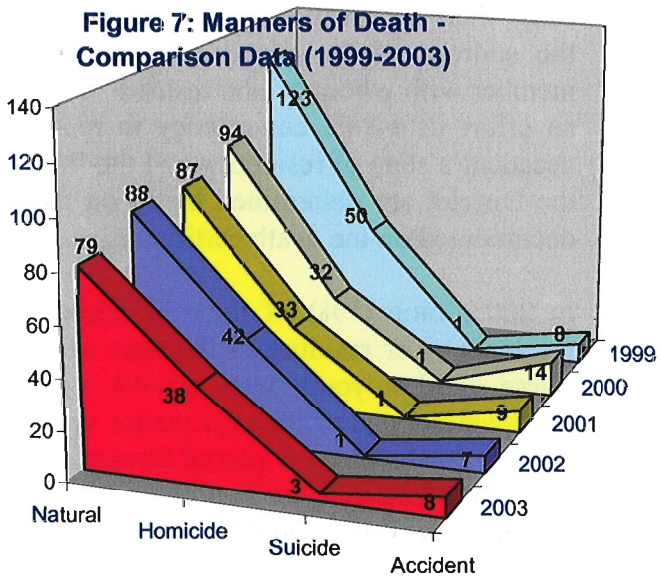
Cause/Manner of Death: Extreme prematurity at 22 weeks of unknown etiology; Pulmonary Insufficiency/Natural

Manner/Cause of 2003 Fatalities

Manner of Death

The manner of death relates to the circumstances under which the death occurred. This is determined based on specific information and details that are available on each case. Unlike the cause of death, manner can differ depending on the conditions and contributing factors revealed during investigation and/or autopsy.

At the point of statistical compilation of the data for this Report, death certificates were received for 132 (99%) of the 133 fatalities. CFRC was unable to obtain a death certificate of a District resident who died in the state of Pennsylvania. Based on a review of death certificates, the manner of death for four of the 2003 fatalities was Undetermined. Figure 7 illustrates the remaining manners of death for CFRC fatalities over a five-year period (1999 through 2003). The data from these review years support the following trends/findings:



- Although Natural remains the primary manner of death for District children/youth, the number of natural deaths over this five year period has decreased by 36%. Consistent with previous years, in 2003 the majority of the children dying from natural deaths was under the age of one year (n = 60, or 76% of 79 fatalities). The majority of these deaths involved infants who died from medical complications related to pregnancy and/or premature birth.

- Homicides have continued to represent the second leading manner of death for District children/youth since 1999. As Figure 7 illustrates, the number of child/youth homicides has fluctuated between calendar years 1999 and 2000. Even with the fluctuation in data, there has been an overall decrease in child/youth homicides by 24%. In calendar year 2003, there was a 10% decrease in the number of deaths that met the CFRC criteria. During this year, homicides accounted for 38, or 29% of the 133 fatalities. Similar to previous years, the majority of the 2003 homicide deaths involved youth over the age of 14 years (n = 35, or 92%). The majority of these deaths were Black/African American males (n = 34). Homicides of older youth were associated with youth violence.
- There were eight deaths attributed to accidents in 2003. Unlike accidental data from calendar years 2000 through 2002, data from 2003 indicates a slight increase after a two-year decline in accidental deaths (n = 14 in 2000, nine in 2001, seven in 2002).
- Different from all other CFRC fatality review years, the number of suicide deaths increased by 200 percent in 2003. There were three suicides in 2003 compared to one similar death in each year from 2000 through 2002.
- Out of the 132 cases where manners of death were known, autopsies were required and completed on 89, or 67% of the fatalities. There were no 2003 fatalities where the autopsy remained "Pending" at the point of statistical compilation of the data for this Report. Calendar year 2003 represents the first year in the history of CFRC where there were no "Pending" cause/manners of death included in data reported.

Table 1 illustrates the Ward of the decedents' residence by manner of death for calendar years 2002 and 2003. Those deaths where the manner remains pending or was unknown have been excluded from this table.

Table 1. Ward of Decedent's Residence By Manner of Death

Ward	Total		Natural		Homicide		Accident		Suicide		Undet'd	
	2002	2003	2002	2003	2002	2003	2002	2003	2002	2003	2002	2003
One	19	9	14	5	5	2	0	1	0	0	0	1
Two	12	8	9	6	1	1	1	0	0	1	0	0
Three	6	2	6	0	0	1	0	1	0	0	0	0
Four	17	16	10	13	6	2	1	0	0	1	0	0
Five	14	16	8	11	4	5	2	0	0	0	0	0
Six	13	9	10	5	3	2	0	2	0	0	0	0
Seven	32	32	17	17	13	12	2	3	0	0	0	0
Eight	22	31	14	17	9	9	0	1	0	1	0	3
Other State	3	9	1	6	1	3	0	0	1	0	0	0

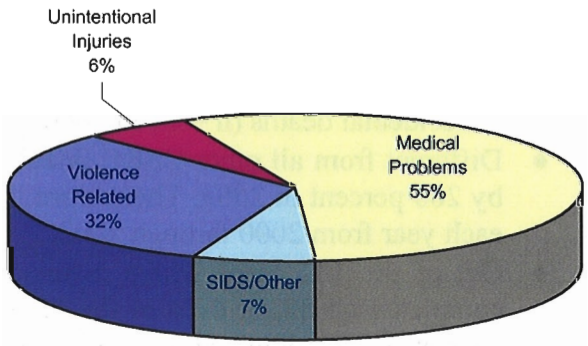
Cause of Death

In 2003 there were 129 fatalities where the cause of death was determined. This includes one case where the autopsy resulted in the manner of death being "Undetermined". The remaining four fatalities included three undetermined causes and manners of death and one unknown cause/manner (child died in another state and CFRC was unable to obtain the death certificate). For purposes of this Report and to ensure consistency in evaluating Committee data, the causes have been grouped in the following categories: Medical Problems, SIDS, Violence Related, and Unintentional Injuries (although SIDS deaths are also natural, for statistical purposes, beginning in 2001, SIDS data was separated from the "medical problem" category). These categories do not

always reflect the actual causes as stated on the death certificate. Specific information on the actual cause of death will be provided as each category is discussed throughout this Section of the Report and is depicted in Appendix D, 2003 Calendar Year Fatality Listing By Age, Cause and Manner of Death.

Medical Problems - As Figure 8 illustrates, the leading causes of death in the District continued to be associated with medical problems. Data also support the fact that the number of children dying from medical related problems continued to decrease in 2003. In calendar year 2003, out of the 129 CFRC deaths where cause was determined/known, 71 involved children/youth who died from medical related problems. The ages of the decedents ranged from birth through 25 years of age, with an average age of four.

Figure 8: 2003 Causes of Death



- Children Under One Year of Age

  In 2003, data indicates that 52, or 73% of medical related deaths involved infants (under the age of one year). Eighty-three percent (n = 43) of infant deaths occurred within the first 28 days of birth and 67% of these children died within the first day of life (n = 29).

  Findings Associated with Medical Related Causes of Infant Deaths

  - Among infant deaths, the leading cause of death was related to prematurity and associated complications. These problems accounted for 52% (n = 27) of the 2003 medical related infant deaths.
  - Prematurity was associated with extremely low birth weight (less than 500 grams) in 31% (n = 16) infant deaths for 2003.
  - Infectious diseases ranked among the top five leading causes of death with nine deaths, representing 17% of the 2003 infant who died from medical related causes.
  - Congenital anomalies were the primary causes of six infant deaths from 2003.
  - Maternal complications were documented on the death certificates of 25 (48%) infants from 2003 as underlying causes of medical related infant deaths. Maternal complications included premature rupture of membranes, chorioamnionitis, Group B Streptococcus, maternal diabetes, incompetent cervix, hypertension, etc.

- Children/Youth One Year of Age or Older

  Children over the age of one year have consistently represented a significantly smaller percentage of the medical related deaths. Nineteen, or 27% of 2003 deaths associated with medical problems involved decedents who were one year of age or older. The ages of the decedents ranged from one through 25 years with an average age of 12.

Findings Associated with Medical Related Causes of Deaths of Children One and Over

- Data from calendar year 2003 indicate that the leading causes of medical deaths in this age group were congenital anomalies (n = 3), neoplasms (n = 1) and infection (n = nine). HIV/AIDS was common to three children/youth who died from infection.

"2003 Natural Fatality"

One night during mid-spring, a 17-year old female mother of a newborn, complained to her parents of shortness of breath. She had just returned to their apartment unit from the store. Shortly afterwards she collapsed onto the floor. 911 was called and EMS responded and found her unconscious and in respiratory distress. Medics initiated lifesaving measures and began transport to a pediatric emergency room. En route the youth went into cardiac arrest, with loss of respiration and pulse. She was intubated and continued with lifesaving measures, arriving at the hospital approximately 45 minutes from the time of the initial call. Lifesaving measures were continued once she arrived in the ER, however, were unsuccessful. While there had been some non-life threatening complications during this adolescent pregnancy and during delivery, there was no documentation of subsequent complications during the post-partum period. At her post-partum check-up she had been placed, per her request, on a therapeutic estrogen contraception patch. Hospital and medical examiner toxicology screens were negative and there were no significant findings of illness or injury. Prior to this episode the decedent had been a healthy teenager with no history of smoking, alcohol or illicit drugs. She was an athlete and reportedly led an active life, with no significant academic or behavioral problems. **Cause/Manner of Death:** Acute pulmonary embolism, source undetermined, while using therapeutic estrogen for contraception/Natural

Based on the review of the death certificates, table 2 depicts the leading and underlying causes of 2003 decedents of all ages (because the majority of death certificates include multiple related causes, the numbers represent contributing factors and not the number of deaths).

TABLE 2: MEDICAL CAUSES OF DEATH AMONG 2003 DECEDENTS

Primary Causes of Death	**Infants < 1 Year**	**1 – 20 Years**	**Total**
Infections	**13**	**9**	**23**
Neoplasms	**0**	**1**	**1**
Respiratory System Disease	**6**	**2**	**8**
Intraventricular Hemorrhage	**3**	**0**	**3**
Congenital Anomalies	**9**	**3**	**11**
Prematurity	**35**	**1**	**36**
Cardiac Disease	**3**	**4**	**6**
Blood Disorders	**0**	**0**	**0**
Other Conditions	**2**	**6**	**8**

Sudden Infant Death Syndrome – Consistent with 2002, there were eight victims of Sudden Infant Death Syndrome (SIDS) during 2003. Reviews of SIDS deaths revealed the following factors (See Table 3 on pages 12 and 13 - SIDS Risk Factors):

- 2003 SIDS Data
  - Infants ranged in age from one to six months, with the average age of three months.
  - The majority of the decedents were male (n = five) and all were Black/African American.
  - Two of the children were being breastfed and one supplemented with formula.
  - The mothers of SIDS victims ranged in age from 19 to 39 years, with an average age of 26 years. The mothers had from one to six other children and none had prior child deaths.
  - Three of the victims of SIDS were twin births and all three had a surviving twin.
  - Seven of the mothers had documented prenatal care with the majority having three or more visits. Two mothers had over four visits.
  - Three, or 38% of the women reported histories of substance use/abuse; one had a positive toxicology screen at the birth of the decedent. Two of the mothers/parents reported tobacco use and both smoked in the home.
  - At the time of the death, mothers were the caregivers in four (50%) of the cases. In the remaining four cases the caregivers at the time of death included: both parents, the father, an 11-year old sibling and the father's housemate.
  - Five of the infants were placed and discovered on their stomachs; one was placed on his back (feeding on a "propped" bottle) and found on his back; one was placed and found on his side in an 11 year old sibling's arm; and one was placed and found on his right side.
  - Three of the victims were sleeping in cribs (one with his twin sibling). Four infants were sleeping in adult beds. Three of these infants were co-sleeping, one with an adult caregiver, one with an 11-year old and one with a twin sibling. One child was co-sleeping with her father on a pull-out sofa.
  - CPR was initiated prior to emergency medical services arrival in 75% (n = 6) of the SIDS deaths.
  - Five of the families were Ward Eight residents and the remaining Wards included Four, Five and Seven.
  - Seven out of eight deaths occurred in the decedent's home.

"2003 SIDS Death"

On a cold winter afternoon in the Southeast quadrant of the District, a 23-year old mother of a 3-month old infant called 911 and requested immediate medical assistance with her unconscious and unresponsive child. An officer and fire department ambulance crew arrived on the scene. The mother stated to emergency medical staff that she fed the infant in her upstairs bedroom leaving the bottle propped up. She left the infant alone for approximately 10 minutes to go downstairs to feed the other children. When she returned the infant was lying on the bed on his back with milk formula coming from his mouth. She picked the infant up and immediately noticed that the baby wasn't breathing. She indicated that she initiated CPR (based on dispatcher's instructions), and the procedure was performed until the Fire Department arrived on the scene. EMS Report of the event reveals on arrival that CPR was being performed by the 10 year old sibling. The infant was transported to a hospital, where lifesaving efforts continued until all efforts to save the infant were exhausted. The infant was pronounced dead at 1822 hours and was transported for autopsy.

The scene of the incident is an apartment building. The apartment is described as a four-bedroom duplex. The incident was confirmed to have occurred in the mother's bedroom, which was located on the upstairs level. The infant was described as lying on the mother's full-size bed. The bed had a fitted full-size sheet on the mattress and 2 pillows along with a bedspread. The mother reported that the infant normally slept in the crib, which was also in the bedroom. Autopsy indicated that toxicology screens were negative for drugs and there were no signs of physical maltreatment or trauma. The infant was up-to-date with well baby medical visits and immunizations. This family was known to the child welfare system as a result of one report of alleged abuse. The investigation was unsupported.

Cause/Manner of Death: Sudden Infant Death Syndrome/Natural

Table 3: *2003 Deaths – Sudden Infant Death Syndrome Risk Factors*

Infant Age/ Race/ ender	Weeks Gestation / Birth Weight	Child Risk Factors/ Medical Indicators	Mother Age/Ed/ Mar Status	Maternal Risk Factors	Prenatal Care	Sleeping Position Placed/Found	Sleeping Environment/Co-Sleeping	CPR Prior to EMS	Caregiver At Death
2Mon/27 Day, Black, Female	33/1615	No well child medical care/pulmonary follow-up/Formula fed	19/9th Grade/ Single	Incompetent cervix, UTI, Hx substance abuse	3 Visits	Stomach–face side/Stomach-face down	Crib – 2 infant blankets, comforter, toys, pair of infant shoes & a sleeper. No heat, room chilly	Mother	Mother
1 Mon/13 Day, Black, Male	36/2500	Hospitalized 5 days prior to death with severe cough, respiratory distress, and gagging; Diagnosis – Acute Viral Syndrome Discharged 1 day prior to death/ Breast fed w/cereal	25/1 yr college/ Single	Asthma, gestational diabetes, overweight, UTI, URI	8 Visits	Right side-face out w/ blanket rolled behind back/right side	Crib	Mother	Mother
3 Mon/3 Day, Black male	38/2291	Cold month prior/Formula fed	33/BA degree/ Single	Asthma/twin gestation	Yes	Side in sibling arm/side in sibling's arm	Adult bed with 11 year old sibling; crib in room filled with toys clothing, other items	Unk	11 year old sibling
3 Mon, Black, female	37/2799	Formula fed.	27/7th grade/ Single	Twin gestation, GBS, Hepatitis B, Anemia, hx drugs, alcohol & tobacco use; tox screen positive for drugs at delivery; hz of mental illness and domestic violence	3 Visits	Stomach/ stomach	Adult bed with twin sibling. Crib in room filled with clothing and other items	Mother	Mother

3 Mon/8 days, Black, male	39/3033	Hx problems w/ diarrhea, tolerating formula, positive syphilis; cold days prior to death, no well child medical care/ caregiver drug user/Formula fed (soy) – given wrong formula	32/10th grade/ single	Hx drug & alcohol use; hz of prostitution, STD, HIV & incarceration	4 Visits	Stomach-head to left/ stomach-face down	Adult bed w/caregiver	Neighbor	Father's housemate
4 Mon/11 days, Black male	39/1729	Low birth weight, bottle propping/ Formula fed	25/9th grade/ single	Previous child welfare hx-unsupported	7 Visits	Back-feeding w/bottle propped/ back w/milk coming from mouth	Adult bed	Mother & 8 year old child	Mother
3 Mon/29 days, Black, male	28/907	Preterm birth, low birth, low birth weight, cold prior to death/Formula fed w/cereal; both parents smoke in home	19/12th grade/ Single	Twin gestation, smokes tobacco in home	Unknown	Stomach-head to side/ stomach-head to side	Crib w/twin sibling	No	Both parents
6 mon/3 days, Black, female	39/2835	Breastfed, supplemented w/ formula; parent smoked in home	25/12th grade/ married, separated	Gestational diabetes, overweight, anemic, smoked tobacco	7 Visits	Stomach/ stomach	Pull-out sofa bed w/ father	Father	Father

UTI – Urinary Track Infection URI – Upper Respiratory Infection GBS – Group B Strep

Violence Related Deaths

Since 1996, the number of child/youth deaths attributed to some form of violence has ranked second in the District. For purposes of this Report, violence related deaths include homicides and suicides. Based on a review of death certificates for calendar year 2003, there were 41 violence related deaths.

Suicides

Suicides have been consistently represented in child death review data in the District since 1999. Fatality review of child/youth suicides from 2003 revealed the following findings:

- Unlike previous CFRC fatality review years, during 2003 the number of suicide deaths increased significantly. Three children/youth died in this category in 2003 compared to one in each year from 1999 through 2002.
- Another notable change in relation to District child suicides is the age of the victims. Unlike previous years, the 2003 suicide deaths involved children who were significantly younger. The ages of the 2003 decedents were 11, 12 and 15 years. In previous years the victims were all over the age of 14.
- All three victims of 2003 suicides were males. Two of the three decedents were Black/African American and one was White.
- Only one 2003 suicide victim was known to the mental health program and was receiving services. This child was also known to the child welfare system.
- The cause of death for all 2003 suicides was hanging and the place of death was the decedents' homes.
- The decedents' caregivers at the time of death included parents for two cases and a maternal relative for one case (decedent's parents were deceased).
- The children were all enrolled in school and two of the decedents had demonstrated problems with attendance and behavior.
- The oldest victim (15 years of age) had a documented history of alcohol and drug use.

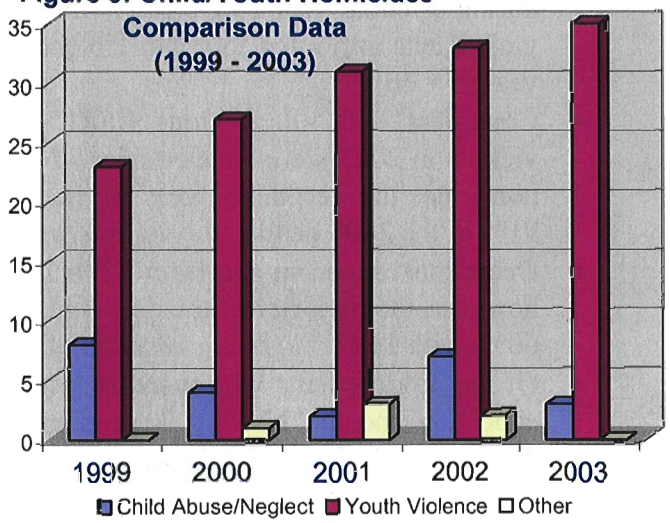
Homicides

The number of child/youth homicides continues to be a major CFRC concern and has remained the second leading manner/cause of death for District children since 1996. CFRC maintains child/youth homicide data in three categories, youth violence, fatal child abuse/neglect and other. For purposes of this report, youth violence refers to those homicides where another juvenile or young adult perpetrated the deaths. The motives were related to gang activity/behavior, drugs use/sales or retaliation/argument. Fatal child abuse and neglect deaths have been defined by the Committee as including those deaths where the manner has been determined to be a homicide and the death occurred at the hands of a parent, legal custodian or person responsible for the child's care at the time of the fatal incident. The "other" category includes those homicides where the child was under the age of 10 and the death was the result of deliberate violent acts by unrelated adults who were not in caretaker roles. In 2003, there were no homicides that fell in the "other" category.

As indicated by Figure 9, CFRC homicide data has continued to be dominated by acts of violence perpetrated by youth on youth (youth violence). Fatal abuse and neglect deaths continued to rank second.

Fatal Abuse and Neglect Fatalities – Over a five-year period (1999 through 2003), fatal child abuse and neglect deaths have fluctuated, with the lowest number of deaths occurring in 2001 (n = 2) and the highest number occurring in 1999 (n = 8).

Figure 9: Child/Youth Homicides - Comparison Data (1999 - 2003)



2003 Fatal Abuse/Neglect Fatalities

- Three 2003 fatalities were caused by injuries associated with fatal abuse/neglect, representing a 57% drop from the seven fatalities in 2002.
- The 2003 victims of fatal abuse/neglect had not reached their third birthday (ages ranged from five months to two years/seven months).
- Two of the decedents were Black/African American and one East Indian.
- There were two female victims and one male victim.
- Two of the fatal incidents occurred within the decedents' homes, in Wards Seven and Three; and one incident occurred in Maryland in the home of the day care provider/babysitter.
- The perpetrators of the abuse for the three fatal abuse/neglect fatalities included the decedent's mother, father and the babysitter's paramour.
- The causes of death were directly associated with abuse, including two caused by "Blunt Trauma" and one caused by "Stab Wounds".
- One of the decedents' families was known to the child protective services systems in the District and Maryland prior to the fatal event, however, neither of the cases involved the decedent as a victim and both cases were closed at the time of the death.

A 2003 Fatal Abuse Death

On a warm spring evening in 2003, at approximately 4:34 PM, police received responded to a radio call regarding an unconscious female. Upon arrival, the unconscious bodies of a female adult and a small child were discovered inside the premises. EMS Unit manned by paramedics responded to the scene and determined that death was apparent for both individuals and an OCME investigator pronounced both individuals dead. The decedents were determined to be a mother and child. According to the police investigation, on the day of the fatal incident, the mother had left a disturbing voice mail message on the answering machine of a friend. After several unsuccessful attempts to contact her, the friend decided to go to the home. Upon entering the home, she observed the body of the mother lying on the floor with blood on her chest. She called 911 from a neighbor's home. The autopsy revealed over 20 stab wounds to the child.
Cause/Manner of Death: Stab wounds to the Neck, Chest and Forearm with Injury to Vasculature, Lung and Heart/Homicide

- In one case, the mother (perpetrator) had a documented mental health history, however, she was not connected to or receiving service in the District.
- There were no documented issues of parental/caregiver substance abuse for any of the three fatal abuse/neglect deaths from 2003.

2003 Youth Violence Related Homicides

- Compared to 2002 data, six percent more youth died violently in the District of Columbia during calendar year 2003. Thirty-five of the 2003 homicides involved youth who died from violent acts attributed to youth violence. This represents 92% of the total homicides for the year (n = 38).
- Consistent with all previous CFRC years, the majority of the youth violence homicide victims in 2003 were Black/African American males. In 97% (n = 34) of the youth violence homicides the decedents were Black/African American youth; one was Hispanic. In 32, or 91% of the 2003 deaths, the victims were males.
- Decedents ranged in age from 15 to 22 years. The average age of the 35 decedents was 18, however, the majority of the decedents were between the ages of 15 and 18 years (n = 21, or 60%) with 11 (31%) being 18 years of age.
- Of the 25 decedents who were 18 years of age or over, three had completed a high school education and the 12 who were enrolled in school were in grades eight through ten. The decedents who were 15 through 17 years of age were enrolled in the 6th through the 10th grades at the times of their deaths. The majority of the decedents who were of compulsory school age (15 through 18) were between one and five years below grade level.
- Table 4 below illustrates the ward of residence for the decedents and the ward of the fatal incident. The Table supports the fact that the majority of the victims of youth violence and the violent activity associated with these deaths occurred in Wards Five, Seven and Eight. Twenty-five decedents (71%) were residents of these Wards, with the majority being from Ward Seven. Twenty-six (74%) of the fatal incidents occurred in the same Wards with the majority of these violent acts occurring in Ward Eight. Nineteen, or 54%, died in the same Ward where they resided.

Table 4: 2003 Homicides – Wards of Residence and Fatal Incident

District Ward	Decedent's Ward of Residence	Ward of Fatal Incident
Ward One	3	3
Ward Two	1	0
Ward Three	0	0
Ward Four	2	1
Ward Five	4	7
Ward Six	3	2
Ward Seven	11	8
Ward Eight	9	11
Other States	2	3

- Thirty-two of the 35 deaths occurred in the District; and 3 occurred in Maryland. The majority of the District deaths occurred on the streets or in public areas (n = 28, or 80%). Three incidents occurred in decedent's homes, three in vehicles and one in a public bus.

- Twenty-two of the victims of youth violence were known to the child welfare and/or juvenile justice systems. Ten (29%) were known to the child welfare system and were either active at the times of their deaths or had been active within four years of their deaths; and 16 (46%) were known to the juvenile justice system and were either active at the times of their deaths or within two years (four youth were known to both systems - see "Summary of CFRC Subcategories" on page 19).
- The majority of the youth violence decedents were known to the District's public assistance program (30, or 86%). Nineteen youth were receiving services at the time of death. Four of these youth were receiving medical assistance, food stamps and TANF; seven were receiving food stamps and medical assistance; seven were receiving medical assistance only and one was receiving food stamps only.
- Ninety-four percent (n =33) of the fatalities were caused by firearms ("Gunshot Wounds"); two decedents died from stab wounds. In the majority of the firearm deaths (n =17, or 49%), the victims were shot multiple times, with the numbers ranging from 2 to 11.

2003 Youth Homicide

On a winter afternoon in 2003, a crowd of students had gathered shortly after a school activity had ended. Several gunshots were heard and a bullet that was allegedly intended for someone else struck a 17-year old African American male. A police officer heard the shots in the area surrounding the school grounds and proceeded in the direction of the shots. When he arrived on the scene he observed the decedent suffering from a gunshot wound. He called 911 and when medics arrived they found the victim pulse less, with no spontaneous respiration, breathing or heartbeat. His mouth and airway were cleared for food particles as he had vomited while in transport. His pupils were fixed and dilated, there was no motor movement, his abdomen was distended and the record noted that there was no sign of life. He was intubated and chest compressions continued. Despite aggressive life saving effort, it was determined that there were no signs of life. The youth was pronounced dead at 5:10 PM. The investigation revealed that the perpetrator was a 16-year old youth who attended the same school. He surrendered to police shortly after the shooting. He indicated that he was aiming for another individual in a vehicle who had attempted to shoot him the day prior. The shooting was related to rivalry between two groups from the SE neighborhood near the school. The teen perpetrator was tried as a juvenile and found guilty of 2nd degree murder. He testified to the fact that the slaying was the culmination of days of increasingly violent encounters between him and 2 other people from the same neighborhood. The youth had no prior criminal history but had previous gang involvement. The handgun used in this murder had been hidden outside the school while classes were in session.

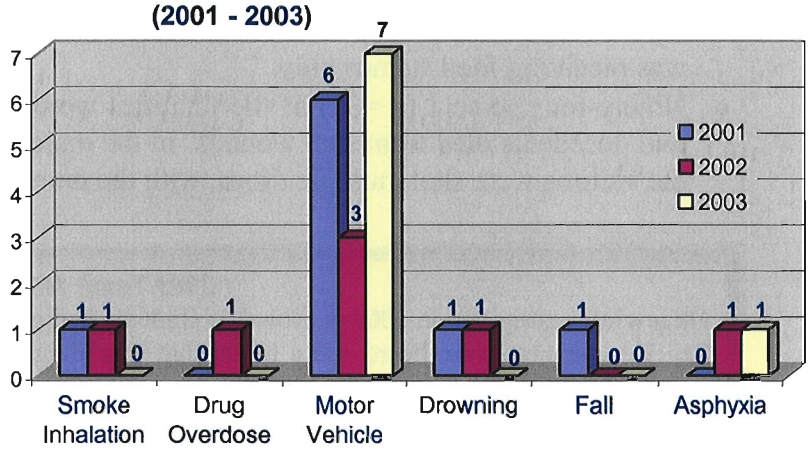
Cause/Manner of Death: Gunshot Wound to Abdomen with perforation of liver and aorta and penetration of spine/Homicide

- The motives for four of the youth violence homicides were unknown; the fatal incident for two of these cases occurred in Maryland and the information was not available. The police investigations for the remaining 31 homicides, where motive was known, indicate that "Argument" (n = 10) was the primary reason for the homicide; in three of these cases drugs were involved and one involved gang activity. Retaliation was the second leading motive (n = 8) and drugs and gang activity were associated with two cases. Six homicides were related to robbery and drugs as the primary motive accounted for four.

- At autopsy, toxicology screens indicated that 14, or 40% of the victims were positive for drugs, with PCP being the primary substance found (n = 10). Other substances included alcohol, marijuana and benzodiazepines.
- Consistent with 2001 and 2002 data, the time of death for the majority of the 2002 youth violence homicides (n = 24, or 69%) occurred between 7:00 PM and 6:00 AM, with half (50%) occurring between 12:00 Midnight and 6:00 AM.

Unintentional Injuries

Figure 10: Accidental Deaths - Comparative Data (2001 - 2003)



For purposes of this report, unintentional injuries are those incidents where the death was not deliberate. This category may include violent or non-violent conditions that were determined by the autopsy to be accidental. There were eight accidental deaths that occurred during calendar year 2003. Figure 10 illustrates the number and types of accidental child/youth deaths involving District residents over a three-year period. As this figure illustrates, the only cause of unintentional deaths from 2003 were motor vehicle accidents and asphyxia.

Based on fatality reviews of these cases, the following findings were highlighted:

- The eight 2003 accidental deaths represent a 14% increase from similar deaths that occurred during 2002 (n = 7) and an 11% decrease from the nine that occurred in 2001.
- The ages of the 2003 decedents ranged from one month to 18 years.
- Consistent with overall 2003 fatality data, the majority of the decedents were Black/African American (n = 7, or 88%). One accidental death involved a White youth.
- Equal numbers of females and males died accidentally during 2003.

Motor Vehicle Accidents

- The major cause of 2003 unintentional injury deaths was motor vehicle accidents. Of the eight accidental deaths, seven, or 88% were caused by motor vehicle incidents.
- Over half (n = 4) of the motor vehicle accidents involved pedestrian fatalities and two involved decedents who were drivers/passengers of the vehicles. One victim (one month old) was born prematurely one day following a motor vehicle accident that involved her mother as the driver. The birth was determined to be induced by the motor vehicle accident and thus the cause/manner of death was associated with the motor vehicle incident.
- The ages of the victims of pedestrian accidents ranged from three through 18, with the average age being 11 years. Of the four pedestrian related accidents, three involved pedestrian violations that included a youth walking in the street because of a snow bank, a youth playing "chicken" (dodging a speeding vehicle) and a three-year old child who broke

away from her mother and ran between parked cars into ongoing traffic. Two included driver violations that involved driving a stolen vehicle at high speed and leaving the scene of an accident. All of the pedestrian accidents occurred during a time when the natural light conditions were dark (after 6:00 PM). The weather conditions were clear on three of the four motor vehicle accidents. There were no incidents where drugs/alcohol were documented as a contributing factor. Three of the pedestrian related accidents occurred in the District and one occurred in Maryland, close to the District boundary.

"Two 2003 Accidental Deaths"

Case 1: A father, his four children and an adult friend were driving, during daylight hours, in a compact car to the grandmother's home for a holiday dinner. The day was dry and overcast and traffic was moderate. The family was driving on a 2-way street with five lanes. They stopped at a traffic light traveling in a northbound intersection waiting for the red signal to change. When the light turned green, they proceeded into the intersection. At the same time the driver of an old model van was traveling in a northwest bound direction towards the same intersection and proceeded through the red light and hit the small passenger vehicle from behind. The 9 year-old, who was one of three rear seat child passengers, was catapulted through the windshield. She was seated and belted, adjacent to the right side door. The child was fatally injured and two of her siblings were significantly injured. The driver of the van was assessed to be at fault; he had run a red light, was driving under the influence of alcohol, was operating an unregistered vehicle, and was driving on an expired license. He was charged with manslaughter. The site of the motor vehicle crash had numerous prior motor vehicle crashes and pedestrian accidents and was under review for traffic studies and recommendations.
Cause/Manner: Blunt Impact Trauma

Case 2: In the early morning of a winter day, a young African American mother found her 4-month old infant unresponsive. 911 was called and a medic team arrived shortly afterwards. CPR was immediately initiated and the child was transported to a local hospital. Upon arrival, the infant was intubated and resuscitation was attempted. However the infant was unable to be revived and was pronounced dead 30 minutes later. The mother reported that the child was fed formula at approximately 5:00 AM and was placed back to sleep on her stomach in the mother's bed. The bed where the infant was co-sleeping with the mother was a mattress with box spring on a frame and headboard. Placed on the mattress was an egg crate mattress cover.
Cause/Manner of Death: Asphyxia Due to Chest Compression/Accident

- One of the two motor vehicle accidents that involved the decedents as drivers/passengers involved an eight-year old female who was a rear passenger of a vehicle that was struck by a motorist who was intoxicated and did not stop at the red signal. The second decedent was an 18-year old male driver, who lost control of his vehicle while returning home from a school activity after 12:00 midnight. Alcohol/drugs was not a factor in this accident. Additionally, in both driver/passenger accidents the decedents were wearing seat belts.

Asphyxia:

- The one accidental death that was attributed to positional asphyxia involved a two-month old infant who was co-sleeping with her mother. She had been fed and placed to sleep on top of a comforter and mattress with an "egg crate" pad. The autopsy findings indicated that the "egg crate" mattress pad was a contributing factor in the infant's death.

SUMMARY OF CFRC SUBCATEGORIES

There are four major CFRC review categories, Infant Mortality, Child Welfare, Juvenile Justice and General Community. These categories dictate the type/level of review (individual, cluster or statistical review). Similar to previous years, many fatalities identified met the criteria for review in two or more categories and may have required more than one review for different purposes. The definitions of these categories are as follows:

- Infant Mortality – Decedents under the age of one year.
- Child Welfare – Decedents whose families were known to the child welfare system within four years prior to the death.
- Juvenile Justice - Decedents who were known to the juvenile justice system within two years prior to the death.
- Community – Decedents one year of age or older who were not known to the child welfare or juvenile justice systems.

Table 5 – Case Type

	2003 #/%
Infant Mortality *	68/51%
Child Welfare *	34/26%
Juvenile Justice *	17/13%
Community	36/27%

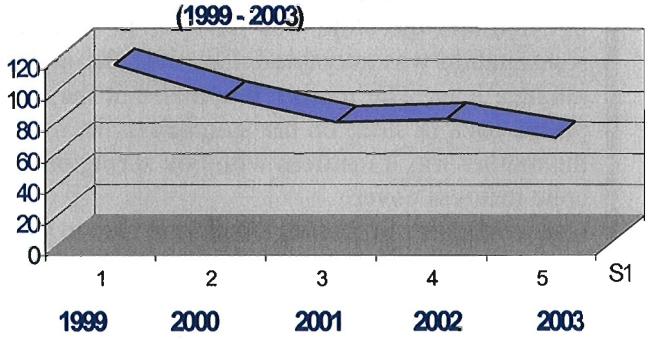
*Numbers and Percentages include duplication in all categories except community

Table 4 above illustrates the total number of deaths for calendar year 2003 for each CFRC category. The following provides a summary of the findings and data elements collected on the CFRC subcategories.

Infant Mortality Data

- **Decedent/Family Demographics**
  - Between 1999 and 2003, the number of infant deaths in the District has been on a steady decline. During this five-year period, infant fatalities decreased by 41%. In 2003, 68 infant deaths were referred to CFRC, which represents 51% of the total child death population for that year. The number of 2003 infant fatalities represents a 15% decline from the number of infant deaths reviewed in 2002 and a 28% reduction from 2001 infant fatalities (n = 80 and 94 respectively).

Figure 11: IMR Fatalities - Comparative Data (1999 - 2003)



  - The ages of the 2003 decedents ranged from birth through nine months. Nearly two thirds (n = 43, or 63%) of the infant population died within the first 28 days of life (neonates) and over half of these infants (n = 29, or 67%) died within the first day of life.
  - Sixty, or 88% of the 2003 infant deaths were Black/African American; five (7%) decedents were Hispanic and two were White. In 2002, 78% of the decedents were Black/African American, while 23% were of other racial backgrounds (Hispanic, White and Asian)

- Males represented over half of the total infant death populations for calendar years 2002 and 2003. In 2003, there were 40 males (59%) and there were 44 (55%) male infant deaths in 2002.

- **District Ward of Decedents**

In calendar year 2003, data indicate that the majority of the infant deaths involved residents of Ward Eight followed by Ward Seven. Half of the infant population were residents of these Wards. Nineteen decedents were from Ward Eight and 15 were residents of Ward Seven. Wards Four and Five rank third and fourth with 10 and nine infant deaths respectively. There were no infant deaths in Ward Three.

- **Gestational Age/Birth Weight**

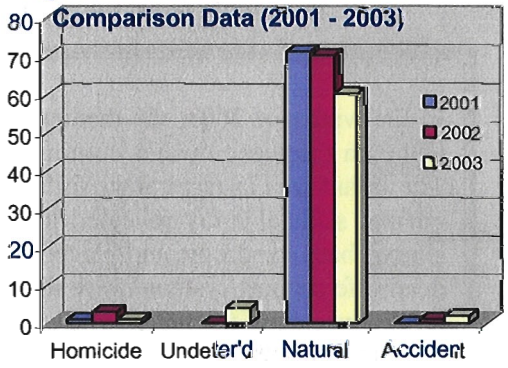
Based on the review of the 2003 birth certificates, 44 (65%) of the infant deaths were born prematurely (under 38 weeks gestation). Eighteen of the preterm births occurred prior to 23 weeks gestation. Of the 44 premature infants, 15, or 34% weighed less than 500 grams and five weighed between 500 and 600 grams. Fourteen, or 21% of 2003 decedents were full term births and had weights that ranged from 1105 to 4366 grams.

- **Manner of Death**

Death certificates were received for 67 of the 2003 infant deaths (99%). As with previous years, the greater majority of the 2003 infants died from natural causes. In 88% (n = 60) of the 2003 infant deaths the manner was determined to be natural. Eight of these deaths were attributed to SIDS and the remaining 52 were associated with prematurity, congenital anomalies and other medical problems.

The second leading manner of 2003 infant deaths was undetermined. The official autopsy report for four infant deaths indicated the manner of death was undetermined. While three of these deaths had causes that were also undetermined, one had a cause of "Sudden Unexpected Infant Death While Co-sleeping with Adult and with Inappropriate Bedding".

Figure 12: Manner of Infant Deaths - Comparison Data (2001 - 2003)



Two infants died of accidental deaths. One was born prematurely as a result of his/her mother being involved in a motor vehicle accident and one suffocated as a result of being wedged between a bunk bed and the wall. One death of an infant was associated with fatal abuse. This child was a five-month old Black/African American female. One child died of a homicide and the injuries were associated with fatal abuse. The manner of death for one infant, who died in the state of Pennsylvania, is unknown

- ***Family Demographic Data***
  - ***Mother's Data***
    - Age was known for 65 of the 68 mothers of the 2003 infant deaths. The ages of the mothers at the time of the death ranged from 16 to 42 years, with an average age of 26.
    - The majority of the mothers for calendar year 2003 infant deaths (n = 53, or 78%) had never married. Thirteen mothers were married and at the time of death one reported being separated.
    - Education level was known for 50 of the 68 mothers of infant decedents from 2003. Thirty-three mothers (66%) had at least a high school education and 11 of these women had either completed college or had some undergraduate level education. Seventeen mothers had less than a high school education, with educational levels ranging from 6^{th} to 11^{th} grades.
    - In 2003, eight mothers had documented histories of mental health problems and 22 had diagnosed physical health problems. Some of the health problems included asthma, allergies, diabetes, cancer, obesity, hepatitis, lupus, fibroids, hypertension, stroke, tuberculosis and back injury. Fourteen mothers had histories of sexually transmitted diseases and two of these women were HIV positive.
    - Fifteen 2003 mothers had documented histories of substance abuse/use and 7 had positive toxicology screens at the time of birth of their child.
    - Of the 50 mothers of 2003 decedents where employment history was known, 32 (64%) were unemployed at the time of the infant death.

  - ***Sibling Data***

    The majority of decedents in 2003 had siblings. Of the 44 (65%) families known to have other children, the average number of siblings was two. Six of the 2003 decedents were twins and in one family both twins died.

"2003 Fatal Abuse Infant Death"

In the winter of 2003, the medics responded to a call in Ward 7 for a 6-month old unconscious infant. Once on the scene medics continued life saving measures and the child was transported to the hospital. The infant was in respiratory failure and a coma upon arrival at the hospital. CT scan revealed cerebral edema; skeletal x-ray revealed a skull fracture and an old left tibia fracture. He was diagnosed with shaken baby syndrome and placed on life support. Several days later the child was determined to be brain dead, life support systems were discontinued and he expired. The investigation revealed that he had been left in the care of the father who eventually admitted to shaking and abusing the child.

Cause/Manner: Blunt head trauma/Homicide

"2003 Accidental Infant Death"

A 1-month old infant was born to a 27-year old mother who was involved in a motor vehicle accident 2 days prior to her child's birth. The infant was born at 23 weeks gestation with birth weight of 480 grams. She was transported to NICU and treated for multiple medical problems associated with extreme prematurity. Despite aggressive medical intervention, she continued to deteriorate; a decision was made to discontinue treatment and she expired one month after birth.

Cause/Manner of Death: Extreme prematurity and complications due to placental abruption due to blunt impact trauma/Accident

Juvenile Justice Fatality Data

Sixteen (12%) of the 133 fatalities from 2003 were youth known to the juvenile justice system. Reviews of these cases revealed the following findings:

- ***Age of Decedent***
  The average age of the 2003 decedents was 18 years. The youngest decedent involved with the juvenile justice system was 15 and the oldest was 21 years of age.

- ***Gender/Race of Decedent***
  One hundred percent of the 2003 juvenile justice decedents were Black/African American males.

- ***Substance Abuse***
  As with previous years, substance abuse continued to be a major concern in the majority of the 2003 juvenile justice fatalities. Fifty-six percent of the decedents (n = 9) had known histories of substance use or involvement. In all of the reviews where substance abuse was a problem, the issue of inadequate drug treatment for juveniles was consistently highlighted as a continuing problem.

- ***Educational Level of Decedent***
  - Two juvenile justice decedents from the 2003 calendar year had completed high school. The remaining 14 decedents' grades ranged from 6^{th} to 9^{th}.
  - Three of the 2003 decedents were in special education programs.
  - The majority of the youth who had not completed high school was exhibiting truant behavior (n = 5) or had withdrawn from District public schools for various reasons (n = 7) at the times of their deaths.

- ***Ward of Decedents Residence***
  The majority of the 2003 juvenile justice deaths involved residents of Ward Seven (n = 6). Wards Eight, Five and Six had equal number of fatalities (n = 2 in each Ward); and Wards One and Four had one youth death each. Two decedents were residents of Maryland, but committed to the District's juvenile justice system.

- ***Manner/Cause of Death***
  Ninety-four percent (n = 15) of the 2003 juvenile justice decedents died from homicides. The causes of these deaths were "Gunshot Wounds". One youth died from a motor vehicle accident.

- ***Juvenile/Court History***
  - *Number of Arrests*
    The majority of the juvenile justice decedents had numerous charges/arrests. Of the 17 decedents from the 2003 calendar year, 13 (81%) had multiple arrests. The types of charges included gun/ammunition possession, drug possession, assault/threat to do bodily harm, sexual abuse, unauthorized use of a vehicle, and destruction of property.

- *Status of Case At Time of Death*
  Fifty percent (n = 8) of the juvenile justice decedents involved youth who had active cases at the time of the deaths. Four of the youth were committed to the District, three were on probation and one was on a detained status. In three of the active cases, the youth were in abscondence from the juvenile system at the time of the death. The cases of the remaining eight juvenile justice decedents had closed within two years of the deaths.

"Two 2003 Juvenile Homicides"

Case 1: On a cold winter night an 18 year-old African American male was walking along an urban street approaching his guardian's home. As he was standing on the sidewalk in front of their home he became one of the last victims of homicide for the 2003 calendar year. His guardian heard gunfire and found him lying on his stomach in the street, bleeding profusely from gunshot wounds. He attempted to get up and run, however fell to the ground again, unable to move. 911 was called and an emergency medical services unit responded and began lifesaving measures. He was immediately transported to a local hospital where resuscitation efforts continued. Despite these efforts, this youth succumbed to his injuries less than two hours later at a nearby emergency room. It was reported that the decedent was an innocent bystander in a bizarre shooting. After a brief exchange of gunfire with a policeman, the perpetrator surrendered to the officer a few blocks away, and was arrested on and plead to a second degree murder charge. Persons close to the perpetrator reported to non-police sources that the decedent's killing was a revenge killing for a previous youth homicide victim.

The decedent's father was incarcerated and his mother had died following an extensive substance abuse history. He had been depressed following the death of his grandmother, with whom he had a close relationship, and remained frustrated by his father's history of addiction and incarceration; though he too had fallen victim to regular drug use. His kinship care guardians struggled to provide him appropriate care, supervision and discipline. The decedent had been truant and failing school for many years and though involved in the juvenile system, he never returned to regular attendance or academic success – appearing to be living largely on the streets. He remained on the periphery of life, receiving no rehabilitation, mental health or intensive school services and was never successfully engaged. At the time of his death, he was committed to the District's juvenile justice system based on a theft plea and after failing to complete a prior period of probation. During the period of commitment he had also picked up an adult charge.
Cause/Manner of Death: Gunshot wound to the left shoulder/Homicide

Case 2: A 19-year old African American male was shot in the summer of 2003 and was transported to a local hospital by a juvenile relative in a private vehicle. Shortly after arrival and after extensive life saving efforts, the youth died from his injuries. Autopsy revealed that the bullet perforated his lung and spinal cord. Toxicology screen indicated that the decedent was positive for illicit drugs. Based on the police investigation, the perpetrator was in his early 20's and was also African American. He had a prior history of involvement in drugs and gang activity. The motive for the shooting was gang revenge. The perpetrator was arrested and charged with Murder 1 and the case was referred for prosecution. The decedent had been known to the juvenile justice system since 2001 because of numerous drug and firearm charges. In late 2001 he was found guilty of "possession with intent to distribute cocaine" and was committed to the District. The decedent had a history of substance abuse, depression and a learning disability. While committed he did well in several group home/facilities and displayed a positive attitude. He was released in the spring of 2003.
Cause/Manner of Death: Gunshot wound of left upper arm/Homicide

Child Welfare Fatality Data

Child welfare deaths include those decedents whose families were known to the protective services, foster care and adoption programs. Although the initial entry point for these services is through the public child welfare agency, a range of services is available through public and/or private service providers. During 2003, 34, or 26% of the 133 deaths identified were children who met the definition for review as a child welfare fatality. The following is data abstracted from child welfare fatalities reviewed:

Age of Decedent

The age of the decedents ranged from birth through 25 years of age, with an average age of 10 years. Consistent with the overall 2003 child/youth death population, the majority of the children were infants (n = 15) or older than 14 years of age (n = 13). Combined, these categories represented 82% (n = 28) of the total child welfare fatalities.

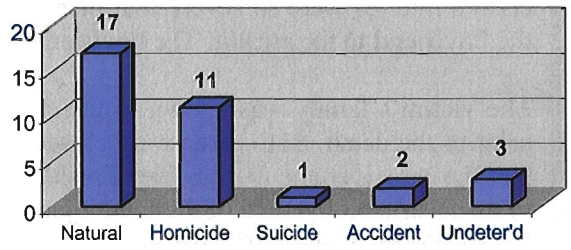
Race and Sex of Decedents

- Ninety-one percent (n = 31) of the 2003 child welfare deaths represented children/youth of African American descent. The remaining children/youth included two Hispanics and one White.
- Males again represented the majority of the child welfare child fatality population. Sixty-five percent (n = 22) of the decedents were male children/youth.

Cause/Manner of Death

- The manner of death for 50% (n = 17) of the 34 child welfare decedents was natural. Five of these deaths were caused by SIDS and 12 were caused by medical problems. Five of the 12 medical related deaths were associated with prematurity, low birth weight and congenital anomalies. Four were associated with infections and three of these decedents had been diagnosed with HIV/AIDS.

Figure 13: Manner of 2003 Deaths Child Welfare Fatalities



- Twelve child welfare decedents were victims of violence. Eleven of these deaths were homicides and 10 involved older youth who died from trauma associated with violence (gangs, drugs and criminal behavior). The 10 youth violence related child welfare deaths represent 26% of the total deaths in this category for the 2003 calendar year (n = 38 total youth violence homicides). One child welfare homicide involved a two-year old female victim of fatal abuse, which represents a third of the total fatal abuse homicides for the year. The final violent death involved an 11-year old Black/African American male who committed suicide.

"A 2003 Child Welfare Fatal Abuse Death"

In the summer of 2003, at approximately 6:46 PM, Maryland police officers responded to a call to assist the fire department with a 2-year old African American female who was not breathing. While in route to the scene, officers were advised that someone had broken into the apartment and the child was found lying on the floor. Upon arrival, the victim was being placed into the ambulance by EMS. Officers interviewed the victim's mother, the female childcare provider and her live-in boyfriend. Interviews revealed that the mother had known CP, the childcare provider. for several years and that she had periodically served as her child's day care provider. Several days prior to the fatal incident, the mother made arrangements for her child to spend the weekend with CP to allow her to start a new job, which began very early in the morning and to also work her second job on the weekend. It was reported that on the day of the fatal event, the mother called the home and spoke to CP and her daughter. She also stopped by the home to bring additional food and clothing. While in the home she did not see her daughter but talked briefly with the caregiver. CP reported that later that day she left the child in the care of her boyfriend while she visited a friend. When she returned at approximately 6:00 PM, she found the child unresponsive and called 911. The boyfriend reported that while the child was in his care, he took out the trash and left the door unlocked with the child inside watching television. When he returned to the apartment, he heard an intruder in the bedroom. Allegedly a brief struggle ensued between the boyfriend and the intruder and afterwards the intruder fled the apartment. The boyfriend indicated that at that point he noticed that the child was unconscious. Neighbors reported to police that they heard a loud "thump" between 3:00 and 4:00 PM. The police report noted that there was a large indentation in the wall in the living room, however, there was no sign of forced entry or a struggle having occurred in the apartment. The autopsy indicated that the decedent was a well-developed, well-nourished, 2 year old African American female child. There were multiple injuries to the head, torso, genitalia and anus, as well as the upper and lower extremities. Other reports also indicated that the child's injuries were so severe that there was hair imbedded in the wall and pubic hair that connected the boyfriend to the assault. The boyfriend was arrested for murder and sexual assault.

The victim's family was known to the child protective services systems in MD and DC several years prior to the death. Both cases were closed at the time of death. Additionally, although, reports indicate that the caregiver and her boyfriend resided in Maryland, they were receiving public assistance services in the District at the time of the fatal injury using a Ward Eight address.

Cause/Manner of Death: Blunt impact of head and torso w/subdural and subarachnoid hemorrhages, cerebral edema, hepatic lacerations w/ hemopertoneum/ Homicide.

- The manner of death for two child welfare fatalities was accident. One death resulted from a motor vehicle accident (15-year old male) and one was caused by asphyxia (three-month old female). Caregiver negligence was determined to be a contributing factor in one of the accidental deaths and victim/driver negligence in the other.
- The manners of three child welfare deaths were undetermined. In two cases, both the cause and manner were undetermined and in one case the cause was determined to be "Sudden Unexplained Infant Death", with co-sleeping and inappropriate bedding as documented contributing factors.

Health/Mental Health of Decedents

- Ten 2003 decedents (29%) had diagnosed chronic health problems/congenital anomalies. Some of the health problems included Asthma, Sickle Cell, heart and respiratory disorders, cerebral palsy, brain tumor, allergies and HIV. Two children were mentally retarded.
- Two of the 2003 decedents had diagnosed mental health problems.
- Half of the 12 child welfare youth from 2003, who were 18 years of age or older, were substance abusers (n = 6).

Educational Level of Decedents

- Over half (n = 18, or 53%) of the 2003 decedents were school age. Seventy-two percent of these children/youth were over 14 years of age (n = 13) and 12 were over 18 years of age. The educational levels (last grade completed) for the 14 children/youth over the age of 14 ranged from 7th through the 12th grades. However, at the time of their deaths, only two had graduated from high school. Eight youth were functioning at least one grade below grade level.
- Seven 2003 school age decedents were enrolled in special educational or alternative programs.

Number and Reasons for Child Protection Services Referral

- The majority of the 2003 families referred to the child welfare system were reported multiple times (n = 18, or 53%). The number of reports ranged from one to 10, with an average of three reports per family.
- In over half of the child welfare fatalities, the decedents were part of the cases (n = 21, or 62%). In the majority of the fatalities where the decedent was not part of the child welfare record, the most common reason for decedents not being involved was that they were born after the case closed (n = 10).
- Based on the last child abuse/neglect reports received, the primary reason for families being referred was "general neglect". Twenty-two (65%) families were reported for general neglect issues. Physical abuse ranked second to neglect reports for both years.
- Based on the outcome of the intake investigations, allegations of at least one of the reports of suspected abuse and/or neglect were supported and the case was opened by intake in over 90% of the cases (n = 32).

Case Status

- At the time of death, 16, or 47% of the 2003 child welfare fatalities were families with active cases. The remaining cases had closed within four years prior to the death, with 10 closures occurring within one year prior to the death.
- Some of the reasons for case closure included decedent aged out, adoption finalized, parental care improved, or the last report was unsupported.

Family Characteristics

- The average age of the mothers known to the child welfare program where age was known (n = 29) was 34 years.
- Four of the 34 mothers known to the child welfare program were deceased. Out of the remaining 30 mothers, most were single and had never been married (n = 26) and 5 of the

seven mothers who were married were married to the decedents' fathers. Sixteen of the 30 mothers were unemployed at the time of the death.

- Maternal substance abuse was a documented factor for 17 of the 34 fatalities (50%).
- Four mothers had prior involvement with the criminal justice system.
- Eight of the 2003 child welfare fatalities documented chronic mental health problems of the mother as a problem.
- The majority of the decedents had surviving siblings (n = 29, or 85%). The number of siblings ranged from one to eight. Four of the decedents were twins and both twins of one family were 2003 fatalities.

"A 2003 Child Welfare Accidental Death"

In the fall of 2003, at approximately 9:00 PM, a 15-year old youth was on foot in a northeast neighborhood of the city when he was struck with by a vehicle. The impact caused the victim to mount the hood of the vehicle where his head made contact with the windshield. His body rolled off the hood and onto the roadway where he came to a final rest approximately 10 feet from the point of impact. The victim was treated on the scene and flown by helicopter to a local hospital in critical condition with an open head wound. Despite aggressive life saving efforts this youth died 3 hours later. The scene was described as a 1 lane asphalt covered, unmarked roadway for north and southbound vehicular traffic. The overhead street lighting was on and operational. The roadway surface was dry with no debris, obstructions or road work in progress. The investigation revealed that the driver of the striking vehicle was a teen who was operating a stolen vehicle without a drivers permit. She was a friend of the victim and resided in the same housing complex and neighborhood as the decedent and where the accident occurred. The housing complex was known for youth joyriding in stolen vehicles. There were numerous bystanders/witnesses to the fatal incident, however, descriptions of the incident varied. Some indicated that the accident was intentional and some indicated that the teen driver and victim were engaging a game of "chicken" (dodge the vehicle). The teen driver reported to police that she expected the victim to jump out of the way of the moving vehicle as he had done several times immediately prior to striking him. The decedent was known to the child welfare and juvenile justice systems. His charges included unauthorized use of a vehicle. The driver was also known to the juvenile justice system.

Cause/Manner of Death: Blunt impact of head trauma with brain contusions/Accident

Appendices

APPENDIX A

2003 CFRC RECOMMENDATIONS

RECOMMENDATIONS	STATUS
Policy and Practice Standards	
American College of Obstetricians and Gynecologist (ACOG), in conjunction with District hospital and the Department of Health (DOH), should include obesity as a high risk factor and develop strategies to provide better care to these patients.	In process
Department of Human Services/Youth Services Administration (YSA), Child and Family Services Agency (CFSA) and DC Public Schools (DCPS) should establish a policy that requires age appropriate youth with a diagnosis of a mental health or other disability to be referred to Rehabilitation Services Administration (RSA) for eligibility determination and linkage/provision of a range of services.	In process
CFSA should develop clinical criteria for determining when an abusive parent should be referred for a psychiatric/psychological evaluation prior to children being returned home.	In process
CFSA should screen all cases for open civil protection orders involving parent, caretaker and guardian as part of the intake/investigation process and provide closer monitoring services.	Ongoing
District of Columbia Superior Court/Court Social Services Division (CSSD) should ensure that youth who come before the courts for juvenile offenses are referred for appropriate assessments and assistance prior to cases being dismissed.	No Response
DCPS and YSA should ensure that youth are released from Oak Hill with an enforceable transition educational plan that is age and level appropriate.	Complete
CFSA and Office of Attorney General (OAG) should develop guidelines and/or clarify existing laws to assist medical professionals in determining reportable medical neglect cases.	Ongoing
Department of Mental Health (DMH) and DCPS should continue to expand services to ensure that all District schools and parents have access to school-based and/or community-based mental health services to ensure that children/youth's mental health needs are being immediately and appropriately addressed. Parents and students should be made aware of the availability of such resources.	Ongoing
YSA and CSSD should establish a system to identify recidivists and develop appropriate intervention programs to reduce the number of re-arrests while cases are active with the juvenile justice system.	Response Pending
CFSA should re-examine its practices to allow limited written or oral disclosure of case information on active cases to hospital medical/social work staff for the purpose of ensuring the safety of high risk/medically fragile infants/children as part of discharge planning.	Complete-Ongoing
District government agencies with commitment responsibility (**CFSA and YSA**) should ensure that recommendations contained in children's/youth's psychological/psychiatric evaluations are incorporated into individual service/treatment plans.	Ongoing
When women at risk of pre-term labor are discharged from emergency room visits with pregnancy complications, **District hospitals** should establish a practice of making referrals for appropriate community-based medical and social services assistance/support.	Practice currently established; DOH assisting with

	strengthening
Existing Service Improvements and Expansions	
Greater Southeast Community Hospital (GSECH) in collaboration with DOH should address the following quality of care issues to ensure optimum newborn and obstetrical care: o Develop/implement standards for providing social service intervention prior to a mother's discharge. At a minimum psychosocial, safety assessments and discharge planning should be provided to all teens, at-risk mothers and infants discharged from the neonatal nursery. Assessment and planning should include parent education and newborn health care. o Revisit or address standards/process for referring appropriate families to the existing nurse home visitation program. o Review current practice and ensure compliance with standards for providing Prophylaxis for high-risk newborns.	In process
DOH/Maternal and Family Health Administration (MFHA) should examine the current referral process/practices for the existing home visitation program and develop/ initiate strategies to enhance utilization, especially for high-risk mothers and/or infants.	Ongoing
DOH/Medical Assistance Administration (MAA) should examine established monitoring practices for Managed Care Organizations and determine whether current resources are sufficient to adequately monitor full compliance with contracts and to establish appropriate plans for corrective action.	Ongoing
CFSA should provide parenting skills training to all teen mothers of active cases, including developmental milestones and the correlation of these milestones with practical parenting applications; appropriate sleeping arrangements; safety when co-sleeping, child supervision, and ways to minimize child risk.	In process
DMH and DOH in collaboration with hospitals and local medical associations should develop models for post-partum depression screening and determine the criteria for routine use.	Ongoing
DMH and DOH should collaborate with the Obstetricians to increase awareness of the need for evaluation and various treatment modalities for postpartum depression and psychosis.	In process
DCPS should assess the problem associated with youth of compulsory school age dropping out of school and develop/expand educational alternatives when regular school is not possible or appropriate.	Ongoing
CFSA should routinely refer mothers known to their programs who are pregnant or have infants under the age of one year to the Healthy Start and/or Home Visitation Programs for support and assistance.	Ongoing
Department of Fire and Emergency Medical Services should improve the current system of monitoring the time it takes to arrive on the scene after 911 calls and evaluate the apparent flaws with the Computer Assisted Dispatch (CAD) System.	Complete
DCPS and Office of State Education in collaboration with DMH and DOH should draft citywide protocols and training for emergency response to child/youth suicides to be widely distributed and utilized in District public and chartered schools and other District government agencies. Protocols should include, at a minimum, the following: o Broad use of a risk assessment instrument to identify trends in youth behavior and serious mental health high risk indicators, o Appropriate and timely response and follow-up for children with severe depression and/or suicidal threats, attempts, o Identification of a central referral system for treatment resources and appropriate interventions/services for attempted suicides (pre) and successful suicides (post), and	Ongoing

○ Suicide prevention and pre and post intervention training program to be used in all schools that targets teachers and other appropriate faculty, parents and students to improve the method of responding to children/youth who present with suicidal ideation/behavior or other emergency psychiatric situations.	
DCPS should consider expanding school curriculum to include abstinence, delayed reproduction and parenting skills training for incorporation into the high school/GED competency assessment for graduation.	Completed
Training and Public Education	
DOH should educate the general community with a particular focus on minority, low income communities, on the importance of the following health concerns: ○ Family planning and preconception health, nutrition and counseling (including folic acid supplements) as a means of reducing birth detects. ○ Prenatal care and nutritional counseling ○ Pregnant HIV infected woman and appropriate medication/treatment options during pregnancy to decrease the transmission of HIV to her infant. ○ Understanding maternal hypertension, possible contribution to morbidity and appropriate treatment and control.	Ongoing
DOH should sponsor a health symposium for practitioners to specifically focus on education related to repeated issues highlighted in IMR fatality reviews and relevant recommendations. Topics should include at a minimum: identification and counseling related to preterm labor and best practices related to treatment modalities for the management of newborns with history of severe respiratory distress.	Ongoing
CFSA, in collaboration with the DC Children's Trust, should take the lead in conducting a city-wide public education campaign related to the importance of providing appropriate supervision and knowing/monitoring children's/youth's activities, friendships, etc.	Ongoing
CFSA and the OAG, in collaboration with other appropriate agencies should educate mandatory reporters (hospital staff, obstetricians, pediatricians, etc.) about the new law and reporting requirements for drug-exposed infants and infants born to mothers who test positive for illegal drugs.	Ongoing
DMH should develop and implement an aggressive public education campaign to expand community awareness of the increase in youth suicides, suicide indicators and how to seek help.	Ongoing
Child/Youth Death Investigations	
Metropolitan Police Department (MPD), Special Victims Unit (SVU) should investigate suicide deaths of all children under the age of 18 years to ensure consistency in investigative practices, including obtaining baseline information during initial interviews at the scene of the fatal injury; providing timely follow-up on all fatalities and referring these cases to CFSA where a child dies in the home and there is a surviving minor sibling(s).	Plans to implement
MPD, SVU should investigate all domestic-related, homicides when the victim is under the age of 18 years.	Plans to implement
Legislative and Regulatory Improvements	
CFSA should evaluate the legal obstacles related to placing and serving uncommitted children of committed teen mothers and the implications for appropriate practice/service provisions, as well as the responsibilities and liabilities of the placement agency/facilities.	Ongoing

CFSA should consult on an interagency level with DCPS, MPD, DMH, DHS and OAG on the age that a child/youth may be left alone and for what period of time and forward to the Mayor for appropriate legislative initiatives for consideration by the District of Columbia Council.	In process
Contractual Service Improvements/Expansions	
CFSA should ensure that contractual agreements for teen mother group home facilities include provisions that require, at a minimum, full compliance with youth residential facilities regulations and internal CFSA policies in the following areas: o Adequate staff/resident (including teens children) ratios and supervision that appropriately considers children of teen parents who reside in the facility; o Appropriate and individualized service planning, provision and monitoring for teens and their children; and o Mandatory staff/volunteer pre-service training to include first aid/CPR.	In process
CFSA should establish stricter guidelines and monitoring practices for community residential facilities for teen mothers and children related to safety, supervision and social work practice, including the following: o Developing a method of conducting age-appropriate infant/child safety assessments including a plan to resolve problems identified prior to placement (i.e., appropriate sleeping arrangements, placement of bed and other furniture, etc). o Developing and implementing corrective action plans for deficiencies identified through routine monitoring of foster care facilities. o Establishing a policy and contract requirements that mandate that teen mother facilities ensure that infants are always placed in their cribs when unattended and on their backs to sleep; and that infants/children are never left alone or without appropriate supervision. o Requiring a minimum number of room checks by staff per shift to ensure oversight and protection of children under the age of five years who are placed in their facilities. Documentation of room checks should be maintained in the facility log. o Requiring that all staff and volunteers have adequate pre-service and ongoing education/training on the care and protection of infants, including appropriate sleeping positions/environments. o Requiring the provision of services, activities, etc. that are specifically focused on assisting teens in achieving independence and self-sufficiency. o Requiring specialized training for social workers responsible for serving committed teen mothers and their children, including planning and realistic goal setting for self-sufficiency, monitoring parenting abilities and knowledge of child developmental milestones. o Establishing a mechanism to ensure comprehensive medical case management for committed teen mothers and their children, who may or may not be committed. Coordination efforts should include appropriate medical and other professionals, internal and external to the agency.	In process
Resource Development	
Deputy Mayor for Children, Youth, Families and Elderly, in collaboration with the DCPS Superintendent and DMH Director should consider expanding funding to support an increased number of schools that have mental health teams.	In process

APPENDIX B

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:

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

(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 (Emolled 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 child 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".

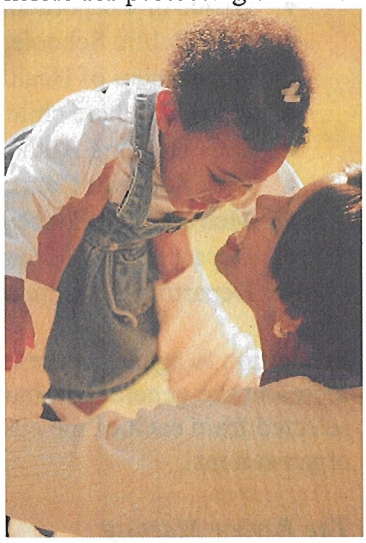
Sec. 4621. Fiscal impact statement.

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

CFRC Goals, Objectives and Operating Process

The District of Columbia Child Fatality Review Committee was established in 1992, by Mayor's Order 92-121, with a mission of reducing the number of children who die from preventable causes. The objectives of the Committee are as follows:

- To identify trends and patterns related to child deaths through collecting, reviewing and analyzing standardized data, and to use such information to improve understanding of the causes and factors that may contribute to child fatalities.
- To work to ensure that all systems, both public and private, which are responsible for protecting children are effective, efficient and accountable.
- To improve and optimize systemic responses to child abuse and neglect by evaluating existing statutes, policies and procedures.
- To recommend appropriate modifications to existing systems, and develop new mechanisms to reduce the incidence of unexpected and preventable child fatalities.
- To encourage inter and intra-agency and interdisciplinary education, communication, coordination and collaboration in the prevention of child fatalities.



In May of 1998, the Mayor's Order governing the Committee was revised for the purpose of establishing a more effective and meaningful review process with responsibility for evaluating the deaths of all city children and youth. In doing so, Mayor's Order 98-67 modified several critical components of the original Order. Two significant changes included expanding Committee membership and the case review criteria. These changes were further supported by the enactment of enabling legislation in 2001 (DC Act 14-028, Child Fatality Review Committee Establishment Act of 2001).

Committee membership is multidisciplinary, representing public and private child service agencies, programs and institutions. Membership is also unique in that it includes, by law, a community member for each of the eight District Wards. The case review criteria includes the following fatalities:

- All children/youth from the age of birth through 18 years who were determined to be District residents or who resided in other jurisdictions but were committed to the care and custody of the District at the time of their deaths.
- All children/youth whose families were known to the District's child welfare system (subjects of abuse and neglect reports) within four years prior to their deaths.
- All children youth known to the District's juvenile justice or mental retardation/ developmental disabilities system within two years prior to their deaths.

Many fatalities by law require an in-depth multi-agency/multidisciplinary review. However, the Committee has the discretion of deciding the scope of review for other categories of deaths. The three types of review processes that are currently available to the Committee are as follows:

- ***Multi-agency Review*** – In-depth reviews utilizing a multi-agency, multi-disciplinary approach to evaluating causative factors and appropriateness of interventions.
- ***Cluster Review Team*** – An examination of groups of fatalities based on similar trends, characteristics, causes/manner of death, or contributing factors, such as parental/child behavior patterns, environmental conditions, etc. These reviews may involve children of any age and are directed toward obtaining general information that is consistent throughout the cluster grouping, that may highlight prevailing community

problems or contributing risk factors. Cluster reviews are ***not*** designed to examine factors unique to any individual decedent and family.

- ***Statistical Review*** – cases in which only data is abstracted from documents routinely obtained on decedents, i.e., death certificates, death reports, school records and/or public assistance records, etc.

Review Participants

The number of participants invited to a review meeting depends greatly on the type of review being planned. Multi-agency reviews require a more diverse group of reviewers. These reviews include, at a minimum, a representative from the following member agencies:

- Office of the Chief Medical Examiner,
- Child and Family Services Agency,
- Department of Human Services,
- Office of Corporation Counsel,
- D.C. Public Schools,
- Department of Health,
- Hospital where child was born and died,
- D.C. Housing Authority,
- D.C. Superior Court,
- Metropolitan Police Department,
- Department of Mental Health, and
- Department of Fire and Emergency Medical Services.

In addition to agency representatives a minimum of two independent reviewers are invited. These individuals represent the general community and have no relationship to the decedent/family. Community members are selected from each of the eight wards of the District, the two local schools of social work and local advocacy organizations.

The Review Meeting

All fatality review meetings are confidential. The meeting begins by providing participants with a copy of a summary of all the information gathered on each case. This includes information on the decedent and his/her family's characteristics, their social and medical histories; description of agency/program involvement; and circumstances surrounding the death.

Based on written and verbal information presented during a review meeting, team members seek to clarify specific issues related to the services and interventions provided to the child and/or family and attempt to answer the following questions:

- Was the investigation/autopsy complete and are there areas of concern that should be considered?
- Were there social, medical, community, systemic or legal factors that contributed to the child's death or compromised the child's quality of life?
- Were there parental or familial behavior factors that contributed to the child's death?
- Were services and interventions appropriate for the needs of the child/family and provided in accordance with established statutes and policies?
- Were staff who were involved with the family prepared to provide protective or other required services?
- Are statutes and policies adequate?
- Was there adequate communication among the various entities/service providers who were involved with the family.

Subsequent to the review meeting, recommendations are developed to address the issues highlighted. These recommendations are shared with Committee member agencies for review and comment. Based on comments received, the recommendations are finalized and adopted by the Recommendations Subcommittee and transmitted to the agencies for implementation consideration.

APPENDIX D

2002 UPDATE OF CASE REVIEW FINDINGS

The following data represents an update of the case review findings for calendar year 2002. This update is based on cases that came to the attention of CFRC after October 2003.

Between October 1, 2003 and December 31, 2003, nine additional child deaths were identified for calendar year 2002, bringing the total number of deaths for that year to 139. The number of 2002 child/youth deaths continues to represent a decline in the overall number of child/youth deaths referred to the Committee.

Decedent Demographics

Age of Decedents

- The ages of the 139 decedents ranged from birth through 22 years. The overall average age of all decedents was six years and the most frequent age was under 1 day (n = 32, 23%).
- As with previous years, the two largest categories of child deaths reviewed from 2002 included infants (under the age of one year) and youth over the age of 14.
- The combined total of infants and youth over 14 years of age was 121, representing 87% of the total population.
- Of the 139 CFRC fatalities, 80 (58%) were infants. This population included 57 neonates (birth through 27 days) and 23 post-neonates (28 days up to one year). Thirty-two of the neonate fatalities died during their first day of life.
- Forty-one, or 29% of the 2002 fatalities identified, were youth 15 through 22 years. The average and most frequent age of decedents in this age grouping was 18 years.
- Eighteen decedents were between the ages of one and 14 years.

Race and Gender of Decedents

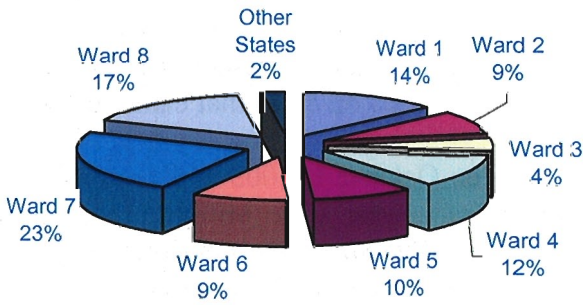
- Data from 2002 revealed a slight difference in the racial composition of the decedent population. Although Blacks continued to represent the majority of the child death population, the number of deaths and percentage of the total was lower than any other year in the CFRC history. One hundred and sixteen, or 83% of the 139 decedents identified were Black. Hispanics continued to rank second, but with a slight increase from 10 deaths in 2001 to 12 in 2002. A significant finding from 2002 data is the increase in the White child death population. This category of children increased by 100% from five deaths in 2000 and 2001 calendar years to 10 in 2002, representing 7% of the child death population. The number of Asian deaths for 2002 was one.
- Males dominated the 2002 child/youth fatalities. Sixty-three percent (n = 87) of the decedents were males.

District Ward of Decedents

- As illustrated in Figures 2 below, the majority of the 2002 deaths involved children/youth who were residents of Wards One, Seven and Eight with the leading Ward being Seven. A review of data indicates that 32 (23%) residents of Ward Seven died during the 2002 calendar year, followed by 23 (17%) from Ward Eight and 19 from Ward One (14%).

- Consistent with all previous CFRC calendar years, Ward Three continued to have the lowest number of child deaths.
- Three deaths of District residents occurred in other states (Maryland, Virginia and New Jersey). These decedents were known to either the juvenile justice or child welfare programs and, as such, met the fatality definition for review.

Figure 2. Wards of Decedents' Residences

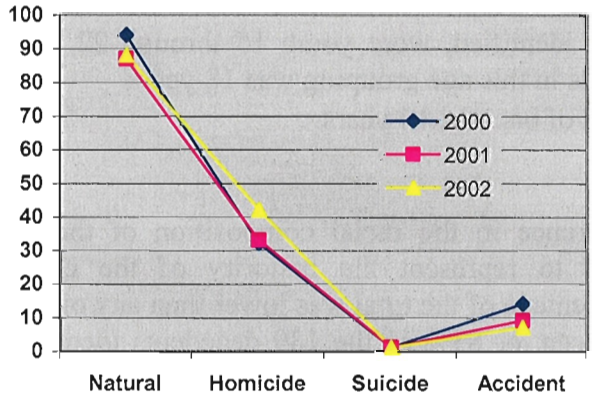


Manner/Cause of 2002 Fatalities

CFRC received final death certificates and/or autopsies for 100% of the 2002 fatalities. Based on a review of these documents, the manners of deaths were determined to be as follows:

- Natural deaths continued to be the leading manner of death for District children/youth. Eighty-eight (88), or 63% of the 2002 deaths were attributed to natural. This represents a slight increase in the number of natural deaths from calendar year 2001 (n = 87). The majority of the natural deaths involved infants (n = 75). Eight of the natural deaths were determined to be SIDS and the remaining deaths were directly associated with prematurity, low birth weight, congenital anomalies and previously diagnosed medical problems.

Figure 2. Manner of Death



- Homicides remained the second leading cause of death for 2002 fatalities. Forty (42) or 30% of the 139 deaths involved children/youth who died violently. Of the 42 homicides, seven children died from injuries associated with fatal abuse and neglect and 33 were associated with youth violence. The ages of these children/youth ranged from one month to 22 years, with the youngest children dying from fatal abuse/neglect and the older population being victims of youth violence. The fatal abuse victims ranged in age from one month to four year, with average being one year 6 months. The majority of the youth violence victims were 15 years of age or older (n = 31, or 77%), with the average age beings 18 years. Additionally, during 2002, two children (ages one and nine years) died from homicides that were not attributed to fatal abuse or youth violence.
- The third leading cause of death was accidents with seven children in this category. The ages of these decedents ranged from five to 20 years and the causes of death were due to motor vehicle accidents, fire, drug overdose and drowning.
- Consistent with 2000 and 2001, there was one suicide death during the 2002 calendar years.
- There was one 2002 infant fatality where the manner of death was undetermined, however, the cause was determined to be "Sudden Unexpected Death of Infant while Co-sleeping".

SUMMARY OF CFRC SUBCATEGORIES

Infant Mortality Data

- ***Total Number*** - The number of infant deaths that met the CFRC criteria for review increased from 78 in 2001 to 80 in 2002. The 2002 infant deaths represented 58% of the total decedent population for that year as opposed to infant deaths representing 53% of the 2001 population
- ***Ages*** - The ages ranged from birth through 10 months of age.
- ***Race/Gender*** - The race of the decedents were more reflective of the overall District child death population in that 62, or 78% were Black; nine (11%) were Hispanic, eight (10%) were White and one was Asian. Decedents were male in 44, or 52% of 2002 infant fatalities and 40 were female.
- ***Gestational Age/Birth Weight*** - Fifty-nine, or 74% of the 80 infant fatalities were born premature and 21 of these births occurred prior to 23 weeks gestation. Of the 59 premature infants, 22 (37%) weighed less than 500 grams and seven weighed between 500 and 600 grams.
- ***Manner of Death*** – The manner of death for 2002 decedents under one year of age included 75 Natural, three Homicides, one Accident and one Undetermined.

Juvenile Justice Fatality Data

Reviews of deaths of youth known to the juvenile justice system revealed the following findings:

- ***Total JJ Population*** – Seventeen, or 12% of the 139 fatalities identified from 2002 were youth known to the juvenile justice system.

- ***Age of Decedent***
  The ages of the 2002 decedents ranged from 15 to 22 years, with the average and most frequent age being 19 years.

- ***Gender/Race of Decedent***
  - Ninety-four percent of the 2002 juvenile justice decedents were African American (n = 16); one decedent was Hispanic.
  - Ninety-four percent of the 2002 decedents were males and one was female.

- ***Substance Abuse***
  - Seventy-six percent of the 2002 decedents (n = 13) had documented histories of involvement in substance use/sales. Three of these youth previously admitted to using both drugs and alcohol.

- ***Educational Level of Decedent***
  - Of the 13 decedents whose educational information was known, only two decedents (ages 18 and 19 years) had completed high school. The majority of decedents had completed grades 9 through 11 (n = 8, or 62%).
  - Four of the 2002 decedents were in special education programs.

- Over 50% of the decedents where education status was known had exhibited chronic problems of truancy during the year prior to the death and four had withdrawn from District public schools for various reasons.

- ***Ward of Decedents Residence***
  - The majority of the 2002 decedents known to the juvenile justice system resided in Ward Seven (n = 8, or 47%). Four decedents resided in Wards Five and Eight (n = 2 each) and two were residents of Maryland and Virginia.

- ***Manner/Cause of Death***
  - The manners of death for the 2002 juvenile justice fatalities included 15 homicides, one suicide and one accident. The cause of death for 16 of the 17 fatalities was gunshot wound (including one suicide). The cause of the accidental death was due to a drug overdose.

- ***Place and Ward of Fatal Incident***
  - The majority of the fatal incidents for 2002 juvenile justice homicides occurred in Wards Seven (n = 5) and Five (n = 4). Four youth homicides also occurred in Wards Six and Eight (n = 2 each). The remaining three fatal events occurred in Wards One and Two. The 15 homicide victims were discovered on the streets of the District in eight, or 47% of the cases and in vehicles in five, or 29% of the cases. One decedent was discovered on school grounds and one in the home of a friend.
  - The one suicide occurred in an apartment in Ward Seven and the accidental death occurred in the decedent's home in Maryland.

- ***Juvenile/Court History***
  - *Number of Arrests*

    The majority of the juvenile justice decedents had numerous charges/arrests. Of the 17 decedents from the 2002 calendar years, 12, or 71% had multiple arrests. The types of charges included gun/ammunition possession, drug possession, assault/threat to do bodily harm, sexual abuse, unauthorized use of a vehicle, and destruction of property.

  - *Status of Case At Time of Death*

    Based on 2002 data, seven of the decedents' juvenile justice cases were active at the time of their deaths and six had been active within two years prior to the death. The seven active cases included one committed youth, five on probation and one in a detained status.

Child Welfare Fatality Data

Reviews of deaths of children/youth known to the child welfare system revealed the following findings:

Total CW Fatality Population – Final 2002 data indicate that 45, or 32% of the 139 decedents were identified as child welfare fatalities.

Age of Decedent - The age of the decedents ranged from birth through 20 years of age. The average age was eight years. There were equal numbers of children under the age of one year and older than 14 years of age (n = 18 in each category). These two groups represented 80% of the total child welfare fatalities for 2002.

Race and Gender of Decedents

- Ninety-five percent (n = 43) of the 2002 deaths were Black and the remaining two children/youth were Hispanic.
- Males represented the majority of the child welfare child fatality population for 2002 (n = 28, or 62%). Seventeen decedents were female.

Cause/Manner of Death

- 2002 Data
  - Twenty of the 45 decedents (44%) from 2002 died naturally. Two of these deaths were attributed to SIDS and 18 were caused by medical problems.
  - Seventeen, or 38% of the deaths were homicides, 14 of which were attributed to youth violence and three to fatal abuse/neglect. The decedents known to the child welfare system who died from fatal abuse/neglect represent 43% of the total abuse/neglect deaths for the 2002 year (n = 7). The ages of these children were three (n = 1) and four years (n = 2).
  - Six child welfare deaths from 2002 were determined to be accidents; three were determined to be motor vehicle related, one resulted from a house fire, one was a drug overdose and one died from positional asphyxia.
  - The one suicide death that occurred in calendar year 2002 involved a youth who was active with the child welfare system at the time of his death and became known to the child protective services system eight years prior to his death for physical abuse. The cause of his death was gunshot wound.
  - One child welfare death involved a one-month old child who died while co-sleeping with his mother. His cause of death was "Sudden Unexpected Death of Infant while Co-sleeping and the manner was undetermined.

Educational Level of Decedents

- Over half of the 45 child welfare decedents from 2002 (n = 23) were school age. Of the 23 school age decedents, 18 (78%) were 15 years of age or older. Data indicates that none had graduated from high school and 11 were documented as functioning below grade level.
- Three of the five decedents from 2002 who were between the ages of five and 14 were enrolled in regular educational programs and were functioning on task and one was enrolled in an un-graded special education program. The fifth child was residing in a convalescent facility at the time of death.

Number and Reasons for Child Protection Services Referral

- The majority of the 2002 families referred to the child welfare system were reported multiple times (n = 26, or 58%). The number of reports ranged from one to 13, with an average of three reports.

- In over half of the child welfare fatalities, the decedent was part of the case (n = 28, or 62%). In the majority of the fatalities where the decedent was not part of the child welfare record, the most common reason was that they were born after the case closed.
- Based on the last child abuse/neglect reports received, the primary reason for families being referred was "general neglect". Thirty families from 2002 (67%) were reported for general neglect issues.
- Maternal substance abuse was a documented factor either as part of the initial report of abuse/neglect or as a problem during service provision for 25 of the 44 child welfare families.
- Based on the outcome of the intake investigations, allegations of at least one of the reports of suspected abuse and/or neglect were supported and the case was opened by intake in over 90% of the cases (n = 42).

Case Status

At the time of death, 25, or 57% of the 2002 child welfare fatalities were families with active cases. Of the remaining 20 fatalities, 13 cases had closed within 4 years prior to the death and 10 of these cases had closed two years prior to the death.

APPENDIX E

2003 Calendar Year Fatality Listing

Years/Months/Days	*Cause of Death*	*Manner of Death*
0/0/0	Extreme prematurity, preterm labor of unknown etiology	Natural
0/0/0	Extreme prematurity , premature rupture of membranes, maternal cervical incompetence	Natural
0/0/0	Previable gestation, incompetent cervix	Natural
0/0/0	Prematurity, previable @17 weeks	Natural
0/0/0	Cardiorespiratory failure, severe respiratory distress syndrome, extreme prematurity @ 23 weeks gestation, unknown etiology	Natural
0/0/0	Extreme prematurity @ 22.5 weeks, pulmonary insufficiency, sepsis, maternal chorioamnionitis	Natural
0/0/0	Premature delivery, non-viable, preterm rupture of membranes, preterm labor of unknown etiology	Natural
0/0/0	Extreme prematurity, premature rupture of membranes of unknown etiology	Natural
0/0/0	Extreme prematurity, previable fetus, unknown etiology	Natural
0/0/0	Extreme prematurity, maternal chorioamnionitis, prolonged rupture of membranes	Natural
0/0/0	Prematurity @ 22 weeks, premature preterm rupture of membranes, chorioamnionitis	Natural
0/0/0	Cardiorespiratory arrest, extreme immaturity 23 weeks, polyhydramnios of undetermined etiology	Natural
0/0/0	Pulmonary immaturity, extreme prematurity, preterm labor	Natural
0/0/0	Cardiorespiratory failure, extreme immaturity, premature rupture of membranes, unknown etiology	Natural
0/0/0	Previable fetus, chorioamnionitis, prolong rupture of membranes	Natural
0/0/0	Pulmonary immaturity, extreme prematurity, preterm labor, preterm rupture of membranes	Natural
0/0/0	Body stalk anomaly	Natural
0/0/0	Severe prematurity, incompetent cervical OS	Natural
0/0/0	Oligohydramnios, pulmonary hypoplasia	Natural
0/0/0	Extreme prematurity, hypoplastic lungs, multicystic kidneys	Natural
0/0/0	Pulmonary hypoplasia, extreme prematurity, premature rupture of membranes	Natural
0/0/0	Extreme prematurity @ 19 weeks	Natural
0/0/0	Severe perinatal asphyxia, amniotic fluid aspiration, preterm @ 36 weeks, maternal uncontrolled diabetes mellitus	Natural
0/0/0	Cardio-respiratory failure and arrest, multisystem failure, extreme prematurity @ 21 weeks	Natural
0/0/0	Prematurity @ 21 weeks, premature rupture of membranes, preterm labor, undetermined etiology	Natural
0/0/0	Extreme prematurity @ 22 weeks gestation, pulmonary insufficiency	Natural
0/0/0	Prematurity due to premature rupture of membranes of undetermined etiology	Natural
0/0/0	Preterm delivery of undetermined etiology	Natural
0/0/0	Pulmonary immaturity, premature delivery, incompetent cervix	Natural
2 Days	Respiratory arrest, multiple congenital anomalies incompatible w/ life	Natural
2 Days	Anencephalus, cranial deformity	Natural
3 Days	Osteogenesis imperfecta	Natural
5 Days	Persistent pulmonary hypertension, pulmonary dysplasia, severe intrauterine, growth retardation, placental insufficiency	Natural
5 Days	Complications of prematurity due to premature rupture of membranes due to maternal chorioamnionitis	Natural
6 Days	Severe hypoxemia/acidosis, hypoplastic lungs, posterior urethral valves	Natural
10 Days	Extreme prematurity @ 25 weeks, maternal oligohydramnios w/ intrauterine growth retardation of unknown etiology	Natural
10 Days	Respiratory failure, severe brain injury, ischemic/infections in-utero process undetermined	Natural
12 Days	Sepsis, intestinal perforation, prematurity @ 24 weeks, incompetent cervix	Natural
14 Days	Neonatal e.coli sepsis, prematurity, preterm labor of undetermined etiology	Natural
16 Days	Extreme prematurity, multi-organ failure, candida sepsis, maternal antiphospolipid syndrome	Natural

	18 Days	Cardiovascular shock, congenital heart disease	Natural
	19 Days	Fungal sepsis, extreme prematurity, placental abruption	Natural
	21 Days	Brain hemorrhage, prematurity, premature rupture of membranes of unknown etiology	Natural
	1 Month 2 Days	Extensive intraventricular hemorrhage w/ hydrocephalus, hyaline membrane disease w/ pulmonary hemorrhage, extreme prematurity	Natural
	1 Month 10 Days	Undetermined	Undetermined
	1 Month 13 Days	Sudden Infant Death Syndrome	Natural
	1 Month 14 Days	Complications following viral gastroenteritis w/ giant cell myocarditis	Natural
	1 Month 19 Days	Extreme prematurity and its complications due to placental abruption due to blunt impact trauma	Accident
	1 Month 23 Days	Persistent pulmonary hypertension of the newborn	Natural
	2 Months	Unknown	Unknown
	2 Months 21 Days	Sudden Infant Death Syndrome	Natural
	2 Months 29 Days	Sudden Infant Death Syndrome	Natural
*	3 Months	Sudden Infant Death Syndrome	Natural
	3 Months	Undetermined	Undetermined
	3 Months	Acute bronchopneumonia	Natural
	3 Months 12 Days	Complications of bacterial pneumonia	Natural
	3 Months 19 Days	Asphyxia due to chest compressions	Accident
	3 Months 24 Days	Sudden Infant Death Syndrome	Natural
	3 Months 29 Days	Sudden Infant Death Syndrome	Natural
	4 Months 11 Days	Sudden Infant Death Syndrome	Natural
	4 Months 14 Days	Sudden unexpected infant death while co-sleeping w/ adult and w/ inappropriate bedding	Undetermined
	5 Months	Unknown	Unknown
	5 Months 24 Days	Blunt head trauma	Homicide
	6 Months	Undetermined	Undetermined
	6 Months 3 Days	Sudden Infant Death Syndrome	Natural
	7 Months	Sepsis, liver failure, short gut, unknown metabolic disorder	Natural
	7 Months 28 Days	Temporal/ parietal brain bleed, acute myelogenous leukemia	Natural
	9 Months 7 Days	Septic shock	Natural
	1 Year 6 Months	Acute bronchopneumonia and sepsis due to global hypoxic ischemic encephalopathy, undetermined etiology	Natural
	1 Year 7 Months	Obstructive apnea /stridor, hydrocephalus, prematurity, adrenal insufficiency	Natural
	2 Years	Stab wounds to neck, chest and forearm w/ injury to vasculature, lung and heart	Homicide
	2 Years	Blunt impact of head and torso w/ subdural and subarachnoid hemorrhages, cerebral edema, hepatic lacerations w/ hemoperitoneum	Homicide
	3 Years	Blunt impact w/ fractures of cervical spine and transection of spinal cord	Accident
	3 Years	Possible arrhythmia, chronic renal failure, dysplastic kidneys	Natural
	3 Years	Overwhelming sepsis, central line infection	Natural
	6 Years	Encephalopathy, human immunodeficiency	Natural
*	8 Years	Multiple injuries	Accident
	8 Years	Blunt impact head trauma w/ subdural, subarachnoid and intraventricular hemorrhage	Accident
*	8 Years	Cardiac arrhythmia due to subvalvular aortic stenosis	Natural
*	9 Years	Acquired Immunodeficiency Syndrome (AIDS)	Natural
	11 Years	Cardiomegaly due to Acquired Immunodeficiency Syndrome	Natural
	11 Years	Respiratory failure, mucor mycosis, immune suppression/compromise, bone marrow transplant	Natural
	11 Years	Metastatic primitive neurocotodermal tumor	Natural
	11 Years	Multi organ failure, pneumonia, sepsis, AIDS	Natural
	11 Years	Hanging	Suicide
	12 Years	Hanging	Suicide
*	13 Years	Volvulus of small bowel	Natural
	13 Years	Cerebral herniation, stroke, progeria, suspected	Natural
	15 Years	Hanging	Suicide
*	15 Years	Two gunshot wounds to torso	Homicide
*	16 Years	Gunshot wounds of head and chest	Homicide
	16 Years	Multiple gunshot wounds	Homicide
	16 Years	Gunshot wound to abdomen w/ perforations of liver, aorta and spine	Homicide
	16 Years	Acute pulmonary embolism, source undetermined, while using therapeutic estrogen for contraceptive	Natural
	17 Years	Gunshot wound of chest w/ perforation of heart and right lung	Homicide

	17 Years	Gunshot wound to hip w/ injuries of iliac vein, urinary bladder and mesentery	Homicide
	17 Years	Gunshot wound to abdomen transecting major blood vessels	Homicide
*	17 Years	Gunshot wound to back of head	Homicide
	17 Years	Sepsis, multi-organ function	Natural
	17 Years	Gunshot wound to back perforating the lung and pulmonary vessels on the left and the heart	Homicide
	17 Years	Gunshot wound to head perforating brain	Homicide
*	18 Years	Gunshot wound of chest injuring heart and lung	Homicide
	18 Years	Blunt impact head trauma w/ subdural, subarachnoid and contusional hemorrhages and skull fractures	Accident
	18 Years	Gunshot wounds to head and torso penetrating brain and perforating heart and lung	Homicide
	18 Years	Gunshot wound to back perforating the inominate vein	Homicide
	18 Years	Gunshot wound to neck w/ injuries to vasculature and trachea	Homicide
	18 Years	Gunshot wounds to head, torso and upper extremity	Homicide
	18 Years	Respiratory failure, renal failure, metastatic medulloblastoma	Natural
	18 Years	Gunshot wound to head w/ perforation of brain	Homicide
	18 Years	Gunshot wound to torso w/ perforations of lungs and aorta	Homicide
	18 Years	Gunshot wound to torso perforating heart and lung	Homicide
	18 Years	Gunshot wound to chest perforating heart and lung	Homicide
	18 Years	Gunshot wounds to torso w/ perforations of lungs, aorta, esophagus and brachial	Homicide
	18 Years	Blunt impact to head and torso w/ bastilar fractures to skull and aortic laceration	Accident
	18 Years	Gunshot wound to head perforating brain	Homicide
	19 Years	Multiple gunshot wounds	Homicide
	19 Years	Gunshot wound to neck transecting spinal cord	Homicide
	19 Years	Gunshot wounds to head and torso w/ perforations of brain, heart, liver, stomach and kidney	Homicide
	19 Years	Gunshot wound to left upper arm w/ perforations of lung and spinal cord	Homicide
	19 Years	Pulmonary thromboembolism due to deep venous thrombosis of lower extremities due to reduced mobility due to hospitalization	Natural
	19 Years	Stab wound of the chest penetrating heart	Homicide
	19 Years	Gunshot wounds to head and back perforating brain, lungs, liver, kidney, pancreas and mesentery	Homicide
	19 Years	Complications of cerebral palsy	Natural
	20 Years	Gunshot wound to thigh perforating femoral vessels	Homicide
	20 Years	Gunshot wound to left shoulder perforating the subclavian vessels	Homicide
	20 Years	Gunshot wound to head perforating brain	Homicide
	20 Years	Immunodeficiency, mycobacterium avium intracellularis, sepsis	Natural
	21 Years	Gunshot to head perforating the brain	Homicide
	22 Years	Stab wound to chest w/ injury to major blood vessels	Homicide
	22 Years	Gunshot wounds to neck and thigh w/ injury to blood vessels and bone	Homicide
	22 Years	Gunshot wound to head w/ injury to brain	Homicide
	22 Years	Gunshot wound to chest perforating lung and transecting spinal cord	Homicide

* Medical Examiner Cases from other jurisdictions

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 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 unwavering 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.

For Copies of this Report Contact:
(202) 698-9097