

District of Columbia
Child Fatality Review Committee
2001 AND 2002 ANNUAL REPORT



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

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

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

2001 and 2002 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**

January 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 effecting the future of other children by reducing the number of preventable deaths and improving the quality of their lives.

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 lives is an admirable and difficult challenge. This challenge speaks to the commitment of members to improving services and truly making life better for the residents of this city. Without this level of dedication the work of the Committee would not be possible.

We would like to thank the members of the Committee for volunteering 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.

January 2004

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


On behalf of the Child Fatality Review Committee I am pleased to present the ninth Annual Report, covering statistical data and recommendations resulting from fatality reviews held during calendar years 2001 and 2002. As with previous years, this Report serves as a reminder that ensuring the safety and protection of our children today is paramount to creating a brighter tomorrow for the District. This is a tremendous responsibility and must be shared by not only the public and private service delivery systems but by families and communities.

As with other state child fatality review processes, the District's process has assisted public service administrators and elected officials in the identification and removal of barriers, gaps or patterns of separation and isolation that may exist within our child and family service delivery structures. This multi-disciplinary and multi-agency approach to critiquing services and systems is unique. It not only unites the government and the public sector, but it also joins the community in the common goal of reducing preventable child deaths and improving the quality of children's lives. One of our primary objectives is to focus on the improvement, integration and coordination of vital services and programs. This level of collaboration is the means for setting a new course that is directed towards saving children and strengthening families, communities and neighborhoods.

This report presents recommendations that we believe can improve policy and practice in order to prevent children from dying. These recommendations also represent the Committee's effort to understand and identify what we can do as a city to improve the quality of our citizens' lives. Although, this challenge is great, as we step forward in acceptance, we must continue to be optimistic and guided by the hope that many of the problems and issues leading to child deaths are preventable.

As we continue in our efforts to improve the systems serving families and children, we must also begin to motivate and encourage more concerned citizens to join us in the quest of making the District a more wholesome and productive place to reside.

Sincerely,


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

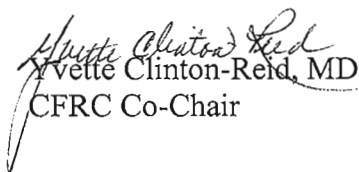

Yvette Clinton-Reid, MD
CFRC Co-Chair

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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 Ninth Annual Report. This Report covers data that resulted from reviews of 148 fatalities from calendar year 2001 and 130 deaths from 2002. As with previous years, the majority of the decedents for both years were African American (n = 133 for 2001/101 for 2002) and males (n = 107 for 2001/78 for 2002).

Key Child Fatality Review Findings

Natural Deaths

A review of death certificates indicates that the majority of District children/youth continue to die from natural causes during the 2001 and 2002 calendar years. There were a total of 87 natural deaths in 2001 and 84 in 2002. For both years, 71 of the natural deaths were children under the age of one year, which accounts for 82% and 85% of the total populations for these years, respectively. The majority of infant deaths were associated with prematurity, low birth weight and congenital anomalies. There were five deaths attributed to Sudden Infant Death Syndrome in 2001 and eight in 2002.

Violence Related Deaths

Death certificates attributed 34 fatalities in 2001 and 36 in 2002 to violence related causes. This included homicide and suicide deaths.

Homicides

- ◆ **Fatal Abuse/Neglect** – There were two child deaths during 2001 where the causes were associated with parental/caretaker abuse and neglect compared to seven in 2002. The children of the fatal abuse/neglect fatalities for 2001 and 2002 ranged in age from one month to four years.
- ◆ **Youth Violence** – Youth violence continued to be the primary cause of child/youth homicides. In 2001, there were 31 youth who died from gunshot wounds and 27 in 2002. Youth in this category were 14 through 20 years of age.
- ◆ **Other Child Homicides** – There were two additional violent child deaths that did not meet the criteria for either a child abuse/neglect or youth violence fatality.

Suicides

In both 2001 and 2002 there was one District youth whose death was determined to be a suicide.

Unintentional Injuries

Accidental or unintentional injuries continued to decrease and continued to rank third for District child deaths. In 2001 there were nine accidental deaths and in 2002 the number fell to six. The causes of accidental deaths in all age groups were:

- ◆ 10 Motor Vehicle Accidents
- ◆ 2 Drownings
- ◆ 2 Smoke Inhalations
- ◆ 1 Drug Toxicity

Top Ten CFRC Recommendations from 2001/2002 Calendar Years

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

- ◆ Evaluate the apparent increase in gun violence and gun availability and develop strategies/resources related to addressing this issue as a public health problem.
- ◆ Increase in-patient drug treatment resources for juveniles, pregnant women and women with children.
- ◆ Address the shortage of emergency/trauma and other medical resources in the far northeast and southeast quadrants of the District.
- ◆ Establish a visiting nurses program for high-risk mothers and/or newborns.
- ◆ Ensure that death scene investigations include re-enactment of sleeping arrangements, at a minimum for all cases of children six months of age or younger.
- ◆ Convene a work group that includes at a minimum the legal, investigative, child welfare, juvenile justice and court systems, to comprehensively examine the issues associated with the chronic problem of child/youth abscondence and devise a multi-agency approach to service delivery. Plans should consider:
 - The need to adequately fund/staff the MPD Abscondence Unit.
 - The need to establish appropriate placements for apprehended absconders pending the identification of safe/appropriate long-term placements.

- The need to develop treatment/management services that address issues unique to this population, including youth with dual neglect/juvenile jackets.
- ◆ Provide education to the medical community regarding the identification of high-risk pregnancies and the appropriate medical management and referrals.
- ◆ Provide genetic assessments of infants who die from congenital abnormalities and provide appropriate counseling to parents regarding recurrence risk.
- ◆ Educate the community on the importance of periconceptual diets and medical care.
- ◆ Evaluate the availability of tertiary care for high-risk mothers and infants, including at a minimum, barriers such as the impact of lack of insurance, bed availability, staffing patterns and MCO/HMO restrictions.



INTRODUCTION

Although all child deaths are tragic and resonate within families and communities, our role as the District of Columbia Child Fatality Review Committee is to learn from these tragedies. Understanding the ways in which children are dying provides us with the knowledge required to identify prevention opportunities and to focus meaningfully on the changes needed to advance our communities and residents. The CFRC is a city-wide effort that, during 2001, was authorized by District statute (see Appendix B: Child Fatality Review Committee Establishment Act of 2001, DC Law 14-028) to conduct retrospective examinations of the circumstances that contributed to the deaths of infants, children and youth who are residents or wards of the District. Identifying risk reduction, prevention and systems improvements factors and recommending strategies to reduce the number of preventable child deaths and improve the quality of residents' lives are the primary purposes of the District's child death review process (see Appendix C: CFRC Goals, Objectives and Operating Process). It is the goal of the Committee to use information gained from fatality reviews as a means of understanding the following:

- ◆ The manner in which District children are dying;
- ◆ 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 protection of our children.

This Report summarizes the data that resulted from reviews that were conducted on infant, child and youth fatalities that occurred during calendar years 2001 and 2002 and the contributory factors and recommendations identified by the District's Child Fatality Review Committee. During this two-year period, the Committee reviewed the deaths of 278 children, from birth through 20 years of age. These children died from a multitude of causes that included extreme prematurity, congenital anomalies, various diseases, homicide, suicide and unintentional injuries.

It is important to note that data presented in this Report for calendar year 2001 is final, *while data from 2002 is preliminary*. Due to problems associated with delays in receiving notification of child deaths and the extensive agency record search and case review processes, the Committee continues to identify and review deaths from calendar year 2002. Therefore, the data contained in this Report for this year is based on information received as of October 1, 2003. An addendum will be provided in the 2003 Annual Report that will update 2002 statistical data.

It is our hope that the child fatality review process will continue to allow those charged with serving District children and families to continue to learn from the past and move forward with a clearer understanding of the steps needed to enhance service delivery and hopefully to prevent future deaths.

CASE REVIEW FINDINGS

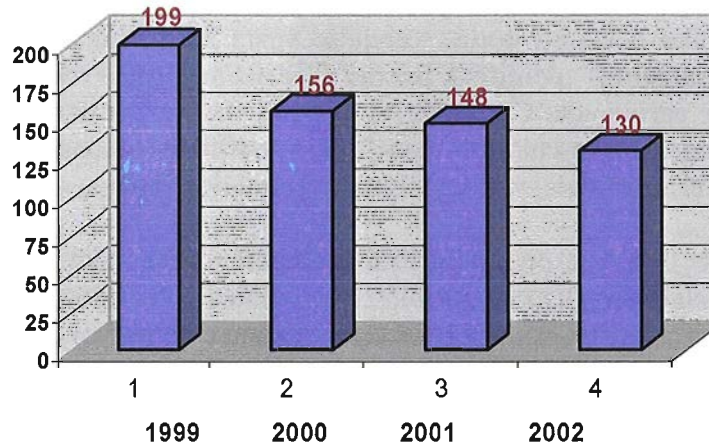
Information presented in annual reports is raw data resulting from the Committee case review process and should not be used as the only tool for measuring true changes in child deaths in the District. This information needs to be evaluated within the context of other statistical measures, such as the changes in the District's adult and child populations and changes in resident demographics, including racial distribution and economic status. These elements are critical to understanding the overall changes that are consistently occurring in the child death population. Coupled with other data measures, CFRC data can benefit agencies in determining patterns in family characteristics and in formulating future changes 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

Based on the established fatality review criteria, the total number of child deaths for calendar years 2001 and 2002 were lower than preceding years.

- ◆ In 2001, there were 148 child fatalities identified by the Committee as meeting the criteria for review, representing a five percent decrease from the 156 fatalities identified in calendar year 2000 and a 26% decrease from the 199 child fatalities from 1999.
- ◆ In 2002, as of October 1, 2003¹, 130 fatalities were identified and/or reviewed.

Figure 1. Total Number of Deaths: 1999 - 2002



Description of Decedent Populations

This section of the Annual Report covers demographic characteristics of the 278 decedents identified as meeting the CFRC criteria from the 2001 (n = 148) and 2002 (n = 130) calendar years. Data is provided in various forms of comparison within a variety of characteristic categories (i.e., age, sex, race), manners 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

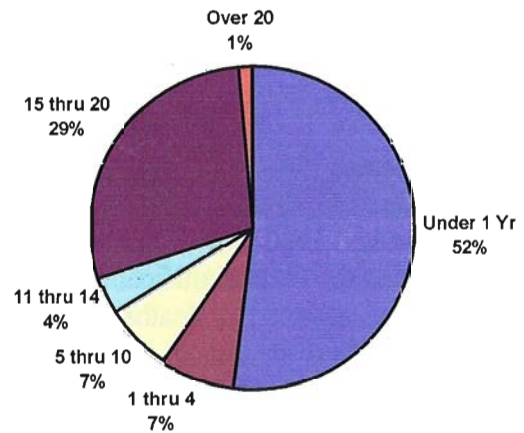
¹ October 1, 2003 was the established cut-off date for data to be included in the 2001/2002 Calendar Year Annual Report. However, cases have continued to be identified and reviewed for calendar year 2002.

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 who aim to better serve District residents.

Age of Decedents

As with previous years, the two largest categories of child deaths reviewed from 2001 and 2002 included infants (under the age of one year) and youth over the age of 14.

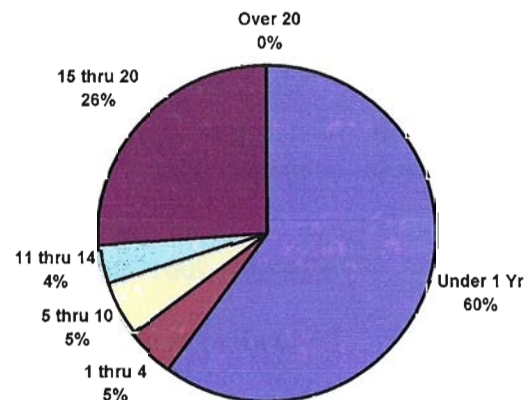
Figure 2. 2001 Ages



◆ 2001 Calendar Year

- The ages of the 148 decedents ranged from birth through 21 years.
- Fatalities of two combined categories, infants and children over the age of 14 years, represented 82% (n = 121) of the 148 CFRC fatalities.
- Although the number of infant deaths continued to decrease during 2001, this population remained the largest group of CFRC fatalities. Out of the 148 CFRC fatalities, 78 (53%) of the children fall into this category, representing a 17% decrease from the same population in 2000 (n = 94). The infant population included 57 neonates (birth through 27 days); 39 of these children died during their first day of life. Twenty-one infants were post-neonates (28 days up to one year).
- Forty-three, or 29% of the 2001 fatalities were of youth 15 through 20 years of age. Two decedents were 21 years old
- The remaining 27 decedents were between the ages of one through 14 years of age, with the largest category being children between one and four years (n = 11).

Figure 3. 2002 Ages



◆ 2002 Calendar Year (Preliminary data based on a compilation date of 10/03)

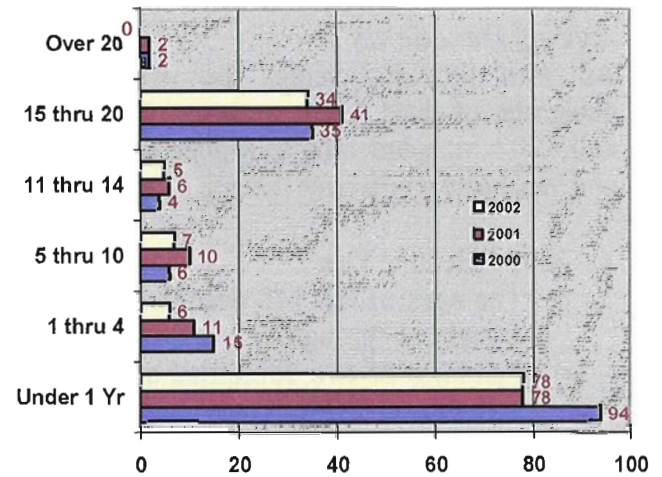
- The ages of the 130 decedents ranged from birth through 20 years of age.
- The combined total of infants and youth over 14 years of age was 112, representing 86% of the total population.
- Out of the 130 CFRC fatalities, 78 (60%) were infants. This population included 57 neonates (birth through 27 days) and 21 post-neonates (28 days up to one year). Thirty of the neonate fatalities died during their first day of life.

- Thirty-four, or 26% of the 2002 fatalities identified, were youth 15 through 20 years.
- Eighteen decedents were between the ages of one and 14 years of age.

Figure 4. Comparison Age Data

◆ Decedent Age Comparison Data

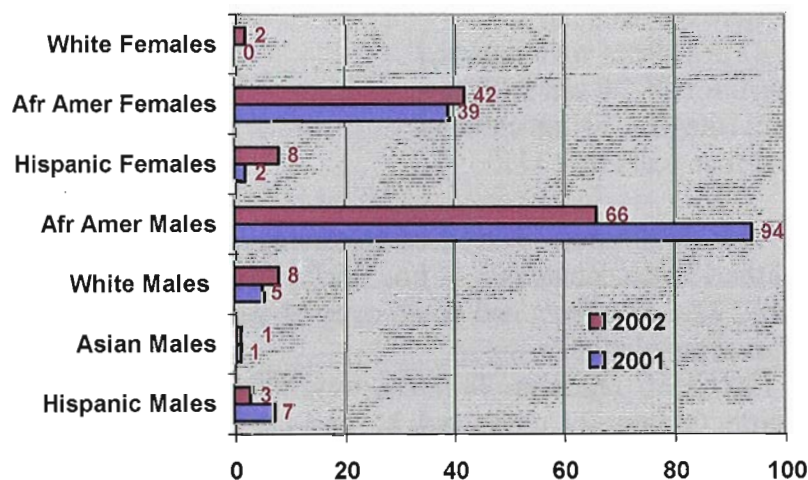
- When comparing the ages of decedents over the past three years (2000 – 2002) the numbers of deaths by age groupings varied during calendar year 2001 in several areas. Figure 4 illustrates the fact that the most significant increases in the number of deaths were among children in the 5 through 20 age categories. Deaths in the infant category decreased by 17% in 2001 and based on preliminary data remained at 78 in 2002. The over 20 years of age category has remained to lowest age grouping with 2000 and 2001 numbers remaining the same and no deaths in the category for 2002.



Race and Gender of Decedents

African American children/youth continued to make up the majority of the fatalities. The disproportionate representation of African Americans among the child death population has continued to be a trend and Committee concern. Similarly, males have also been over-represented in the fatality data.

Figure 5. 2001/2002 Race and Gender



◆ **2001 Racial and Gender Findings**

- One hundred and thirty-three, or 90% of the 148 decedents were African American. The second largest racial group was Hispanics, which represented 6% (n = 9) of the total population. Five 2001 decedents were Caucasian children/youth (3%) and one was Asian.
- One hundred and seven decedents who died in 2001 were males, representing 72% of the total CFRC population.

◆ **2002 Racial and Gender Findings**

- Based on preliminary data, 2002 compilation revealed a slight difference in the racial composition of the decedent population. Although African Americans 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. Preliminary 2002 data indicates that 108, or 83% of the 130 decedents identified were African American. Hispanics continued to rank second, but with a slight increase from 10 deaths in 2001 to 11 in 2002. A significant finding from 2002 data is the increase in the Caucasian child death population. This category of children increased by 100% from the five deaths in 2000 and 2001 calendar years to 10 in 2002, representing 8% of the child death population. The number of Asian deaths for 2002 remained one.
- Preliminary 2002 data also revealed a slight change in the gender of the decedents. Males represented 60% of the population (n = 78). The number of females increased by 27% from the 2001 child death population (n = 52).

District Ward of Decedents

Figure 6. 2001 Ward Data

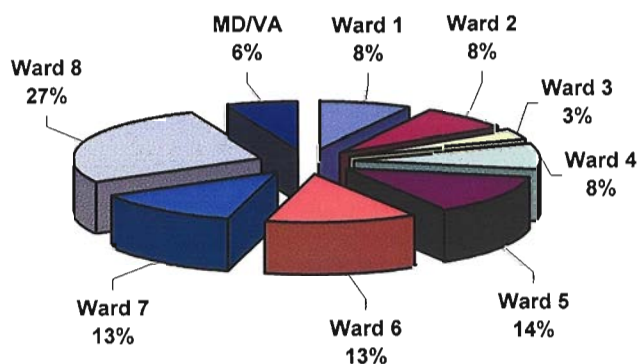
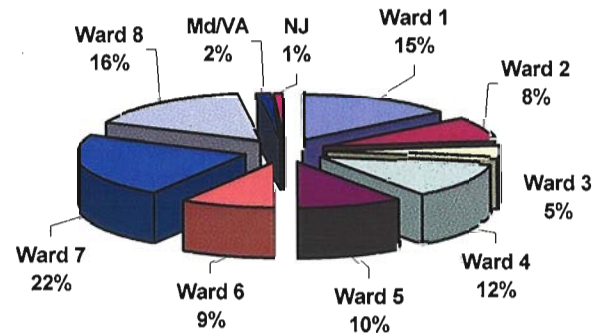


Figure 7. 2002 Ward Data



Residency of decedents is determined based on the review of various documents/records, including the birth and death certificates. In many cases there is conflicting information related 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. As illustrated in Figures 6 and 7 above, it was determined that 139 of the 148 deaths that occurred during 2001 and 127 of the 130 deaths from 2002 involved children who resided in the District. The remaining children (n = nine from 2001 and three from 2002) were either District residents

residing in out-of-state child welfare facilities or were prior residents and were known to either the juvenile justice or child welfare programs and, as such, met the fatality definition for review.

Consistent with previous years, the majority of the 2001 decedents were residents of Ward Eight (n = 40, or 27%), followed by Ward Five (n = 20). Wards Six and Seven ranked third with 19 fatalities each in 2001. Preliminary data from 2002, however, indicates a change with Ward Seven having the highest number of fatalities (n = 29, 22%), and Ward Eight deaths being second (n = 21). Ward One had the third highest number of deaths in 2002 (n = 19). As with previous years, Ward Three continued to have the smallest number of deaths during calendar years 2001 and 2002.

"Three 2001 and 2002 Case Descriptions"

Case 1:

In the winter of 2001, at approximately 9:35 PM, a 13-year old female, was the operator of a vehicle that was traveling westbound in the NW quadrant of the District. After the vehicle entered a major intersection against a red signal, it was struck by a van, traveling north, causing both vehicles to rotate counterclockwise. After separating, the decedent's vehicle rotated through the intersection and mounted the northwest corner where it struck fixed objects. It was redirected by the impact and the decedent was ejected from the driver's door and came to rest face up in the roadway. The vehicle continued into another fixed object where a 17-year old male, who was a rear seat passenger, was ejected through the rear windshield and hit a wrought iron fence. The driver and rear seat passenger were treated by EMS but died on the scene. Neither the driver nor the passengers of the vehicle were wearing seat belts.

Cause/Manner: Blunt Impact Trauma w/ Fracture of Skull/Accident

Case 2:

On a spring afternoon in 2002, members of the Fire Department were dispatched to an apartment for an unconscious female toddler. Once on the scene, CPR was immediately initiated and the child was intubated and transported to a local hospital. Several days later life saving measures failed and the child was pronounced dead. The investigation revealed that the victim's caregiver (mother's paramour) reported several different versions of the events surrounding the fatal incident to the medics, hospital staff and police, all of which were inconsistent with the child's injuries. It was also revealed by the paramour that the fatal event occurred hours prior to his calling 911 and that he waited to call because of his concern of not being the child's legal guardian. He finally called 911 when the child stopped breathing. The 5-year old sibling revealed during interviews that she and her sister were home with the mother's paramour and that he had beaten the decedent on the day of the fatal incident. She also alleged that there were previous times when she and other siblings were abused while left in his care.

Cause/Manner: Blunt Impact Head Trauma/Homicide

Case 3:

In the early morning of a cold winter day, the mother discovered her 2 month old child, not breathing. She called 911. Upon arrival, medics found the infant on the floor and observed him to be cold and rigid, as well as severely dehydrated. CPR was initiated and the child was transported to the hospital where he was determined to be dead on arrival. Information in the medical record indicated that the decedent was malnourished and that the mother appeared to be intoxicated. The mother reported last seeing her child alive at 12:15 AM that morning when she placed him to sleep in a car seat and then placed the seat in the decedent's crib. The mother also reported that the decedent had exhibited flu-like symptoms and was less active two days prior to his death. The mother called the pediatrician twice, but her calls were not returned, which was confirmed by police investigation. Thus, she treated the decedent with Pedialyte and liquid Tylenol. The child's last bowel movement was around 5:00 P.M., the day before her death. According to the investigation, the home was clean with ample food, including the infant's formula.

Cause/Manner: Dehydration Due to Respiratory Tract Infection/Natural

Manner/Cause of 2001 and 2002 Fatalities

Manner of Death

The manner of death relates to the circumstances under which the death occurred. This determination is made 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.

At the point of statistical compilation of the data for this Report, there were 129 of the 148 child fatalities from calendar year 2001 in which the manner of death was determined. Out of the 19 deaths in which the manner was not determined, three involved District children who died in the airplane crash on September 11, 2001 as a result of a terrorist act. The incident occurred in Virginia and CFRC was unable to obtain copies of the death certifications, therefore, for purposes of this Report, these deaths are included statistically as “unknown”. The remaining 16 deaths include 13 where the manner remains pending and three undetermined manners of death. Based on 2002 data, there were 126 of the 130 deaths where the manner was determined. The cause/manner of four 2002 deaths remain pending.

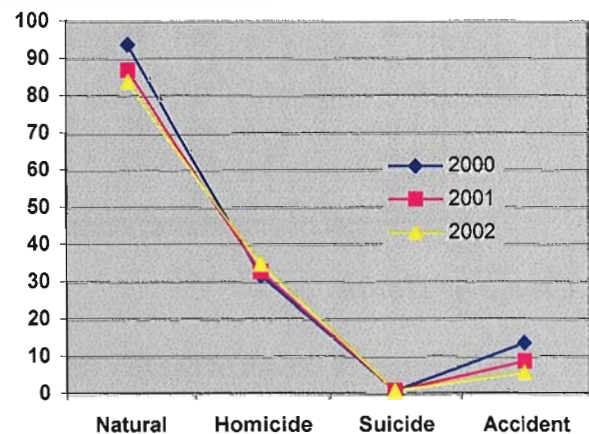
As illustrated by Figure 8, data from calendar years 2000 through 2002 support the fact that the number of natural deaths has continued to decrease, and that this manner of death continues to be the primary method in which District children are dying.

- ◆ In 2001, natural deaths were 59% (n = 87) of the 148 fatalities. Preliminary data for calendar year 2002 indicated that 65% (n = 84) of the 130 fatalities were natural.
- ◆ The majority of natural deaths involved infants who died from medical complications related to pregnancy and/or premature birth. There were also five natural deaths in 2001 and eight in 2002 that were attributed to Sudden Infant Death Syndrome (SIDS).

Since 1996, homicides have represented the second leading manner of death for District children/youth. Although the total number of homicide deaths has increased slightly over the past three years, reviews revealed fluctuating and vastly different data by type of homicide, i.e., child abuse/neglect, youth violence, other (see page 14, “Violence Related Deaths” under “Cause of Death”).

- ◆ During 2001 and 2002, homicides accounted for 33 and 35 deaths respectively.
- ◆ The majority of the victims of homicide continued to be African American and males.
- ◆ Twenty-eight of 2001 decedents and 25 of 2002 victims of homicides were African American males, representing 21% and 23% of the total populations for this racial group.

Figure 8. Manner of Death



Accidental deaths continued to decline and rank third among manners of death. Findings indicate:

- ◆ There were nine deaths attributed to accidents in 2001, representing a 36% decrease from the 14 accidental deaths in 2000.
- ◆ 2002 data reveals a further decline, with six accidental deaths, representing a 33% decrease from 2001 data.

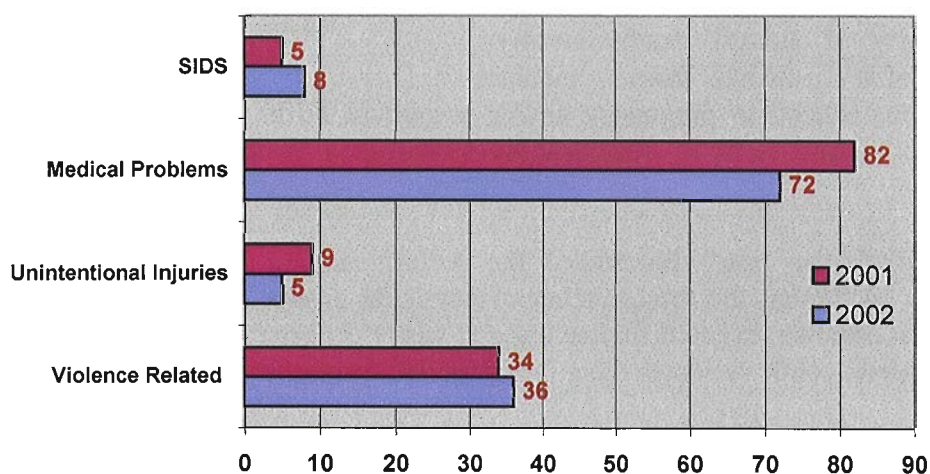
Consistent with 2000, there was one suicide death during the 2001 and 2002 calendar years.

Table 1 illustrates the Ward of the decedents' residence by manner of death for calendar years 2001 and 2002. Those deaths where the manner remains pending or unknown have been excluded from this table.

<i>Ward</i>	Total		Natural		Homicide		Accident		Suicide		Undet'd	
	2001	2002	2001	2002	2001	2002	2001	2002	2001	2002	2001	2002
One	11	20	5	13	2	5	2	0	0	0	2	0
Two	12	11	8	9	3	0	1	2	0	0	0	0
Three	5	6	5	6	0	0	0	0	0	0	0	0
Four	12	16	12	10	0	5	0	1	0	0	0	0
Five	17	12	11	8	3	3	3	1	0	0	0	0
Six	17	12	9	9	7	3	1	0	0	0	0	0
Seven	16	29	10	16	4	11	1	2	1	0	0	0
Eight	38	19	26	12	10	7	1	0	0	0	1	0
Other State	7	3	1	1	6	1	0	0	0	1	0	0

Cause of Death

Figure 9. Cause of Death - Total Population



In 2001, there were 138 fatalities where the cause of death was determined. This includes five of the 15 fatalities where the manner of death was undetermined or remained pending. In 2002, the

number of deaths where the cause was determined was the same as the number where the manner was determined (n = 126). 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 will be 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, Listing of 2001 and 2002 Fatalities By Age, Cause and Manner of Death.

Medical Problems - As Figure 9 (see page 10) illustrates, data from calendar years 2001 and 2002 indicate that although the number of natural deaths continues to decrease, the majority of District children continued to die from causes related to medical problems. Eighty-two, or 55% of the total 2001 fatalities involved children who died from medically related problems, representing a five percent decrease from the 86 medically related fatalities from 2000. Preliminary 2002 data indicates that out of the 130 child deaths, 76 (58%) were attributed to medical problems, a drop of seven percent from 2001. The ages of the decedents ranged from birth through 20 and birth through 17 years of age for calendar years 2001 and 2002 respectively. The average age of the decedents for both calendar years was 2 days.

◆ **Children Under One Year of Age**

In 2001, data indicates that 66, or 80% of medically related deaths involved infants (under the age of one year). Eighty-two percent (n = 54) of infant deaths occurred within the first month after birth and over three fourths of these children died within the first day of life (n = 41, or 76%). It should be noted that the District’s infant mortality rate decreased to 10.6 deaths per 1000 live births in 2001, which represents a drop from 11.9 in calendar year 2000.

Preliminary data from 2002 indicate similar age related findings for medical deaths among fatalities reviewed. Eighty-three percent (n = 63) of the 76 deaths attributed to medical problems were of children under the age of one year and 58 (92%) of these children were one month of age or younger. Thirty-two children died within one day.

◆ **Findings Associated with Medically Related Causes of Infant Deaths**

- Among infant deaths, the leading cause of death was related to prematurity and associated complications. These problems accounted for 80% (n = 43) of the 2001 and 49% (n = 31) of 2002 medical related infant deaths.
- Prematurity was associated with extremely low birth weight (less than 500 grams) in 29% (n = 19) infant deaths for 2001 and in 35% (n = 22) of 2002 infant deaths.
- Infectious diseases ranked among the top five leading causes of death with 15 deaths each year, representing 28% of 2001 and 23% of 2002 infant deaths.
- Congenital anomalies continued to rank high among infant medically related fatalities. During 2001 and 2002, congenital anomalies were primary causes of 16 and 10 deaths respectively. One of the 2001 and three of the 2002 fatalities had major heart anomalies.

- Maternal complications were documented on the death certificates of 31 (57%) infants from 2001 and 24 (38%) from 2002 as underlining causes of infant death. Maternal complications included premature rupture of membranes, chorioamnionitis, Group B Streptococcus, maternal substance abuse, incompetent cervix, hypertension, etc.
- ◆ **Children/Youth One Year of Age or Older**
Children over the age of one year have consistently represented the significantly smaller percentage of the medically related deaths. Sixteen, or 20% of 2001 and 13, or 17% of 2002 medical deaths involved decedents who were one year of age or older. The age of the 2001 decedents ranged from one to 20 years with an average age of 8; while the 2002 population ranged from four to 17 years of age, with an average age of 12 years.

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

- Data from calendar years 2001 indicate that the leading causes of medical deaths in this age group were infection (n = 5), congenital anomalies (n = 4) and neoplasms (n = 3). HIV/AIDS was common to two children who died from infection.
- In 2002, the leading causes were infection, neoplasms and cardiac disease (n = 3 deaths in each category). In addition to these deaths, two children died from sickle cell anemia.

Based on the review of the death certificates, table 2 below depicts the leading and underlying causes of 2001 and 2002 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 District Children						
<i>Medically Related Causes of Death</i>	Infants < 1 Year		Children 1 – 20 Years		Total 0 – 20 Years	
	2001	2002	2001	2002	2001	2002
Infections	19	21	5	3	24	24
Neoplasms	0	0	3	5	3	5
Respiratory System Disease	10	16	3	4	13	20
Intraventricular Hemorrhage	3	1	0	0	3	1
Congenital Anomalies	14	13	4	2	18	15
Prematurity	59	50	1	0	60	50
Cardiac Disease	0	2	0	3	0	5
Blood Disorders	0	0	1	3	1	3
Other Conditions	0	1	2	0	2	1

Sudden Infant Death Syndrome – Five of the 2001 and eight 2002 decedents were victims of Sudden Infant Death Syndrome (SIDS). This data indicates that the incidence of SIDS dropped by 38% in 2001 followed by a 60% increase in 2002. Reviews of SIDS deaths revealed the following factors (See Appendix E: Table 3 - SIDS Risk Factors):

- ◆ **2001 SIDS Data (Five Deaths)**
 - Infants ranged in age from two to four months, with the average age being four months.
 - The majority of the decedents were male (n = four) and all were African American.

- None of the children was being breastfed.
- The average age of the mothers of SIDS victims was 22 years (ranged in age from 18 to 25 years). The mothers had from one to five other children and one mother had a prior child death during calendar year 2000 (natural/medical cause).
- All the mothers had prenatal care with the majority having five or more visits. One mother reported having only one visit.
- Eighty percent mothers (n = four) reported histories of substance use/abuse, accounting for 80% of the SIDS population. Four of the five mothers also reported tobacco use.
- At the time of the death, mothers were the caregivers in 100% of the cases.
- Two of the infants were placed and discovered on their stomachs, one was placed on his side and discovered on his stomach and two were placed and discovered on their backs.
- None of the infants was sleeping in cribs although only one death investigation documented that there was no crib at the scene. Three children were on sofas/sofa cushion, one was on an adult mattress on the floor and one was one placed on the mother's chest. The infants were co-sleeping with between one and four other family members.
- CPR was initiated prior to emergency medical services arrival in 100% of the deaths.
- Three out of five deaths occurred in the decedent's home and two of the scene investigations for these deaths described unsafe/unkempt living environments.
- Two families resided in Ward Eight with the remaining three residing in Wards Five, Six, Seven.

"A 2001 and 2002 SIDS Death"

Case 1:

On an early spring morning in 2002, a young mother awoke and found her 6-month old son unresponsive on the sofa. She initiated CPR while the father went to a neighbor's home to call 911. Medics in route to the nearest hospital continued CPR. Resuscitation efforts were not successful and the infant was pronounced at 8:55 AM. According to the parents at midnight the infant was placed on his stomach on a sofa type cushion in the living room where he slept with his 4-year old sister. At approximately 8:00 AM the sibling woke his parents and indicated that her brother was "bleeding". The parents rushed to the living room and found the infant unconscious with dried blood around his nose lying on his back.

Case 2:

In the early morning of a late summer day in 2001, a newborn infant was being breastfed in bed in an upright position. After feeding she and her mother fell asleep. Several hours later, a relative entered the room and discovered the child limp and unresponsive, positioned on her side, facing her mother. Despite aggressive resuscitation efforts by the family and emergency medical staff, the infant was pronounced dead several minutes later.

CAUSE/MANNER: Sudden Infant Death Syndrome/Natural

◆ **2002 SIDS Data (Eight Deaths)**

- Infants ranged in age from two days to two months, with the average being one month.
- There were equal numbers of male and female decedents. Six infants were African American and two were Caucasian.
- Two of the children were being breastfed and six formula fed.

- The average age of the mothers of SIDS victims was 28 years (ranged in age from 18 to 39 years). Six of the mothers had from one to seven other children and two mothers had no other child. None of the mothers had prior child deaths.
- Seven of the eight mothers reported histories of substance use/abuse, which accounts for 88% of the 2002 SIDS population. Five of the mothers reported tobacco use.
- Seven of the mothers had prenatal care with the number of visits ranging between five and 10 with the majority having received eight or more. One mother had no prenatal care.
- At the time of the death, mothers were the caregivers in 50% (n = 4) of the cases; father in one, both parents were caregivers in two cases and an aunt in one.
- Two of the infants had just finished breastfeeding at the time of their deaths; both were discovered in their mothers' arms and one still in the breastfeeding position. Two infants were placed on their sides prior to their deaths; however, in one case the child was also discovered in the same position while the other was found face down. One was placed and discovered on his stomach and two were placed and discovered on their back. In one case the placement position was unknown, however, he was discovered on his back.
- Two children were reported to be sleeping in a crib/bassinette. Five were sleeping in adult size beds and were co-sleeping with one to two adult family members. One was in a chair with the mother in an upright position, breastfeeding.
- CPR was initiated prior to the arrival of emergency medical personnel in 88% (n = 7) of the deaths. One child was discovered unresponsive in the hospital and resuscitation efforts were made by hospital medical staff.
- Seven of the eight deaths occurred in the decedent's home and in one case the investigative report described an unsafe/unkempt living environment. One death occurred in the hospital, two days after the infant's birth.
- Three (3) families resided in Ward One, two in Ward Five and the remaining three resided in Wards Two, Four and Eight.

Violence Related Deaths

Since 1996, 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 years 2001 and 2002, there were 34 and 35 violence related deaths. Additionally, during 2001, there were three deaths of children that were related to violence, however, these deaths are not included in homicide and/or violence related deaths because we were unable to obtain copies of the death certificates to verify the actual cause/manner. These children (two 11 year old African American males and one 11 year old African American female) died in the airplane crash on September 11 as a result of a terrorist act.

Suicides

Since 1999 suicides have been consistently represented in child death data. As with previous years, in 2001 and 2002, there was one death for each year that was determined to be a suicide. Unlike previous years, the method of suicide changed from hanging to "Gunshot Wound". Both suicides involved African American males, 18 and 19 years of age.

Homicides

As with previous CFRC years, 2001 and 2002 homicide data was dominated by acts of violence perpetrated by youth on youth. Fatal abuse and neglect deaths continued to rank second. Similar to 2000 data, calendar year 2002 included two homicides that did not fit into either the youth violence or abuse/neglect category. For purposes of this report, fatal child abuse and neglect deaths have been defined by the Committee as including those children 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.

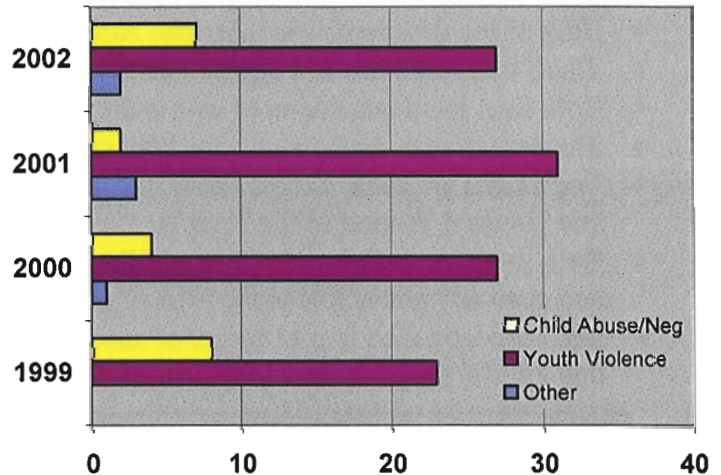
A 2001 Fatal Abuse Death

On a fall morning in 2001, a teenage mother discovered her 7-week old child cold and unresponsive in his crib. She took him to a family member's house where she called 911. Medics found the child without a pulse and unresponsive; he was intubated and CPR was initiated while being transported to a hospital. Despite resuscitation efforts, the infant was pronounced dead at 11:00 AM. Hospital records indicated that the infant was severely emaciated. Based on interviews with the mother, she indicated that between 7:00 PM and 9:00 AM, she feed and changed the infant 3 times and after his 9:00 AM feeding, she checked on him, kissed his arm, noticing movement, and covered him while he slept in his crib. She checked on him several additional times and found him in the same position. When she attempted to awaken him for his feeding she noticed he was cold and unresponsive. She removed his sock and plucked his foot to arouse him with no change. She changed his diaper and his clothes and went to get assistance.

Cause/Manner: Starvation Due to Nutritional Neglect

Calendar year 2002 included fatalities of two children under the age of 10 years whose deaths were not associated with either child abuse/neglect or youth violence issues. These deaths involved children who were killed by deliberate violent acts of unrelated adults who were not in caretaker roles. One case involved a 21-month old, African American male who died as a result of "incised wound of neck". The investigation determined that the child was killed along with his paternal grandmother as a result of a dispute/argument between the father and an unrelated adult. The second case involved a nine-year old African American female who, along with her father, was found dead in the father's home from gunshot wounds. Reviews of homicide fatalities revealed the following findings:

Figure 10. Child/Youth Homicides



2001 Youth Violence Related Homicides:

- ◆ Compared to 2000 data, 15% more youth died violently in the District of Columbia during calendar year 2001. There were 31 deaths attributed to youth violence in 2001 compared to 27 in 1999.

- ◆ Twenty-nine, or 94% of the youth violence related deaths involved African Americans. Two of the decedents were Hispanic.
- ◆ Twenty-nine, or 94% of the decedents were male.
- ◆ Decedents ranged in age from 15 to 21 years. The average, median and most frequent age for the 31 decedents was 18.
- ◆ The majority of the fatal events for the violence related homicides occurred in Ward Five of the District (n = 12, or 41%).
- ◆ Consistent with previous years the most common method of violence was the use of firearms. Thirty, or 97% of the 31 youth violence related homicides were caused by gunshot wounds and one was caused by strangulation.
- ◆ The majority of the deaths occurred on the streets or in public areas of the District (n = 23, or 74%). Two incidents occurred in a residence and one occurred in a vehicle. Three incidents occurred in Maryland.
- ◆ The majority of the 2001 deaths occurred during the late evening or early morning. Over two thirds (21, or 68%) occurred between 7:00 PM and 6:00 AM.
- ◆ Thirteen, or 42% of the decedents were known to the child welfare system and 20, or 65% were known to the juvenile justice system.

2001 Fatal Child Abuse and Neglect:

- ◆ Two, or 6% of the total homicides for calendar year 2001 were child abuse and neglect related fatalities. Compared to 2000 data, this represents a 50% reduction.
- ◆ Both of the 2001 victims of fatal abuse and neglect had not reached their second birthday (ages one month and one year).
- ◆ Both of the decedents were African American.
- ◆ There was one male and one female victim.
- ◆ Both fatal incidents occurred within the decedents' homes, in Wards Seven and Eight.
- ◆ The perpetrators of the abuse for both cases were the decedents' mothers.
- ◆ The causes of death were directly associated with abuse and neglect issues ("Starvation" and "Incised Wound of the Neck").
- ◆ Both mothers were known to the child protective services system prior to the fatal event and one case was active at the time of death.
- ◆ Both mothers also had histories of substance abuse and mental health problems and one had a history of domestic violence.

2001 Homicides

At 2:30 AM during the winter of 2002, police responded to the sound of gunshots in the NE quadrant of the District. Upon arrival they found a 20-year old youth at the entrance of an elementary school, suffering from multiple gunshot wounds to his head and body. Shortly afterwards, he was pronounced dead. Toxicology results were positive for PCP and alcohol. The decedent was known to the juvenile and adult criminal justice systems. His charges included drug possession and sales. He was also known to the child welfare system. Based on the investigation, the decedent was killed by 2 young adult males in an apparent act of retaliation for gang related activities. One other youth was killed and several others injured during the same incident.

Cause/Manner: Gunshot Wound to Head with Perforation of Brain/Homicide

2002 Youth Violence Related Homicides:

- ◆ Based on preliminary data for calendar year 2002, 26 youth identified as meeting the CFRC review criteria died from homicides attributed to youth violence. This represents 74% of the total homicides for the year (n = 35).
- ◆ In 96% of the youth violence homicides the decedents were African American youth; one was Hispanic.
- ◆ In 21, or 81% the decedents were males and five were females.
- ◆ Decedents ranged in age from 14 years to 20 years. The average, median and most frequent age for the 26 decedents was 18.
- ◆ The majority of fatal events for the violence related homicides occurred in Ward Seven (n = 9, or 35%) with Ward Five having the second largest number of deaths (n = 7).
- ◆ 100% of the fatalities were caused by firearms ("Gunshot Wounds").
- ◆ In 13 of the 18 cases where motive was known, argument or retaliation was the reason for the homicide (50% of the total youth violence related homicides). In two cases, although the manner of death was determined to be a homicide, investigations determined them to be accidental because the perpetrator admitted that the gun fired while playing with or showing the victim a gun.
- ◆ The majority of the deaths occurred on the streets or in public areas of the District (n = 15, or 58%). Three incidents occurred in a District residence, seven occurred in vehicles and one victim was found on school grounds although the investigation determined that the fatal event occurred elsewhere. One incident occurred in Maryland.
- ◆ Consistent with 2001 data, the time of death for the majority of the 2002 youth violence homicides (n = 21, or 81%) occurred between 7:00 PM and 6:00 AM.
- ◆ Nine, or 35% of the decedents were known to the child welfare system and 12, or 46% were known to the juvenile justice system.

2002 Fatal Child Abuse and Neglect:

- ◆ Fatal abuse and neglect deaths increased by 250% between calendar years 2001 and 2002. In 2002, seven children died from injuries attributed to abuse and/or neglect, representing 20% of the total number of child/youth homicides (n = 35).
- ◆ The seven victims ranged in ages from one month to four years, with the average age being two. Unlike 2000 and 2001 data, there were two victims over three years of age. Three children were under one year of age and four were between one and four years.
- ◆ Eighty-six (86) percent of the seven decedents who died from fatal abuse/neglect homicides were African American; one decedent was Hispanic.
- ◆ Seventy-one (71) percent (n = 5) were males and two were females (29%).
- ◆ Four, or 57% of the fatal incidents occurred within the decedents' homes, two in relatives' and one in the victim's godfather's residence. Five of these incidents occurred in Wards One, Four, Six, Seven and Eight; and two occurred in Maryland.
- ◆ Six, or 86% of the causes of death for the seven fatalities were associated with abuse (two "Shaken Baby Syndrome"; four Blunt Force Trauma"). One death was more associated with parental neglect. This case involved several children being left alone and one child, known for firesetting, started a fire in the bedroom of the victim who was disabled. The cause of death was "Thermal body Burns" and manner was determined to be homicide.

- ◆ The perpetrators of the seven fatal abuse/neglect deaths included fathers (n = 3), parent's paramours (n = 2), godfather (n = 1) and unrelated juvenile (n = 1).
- ◆ Three, or 43% of the mothers were known to the child protective services system prior to the fatal event and two cases were active at the time of death.
- ◆ Substance abuse was not a documented risk factor for any of the mothers of victims of 2002 fatal abuse/neglect deaths.

2001 Homicides

On an early winter morning of 2002, Maryland Fire and Rescue Units responded to a home in a surrounding state for a report of an unconscious child. When they arrived they found a 3-year old male child unconscious and unresponsive. The father reported to EMS staff that his son had fallen down approximately 6 carpet steps onto linoleum floor. He was immediately immobilized and transported to a local pediatric hospital. The father further explained to hospital staff that the child got up after falling and approximately 20 minutes later complained of head pain and then went to sleep. He called 911 because his child became unresponsive. Medics reported that upon their arrival the decedent's pupils were fixed and dilated; and he was in sinus bradycardia. There was also "small bruising" noted on his legs and chest and his abdomen was noted to be soft. Upon arrival at the hospital, the decedent was noted to be in a comatose state, with fixed and dilated pupils. Upon assessment/evaluation the child was determined to have subdural hematoma with herniation of the brain with left to right shift, parenchyma edema of the brain, and suspected laceration of the liver. The hospital assessment included "inflicted head trauma, inflicted abdominal trauma, and inflicted skin trauma. When questioned about the child's injuries, the father indicated that his son "fell down approximately 6 steps, hitting a concrete landing; he seemed to be okay; but 20 minutes later he was not okay and 911 was called." The assessment of the medical team was that the decedent's injuries were not consistent with the "alleged fall" reported by his father. His mother was interviewed on and she stated that "her son was on a court ordered visitation with his father" at the time of his death. Approximately one week later, the decedent was determined to be brain dead and was moved to a private room and with his mother, other family members and the hospital chaplain at his bedside, life support was withdrawn and he was pronounced dead at 3:55 PM. Based on review of multiple records there was documentation of past history of allegations of abuse of the decedents and domestic violence of the mother. The father was arrested and charged with 1st degree murder.

Cause/Manner: Blunt Impact Trauma/Homicide

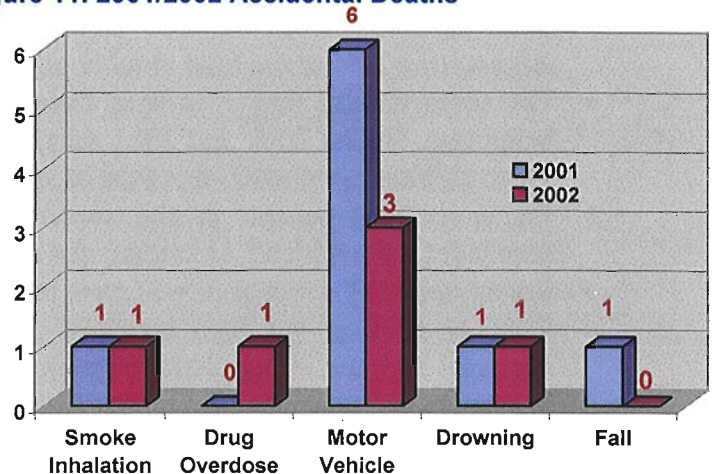
Unintentional Injuries

For purposes of this report, unintentional injuries are those incidents where the death was not deliberate. This cause category may include violent or non-violent conditions that were determined by the autopsy to be accidental. There were nine accidental deaths that occurred during calendar year 2001 and six that occurred during 2002. Figure 10 illustrates the number of deaths and types of accidents for 2001 and 2002.

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

- ◆ The number of 2001 accidental deaths represents a 36% (n = 9) decrease from the 14 similar deaths that occurred during 2000. Preliminary data from 2002 indicates a further reduction by one third from calendar year 2001 (n = 6).

Figure 11. 2001/2002 Accidental Deaths



- ◆ The ages of the 2001 decedents ranged from one to 21 years and from 5 to 20 years for calendar year 2002.
- ◆ Eighty-nine (89) percent (n = 8) of the 2001 decedents and 100% of the 2002 fatalities were African American. One accidental death from 2001 involved a Hispanic child.
- ◆ The majority of the decedents from 2001 and 2002 were male (n = 8 for 2001 and four for 2002).

Motor Vehicle Accidents

- ◆ The major cause of unintentional injury deaths examined by the Committee was motor vehicle accidents. The six deaths occurring in 2001 involved four motor vehicle accidents (two motor vehicle accidents had two decedents each) and one of the three accidents from 2002 included two decedents. One death from 2002 involved an accident that occurred in 1994 and the child died of injuries associated with that event.
- ◆ There were no pedestrian related motor vehicle accidents.
- ◆ Four of the 2001 and one of the 2002 decedents were passengers. Two 2001 and one 2002 decedents were the drivers of the vehicles at the time of the death. The ages of the decedents who were drivers ranged from 13 to 17 years with the average being 15.
- ◆ During 2001, all of the motor vehicle accidents occurred in the District, however, the locations varied throughout the city with no Ward specific trends. Two of the three motor vehicle accidents from 2002 occurred in Maryland.
- ◆ Based on investigations of these deaths, 100% of the 2001 decedents were not wearing seat belts at the time of their deaths. Seat belt information was not noted as part of the investigations of the 2002 motor vehicle fatalities. Three of the decedents were intoxicated at the time of their deaths. Other factors contributing to the deaths included speed in three of the four 2001 accidents and one of the 2002 accidents.

Smoke Inhalation and Drownings:

- ◆ There were equal numbers of drowning and smoke inhalation deaths during 2001 and 2002 (one for each year). Both of the drowning deaths involved five-year old African American children. One was a male who was committed to the District's child welfare system and, while visiting relatives in Virginia, drowned in a neighborhood swimming pool. Based on the review, caregiver negligence was a primary contributing factor. The second drowning involved a female child who was walking with her parents along the C & O Canal when she slipped and fell into the Canal.
- ◆ The two smoke inhalations involved five- and eight-year old African American males. The fires occurred within Wards Six and Seven in the decedents' homes. The 2001 fire was caused involved electrical wiring and combustibles. The 2002 fire was allegedly started by the decedent using an open flame and combustibles. He also had a history of mental health problems and fire setting.

Acute Intoxication:

- ◆ There was one accidental death during 2002 attributed to "Phencyclidine Toxicity". This death involved a 20-year old African American male. The youth was known to the juvenile justice and child welfare systems and the fatal incident occurred in Maryland in the decedent's home.

"2001 and 2002 Accidental Deaths"

Case 1:

During the summer of 2001, a 5-year old male who was committed to the foster care system was allowed to visit a relative in Virginia. During the visit he was permitted by this relative to accompany other relatives to a family reunion at a community pool in a surrounding state. During a lapse in supervision, he wandered off and was later found at the bottom of the deep end of the pool. Family members reported that they were unaware that the decedent had wandered off until they heard the lifeguard's whistle. The decedent required intensive supervision due to his history of attention deficit/hyperactivity disorder.

Cause/Manner: Drowning/Accident



Case 2:

Hospital reports indicate that in late winter of 2002 a 20 year old African American male was transported to the emergency room by EMS with CPR in progress and was pronounced dead shortly after arrival. During the investigation, the decedent's family and girlfriend reported that he had a history of mental illness, drugs, alcohol and tobacco use. Per the mother, the decedent received several mental health evaluations and had been increasingly depressed due to his problems with the criminal justice system. The decedent was known to act out and become violent when angry. Allegedly, he had often talked of suicide to his friends and family. When the family was questioned about the decedent's use of methadone, the mother stated that on the day of his death she was told, by her son's friend that he bought 10 Methadone pills apparently to commit suicide. The detective reported that the decedent had been suicidal, however, a note was not found. He also indicated that the girlfriend stated that the decedent had taken 20 unknown pills two to three days prior to his death however none were found at the residence. The girlfriend also stated that he would sometimes play dead and on the day of his death she thought that was what he was doing but when she later checked on him he was cold. Toxicology screens were positive for PCP and methadone and negative for alcohol.

Cause/Manner of Death: Phencyclidine Toxicity/Accident

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 10 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.

<i>Table 3 – Case Type</i>		
	2001 #/%	2002 #/%
Infant Mortality *	78/53%	78/60%
Child Welfare *	51/34%	37/28%
Juvenile Justice *	23/16%	13/10%
Community	29/20%	22/17%
* Percentages include # duplication in all categories except community		

Table 4 above illustrates the total number of deaths for calendar years 2001 and 2002 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

- There were equal numbers of infant deaths in calendar years 2001 and 2002 (n = 78), however, these infants represent different percentages of the total child death populations for those years. There were 78 infant deaths reviewed from calendar year 2001, representing 53% of the total child death population (n = 148). This represents a 16% decrease from the number of infant deaths reviewed in 2000 (n = 94). Based on preliminary 2002 data, there were also 78 infant deaths during this year, representing 60% of the 130 children identified.
- The ages of the decedents ranged from birth through 10 months, with the oldest 2001 decedent being nine months of age and the oldest 2002 decedent being 10 months. In 2001 and 2002, nearly three quarters (n = 57, or 73% and 56, or 72% respectively) of the infant population died within the first month. Out of the number of infants who died within the first month, 71% in 2001 (n = 44) and 61% in 2002 (n = 32) died within the first day of life.
- Sixty-nine, or 88% of the 2001 infant deaths were African American. There were equal numbers of Caucasian and Hispanic decedents (n = 4) and one Asian. Data from 2002 reflect a decrease in the number of African American infant deaths. During this year, 59 of the 77 infant fatalities were African American, representing a reduction of 10, or 14%.

Hispanic and Caucasian infant fatalities increased to nine and eight respectively, representing a 125% and 100% increase.

- In 50, or 64% of 2001 infant deaths the decedents were males. The number of female deaths increased during 2002 (n = 36) resulting in a decrease in the percentage of male deaths by 18% (n = 41).

◆ **District Ward of Decedents**

- In calendar year 2001, data indicate that the majority of the infant deaths involved residents of Ward Eight. Twenty-four, or 31% of the 78 decedents were residents from this Ward. Ward Seven ranked second with 11 deaths and Wards Six and Four ranked third, with 10 deaths each.
- During 2002, data revealed a different Ward distribution among the infant fatality population. Ward Eight ranked second (n = 11, 14%) to Ward Seven (n = 15, or 19%). The number of Ward Eight infant deaths represents a 54% reduction from 2001 infants while Ward Seven numbers increased by over a third (37%). In 2002, Ward Four continued to rank third (n = 10).

◆ **Gestational Age/Birth Weight**

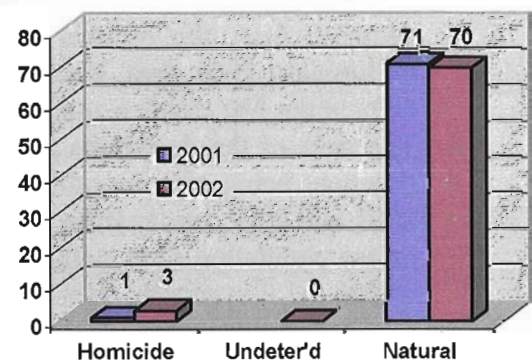
- Based on the review of the 2001 birth certificates, 65 (83%) of the infant deaths were born prematurely (under 38 weeks gestation). Twenty-one of the preterm births occurred prior to 23 weeks gestation. Out of the 66 premature infants, 22, or 33% weighed less than 500 grams and 12 weighed between 500 and 600 grams. Twelve, or 15% of 2001 decedents were full term births and had weights that ranged from 1672 to 3810 grams.
- Although, preliminary 2002 data indicate that the number of premature births decreased from 2001, it also supports the fact that premature and low birth weight births continue to be critical problems in the District and major contributing factors to infant mortality. Fifty-six, or 72% of the 78 infant fatalities were born premature and 20 of these births occurred prior to 23 weeks gestation. Out of the 56 premature infants, 22, or 39% weighed less than 500 grams and seven weighed between 500 and 600 grams. Twenty of the 2002 infants were full term births with weights that ranged from 2834 to 4621 grams.

◆ **Manner of Death**

Official manners of death were determined for 72 of the 2001 infant deaths (92%) and 74 of 2002 (95%). As with previous years, the greater majority of the 2001 and 2002 infants died from natural causes. In 99% (n = 71) of the 2001 infant deaths the manner was determined to be natural. Five of these deaths were attributed to SIDS and the remaining 66 were associated with medical problems.

Ninety-six percent (n = 71) of the 74 infant fatalities, where the manner of death was determined, were attributed to natural causes. Eight of these deaths were determined to be SIDS and 63 were related to medical problems.

Figure 12. Manner of Death - Infants



One of the 2001 and three of the 2002 infant deaths were determined to be homicides, all of which involved fatal abuse by a parent/caregiver. There was one death from 2001 where the manner was “undetermined”, and five from 2001 and four 2002 deaths where the manner remains pending.



◆ **Family Demographic Data**

○ **Mother's Data**

- Age was known for 74 of the 78 mothers of the 2001 and 73 of the 78 2002 infant deaths. In 2001, the ages of the mothers at the time of the death ranged from 16 to 46 years, with an average age of 27. In 2002, the ages ranged from 15 to 43, with an average age also of 27. The average age of the mothers of 2001 infants at the time of their first child was 18 and for the 2002 mothers the average was 22.
- The majority of the mothers for calendar years 2001 (n = 59) and 2002 (n = 55) had never married. In both years (2001 and 2002), 14 mothers were married.
- Education level was known for 55 of the 2001 and 53 of the 2002 mothers. Forty-two mothers of 2001 infants had at least a high school education and 10 of these women had either completed college or had some undergraduate level education. Thirteen mothers had less than a high school education, with educational levels ranging from 9th to 11th grades. Preliminary data from 2002 indicates that 32 mothers had a minimum of a high school education and 14 had education beyond high school with 11 having a bachelor's degree. Eighteen mothers had less than a high school education, with the lowest grade completed being seventh.
- In 2001, five mothers had histories of mental health problems and 24 had diagnosed physical health problems. Thirteen mothers had histories of sexually transmitted diseases and two of these women were HIV positive. Preliminary 2002 data indicates that three mothers had histories of mental health problems, 11 had diagnosed physical health problems and 12 had histories of sexually transmitted diseases, two of which were HIV positive.
- Twenty-five 2001 mothers had documented histories of substance abuse/use and 16 had positive toxicology screens at the time of birth of their child. In 2002, there were 13 mothers with documented substance abuse problems and five were positive at birth of the 2002 decedents.
- Of the 55 mothers of 2001 decedents where employment history was known, 39 (71%) were unemployed at the time of the infant death. Preliminary 2002 information revealed similar data in that the majority of the mothers where information was known were unemployed (59%).

○ *Sibling Data*

The majority of decedents in 2001 and 2002 had siblings. Out of 56 families from 2001 who were known to have other children, the average number of siblings was two and of the 44 families from 2002 with surviving siblings, the average was three. In 2001, five cases involved families who had experienced prior child deaths in calendar year 2000. There were no families in 2002 with prior deaths known to CFRC.

“2002 Natural Infant Death”

At 4:00 AM on a summer morning in 2002, a mother awoke and discovered her newborn child cold and unresponsive. She woke the father and called 911. The medics arrived and initiated CPR and the infant was transported to the nearest hospital. The infant was noted to be blue in color, without pulse and asystolic. Resuscitation attempts failed and the infant was pronounced dead 1 hour later. The father indicated that on the night prior the mother laid down on their queen size bed with their infant at 10:00 PM and they fell asleep. He later joined them, positioning himself on the opposite side of the mother. The father indicated that he heard the infant making noises at approximately 1:00 AM. It was also reported that the infant was in good health and was feeding well. She did not have a cold or any other problems. She was scheduled to see her pediatrician 3 days after her death. Her parents also reported that prior to the event the child slept in her crib.
Cause/Manner: Fossa Atrial Septal Defect/Natural

Juvenile Justice Fatality Data

Twenty-three of the 148 fatalities from 2001 and, as of the writing of this Report, 13 of the 131 fatalities identified from 2002 were youth known to the juvenile justice system. Reviews of these cases revealed the following findings:

◆ *Age of Decedent*

The average age of the 2001 and 2002 decedents was 18 years. The youngest decedent involved with the juvenile justice system was 15 in 2001 and 16 in 2002, and the oldest were 21 and 20 respectively.

◆ *Gender/Race of Decedent*

- Over 90% of the 2001 and 2002 decedents were African American (n = 22 in 2001 and 12 in 2002). There was one Hispanic decedent involved with the juvenile justice system in 2001 and 2002.
- Ninety-one percent of the 2001 (n = 21) and 100% of 2002 decedents involved with the juvenile justice system were male.

◆ *Substance Abuse*

As with previous years, substance abuse continued to be a major concern in the majority of the 2001 and 2002 juvenile justice fatality cases. In all of the reviews where substance abuse was a problem, the issue of inadequate drug treatment for juveniles was consistently highlighted.

- Ninety-one percent of the 2001 decedents (n = 22) had documented histories of involvement in substance use/sale.
- Preliminary 2002 data indicates that 11 out of the 13 cases identified included decedents who had been involved in substance use/sale.

◆ ***Educational Level of Decedent***

- Two decedents from each calendar year 2001 and 2002 had completed high school (one obtained a GED). The majority of decedents had completed grades 9 through 11 (n = 13, or 59% for 2001 and n = 9, or 69% for 2002).
- Eight of the 2001 and three 2002 decedents were in special education programs. Two 2001 decedents were enrolled in alternative programs that were ungraded.
- The majority of the decedents from both years who had not completed high school were exhibiting truant behavior (n = 11 for 2001/7 for 2002) and several had withdrawn from District public schools for various reasons (n = 1 for 2001/4 for 2002).

◆ ***Ward of Decedents Residence***

The majority of the decedents known to the juvenile justice system resided in Wards Six, Seven and Eight. Thirteen, or 59% of the youth from 2001 and nine, or 69% from 2002 were residents of these Wards.

◆ ***Manner/Cause of Death***

- Twenty-one of the 22 juvenile justice fatalities from 2001 were homicides and one was an accident. Twenty of the homicides were caused by gunshot wounds and one by strangulation. The accidental death was related to a motor vehicle accident.
- The manners of death for the 2002 juvenile justice fatalities included 11 homicides, one suicide and one accident. The cause of death for 12 of the 13 fatalities was gunshot wounds (including one suicide). The cause of the accidental death was related to a drug overdose.

◆ ***Juvenile/Court History***

○ ***Number of Arrests***

The majority of the juvenile justice decedents had numerous charges/arrests. Out of the 35 decedents from the 2001 and 2002 calendar years, 34, or 97% 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***

- Out of the 22 juvenile justice decedents from 2001, 15, or 68% of the cases were active at the time of the death. Nine of these youth were on probation, five were committed to the District and one was detained pending court/trial. In five of the active cases, the youth were in abscondence from the juvenile system. Three 2001 cases were closed within two years prior to the death as a result of either the juvenile satisfying the terms of probation/commitment or charges being dropped.
- Based on preliminary 2002 data, six of the 2002 decedents' juvenile justice cases were active at the time of their deaths and seven had been active within two years prior to the death. The six active cases included one committed youth, four on probation and one in a detained status.

"A 2002 Juvenile Homicide"

An 18-year old male was shot in the head and chest in a vehicle, at a busy intersection in Ward 5. The motive for the shooting was retaliation. There were other victims of non-fatal injuries at the scene. At autopsy he was positive for cocaine and PCP.

Cause/Manner of Death: Multiple Gunshot Wounds to Head/Chest/Homicide

Child Welfare Fatality Data

Child welfare deaths include children known to the protective services, foster care and adoption programs. Although the initial entry point for children and families known to the child welfare system is through the public child welfare program, services may have been provided to families/children through either the public and/or numerous private contract child welfare programs. During 2001, 51, or 34% of the 148 deaths identified were children who met the definition for review as a child welfare fatality. Preliminary 2002 data indicate that 37, or 28% of the 130 decedents were identified as child welfare fatalities. The following is data abstracted from child welfare fatalities reviewed:

Age of Decedent

The age of the decedents ranged from birth through 21 years of age for calendar year 2001 and birth through 20 for 2002. In 2001 and 2002, the average age was eight years. The majority of the children were under the age of one year (n = 21 for 2001/n = 16 for 2002) or older than 14 years of age (n = 18 for 2001/n = 12 for 2002). These two groups represented 76% of the total child welfare fatalities for both 2001 and 2002.

Race and Sex of Decedents

- ◆ Ninety-four percent of the 2001 and 97% of the 2002 deaths represented children/youth of African American descent. The remaining children/youth for both years were Hispanic.
- ◆ Males represented the majority of the child welfare child fatality population for both years (n = 36, or 70% for 2001/n = 22, or 59% for 2002).

Cause/Manner of Death

- ◆ 2001 Data
 - The manner of death for 26 of the 51 child welfare decedents (51%) was natural. Five of these deaths were caused by SIDS and 21 were caused by medical problems. Consistent with the overall population, the majority of the medical problems related to prematurity, low birth weight and congenital anomalies. The five SIDS deaths represent the total SIDS population for the year.
 - Sixteen decedents were victims of violence and 14 of these deaths involve older youth whose deaths were associated with youth violence (gangs, drugs and criminal behavior). The remaining two were children one year of age or younger who were victims of fatal abuse (100% of the fatal abuse deaths for 2001).
 - There were four accidental deaths, two resulted from motor vehicle accidents, one a fall from a window and one a drowning. Caregiver negligence was determined to be a contributing factor in two of the accidental deaths.
 - Six of the 2001 fatalities remain pending.

◆ **2002 Data (Preliminary Data)**

- Sixteen of the 37 decedents from 2002 died naturally. Two of these deaths were attributed to SIDS and 14 were caused by medical problems.
- Twelve deaths were homicides, eight of which were attributed to youth violence and 4 to fatal abuse/neglect. The decedents known to the child welfare system who died from fatal abuse/neglect represent 57% of the total abuse/neglect deaths for the 2002 year (n = 7). These children's ages ranged from 10 months to four years.
- Five child welfare deaths from 2002 were determined to be accidents; three were determined to be motor vehicle related, one resulted from a house fire and one was a drug overdose.
- Three of the 2002 child welfare fatalities remain pending.

Health/Mental Health of Decedents

- ◆ Half of the 2001 decedents (n = 26) had diagnosed health problems. Seven were born premature and died within one month of birth of congenital anomalies. Four of these children were prenatally exposed to drugs and/or alcohol. Fifteen children between the ages of two months through 20 years had diagnosed chronic health problems, such as Asthma, Diabetes, Heart Murmur, Brain Tumor, Allergies, Edward's Syndrome and HIV positive. Two children were mentally retarded.
- ◆ Less than a third (n = 10, or 27%) of the 2002 decedents had diagnosed health problems.
- ◆ Twelve youth (15 years of age or older) from 2001 and seven from 2002 were substance abusers.

Educational Level of Decedents

- ◆ Less than half of the 2001 decedents were school age (22, or 43%). Eighty-two percent of school age children were over 14 years of age (n = 18) and nine were over 18 years of age. The educational levels (last grade completed) for the 18 children/youth over the age of 14 ranged from 7th through 11th grades. However, at the time of their deaths, only three had graduated from high school and nine were enrolled in school. Thirteen youth were functioning at least one grade below grade level.
- ◆ In 2002, 13, or 35% of the 37 child welfare fatalities involved decedents 15 years of age or older; nine of whom were enrolled in school. None of the decedents had graduated from high school and eight were functioning below grade level.
- ◆ Four 2001 decedents and five from 2002 between the ages of five and 14 were enrolled in either special developmental programs or were functioning on task in regular programs.

Number and Reasons for Child Protection Services Referral

- ◆ The majority of the 2001 and 2002 families referred to the child welfare system were reported multiple times (n = 23, or 45% of the 2001/21, or 57% of the 2002 fatalities). The number of reports for 2001 ranged from one to 12 and for 2002 reports ranged from one to 13, with an average of three reports per family for both years.
- ◆ In over half of the child welfare fatalities, the decedent was part of the case (n = 28, or 55% for 2001/25, or 68% for 2002). In the majority of the fatalities where the decedent was not part of the child welfare record, the most common reason was they were born after the case closed (n = 15 for 2001/8 for 2002).

- ◆ Based on the last child abuse/neglect reports received, the primary reason for families being referred was “general neglect”. Thirty-three families from 2001 (65%) and 28 from 2002 (76%) were reported for general neglect issues. Physical abuse ranked second to neglect reports for both years.
- ◆ Maternal substance abuse was a documented factor for 30 of the 51 2001 fatalities and 14 of the 2002 fatalities.
- ◆ Twelve of the 2001 and three of the 2002 child welfare fatalities documented chronic mental health problems of the mother as a problem.
- ◆ 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 for both years (n = 48 for 2001 and 34 for 2002).

Case Status

- ◆ At the time of death, 24, or 47% of the 2001 child welfare fatalities were families with active cases. The remaining cases had closed within nine years prior to the death, with at 16 closures occurring four years prior to the death and nine of these cases closed two years prior to the death.
- ◆ In 2002, 23, or 62% of the families had active cases at the time of the child/youth’s death. Twelve of the remaining 14 cases closed four years prior to the death and ten of these cases closed within two years prior to the death.

“Two 2001 Child Welfare Deaths”

On an early spring morning of 2002 a 17-year old youth was driving a stolen vehicle. Other passengers in the vehicle included his 15-year old sister and her boyfriend. According to a park police report, the vehicle was noted to have the temporary tags improperly displayed and was pulled over. The officer approached the vehicle on the passenger side and requested a license and registration. The teenage driver reportedly looked at officers with a “blank stare” and sped off. A pursuit ensued. The teenager’s vehicle exited the parkway outside the District, then re-entered with the car headlights off. The vehicle came back on the ramp with its lights back on. A second officer joined in the pursuit and the teenager proceeded to repeatedly hit the brakes and intentionally swerved into one of the cruisers, causing minor sideswipe damage. The teenager continued at high speed in an attempt to evade the police, again striking the same cruiser, causing front right side bumper damage. Eventually, the driver lost control of the vehicle and hit a tree. The sister’s boyfriend fled from a window into the tree line but was eventually apprehended by the police. Shortly afterwards, flames were seen from the back of the vehicle. Reports by different officers reflect efforts to utilize extinguishers to smother the flames and efforts made to rescue the teenagers (driver and his sister) from the vehicle. Reportedly, the driver appeared dead, however, his sister was screaming for help and indicating that her foot was stuck, which made removal difficult. Ultimately, signs indicated that the vehicle was about to explode and the officers were directed to stand back, giving up efforts to rescue the youth, whose screams ceased only as the vehicle became totally engulfed in flames. Both teenagers died on the scene. They were both in abscondence from child welfare placements.

CAUSE/MANNER: Multiple Injuries Complicated by Smoke Inhalation

Appendices

2002 CFRC RECOMMENDATIONS

<i>General District-Wide Child and Family Services Programs</i>	<i>Status</i>
The Office of the Deputy Mayor for Children Youth and Families and the Elderly (ODMCYFE) should consider establishing a multi-agency case management system, including: a uniform initial intake and referral process; a mechanism for conducting multi-agency/multi-disciplinary staffing on high risks clients of multiple agencies; a city-wide management information system (database); a mechanism to provide joint interagency training/orientation; a "Funding Pool" to assist in meeting the costly needs of children, youth and families serviced by multiple District agencies, and a specialized clinical case management program that provides intensive services to high-risk families with multiple/complex problems that cross multiple systems.	Implementing as part of Safety Net
Metropolitan Police Department (MPD) and DOH should evaluate the apparent increase in gun violence and gun availability and develop strategies/resources related to addressing this issue as a public health problem.	Implementing
<i>Resource Development</i>	
DOH should increase funding and develop a continuum of drug treatment resources (in/out patient services) for juveniles, pregnant women and women with children.	Implementing
DOH should devise a plan to address the shortage of emergency/trauma and other medical resources in the far NE, SE areas of the District causing more children to be transported to Maryland hospital.	Implementing
DOH should take the lead in reviewing the need for developing a District-wide long-term home visiting nurses program for high-risk parents.	Implementing
DMH should take the lead in developing a pool of residential treatment facilities that meet varying needs of children/youth and meet the standards established by the District.	Implementing
DHS/Early Intervention Program (EIP) should add "neonatal abstinence syndrome" or "intrauterine exposure to drugs" to the at-risk neonatal conditions that qualify for EIP services.	Response Pending
To supplement the effectiveness of domestic violence restraining orders, the MPD, should consider providing cellular phones to improve communication between abused women and the police; and improve training for police officers regarding domestic violence and improve protocols related to response of police in domestic violence cases	Response Pending
<i>Interagency Coordination and Collaboration</i>	
DHS/YSA and CSSD should implement procedures and practices to ensure consistent random urine surveillance throughout the periods of detainment and commitment for youth with drug related histories, drug charges or initial positive drug test results.	Response Pending
YSA and CSSD should develop formal methods of collaboration regarding the progress or problems of juveniles who are supervised by CSSD, but receive YSA community residential, detention, supervision or other services.	Response Pending
YSA, CSSD and CFSA should establish a procedure for conducting mandatory data	Implemented

system crosschecks for all adolescents entering their systems to determine if they have dual child welfare and juvenile involvement, and require cross-agency service coordination and planning.	and Ongoing
CFSA and DHS should develop policy and establish/strengthen agreements related to the provision of Mental Retardation and Developmental Disabilities Administration (MRDDA) and Rehabilitation Services Administration (RSA) services to parents, children, and adolescents with disabilities, mental retardation and developmental delay.	Implementing
Metropolitan Police Department (MPD), CFSA, DHS and CSSD should examine the issues associated with the chronic problem of child/youth abscondence and devise a multi-agency approach to service delivery, including adequate staff, appropriate placements and treatment/management services.	Response Pending
DOH, Managed Care and Health Maintenance Organizations (MCO/HMO) and appropriate child serving agencies should collaborate to identify a mechanism to assist health care providers and MCO/HMO's in locating high-risk families/infants when children are not receiving appropriate medical care. Consideration should be given to devising methods of sharing and/or linking information among agencies serving the same families.	Implementing
<i>Monitoring and Accountability</i>	
DCPS should ensure appropriate and timely assessment of special education eligibility and IEP development, including an adequate system of post-placement monitoring to ensure stability.	Ongoing
DCPS should establish a mechanism to monitor and enforce local schools' compliance with established attendance intervention procedures for children who have chronic attendance problems or who are truant.	Implemented & Ongoing
DOH should require MCO/HMO's to establish a system that "flags" infants who have not received follow-up medical care after hospital discharge (30 days or more after discharge) and refer these infants for case management services.	Implementing
DMH should take the lead in developing and implementing: city-wide standards and protocols for multi-agency monitoring of residential treatment facilities where District children are placed; and standards of care for intensive monitoring of children receiving multiple or high dose psychotropics who are living in the community.	Response Pending
CFSA should provide medical counseling and education appropriate to parents'/families' level of function or developmental capacity related to medical decision-making and treatment of their children (including "do not resuscitate".)	Complete and Ongoing
<i>Policy and Practice Standards</i>	
OCME, in collaboration with District based obstetricians, should establish a process to review all maternal deaths.	Response Pending
DMH and DOH in collaboration with hospitals and medical associations should develop models for post-partum depression screening and determine the criteria for routine use.	Implementing
Working with local hospitals, medical associations and social work organizations, DOH should take the lead in improving citywide hospital policy and practice regarding comprehensive and consistent discharge planning, including depression and domestic violence screening.	Implementing
DOH with the assistance of DC Hospital Association should encourage District hospitals to use a standard risk assessment tool to evaluate patients' need for service referrals.	Implementing

DOH should collaborate with MCO/HMO's and other insurance providers to ensure that observation beyond the routine newborn nursery stay, for adverse effects on intrauterine exposure to toxic/addictive substances is a valid and reimbursable medical treatment.	Complete
DOH and other appropriate District government and private agencies should examine the feasibility of developing a team approach to managing high risk pregnancies that includes social services, visiting nurses, nutritionists and health educators.	Implementing
DOH should provide a structured program of support and follow-up for families affected by SIDS.	Implementing
DOH should take the lead in exploring the feasibility of establishing a standard of care for women to receive HIV screening as part of obstetrical medical care.	Implementing
DOH should establish a data system to identify the incidence of congenital abnormalities in infants born in the District.	Implementing
DOH should ensure that managed care organizations and other insurers provide reimbursement to hospitals for genetic studies and counseling.	Complete
CFSA should consider a policy of acquiring birth records of committed children, ages four and younger, and medical treatment history for all committed children/youth.	Implementing
MPD and OCME should ensure that the death scene investigation includes re-enactment of the sleeping arrangements for all cases of children six months or younger where it was known that co-sleeping and sleeping environments/positions were factors in the death.	Response Pending
<i>Training and Public Education</i>	
DOH, in collaboration with DHS, CFSA, MCO/HMO's and other community organizations should make a concerted effort to reach those most at risk and provide SIDS education/literature.	Implementing
DOH and ACOG should educate the medical community regarding the identification of high-risk pregnancies and the appropriate medical management and referrals.	Implementing
DOH should establish a clearinghouse of information (English and Spanish) on child safety including CPR, immunization, shaken baby syndrome, and "danger signals" for seeking emergency medical care. This information should be made available to hospitals, health care providers and the general public.	Implementing
DOH should conduct a public education campaign that encourages adequate periconceptual diets and medical care.	Implementing

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) Information 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 28 of the Health 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)(1) of this section, information and records concerning a current law enforcement investigation may be withheld, at 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 18 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 et seq.), 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 pursuant 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 (Enrolled 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 residents 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 files 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".

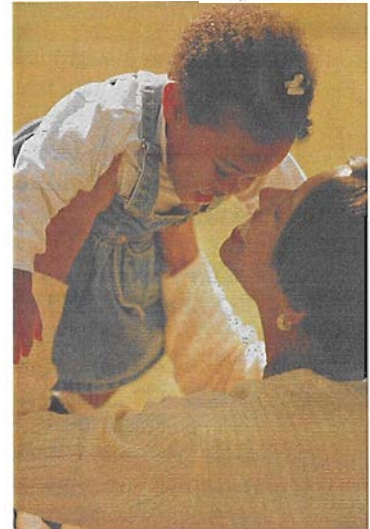
Sec. 4621. Fiscal impact statement.

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 10 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.

2001 Calendar Year Fatality Listing

<i>Years/Months/Days</i>	<i>Immediate Cause of Death</i>	<i>Manner of Death</i>
0/0/0	Extreme prematurity, non-viable gestational age, pre-term labor, maternal incompetent cervix	Natural
0/0/0	Termination of pregnancy, therapeutic, premature cervical dilation, incompetent cervix	Natural
0/0/0	Extreme prematurity 22-23 weeks, maternal placental abruption, undetermined etiology	Natural
0/0/0	Extreme prematurity @ 21 weeks, premature rupture of membranes, undetermined etiology	Natural
0/0/0	Prematurity, preterm delivery, undetermined etiology	Natural
0/0/0	Previae preterm infant, premature labor, incompetent cervix	Natural
0/0/0	Extreme prematurity 21 weeks, preterm labor w/ premature rupture of membranes, maternal incompetent cervix	Natural
0/0/0	Extreme prematurity incompatible w/ life	Natural
0/0/0	Fetal sepsis, chorioamnionitis	Natural
0/0/0	Anacephaly, respiratory failure	Natural
0/0/0	Extremely premature EGA 23 weeks, pulmonary insufficiency, multiple congenital anomalies	Natural
0/0/0	Extreme prematurity @ 22 weeks, prolonged rupture of membranes, incompetent cervix	Natural
0/0/0	Extreme prematurity	Natural
0/0/0	Previability @19 weeks gestation, etiology undetermined	Natural
0/0/0	Extreme prematurity @ 23 weeks, prolonged rupture of membranes, incompetent cervix	Natural
0/0/0	Extreme prematurity @ 22 weeks, prolonged rupture of membranes	Natural
0/0/0	Pulmonary hypoplasia, oligohydramnios, bladder outlet obstruction	Natural
0/0/0	Induced abortion by urea intra-amniontic injection, severe congenital anomaly, conjoined twins	Natural
0/0/0	Induced abortion by urea intra-amniontic injection, severe congenital anomaly, conjoined twins	Natural
0/0/0	Congenital anomalies	Natural
0/0/0	Preterm labor, premature delivery, chorioamnionitis of unknown etiology	Natural
0/0/0	Pending	Pending
0/0/0	Respiratory failure, immaturity (22 weeks), premature rupture of membranes, incompetent cervix	Natural
0/0/0	Pulmonary immaturity; extreme prematurity, preterm labor, premature rupture of membranes undetermined etiology	Natural
0/0/0	Pending	Natural
0/0/0	Extreme prematurity @ 21 weeks, premature rupture of membranes, unknown etiology	Natural
0/0/0	Germinal matrix hemorrhage, prematurity, maternal cocaine abuse	Natural
0/0/0	Cardio-respiratory failure and arrest, multi-system failure, extreme prematurity	Natural
0/0/0	Provability @ 23 weeks gestation, twin gestation	Natural
0/0/0	Extreme prematurity, chorioamnionitis and funisitis	Natural
0/0/0	Prematurity @ 23 weeks, premature rupture of membranes, incompetent cervix	Natural
0/0/0	Cardio-pulmonary failure, severe respiratory distress syndrome, extreme prematurity 23-24 weeks	Natural
0/0/0	Cardio-respiratory failure	Natural
0/0/0	Cardio-pulmonary failure, fulminant gram negative septic shock, prematurity 30 weeks, chorioamnionitis and funisitis	Natural
0/0/0	Severe prematurity (23 weeks gestation), chorioamnionitis	Natural
0/0/0	Previae fetus, incompetent cervix, group beta strep infection	Natural
0/0/0	Pending	Pending
0/0/0	Congenital anomalies, trisomy 18, congenital diaphragmatic hernia, congenital heart disease	Natural
0/0/0	Previae birth due to ascending infection of amniotic fluid due to premature rupture of membranes	Natural

1 Day	Extreme immaturity, (24 weeks gestation), prolonged premature rupture of membranes, chorioamnionitis, twin gestation	Natural
1 Day	Complications of prematurity including intraventricular hemorrhage, maternal hypertension	Natural
1 Day	Previa infant (21 weeks), premature delivery, preterm premature rupture of membranes	Natural
1 Day	Respiratory failure due to extreme prematurity	Natural
1 Day	Extreme prematurity, incompatible w/ life	Natural
2 Days	Prematurity	Natural
3 Days	Polysplenia syndrome w/ atrial septal defect	Natural
3 Days	Extreme immaturity @ 23 weeks gestation, preterm labor, premature rupture of membranes, undetermined etiology	Natural
3 Days	Congenital cyanotic heart disease, etiology unknown	Natural
4 Days	Cardiac arrhythmia, electrolytes imbalance, 23 weeks extreme prematurity, incompetent cervix	Natural
7 Days	Respiratory failure, hyaline membrane disease, extreme prematurity, premature rupture of membranes, unknown etiology	Natural
8 Days	Sepsis, Hirschsprung's disease	Natural
8 Days	Bilateral intraventricular hemorrhage, respiratory distress syndrome, extreme prematurity, undetermined etiology	Natural
8 Days	Overwhelming sepsis, extreme prematurity, unknown etiology	Natural
8 Days	Pulmonary failure, trisomy 18	Natural
9 Days	Septic shock, serratia marcescens sepsis	Natural
17 Days	Renal failure, extreme prematurity, hyperkalemia	Natural
22 Days	Dandy Walker Malformation	Natural
1 Month/7 Days	Intracranial hemorrhage, thrombocytopenia, disseminated intravascular, coagulation, septic shock, meningitis	Natural
1 Month/15 Days	Necrotizing enterocolitis, presumed sepsis, pulmonary hemorrhage, prematurity	Natural
1 Month/21 Days	Pending	Pending
1 Month/29 Days	Starvation due to nutritional neglect	Natural
2 Months/4 Days	Renal failure w/ metabolic aberration, necrotizing enterocolitis, premature delivery	Natural
2 Months/7 Days	Pending	Pending
2 Months/15 Days	Undetermined	Undeter'd
2 Months/25 Days	Pneumonia, sepsis, prematurity	Natural
3 Months/3 Days	Hypoxic ischemic encephalopathy, broncho pulmonary dysplasia, extreme prematurity @ 24 weeks, cervical incompetence	Natural
3 Months/5 Days	Sudden infant death syndrome	Natural
3 Months/7 Days	Sudden infant death syndrome	Natural
3 Months/23 Days	Sudden infant death syndrome	Natural
4 Months/1 Day	Chronic lung disease, respiratory failure, prematurity, maternal hypertension and diabetes	Natural
4 Months/26 Days	Sudden infant death syndrome	Natural
5 Months	Sudden infant death syndrome	Natural
5 Months/11 Days	Dehydration due to respiratory tract infection complicating prematurity due to placenta previa	Natural
5 Months/15 Days	Dehydration due to infectious gastroenteritis, etiology unknown	Natural
5 Months/23 Days	Bronchopneumonia due to chronic complications of prematurity due to placental uterine insufficiency	Natural
7 Month/1 Day	Intractable bradycardia, electrolyte imbalance, renal failure, overwhelming sepsis	Natural
8 Months/3 Days	Double outlet right ventricle, trisomy 18	Natural
9 Months/15 Days	Strangulated inguinal hernia	Natural
1 Year/1 Day	Blunt impact head trauma	Accident
1 Year/1 Day	Aspiration pneumonia	Natural
1 Year/3 Days	Pending	Pending
1 Year/3 Days	Incised wound to neck	Homicide
1 Year/7 Days	Complications of septio-optic dysplasia	Natural
1 Year/10 Days	Brain herniation, neuroblastoma	Natural
2 Years	Pending	Pending
2 Years	Anemia, pancytopenia, thrombocytopenia, hypersplenism, chronic hepatitis, cholestasis	Natural
2 Years	Sepsis, presumed sepsis	Natural

3 Years	Acute respiratory failure, aspiration pneumonia, static encephalopathy	Natural
4 Years	Brainstem glioma	Natural
5 Years	Smoke inhalation	Accident
5 Years	Drowning	Accident
5 Years	Alpers-Huttenlocher syndrome and sequelae	Natural
7 Years	Inhalation of products of combustion	Undeter'd
8 Years	Inhalation of products of combustion	Undeter'd
8 Years	Brain stem dysfunction and seizures, progressive metastatic spinal cord tumor	Natural
9 Years	Acute viral myocarditis	Natural
10 Years	Cardiogenic shock, respiratory failure w/ bilateral Pneumonia, HIV/AIDS infection	Natural
10 Years	Pending	Pending
10 Years	Pending	Pending
11 Years	Unknown (911 Plane Crash)	Unknown
11 Years	Unknown (911 Plane Crash)	Unknown
11 Years	Unknown (911 Plane Crash)	Unknown
13 Years	Diabetic ketoacidosis	Natural
13 Years	Blunt impact trauma w/ fracture of skull	Accident
13 Years	Blunt impact head trauma	Accident
15 Years	Gunshot wound to head w/ perforation of brain	Homicide
15 Years	Blunt impact head trauma	Accident
15 Years	Gunshot wound to head and torso perforating brain and heart	Homicide
16 Years	Cardiac respiratory failure, septic shock, end stage AIDS	Natural
16 Years	Neurofibromatosis	Natural
16 Years	Gunshot wound to back w/ perforation of kidney, liver, heart and lung	Homicide
16 Years	Gunshot wound to back w/ perforation of lung and heart	Homicide
16 Years	Gunshot wound to head w/ perforation of brain	Pending
16 Years	Gunshot wound to head w/ perforation of brain	Pending
16 Years	Complications of congenital heart disease, tetralogy of fallot, surgically repaired	Natural
17 Years	Gunshot wound of head w/ perforation of brain	Homicide
17 Years	Gunshot wound to chest perforating heart	Pending
17 Years	Gunshot wound to torso w/ injuries of aorta, kidney and inferior vena cava	Homicide
17 Years	Gunshot wounds to torso w/ perforations of liver, spleen, lung mesentary	Homicide
17 Years	Blunt impact trauma w/ fracture of skull and atlanto-axial dislocation	Accident
17 Years	Gunshot wound to torso perforating liver	Homicide
17 Years	Gunshot wound to head w/ perforation of brain	Homicide
18 Years	Gunshot wounds to chest w/ perforations to heart and lungs	Homicide
18 Years	Gunshot wound to head w/ penetration of brain	Suicide
18 Years	Gunshot wound to back w/ injury to lung	Homicide
18 Years	Gunshot wounds w/ injuries of brain, aorta and lung	Homicide
18 Years	Gunshot wound to chest	Homicide
18 Years	Gunshot wound to head w/ perforation of brain	Homicide
18 Years	Gunshot wound to head w/ perforation of brain	Homicide
18 Years	Multiple gunshot wounds	Homicide
18 Years	Multiple gunshot wounds	Homicide
18 Years	Blunt impact trauma w/ skeletal fractures and visceral lacerations	Accident
18 Years	Gunshot wound of posterior chest perforating lung and aorta	Homicide
19 Years	Gunshot wound of back w/ perforation of spinal cord and lung	Homicide
19 Years	Gunshot wound of back w/ perforation of lung	Homicide
19 Years	Gunshot wound to head and back w/ perforations to brain, lung and heart	Homicide
19 Years	Multiple gunshot wounds	Homicide
19 Years	Gunshot wounds of head w/ injuries of brain	Homicide
19 Years	Gunshot wound to back w/ injuries of heart, lungs and esophagus	Homicide
19 Years	Gunshot wound of head w/ perforation of brain	Homicide
20 Years	Gunshot wound of chest	Homicide
20 Years	Multiple gunshot wounds	Homicide
20 Years	Gunshot wound to head w/ perforation of brain	Homicide
20 Years	Gunshot wound of torso w/ injury to spleen, liver, heart and lung	Homicide

20 Years	Seizure disorder	Natural
20 Years	Gunshot wound to head perforating brain	Homicide
21 Years	Multiple blunt impact trauma	Accident
21 Years	Strangulation, suffocation	Homicide

2002 Calendar Year Fatality Listing

<i>Years/Months/Days</i>	<i>Immediate Cause of Death</i>	<i>Manner of Death</i>
0/0/0	Cardiorespiratory arrest, cardiovascular shock, congenital heart disease and sepsis	Natural
0/0/0	Extreme prematurity, preterm labor, prolonged premature rupture of membranes	Natural
0/0/0	Extreme prematurity, prolonged premature labor	Natural
0/0/0	Cardiorespiratory failure and arrest, multi-system failure, extreme prematurity	Natural
0/0/0	Cardiorespiratory failure and arrest, multi-system failure extreme prematurity	Natural
0/0/0	Abnormal cerebellum hydrocephalus	Natural
0/0/0	Acute chorioamnionitis	Natural
0/0/0	Extreme prematurity, premature rupture of membranes, etiology undetermined	Natural
0/0/0	Prematurity, therapeutic termination of pregnancy	Natural
0/0/0	Prolonged rupture of membranes, extreme prematurity, undetermined etiology	Natural
0/0/0	Fetal immaturity, congenital anomalies, cortical atrophy	Natural
0/0/0	Cardiopulmonary failure, extreme prematurity, preterm labor	Natural
0/0/0	Cardiopulmonary failure, extreme prematurity, preterm labor of undetermined etiology	Natural
0/0/0	Chorioamnionitis	Natural
0/0/00	Sepsis, premature rupture of membranes	Natural
0/0/00	Extreme prematurity, respiratory distress, congenital anomalies	Natural
0/0/0	Chorioamnionitis	Natural
0/0/0	Cardiopulmonary failure, extreme prematurity 21 wks, premature rupture of membranes, premature labor	Natural
0/0/0	Extreme immaturity	Natural
0/0/0	Pending	Pending
0/0/0	Infection, chorioamnionitis @ 22 weeks gestation	Natural
0/0/0	Respiratory failure, fetal hydrops, congenital syphilis	Natural
0/0/0	Severe prematurity	Natural
0/0/0	Chorioamnionitis, extreme prematurity	Natural
0/0/0	Therapeutic termination of pregnancy @23 weeks gestation, Hunter's disease	Natural
0/0/0	Extreme prematurity, incompetent cervix	Natural
0/0/0	Preterm labor failed tocolysis	Natural
0/0/0	Preterm labor, failed tocolysis	Natural
0/0/0	Cardiopulmonary failure, extreme prematurity, chorioamnionitis	Natural
0/0/0	Extreme prematurity @ 21 weeks gestation, incompetent cervix	Natural
1 Day	Pulmonary hemorrhage, extreme prematurity	Natural
1 Day	Hypoplastic left heart syndrome	Natural
1 Day	Respiratory distress syndrome, sepsis	Natural
2 Days	Sudden infant death syndrome	Natural
3 Days	Severe hypoxemia, persistent pulmonary hypertension, sepsis	Natural
3 Days	Respiratory failure, pulmonary interstitial emphysema, extreme prematurity	Natural
4 Days	Grade 3 intracranial hemorrhage intraventricular, 23 wks gestation, premature rupture of membranes, unknown etiology	Natural
4 Days	Fossa (secundum) atrial septal defect	Natural
4 Days	Pulmonary hypertension	Natural
5 Days	Extreme prematurity, premature labor of unknown etiology	Natural
5 Days	Trisomy 13, apnea	Natural
5 Days	Respiratory insufficiency, pneumonia, premature rupture of membranes	Natural
7 Days	Sudden infant death syndrome	Natural

8 Days	Cardiorespiratory failure and arrest, severe respiratory distress syndrome and air leak syndrome, extreme prematurity	Natural
9 Days	Prematurity of unknown etiology, aortic clot due to UAC line	Natural
9 Days	Extreme prematurity, maternal drug abuse, sepsis, metabolic acidosis	Natural
10 Days	Sepsis, left lower extremity, lower abdomen and perineal necrosis, extreme prematurity, maternal preeclampsia	Natural
10 Days	Congenital renal failure, congenital renal anomalies of undetermined etiology	Natural
11 Days	Sepsis, respiratory failure, omphalocele	Natural
14 Days	Sudden infant death syndrome	Natural
14 Days	Hypoplastic left heart syndrome	Natural
15 Days	Necrotizing enterocolitis, extreme prematurity	Natural
21 Days	Fetal immaturity, premature labor, premature rupture of membranes, undetermined etiology	Natural
21 Days	Fulminant gram negative sepsis, necrotizing enterocolitis, extreme prematurity, maternal nephritic syndrome	Natural
21 Days	Pending	Pending
25 Days	Sudden infant death syndrome	Natural
29 Days	Sepsis, bronchial pneumonia, prematurity 22-23 wks, etiology undetermined	Natural
1Month/1 Day	Sudden infant death w/ diffuse alveolar damage in association w/ gastroesophageal reflux	Natural
1 Month/4 Days	Complications of prematurity due to maternal cocaine abuse	Natural
1 Month/18 Days	Acute bronchopneumonia following probable viral respiratory infection	Natural
1 Month/18 Days	Sudden infant death syndrome	Natural
1 Month/20 Days	Pending	Pending
1 Month/20 Days	Sudden infant death syndrome	Natural
1 Month/20 Days	Shaken baby syndrome	Homicide
2 Months/3 Days	Sudden infant death syndrome	Natural
2 Months/12 Days	Arrhythmia, unbalanced atrioventricular canal defect	Natural
2 Months/27 Days	Sudden infant death syndrome	Natural
3 Months/2 Days	Acute leptomeningitis	Natural
4 Months/11 Days	Blunt impact head trauma	Homicide
4 Months/12 Days	Cor pulmonale, severe bronchopulmonary dysplasia, 26 weeks gestation	Natural
4 Months/15 Days	Extreme prematurity, respiratory failure, bronchopulmonary dysplasia	Natural
5 Months	Congestive heart failure/ COR pulmonale, prematurity, hyaline membrane disease, bronchopulmonary dysplasia	Natural
5 Months	Neisseria meningitis	Natural
5 Months	Right ventricular failure, bronchopulmonary dysplasia, extreme prematurity, preterm labor of unknown etiology	Natural
7 Months/18 Days	Pending	Pending
7 Month/28 Days	Lymphocytic myocarditis	Natural
8 Months/12 Days	Streptococcus pneumonia sepsis, meningitis	Natural
10 Months	Shaken baby syndrome	Homicide
1 Year	Blunt force impact trauma to abdomen	Homicide
1 Year	Incised wound of neck transecting larynx and major blood vessels	Homicide
3 Years	Blunt impact head trauma	Homicide
4 Years	Disseminated fungal sepsis, acute relapsed myelogenous leukemia, Down's syndrome	Natural
4 Years	Thermal body burns to 60% of total body area	Homicide
4 Years	Blunt impact head trauma	Homicide
5 Years	Drowning	Accident
7 Years	Acute bronchopneumonia due to global hypoxic ischemic encephalopathy due to intrauterine blunt trauma	Accident
8 Years	Smoke inhalation	Accident
9 Years	Multiple gunshot wounds	Homicide
9 Years	Respiratory failure, brain stem glioma	Natural
9 Years	Respiratory arrest, S/P partial brainstem herniation, brainstem tumor	Natural
10 Years	Idiopathic hypertrophic cardiomyopathy	Natural

11 Years	Respiratory distress	Natural
12 Years	Cardiogenic shock, metastatic mesothelioma	Natural
13 Years	Streptococcus viridans group sepsis due to microcephaly	Natural
13 Years	Acute respiratory failure, pneumonia, severe aplastic anemia	Natural
14 Years	Gunshot wound to chest lacerating aorta and left brachiocephalic vein	Homicide
15 Years	Mitral valve disease, congested heart failure, multi-organ dysfunction	Natural
15 Years	Gunshot wound to head w/ perforation of brain	Homicide
15 Years	Gunshot wound to head w/ perforation of brain	Homicide
15 Years	Multiple injuries complicated by smoke inhalation	Accident
15 Years	Bronchial asthma w/ acute exacerbation	Natural
15 Years	Gunshot wound to head w/ perforation of brain	Homicide
16 Years	Vaso-occlusive crisis of sickle cell anemia	Natural
16 Years	Multiple gunshot wounds to neck and chest	Homicide
16 Years	Brain tumor (medulloblastoma) progression	Natural
16 Years	Multiple injuries complicated by smoke inhalation	Accident
17 Years	Multiple gunshot wounds	Homicide
17 Years	Gunshot wounds of chest perforating aorta, pulmonary artery and left main bronchus	Homicide
17 Years	Sickle cell anemia	Natural
17 Years	Gunshot wounds	Homicide
17 Years	Gunshot wounds of head w/ perforations of brain	Homicide
17 Years	Gunshot wound of head w/ perforation of brain	Homicide
17 Years	Gunshot wound	Homicide
18 Years	Gunshot wounds to head w/ transection of medulla	Homicide
18 Years	Gunshot wound to head penetrating brain	Homicide
18 Years	Gunshot wounds to head and chest w/ injuries of brain, heart and lung	Homicide
18 Years	Gunshot wound to head w/ perforation of brain	Homicide
18 Years	Multiple gunshot wounds	Homicide
18 Years	Gunshot wounds to torso penetrating heart and lung	Homicide
18 Years	Gunshot wound to head perforating cervical spinal cord	Homicide
18 Years	Gunshot wound to chest w/ perforation of subclavian vein and right lung	Homicide
18 Years	Gunshot wounds of head w/ perforations of brain	Homicide
19 Years	Gunshot wound to head w/ perforation of brain	Homicide
19 Years	Gunshot wound to head penetrating brain	Homicide
19 Years	Gunshot wound to neck injuring jugular vein and the cervical spinal cord	Homicide
19 Years	Multiple gunshot wounds	Homicide
19 Years	Gunshot wound	Homicide
20 Years	Gunshot wound to back w/ injuries of heart, aorta, liver, kidney, lung and spinal cord	Homicide
20 Years	Gunshot wound of head w/ perforation of brain	Homicide
20 Years	Phencyclidine toxicity	Accident

District of Columbia Child Fatality Review Committee



2001/2002 Annual Report

Sudden Infant Death Syndrome Risk Factors

<i>2001 Deaths - SIDS Risk Factors</i>										
Infant Age	Weeks Gestation / Birth Weight	Child Risk Factors/ Medical Indicators	Mother Age/Ed	Maternal Risk Factors	Prenatal Care	Sleeping Position	Sleeping Environment/Co-Sleeping	CPR Prior to EMS	Caregiver At Death	
4 Months/ 19 Days	38/2069 grams	Upper Respiratory Infection (URI); No crib; Formula feed; Living in shelter	23/GED	None	10 visits	Side	Sofa w/ mother sleeping at opposite end	Mother	Mother	
5 Months/ 8 Days	40/2579 grams	URI; No crib; Formula feed	21/10 th	Drug/alcohol/ Tobacco use; STD	10 visits	Stomach	Sofa cushion w/ sibling; 4 infant blankets and 1 twin blanket	Mother	Mother	
3 Months/ 5 Days	38/2580 grams	URI; no crib; formula feed; Hx of Cardio-Respiratory Arrest, Apnea; Unkempt living environment	24/12 th	Alcohol/tobacco use;	1 visit	Back	King mattress on floor w/ mother, father and 3 sibling; 2 pillows, blankets, sheet	Relative	Mother	
4 Months/ 26 Days	40/3798 grams	URI; No crib; Formula feed	25/10 th	Alcohol/tobacco use; STD	9 visits	Stomach	Sofa on mother's chest w/ 2 blankets and 3 pillows	Mother	Mother	
3 Months/ 23 Days	37/2325 grams	URI; mild respiratory distress/GBS at birth, no crib; Formula feed; Unkempt living environment	18/11 th	Drug/tobacco use; STD	5 visits	Back	Sofa; blanket, pillow and crib bumper	Relative	Mother	

2002 Deaths - SIDS Risk Factors

Infant Age	Weeks Gestation / Birth Weight	Child Risk Factors/ Medical Indicators	Mother Age/Ed	Maternal Risk Factors	Prenatal Care	Sleeping Position	Sleeping Environment/Co-Sleeping	CPR Prior to EMS	Caregiver At Death
2 Months/ 2 Days	39/3005 grams	Drug exposure; Sleeping problems; Formula fed	35/Unk	Drugs; criminal behavior; STD; hypertension; allergies	8 visits	Side	Bassinet	Aunt	Aunt
7 Days	38/2579	Breast fed; Twin	39/12 th	Alcohol use; twin gestation; hypertension	9 visits	NA	Breastfeeding at time of death	Mother	Mother
1 Months/ 19 Days	39/3288	Formula fed; Living in shelter	22/9 th	Alcohol/drugs/ tobacco; criminal behavior; learning disabled; GBS; homeless; depression	10 visits	Stomach	Crib w/infant blanket and 2 other blankets	Shelter staff	Mother
25 Days	40/2948	Formula fed; No crib; Lives in home w/ 12 relatives; Unkempt living environment	21/12 th	Alcohol/tobacco use; STD	None	Side	Adult bed on pillow w/mother & grandmother	Mother	Mother
2 Days	38/3370	Breastfed	32/16	None	8 visits	Side	Hospital adult bed w/ mother	NA	Both Parents
14 Days	35/2530	Formula fed; Feeding problems; No medical follow-up; Respiratory distress; Unresolved elevated bilirubin count	18/9 th	Alcohol/Drugs/ Tobacco use; Asthma	10 visits		Adult Queen size bed w/ mother & father	Father	Mother
15 Days	40/2665	Formula fed; Feeding problems; Gastro- reflux; Failure to thrive diagnosis	35/12 th	Alcohol/Tobacco use; hx Graves disease; Post partum depression	10 visits	Unknown	Adult full size bed w/ father	Father	Both Parents
48 Days	35/2296	Intrauterine drug exposure; Formula fed; Hx URI/ Bronchiolitis/Apnea; Heat off - room temp 48 degrees	23/GED	Drugs/Tobacco use; STD	5 Visits	Back	Adult twin size bed w/father, pillow, 4 quilts	Grand- mother	Father



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