

DISTRICT OF COLUMBIA CHILD FATALITY REVIEW COMMITTEE 2005 ANNUAL REPORT



GOVERNMENT OF THE DISTRICT OF COLUMBIA
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PUBLIC SAFETY AND JUSTICE

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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.

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

2005 ANNUAL REPORT

MISSION:

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

PRESENTED TO:

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

December 2006

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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 twelfth Annual Report. This Report covers data that resulted from reviews of 154 child/youth fatalities from calendar year 2005. The 154 fatalities reviewed by the Committee from 2005 represent a slight decrease from the 155 deaths reviewed in 2004.

Key Child Fatality Review Findings

Decedent Demographics

- ◆ The ages of the 2005 decedents ranged from birth through 23 years.
- ◆ Consistent with previous CFRC years, the largest population of child fatalities was children under the age of one year. Eighty-one infants died in 2005, representing a significant increase from 2004 infant deaths (n = 68). The 81 infant deaths represent 53% of the total child/youth deaths from 2005. The second largest population of District child deaths was youth over the age of 14 years (n = 54, or 35%).
- ◆ Black/African American children/youth continue to be disproportionately represented in the District's death population. In 2005, 138, or 90% of the child/youth deaths involved Black/African American residents.
- ◆ Also consistent with previous years' data, males continued to dominate the CFRC fatality population. There were 107 (n = 69%) male deaths in 2005 compared to 47 females.
- ◆ The majority of the 2005 decedents were residents of Wards Five, Seven and Eight. The number of deaths from these Wards ranged from 21 to 50 with Ward Eight having the highest number of deaths.

Manners of Death

Natural Deaths

- ◆ A review of death certificates indicated that the majority of District children/youth continued to die from natural causes during the 2005 calendar year. There were a total of 82 Natural deaths. As with previous years, children under the age of one year accounted for the majority of these child deaths (n = 62, or 77%).
- ◆ The majority of infant Natural deaths were associated with prematurity, low birth weight and congenital anomalies.
- ◆ The leading cause of death for children/youth over the age of one was Neoplasm (cancer) and Respiratory System Disease (n = 6 each).

Violence Related Deaths

Death certificates attributed 44 fatalities from 2005 to acts of violence. The majority of these deaths (n = 43) were Homicides. There was one 2005 death attributed to Suicide.

Homicides decreased from 54 in 2004 to 43 in 2005, representing a 20% overall reduction. This decrease was apparent in both the fatal abuse and youth violence categories.

- ◆ **Fatal Abuse/Neglect** – There were four child deaths during 2005 where the causes were associated with parental/caretaker abuse/neglect compared to six in 2004. The children who died from fatal abuse/neglect during 2005 ranged in age from two months to six years. All the victims were Black/African American and the majority were males (n = 3).
- ◆ **Youth Violence** – Youth violence continued to be the predominant cause of child/youth Homicides. In 2005, there were 37 youth who died from violent acts that included gunshot wounds, stab wounds and blunt force trauma. Youth in this category were between 14 and 23 years of age. Similar to previous years, the victims were primarily Black/African American (100%) and male (89%).
- ◆ **Other Homicides** – There were two Homicide deaths in 2005 that were not associated with youth violence or fatal abuse/neglect.

Unintentional Injuries

Accidental or unintentional injuries decreased significantly in 2005. There were 11 unintentional deaths in calendar year 2005 compared to 15 in 2004. The causes of accidental deaths in all age groups were:

- ◆ Five Motor Vehicle Accidents,
- ◆ Three Fire Related,
- ◆ One Drowning,
- ◆ One Fall (causing the premature birth of an infant), and
- ◆ One Asphyxia (associated with overlay).

Undetermined

- ◆ In 2005, there were 17 2005 deaths where the manner was Undetermined, representing a 113% increase from the eight deaths from 2004. This increase is directly associated with a change in practice for those deaths where infants were determined to be co-sleeping or sleeping in inappropriate environments (i.e., sofa, floor, etc.).
- ◆ The majority of the decedents who died of Undetermined manners of death were under the age of one year (n = 15). In two of these deaths the cause was also Undetermined. Thirteen of the deaths had a cause of Sudden Unexplained Death in Infancy.
- ◆ Two Undetermined deaths that involved decedents over the age of one year included a one year, nine month old and a 20 year old. The causes of death were Undetermined and Gunshot Wound respectively.

CFRC Special Report on Washington Highlands Fatalities

After years of reviewing Homicides of District children/youth, the Committee has observed a relationship between the decedents' environment and events leading to their untimely deaths. This relationship became especially significant through the process of conducting a retrospective

review of the deaths of youth from the Washington Highlands neighborhood of Ward Eight. The CFRC Special Report: Washington Highland Fatalities focuses on the special social and economic circumstances faced by the residents in this small Ward Eight neighborhood.

Key Factors Highlighted in Special Report:

- ◆ Lying at the center of the Washington Highlands neighborhood is one of the city's designated Violent Crime Focus Areas of the District's "Hot Spots" initiative.
- ◆ Children and youth residing in this area are exposed to a range of criminal activities and acts of violence, which is a nationally recognized risk factor for youth violence homicides.
- ◆ Of the known CFRC Washington Highlands decedents, 76% were involved with the District's public child welfare and juvenile justice agencies at the time of their deaths. Ninety-five percent of the decedents were also known to the District's public assistance program.

The issues discussed in the Special Report provides information that District government agencies, community based organizations and youth advocates can utilize to improve out-reach efforts and services provided to at-risk and disengaged youth.

Top CFRC Recommendations from Calendar Years 2005

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 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 is provided as part of the Appendices (see Appendix A).

INTRODUCTION

The Child Fatality Review Committee (CFRC) is a citywide collaborative effort that was authorized by the Child Fatality Review Committee Establishment Act of 2001 (see Appendix B: DC Law 14-028). The Committee was established for the purpose of conducting retrospective examinations of the circumstances that contributed to the deaths of infants, children and youth who were residents or wards of the District. The primary goals of the District's child death review process are identifying risk reduction, prevention and system improvement factors; recommending strategies to reduce the number of preventable child deaths; and improve the quality of residents' lives.

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

This Annual Report summarizes data collected from case reviews conducted on infant, child and youth fatalities that occurred during the 2005 calendar year. Coupled with other data measures, CFRC data is designed to benefit agencies in determining patterns related to family characteristics and needs; and in formulating strategies that may assist in improving programs and services to District residents. By understanding the ways children/youth are dying and the contributing risk factors, policies, programs and funding can be better targeted to address prevention initiatives and the needs of District residents.

During calendar year 2005, the Committee identified 154 children/youth deaths which met the criteria for review. The ages of these children ranged from birth through 23 years. This Report summarizes the data that resulted from the reviews held on the 2005 District child/youth deaths. It also highlights some of the critical recommendations identified through case review meetings held on fatalities in all manner of death categories. Additionally included in the 2005 Annual Report is a *Special Report on Washington Highlands CFRC Fatalities*.

2005 CASE REVIEW FINDINGS

Summary of Total Child/Youth Fatalities ¹

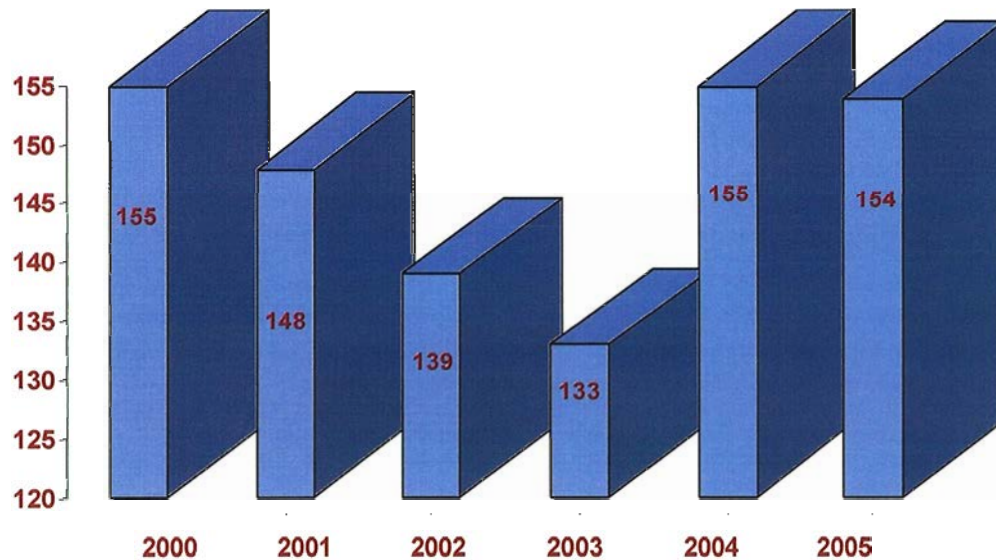


Figure 1: CFRC Total Child/Youth Fatalities (2000 - 2005)

- ◆ In 2005, 154 child/youth deaths were identified as meeting the criteria for review.
- ◆ As Figure 1 illustrates, calendar years 2004 and 2005 represent a reverse in trend after years of a consistent decrease in CFRC fatalities.

Description of Decedent Population

Ages of Decedents

- ◆ The ages of the 154 decedents ranged from birth through 23 years.
- ◆ Although the total number of 2005 child deaths was only slightly lower than calendar year 2004 fatalities, there were several significant changes in the number of deaths in specific age categories.
- ◆ As with previous years, the two largest categories of child deaths from 2005 continued to be infants (under the age of one year) and youth over 14 years of age.

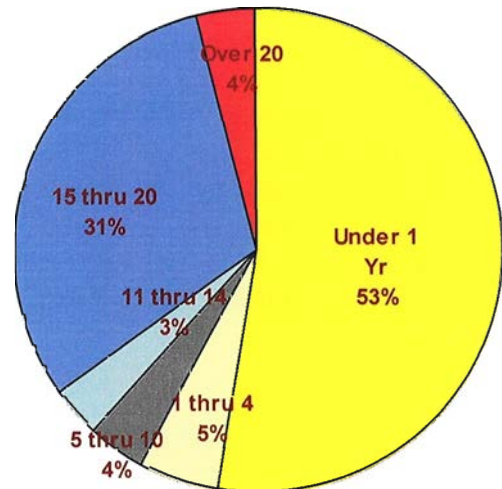
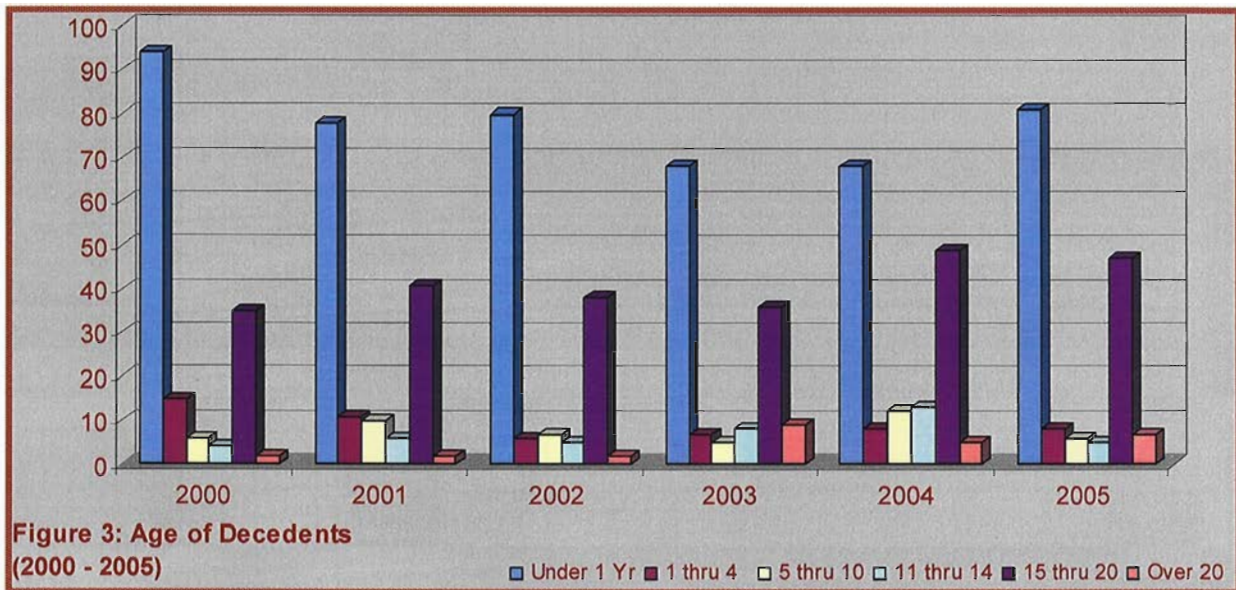


Figure 2: Ages of 2005 Decedents

¹ Information presented in all CFRC annual reports represents raw data that results from the case review process and should not be used as the only tool for measuring true changes in child deaths in the District. This information should be evaluated within the context of other statistical measures that are also critical to understanding the overall trends and patterns that are consistently occurring in the child death population.



- ◆ During 2005, the number of decedents under the age of one year increased significantly from 2004 infant deaths. Eighty-one, or 53% of the 2005 CFRC fatalities were infants, representing a 19% increase from the 68 infant deaths from calendar year 2004. Of the 81 infant deaths, 54 were neonates (birth through 28 days) and 27 were post neonates (29 days up to one year). The number of neonatal deaths from 2005 increased by 14, or 35% from the 40 similar deaths in 2004. One hundred percent of the 2005 infant death increase occurred in the neonatal age range. Post neonatal deaths decreased slightly from 28 in 2004 to 27 in 2005.
- ◆ Fifty-four, or 35% of the 2005 fatalities were of youth over the age of 14 years. This group of youth fatalities included 47 decedents ages 15 through 20 years, and seven who were 21 years or older.
- ◆ During 2005, there was a significant decrease in the number of deaths of children who were between the ages of one through 14 years of age. In 2004 there were 33 decedents in this age category compared to 19 in 2005 (42% decrease).

"A 2005 Accidental Infant Death"

At 2:30 AM, the Office of Unified Communications Center received a 911 call concerning a fire at a residence where the mother, an infant and other family members resided. The Fire Department responded to the scene and fire fighters entered the apartment and discovered the infant lying in the crib in the rear bedroom. The infant was transported to the nearest hospital where she was noted to have no signs of life and severely charred. She was pronounced dead at 2:50 AM. The mother reported that she and the father of the infant had gone out for the evening leaving the infant and other children in the care of an adult relative. Prior to leaving the mother reported that she checked on the infant who was sleeping in her crib; and she lit a candle which was in a candle holder that was attached to the wall in the child's room. According to the mother she was using candles because the electricity had been turned off in the apartment 2 weeks prior to the fatal incident due to lack of payment. During the review it was revealed that the mother had applied and been approved for energy assistance however the electric company was unaware of the approval. The cause of the fire was the candle which ignited combustible items in the room causing extensive damage to the walls and ceilings where the child was sleeping.

Cause/Manner of Death: Asphyxia due to Soot and Smoke Inhalation/Accident

Race and Gender of Decedents

- ◆ CFRC child fatality data from calendar year 2005 continued to support the fact that Black/African American and male children/youth are disproportionately represented in the decedent population.

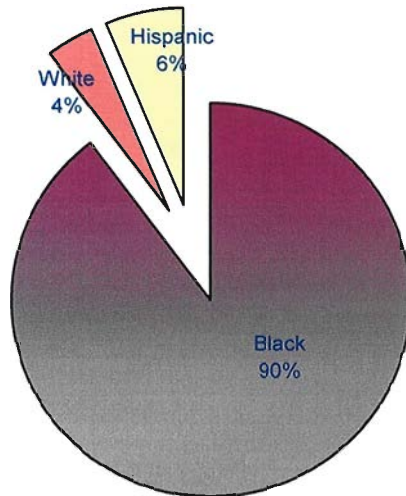


Figure 4: Race - 2005 Decedents

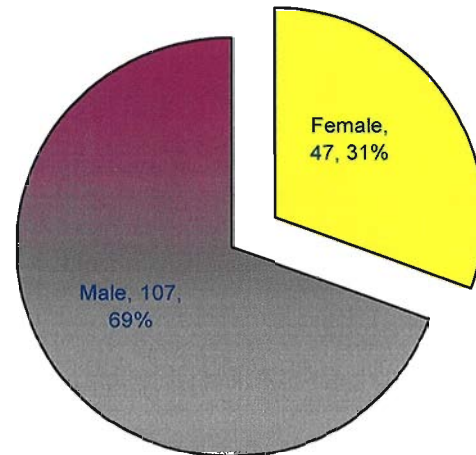
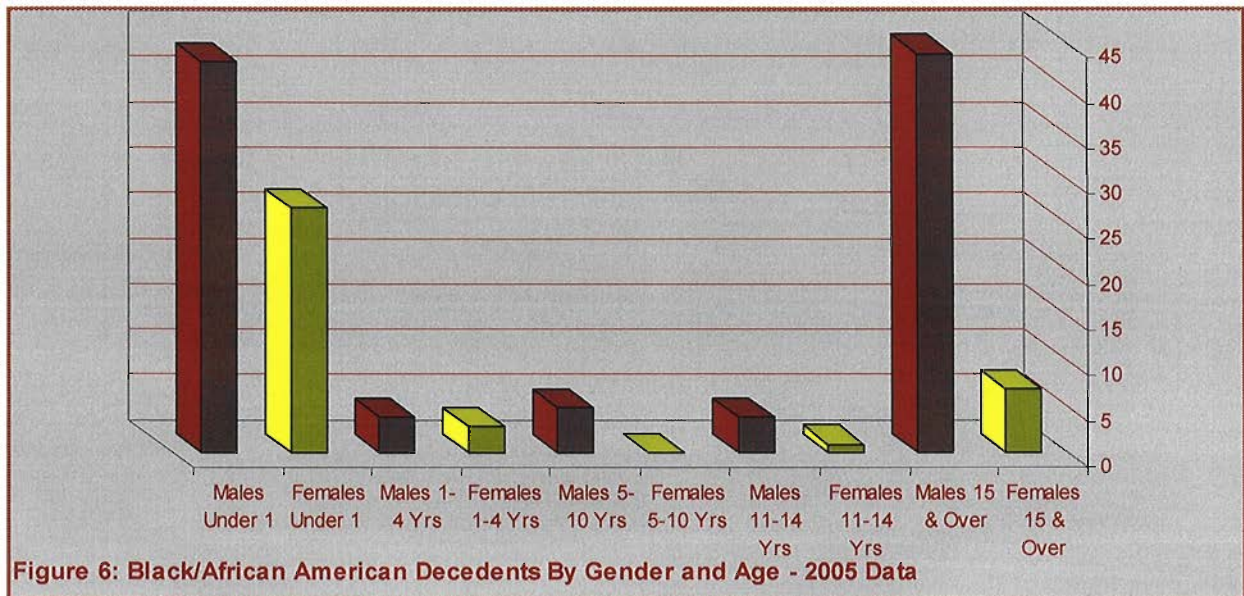


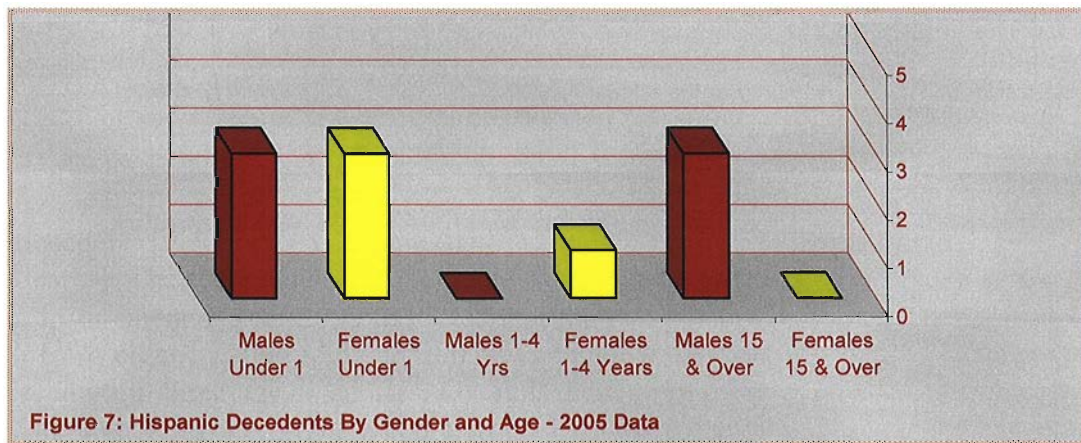
Figure 5: Gender - 2005 Decedents

- ◆ As Figure 4 depicts, Black/African American children/youth represented 90% of the 154 fatalities identified from calendar year 2005 (n = 138). During the 2000 through 2004 calendar years, Black/African American children/youth represented between 83 and 90% of CFRC deaths, with 2004 having the highest number of decedents of this racial background and 2002 having the lowest.
- ◆ Also consistent with other CFRC years, Hispanic and White children/youth have consistently represented the second and third leading child death populations.
- ◆ Similarly, male children/youth have continued to be over-represented in the fatality data. As Figure 5 illustrates, in 2005, 107, or 69 % of the decedents were males, representing an eight percent increase from the 99 male decedents from the 2004 calendar year. Forty seven of the 2005 decedents were females.
- ◆ Figure 6 (see page 5) illustrates the vast disparity in gender among 2005 Black/African American decedents within each age category.
 - In 2005, 100 of the 138 Black/African American decedents were males and 38 were females. Although males ranked higher in all categories, there was a significantly larger number of females in the population of Black/African American decedents who were under the age of one year than in any other age category (n =27). The two age categories where females represented the largest percentage of deaths among Black/African American decedents were infant (n = 39%) and children between one and four years of age (n = 43%). In the remaining age categories, females represented less than 14% of 2005 Black/African American decedents.
 - Consistent with the total CFRC 2005 fatalities, the majority of the Black/African American decedents (male and female) were infants, with the most frequent age being



decedents under one day of age ($n = 24$, or 35% of the 69 Black/African American infant deaths). The second most frequent age was 18 years ($n = 15$).

- ◆ Data from calendar year 2005 indicates that the number of Hispanic decedents increased by 25% from eight in 2004 to 10 in 2005. As Figure 7 below illustrates, Hispanics were only represented in three age categories. Overall, there were more male Hispanics decedents ($n = 6$) than female. There were equal numbers of males and females in the Hispanic infant population ($n = 3$ each). There was one female Hispanic decedent in the one through four age category and three male decedents who were 15 years and older. The overall average age of the 2005 child/youth Hispanic fatality population was six years.



- ◆ Consistent with 2003 and 2004 CFRC data, six deaths of White children/youth occurred during 2005. The greater majority ($n = 5$, or 83%) were females, four were under the age of one year and one was six years of age. The one male White decedent was under the age of one year. The average age of the 2005 White decedents was one year.

Decedents' Ward of Residence

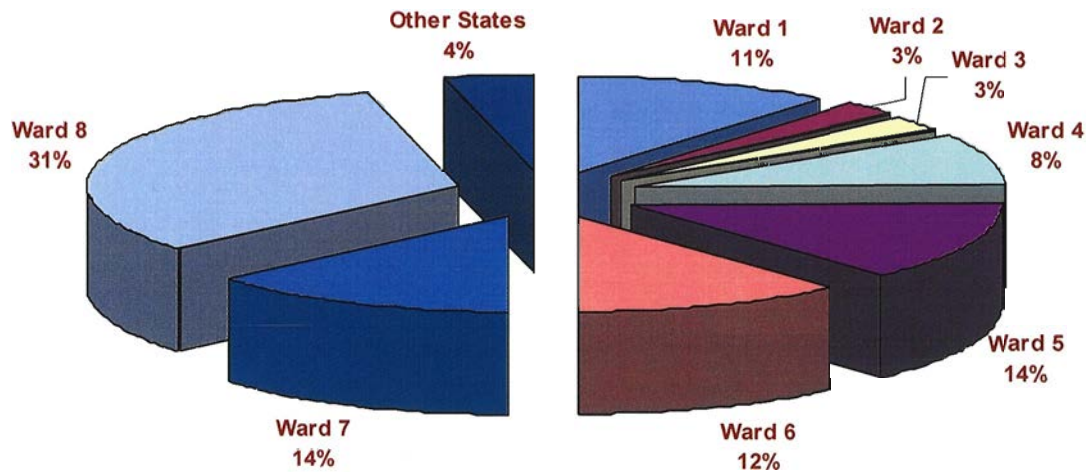


Figure 8: Ward of Residence - 2005 Data

Decedents' residency and/or District Ward are primarily determined based on the information contained on the death certificate. However, based on other supporting documentation, other forms of verification may be used (i.e., child welfare, public assistance records/databases, etc.).

- ◆ In 2005, six of the 154 decedents were residents of or temporarily residing in other states. These children were known to the child welfare and/or juvenile justice systems and based on the decedents' or families' involvement with these programs met the CFRC review criteria.
- ◆ As illustrated in Figure 8 above, similar to 2004 calendar year, the majority of the 2005 decedents were residents of Wards Five, Seven and Eight, with the largest percentage residing in Ward Eight (n = 50, or 31%). The number of deaths for these Wards ranged between 21 and 50, with a total of 92 (60%) decedents from these combined Wards. Wards Six and One had 18 and 17 deaths respectively.
- ◆ Figure 9 below illustrates decedents' Wards of residence from calendar years 2003 through 2005.

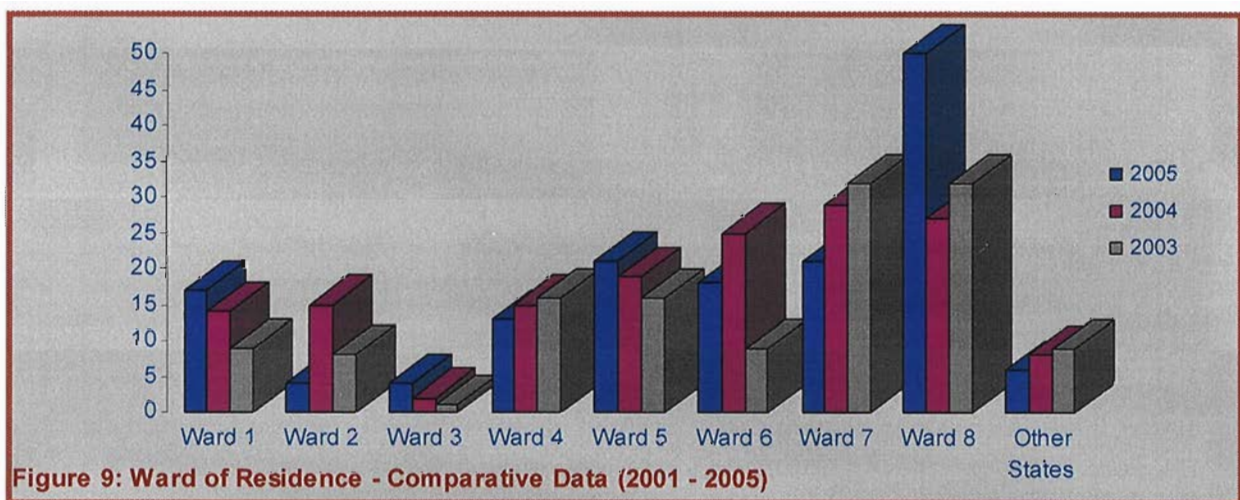


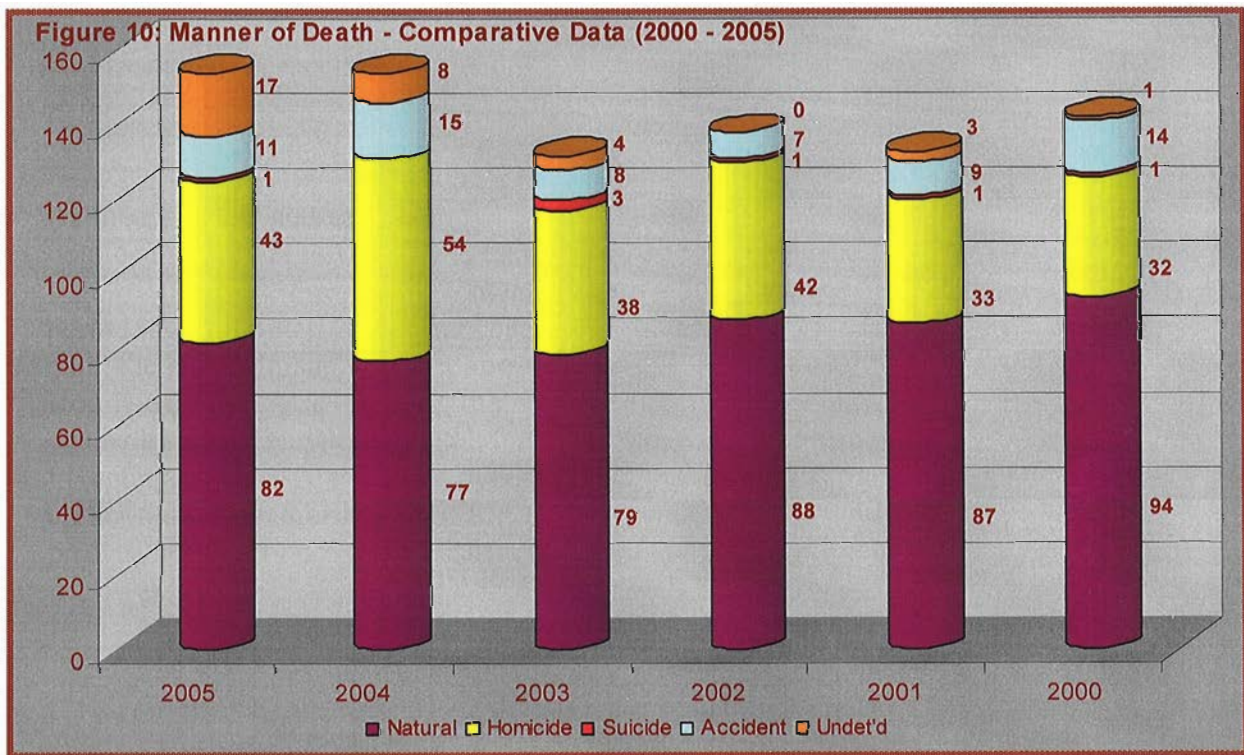
Figure 9: Ward of Residence - Comparative Data (2001 - 2005)

Manner/Cause of 2005 Fatalities

Manner of Death

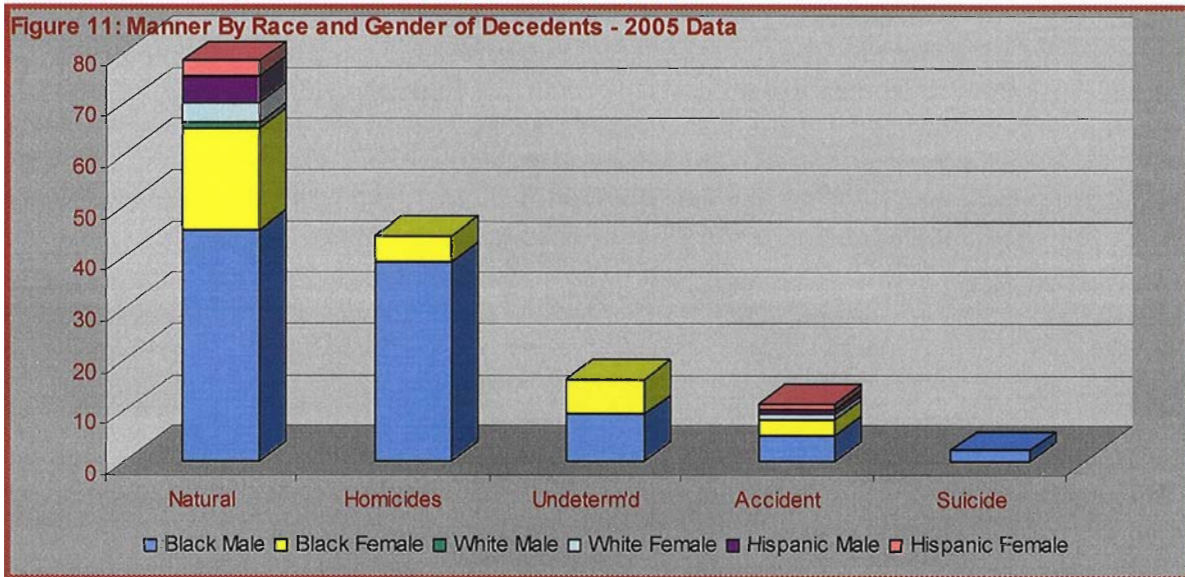
The manner of death relates to the circumstances under which the death occurred. This is determined based on specific information and details that are available on each case. Unlike the cause of death, manner can differ depending on the conditions and contributing factors revealed during the investigation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

- ◆ At the point of statistical compilation of the data for this Report, manners of death were obtained for all of the 154 CFRC fatalities that occurred during calendar year 2005.
- ◆ Figure 10 below illustrates the manners of death for District children/youth for a six year period (2000 through 2005) and several significant trend changes. Based on a review of this data, the leading manner of death for calendar year 2005 continued to be Natural followed by Homicides. Data also supports the fact that between 2004 and 2005, the number of Natural deaths increased slightly while Homicides dropped at a more significant rate.
- ◆ In calendar year 2005, there were 82 natural deaths, representing 53% of the overall child/youth deaths for the year. Since 1998, natural deaths have consistently represented the primary manner of death for District children/youth.

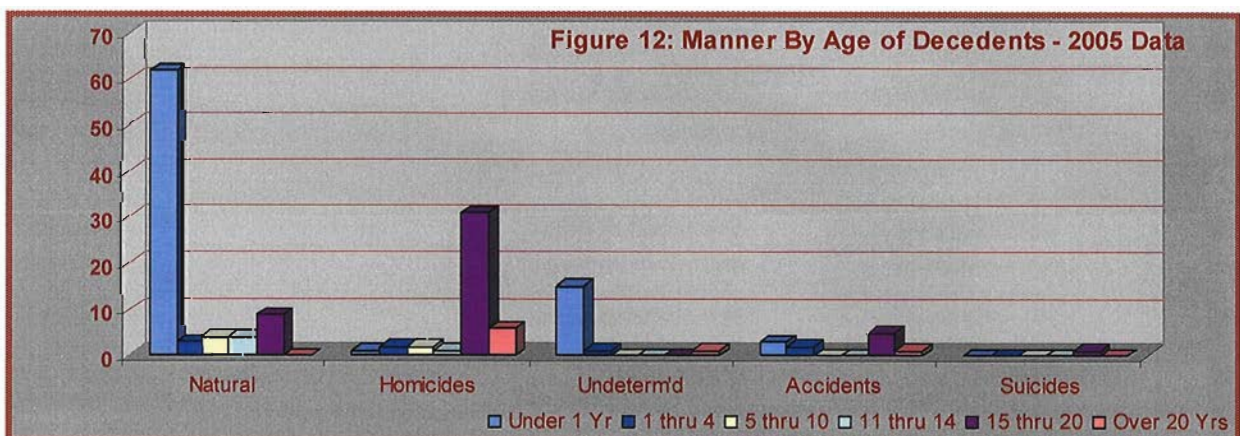


- ◆ Another reliable trend for District child/youth fatalities indicates that Homicides have consistently represented the second leading manner of death. Although this fact remained constant in 2005, the number of child/youth Homicides decreased significantly during this calendar year. As Figure 10 illustrates, 43 or 28% of the 2005 children/youth fatalities were attributed to Homicides. This represents a 20% decrease from the 54 Homicides from 2004.

- ◆ One noteworthy trend change documented from 2005 data is the number of Undetermined manner of deaths. Unlike previous CFRC years, fatalities attributed to Undetermined manner ranked third during 2005. There were 17 deaths in 2005 where the manner was Undetermined, representing 11% of the total fatalities for this year. This represents a 113% increase from the eight Undetermined 2004 fatalities.
- ◆ The manner of death for eleven of the 2005 fatalities was Accident. In 2005, there was one death attributed to Suicide.



- ◆ As Figure 11 above illustrates, 2005 data indicates that Black/African American males dominated all manners of death categories, followed by Black/African American females. Deaths attributed to Homicide, Undetermined and Suicides involved only Black/African American children/youth. The manner of death for the four White male deaths from calendar year 2005 was Natural. White female and Hispanic male and female decedents were represented in Natural and Accidental manner of death categories in 2005.



- ◆ When reviewing the three leading manners of death, data supports the fact that infants dominated fatalities attributed to Natural and Undetermined deaths while youth between the

ages of 15 and 20 years of age were the primary victims of Homicides in the District (see Figure 12 on page 8).

- ◆ Out of the 154 fatalities from calendar year 2005, autopsies were completed on 100, or 65% of the deaths. In 67 cases (67%), autopsies were performed by the DC Office of the Chief Medical Examiner and 15 were completed by District hospitals. The remaining autopsies (n = 18) were conducted by out-of-state facilities, 16 of which these were performed in the State of Maryland.

"A 2005 Undetermined Death"

On the early afternoon of a winter day, a father awakened to find his 5 month old child, face down and non-responsive. The infant was co-sleeping in the bed that she shared with her parents and a sibling. The infant was last seen at approximately 5:00 AM when she was fed, burped and placed face up on an adult size pillow. Upon finding the infant, the mother was awakened and initiated CPR while the father called 911. The infant was transported to the nearest hospital with CPR in progress. Upon arrival the infant was determined to be in full cardiac arrest. Down time was not known. Resuscitation was attempted but failed; the infant was pronounced dead at 2:30 PM and transported for autopsy. The hospital social worker provided support for the family and the record noted that in the process it was observed that both parents smelled of alcohol. During the investigation, the parents reported that the night prior to the terminal event they had several beers while watching a football game. Records noted that the infant had not been seen by a physician since hospital discharge after birth. Several appointments had been scheduled however all were missed. It was also revealed that the birth hospital had referred to family to a visiting nursing program however this service was unable to be schedule because the mother could not be located. The decedent resided with her family in a 2 story row house that was being used as a boarding home. The room where the family resided was furnished with a mattress on the floor where 4 persons slept, including the decedent. The room was described as "cluttered, filthy-messy with no lights". The mother had several other children who resided with relatives in Maryland. The family was known to the District's child welfare system based on several reports of neglect.

Cause/Manner of Death: Sudden Unexpected Death in Infancy Associated with Co-sleeping and Soft bedding/Undetermined

Table 1 below, illustrates the Ward of the decedents' residence by manner of death for calendar years 2005.

Ward	Total Deaths	Natural	Homicide	Accident	Suicide	Undetermined
One	17	7	7	2	0	1
Two	4	1	2	0	0	1
Three	4	4	0	0	0	0
Four	13	9	2	2	0	0
Five	21	16	4	1	0	0
Six	18	7	4	2	1	4
Seven	21	11	7	1	0	2
Eight	50	26	15	2	0	7
Other State	6	1	2	1	0	2

Cause of Death

The cause of death is obtained primarily from the death certificate. However, in cases where the child died in other states/jurisdictions and the death certificate was not provided, other records (i.e., hospital, nursing homes, etc.) were used to document the cause of death. In 2005 there were

153 (99%) fatalities where the cause of death was determined or known. This population includes three of the 17 Undetermined manners of death cases where the autopsy also resulted in the cause of death being “Undetermined”. The remaining death included one child who died in the state of Maryland and although the manner of death was provided, the Committee was unable to verify the exact cause of death.

For the purposes of this Report and to ensure consistency in evaluating Committee data, the causes of death have been grouped in the following five categories: Medical Conditions, SIDS², Violence Related, SUDI/Undetermined and Unintentional Injuries. These categories do not always reflect the actual causes as stated on the death certificate. However, specific information on the actual cause of death is provided as each category is discussed throughout this Section of the Report and is depicted in Appendix C, 2005 Calendar Year Fatality Listing By Age, Cause and Manner of Death.

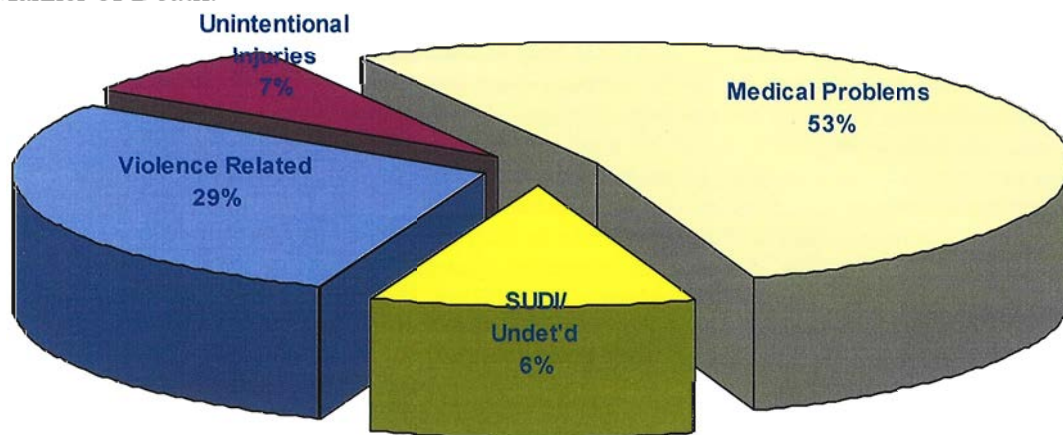


Figure 13: 2005 Causes of Death

Medical Conditions

- ◆ As Figure 13 illustrates, the leading causes of death in the District continued to be associated with medical conditions. In calendar year 2005, of the 153 CFRC deaths where causes were determined/known, 81 involved children/youth who died from medical related problems (n = 53%).
- ◆ The ages of the 2005 decedents who died from medical related causes ranged from birth through 20 years of age, with an average age of three years.

Children Under One Year of Age - In 2005, data indicates that 62 or 77% of the medically related deaths involved infants (under the age of one year). Eighty-one percent (n = 50) of infant deaths occurred within the first 28 days after birth and 52% of these children died within the first day of life (n = 26).

² Although SIDS deaths are also included in the “Natural” manner of death, for statistical purposes, beginning in 2001, CFRC began separating SIDS data from the “medical problem” category.

"A 2005 Natural Infant Death"

A 23 year old mother of 2 was pregnant with her 3rd child. Medical history was significant for STD and history was also positive for illicit drug use to include Marijuana. Prenatal care was received from a private physician. Her first visit was at 19 weeks and she had a total of 3 visits. The prenatal course was complicated by vaginal bleeding, nausea/vomiting in the first trimester (no treatment indicated), and preterm labor noted at 30 weeks. At the time of hospital admission, mother's vital signs were temperature of 97.7, Pulse of 110, Blood Pressure of 116/61, and Respiration of 20. Mother was admitted with a diagnosis of preterm labor. She was placed on bed rest and started on Terbutaline therapy. She was also placed on Dexamethasone and Ampicillin as a prophylaxis for Group B Strep. Mother had positive fetal movement with fetal heart rate in the 150's. She responded to the treatment and contractions subsided. She was cleared for discharge several days later with instructions to be seen by the prenatal provider in one week, and to be on pelvic rest. She was also told to call the doctor if she had fluid leakage. On the same day of hospital discharge, at approximately 7:00 PM, the mother contacted her physician to report that contractions have resumed, and that she could not make it back to the same hospital. Mother presented to the delivery hospital (different hospital) and was determined to be in active labor. She was taken to the delivery suite for imminent delivery. She progressed well after delivery and was discharged home several days later. The male infant was determined to be 30 weeks gestation; birth weight was 3 lbs/12 ozs; Apgar scores were 5 @ 1 minute and 6 @ 5 minutes. Complications at birth were noted as respiratory distress syndrome characterized by moderate to severe grunting, retractions and nasal flaring. The infant received extensive treatment over a period of 15 days. However, his condition deteriorated significantly. Following a conference with the treatment team, the mother made the decision to withdraw life support. The infant was baptized by hospital clergy while being held by his mother. The infant died in his mother's arms at 2:05 PM. Records indicate that the mother was married; she had completed several years of college education and was employed at the time of the fatal event. Her history was negative for alcohol but positive for illicit drugs. She was not known to public service systems.

Cause/Manner of Death: Prematurity, Necrotizing Enterocolitis/Natural

Findings Associated with Medically Related Causes of Infant Deaths

- ◆ As with previous CFRC years, the leading cause of death among the infant population was related to prematurity and associated complications. These problems accounted for 71% (n = 44) of the 2005 medical related infant deaths.
- ◆ Of the 44 deaths where prematurity was a contributing issue, extremely low birth weight (less than 500 grams) was a factor in 30% (n = 13) of the infant deaths and 11 (n = 25%) additional cases involved infants with birth weights between 500 and 700 grams. The majority of the mothers of decedents whose deaths were associated with prematurity received routine prenatal care (26, or 59%); nine mothers (20%) received either no prenatal care or were late entrants and/or received sporadic care during their pregnancies. Prenatal care was unknown for nine mothers.
- ◆ Congenital anomalies ranked second with nine deaths in this category.
- ◆ Maternal complications were documented on death certificates as underlying causes for 19 or 31% of the 62 medically related infant deaths from 2005. Maternal complications included premature rupture of membranes, chorioamnionitis, placental abruption, incompetent cervix, maternal substance abuse, hypertension, etc.

Children/Youth One Year of Age or Older - Children over the age of one year have consistently represented a significantly smaller percentage of the medically related deaths. Twenty, or 24% of 2005 deaths associated with medical problems involved decedents who were one year of age or older. The ages of the decedents ranged from one through 20 years with an average age of 13.

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

- ◆ Data from calendar year 2005 indicate that Neoplasm (cancer) and Respiratory System Disease were the leading causes of medical deaths in this age group with equal numbers of deaths in each category (n = 6).
- ◆ Infection (child related) ranked second (n = 4). One child whose death was attributed to infection had been previously diagnosed with HIV/AIDS.

“A 2005 Natural Death of A Young Child”

One winter evening, a 6-year old female child, FT, was brought to a local pediatric hospital in critical condition by ambulance and accompanied by a relative. Medical records indicated that there were no signs of trauma or injury; her brain was swollen, but there was no bleeding present. On the day after hospitalization, FT coded and had to be resuscitated. A brain study was performed which indicated that there was no brain activity. The grandmother stated that when her grandchild FT arrived at her home on Saturday, she appeared healthy and happy and his mother had not notified her of any problems, illnesses or injuries. The grandmother reported that FT had 8 teeth pulled at a local university several weeks prior, but she appeared fine. She reported no history of falls, fights, accidents or known illnesses. She stated that FT played outside and was very active, playing with the other grandchildren who were at her home. The maternal grandmother further reported that at approximately 7:00 pm on the day prior to FT's hospitalization, she woke up complaining that her stomach and legs were hurting. She offered her something to eat, but she refused; she gave her some ginger ale to sooth her stomach and a half dropper of children's liquid Tylenol. The child also complained of her ear hurting so she placed toilet tissue in his ear in the absence of cotton ball. The grandmother indicated that FT's head felt warm so she assumed she had the flu. Her symptoms continued and she was given another dose of Tylenol with ginger ale. The next day, FT did get out of bed; she slept and sporadically watched television. She ate a little soup and drank a little ginger ale. She was given more Tylenol and she went back to sleep. FT became weaker and began complaining of pain in her legs and was unable to walk unassisted. The grandmother rubbed her legs with an ointment to soothe the pain. On the day of her hospitalization, FT began talking incoherently and laughing and crying inappropriately. It was at this point, that the grandmother realized she could no longer treat the child and sought medical attention.

Based on a review of the child's dental records, she was taken to a clinic in early January, escorted by her school teacher, who had acquired consent from her mother for a special dental program that provides dental services to needy children. During this one visit, FT had 8 teeth extracted, which were described as “rotten”. Prophylactic antibiotics were not given prior to the procedure. Additionally, antibiotics were not given following the procedure and were not prescribed as part of the discharge instructions. In addition to the extractions, FT received several fillings and was given Fluoride treatment. The discharge instructions which were provided to the teacher included: stay home for 24 hours; use Chloroseptic mouth wash as needed; use Advil 200 mg for fever and or pain; and see physician in 72 hours. Based on a review of school records, FT returned to the school with his teacher. The school nurse noted as part of Progress Notes the following: “Gauze packing applied to tooth extraction sites with noted decrease in amount of bleeding.” The nurse's notes also documented that the mother picked FT up from school and that she “gave her instructions to follow to relieve further bleeding from her gums and to contact the doctor immediately if the bleeding continued or increased.” The mother did not speak to the dentist or clinic staff and it was unclear during the case review meeting whether she fully understood the importance of follow-up with the pediatric physician or the significance of symptoms of fever and lethargy that ensued over a 2-week period.

Cause/Manner of Death: Acute Bacterial Meningitis/Natural

- ◆ *CFRC Medical Cluster Reviews* - After several years of reviewing natural deaths of children over the age of one year, the Committee recognized that a significant number of cases involved children dying from chronic, usually non-life threatening illnesses and from undiagnosed acute or chronic illnesses. As a result of this finding, during 2004 and 2005, several medical cluster reviews were held in an effort to assess trends associated with these deaths and to assist with the formulation of recommendations to more

appropriately address these concerns. These meetings (which included between 15 and 20 cases each) resulted in the identification of numerous trends and systems issues that contribute to poor health outcomes for children. The most consistent and salient trends highlighted during these meetings included:

- Many children dying from medical causes received little or no primary/general pediatric care despite the fact that most were enrolled in a health care plan.
- Many children were diagnosed late increasing their chance of advanced disease and poor outcome.
- There is a need for increased and improved professional medical management and monitoring of children with diseases that are not commonly fatal (i.e., asthma, diabetes, etc.).
- There is a need to increase education to the general public and to families with children with chronic illnesses related to ways to better manage these illnesses and symptoms that require medical intervention.
- There is a need to ensure access to specialty medical care for children with certain chronic illnesses.
- There is a need to increase home-based services and other ancillary or family supports for children with terminal, debilitating and chronic illnesses.
- Poor interagency communication and coordination for children known to multiple systems may result in erratic care and can lead to poor health outcomes.

The recommendations that resulted from these reviews are included in Appendix A: CFRC Recommendations (see Appendices).

Categorization of Underlying Medical Causes of Death

Based on the review of the death certificates of all children who died from medical related causes, Table 2 depicts the leading and underlying causes of 2005 decedents of all ages (because the majority of death certificates included multiple related causes, the numbers represent only the primary cause for the 82 medical related deaths).

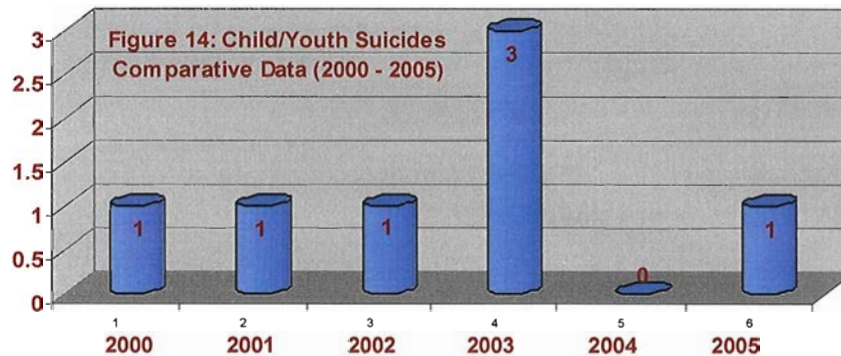
<i>TABLE 2: MEDICAL CAUSES OF DEATH AMONG 2005 DECEDENTS</i>			
<i>Primary Causes of Death</i>	Infants < 1 Yr	1 – 20 Yrs	Total
Infections	4	4	8
Neoplasms	0	6	6
Respiratory System Disease	2	6	8
Intraventricular Hemorrhage	0	0	0
Congenital Anomalies	9	0	9
Prematurity	44	0	44
Maternal Complications	1	0	1
Metabolic Disorders	1	1	2
Other Conditions	1	3	4

Violence Related Deaths

Since 1996, the number of child/youth deaths attributed to some form of violence has ranked second in the District. For the purposes of this Report, violence related deaths include Homicides and suicides. Based on a review of death certificates for calendar year 2005, there were 43 Homicides and one suicide of District children/youth.

Suicide

In calendar year 2005, there was one death that was attributed to "Suicide." This death involved a 15 year old Black/African American male who was a resident of Ward Six. The cause of death was "Hanging" and the location of the fatal incident was his home. The case review revealed that the decedent was known to several public service delivery systems prior to his death, including public schools, child welfare and mental health. As indicated by Figure 14, CFRC data has included child/youth Suicides since calendar year 2000. The number of Suicides remained constant for three years and in 2003 increased by 200% to three deaths through this manner. The 2005 Suicide represents an increase from 2004 when there were no deaths that were the result of a child intentionally taking his life.



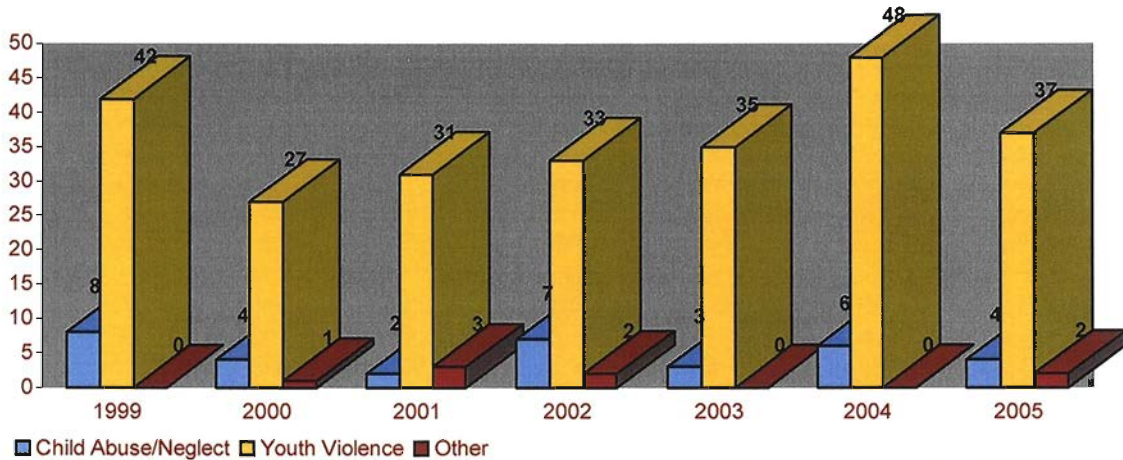
Homicides

CFRC maintains child/youth Homicide data in three categories: youth violence, fatal child abuse/neglect and other. For the purposes of this Report, youth violence refers to those Homicides where another juvenile or young adult perpetrated the deaths. The motives for youth violence deaths are usually related to gang activity/behavior, drug use/sales or retaliation/argument/conflict. Fatal child abuse and neglect deaths have been defined by the Committee as including those deaths where the manner has been determined to be a Homicide and the death occurred at the hands of a parent, legal custodian or person responsible for the child's care at the time of the fatal incident. During 2005, the "Other" category was expanded in order to more accurately group Homicides that were not associated with child abuse or youth violence. The expansion broadens the age of the child/youth and accounts for situations that may involve parents who are not in a caretaker role. The expanded definition includes a child/youth of any age where the death was the result of a deliberate act of violence by either a related or unrelated adult not in a caretaker role.

- ◆ During calendar year 2005, the number of child/youth Homicides decreased from 54 in 2004 to 43, representing a 20% decline. As Figure 5 illustrates, this represents a reversal in trend after four years of a steady increase in child/youth Homicides.

- ◆ The Homicide reduction is represented in both the youth violence and fatal abuse data, however, as with previous CFRC years, Homicide data continued to be dominated by acts of violence perpetrated by youth on youth (youth violence).

Figure 15: Homicides - Comparative Data (1999 - 2005)



Fatal Abuse and Neglect Fatalities

- ◆ Since 1999 fatal child abuse and neglect related deaths have continued to fluctuate. Although, the highest number of deaths occurred during 1999 and 2002, fatal abuse deaths represented the highest percentage of overall Homicides in 2000 and 2002 (n = 4, or 16% in 2000 and n = 7, or 17% for 2002 respectively).
- ◆ In 2005, the number of fatal abuse deaths decreased by two, representing a 33% decrease from 2004. Fatal abuse/neglect deaths represent nine percent of the total 2005 Homicide fatalities.
- ◆ The causes of death for the four 2005 fatal abuse/neglect Homicides were associated with physical abuse. All of the cases involved "blunt impact/force injuries" however one also involved drowning/asphyxia.
- ◆ The ages of the victims of fatal abuse/neglect were between two months and six years, with an average age of three years.
- ◆ Consistent with previous years' data, the majority of the 2005 victims of fatal abuse and neglect were Black/African Americans (n = 4, or 100%). Unlike 2004, the majority of the victims were males (n = 3, or 75%).
- ◆ Three (75%) of the fatal incidents occurred in Ward Eight of the District of Columbia, two occurred within the decedents' homes and one in the home of the mother's paramour. One fatal incident occurred in Maryland in the home of the decedent's father.
- ◆ All of the perpetrators were in caregiver roles at the times of the deaths. Two perpetrators were the fathers of the decedents, one was the mother, and one was the mother's paramour. The ages of the perpetrators ranged from 21 to 34 years.
- ◆ Seventy-five percent (n = 3) of the decedents' families were known to the child protective services system in the District. One case was active at the time of the death; one had closed within one month prior to the death and one had closed years prior to the decedent's birth.

- ◆ Two perpetrators had documented prior histories with the criminal justice system; two had substance abuse histories and one had a documented history of prior mental health problems, including attempted suicide.

"Two 2005 Fatal Abuse Deaths"

Case 1: During the early morning hours of a fall day, a relative called 911 to report that a 4-month old child in his care was found unconscious. EMS arrived, initiated resuscitation efforts and transported Baby B to a local hospital. The infant arrived in full cardiac arrest at 8:52 a.m. There was no spontaneous respiration, pulse, or heart beat; and pupils were fixed and dilated. Baby B was pronounced approximately one hour later. Initial reaction from medical personnel was that there were no signs of foul play, no marks or bruises or any "red flags" however further examination at the hospital revealed a "lump" on the side of the child's head. Examination at autopsy revealed a "well-developed, under-nourished infant;" toxicology reports were negative. Findings also indicated numerous head and torso injuries and microscopic findings indicating infections of various types in most organ systems. The relative caregiver reported that at 6:00 AM he was awakened by the infant's cry. The caregiver described having removed him from the couch, where he usually slept, and fed him 4-5 oz of an 8-oz bottle of formula. He reported changing his diaper prior to laying him next to him on the floor. According to the relative caregiver the decedent was on his left side and he placed him on his back. He stated he went back to sleep and thought the decedent went to sleep also. At 8:00 AM, he awoke to find the decedent lying on his right side, appearing to be gasping for breath. He held him up, shook him lightly and laid him back onto the floor. According to the relative, he then began to breathe into the decedent's mouth and it appeared that either milk or a mucus-like substance came from the decedent's nose. He then laid the child on the floor and called 911 for assistance. While the ambulance was en route, the dispatcher provided CPR instructions to the caregiver. He continued resuscitation efforts until medics arrived. He stated that Baby B appeared normal during the 6:00 AM feeding. Prior to that he last fed the child at 11:00 PM, changed his diaper, at which time he noted that his bowels were runny and brown. He reported that the infant went to sleep at 12:00 PM; at which point he laid him on the couch, positioning him on his back; and he remained asleep throughout the night. He reports, however, hearing him make noises, but not completely awakening. During the investigation the relative caregiver also reported that 1 month prior to the fatal incident he left the child unattended on the couch and the baby fell off the couch; however the child had no injuries and did not require medical attention. Later during the investigation the relative caregiver also admitted that he dropped the child on the kitchen floor on another occasion and that he "hurt his head". The caregiver was arrested and at the time of the review the trial was pending.

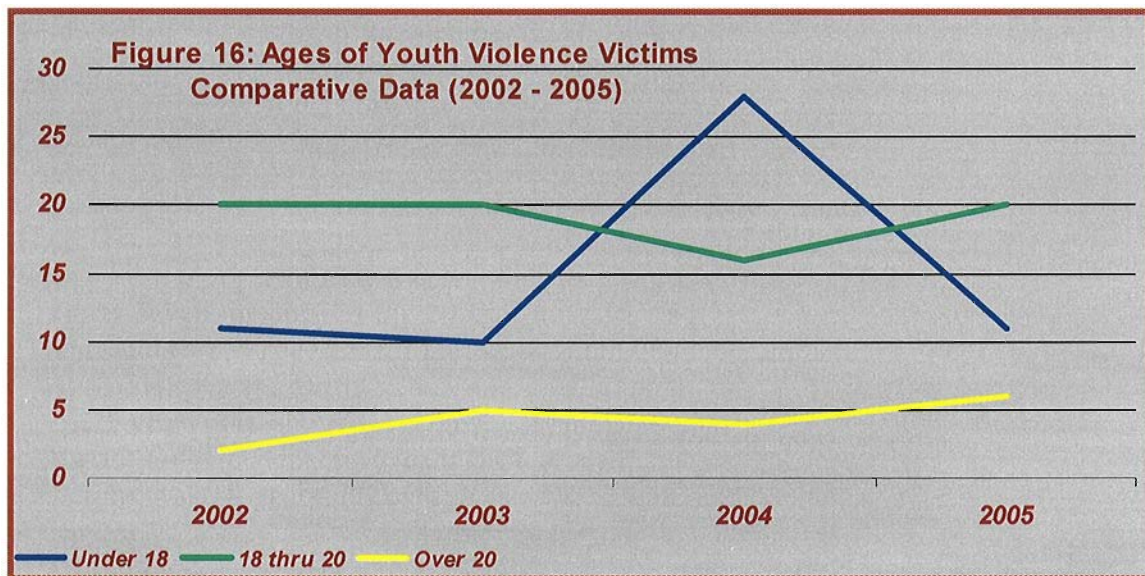
Cause/Manner of Death: Multiple Blunt Impact Injuries Including Recent Scalp Hemorrhages with Subarachnoid Hemorrhage and Healing Rib Fractures/Homicide

Case 2: At approximately 8:37 AM a 911 call was made for a report of an unconscious child. Upon arrival of the emergency response team, the victim was immediately noticed lying face down with his hands tied behind his back. The caller reported that the child was discovered face down in a tub full of water with his hands and feet bound. The victim was pulled from the tub and CPR was attempted although medics advised that there were no signs of life. The body was wet and clammy; with rigor mortis noted in the lower legs; and the lower jaw was rigid. The body was noted to have abrasions on the left side of the face and to the left side of the back. There were also old scars noted on the left and right lower leg. Death was apparent and the victim was pronounced dead on the scene. During the investigation, a relative admitted to killing the child and based on the evidence was arrested and charged with the murder.

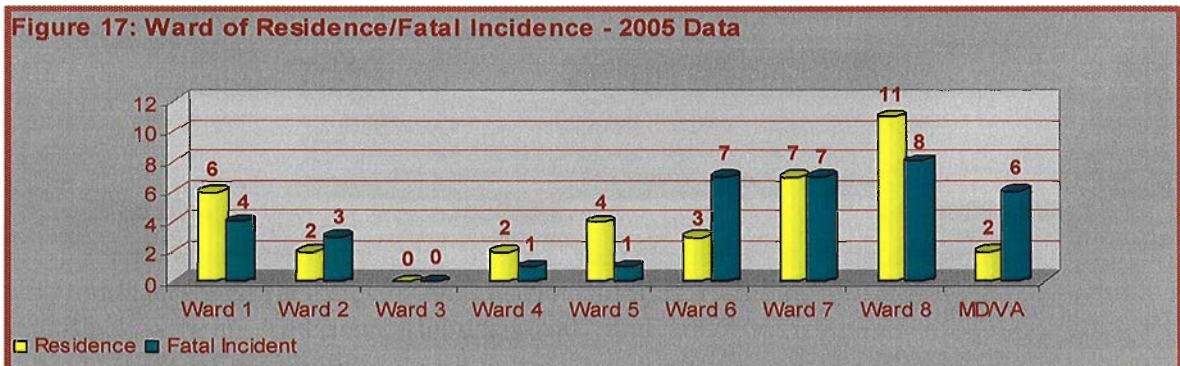
Cause/Manner of Death: Multiple Injuries Including Drowning, blunt Impact Head Trauma and Asphyxia/Homicide

◆ **Youth Violence Related Homicides**

- ◆ Thirty-seven, or 86% of the 2005 Homicides were associated with youth violence. This represents a 23% decrease from the 48 youth violence deaths from 2004.
- ◆ **Age of Decedent** - During 2005, the ages of the victims of youth violence ranged from 14 to 23 years. As shown in Figure 16, unlike 2004 and similar to 2003 and 2002, the majority of decedents were over the age of 17 years (n = 27, or 73%) . The average age of victims was 19 years however the youngest age was nine and the most frequent age was 18 years.

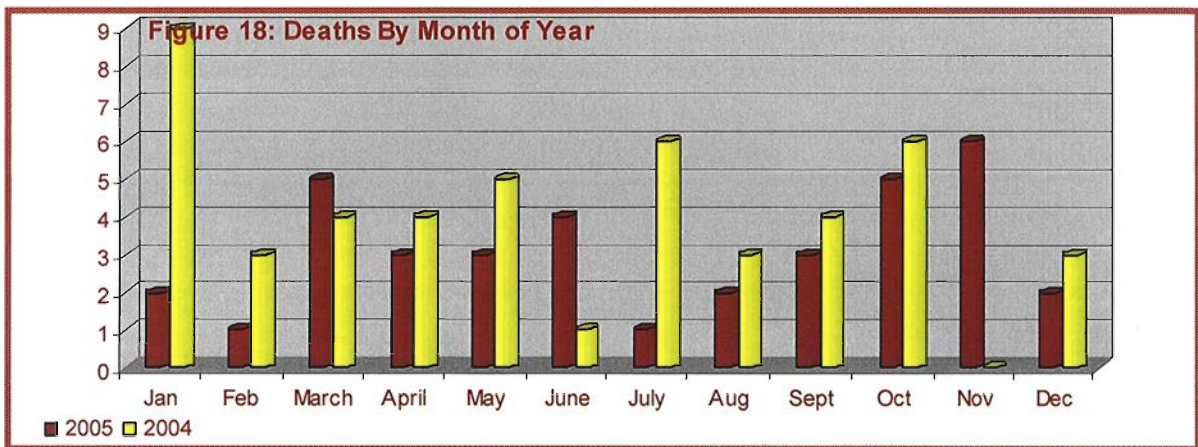


- ◆ **Race/Gender of Decedent** – Black/African American males continued to dominate the youth violence fatalities in the District. Similar to 2004, 100% of the 2005 victims were Black/African American. Between 2002 and 2005, males have represented between 85 and 91 % of the youth violence Homicides. Eighty-nine percent of the victims from 2005 were males.
- ◆ **Ward of Residence/Fatal Incident** - As Figure 17 illustrates, the majority of the decedents from calendar years 2005 were residents of Ward Eight followed by Wards Seven and One. The combined total for these Wards represented 63% (n = 24) of the total number of youth violence deaths for 2005. Similarly, the majority of the fatal events during 2005



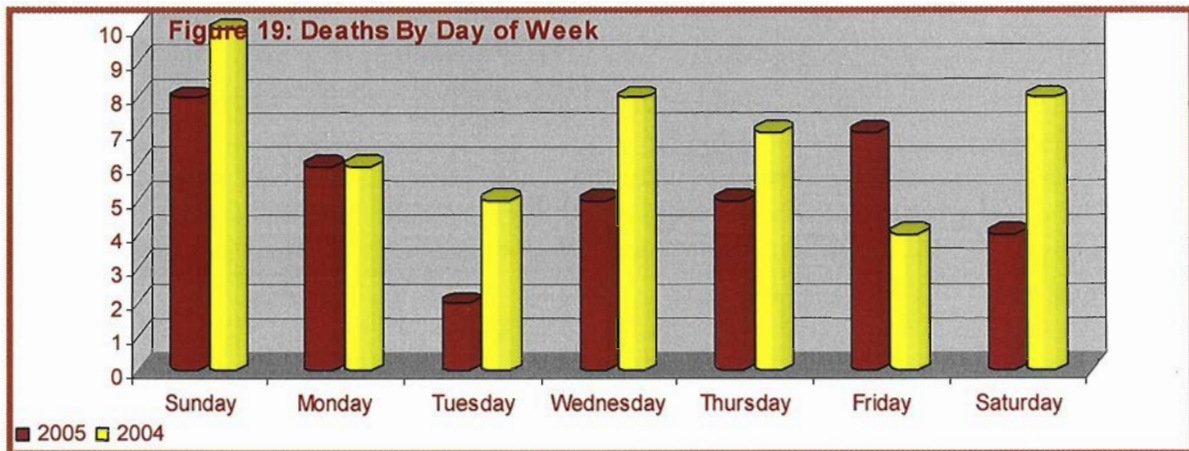
occurred in Ward Eight, followed by Ward Seven and Six which had equal number of fatal incidents ($n = 7$). Six fatal events occurred in surrounding states ($n = 6$), with the majority occurring in Maryland ($n = 5$). Seventy percent ($n = 26$) of the victims of youth violence were found in public areas (i.e., streets, alleys, parking lots, ravine, etc.). Five youth were found in vehicles and four fatal incidents occurred at the victims' homes or temporary place of residence.

- ◆ **Cause of Death** - As with all other CFRC years, gunshot wound continued during 2005 to be the leading cause of death for District youth Homicides. Ninety-seven percent ($n = 36$) of the 37 youth violence Homicides were caused by firearms. While the majority of the 2005 firearm victims ($n = 16$, or 43%) were shot once in a major part of their bodies (head, chest, abdomen, etc), many were shot multiple times. The number of shots to victims of multiple gunshot wounds ranged from three to 30 with an average of 5.7 gunshots. The remaining youth violence fatality from 2005 was caused by "Blunt Force Head and Neck Injuries". The circumstances involved an 18 year old youth who was involved in a physical altercation while incarcerated in the District's youth detention facility.
- ◆ **Toxicology Screen** - Based on the results of toxicology screens conducted at the time of autopsy, 16, or 43% of the 37 decedents were positive for drugs and/or alcohol use at the time of the fatal incident. This represents an increase from the 2004 calendar year when 14 of the 48 ($n = 29\%$) youth violence victims were positive for drug and/or alcohol use. Thirteen of the 16 decedents tested positive for Ethanol (alcohol) and six tested positive for drugs that included PCP, cannabinoids, amphetamine, and methamphetamine. Three of these decedents tested positive for both drugs and alcohol. The toxicology screen results for calendar year 2005 also revealed five decedents tested positive for tobacco use (nicotine) and only one was under the age of 18 years.

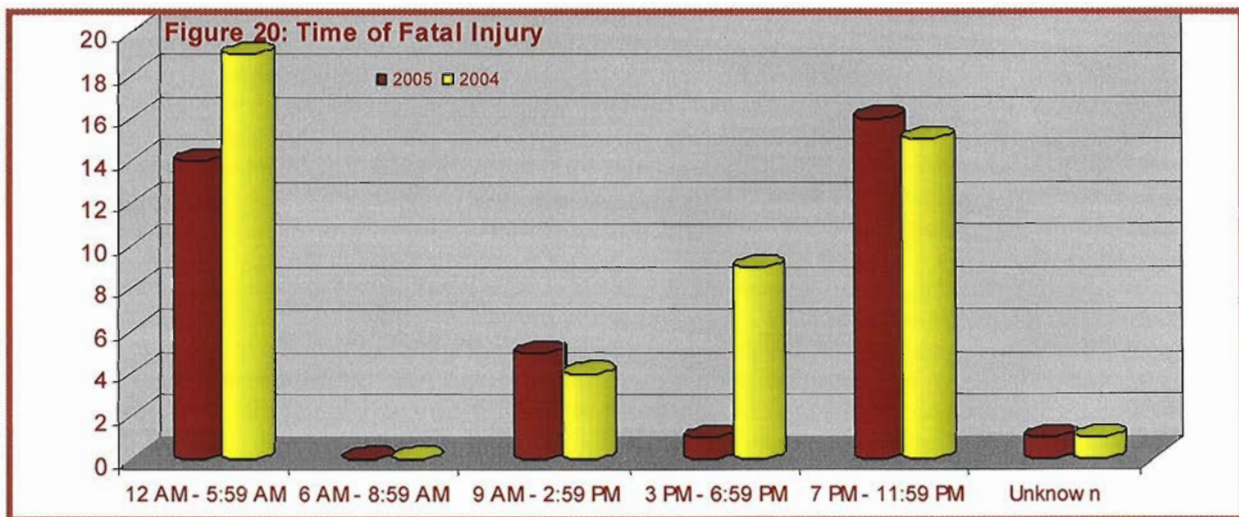


- ◆ **Month/Day of Week of Fatal Incident** - Figure 18 above illustrates the number of youth violence Homicides by month of the year. During 2005, youth violence deaths occurred in every month. The highest number of deaths occurred during March, October and November ($n = 5$ to 8 youth each month); with the largest number of deaths occurring in November. April, May, June and September had between three and four deaths each and

the remaining five months (January, February, July, August and December) had the lowest number of youth deaths (n = 1 to 2 each).



Similar to the months, youth violence deaths occurred on each day of the week (see Figure 19 above). The highest numbers of deaths (over four) occurred on Sunday, Monday, Wednesday, Thursday and Friday, with the largest numbers occurring on Sunday (n = 8) and Friday (n = 7).



- ◆ **Time of Fatal Incident** – Based on death certificates and police Death Reports, the majority of the fatal incidents that were associated with youth violence in calendar year 2005 occurred between 7:00 PM and 6:00 AM (n = 32, or 80%). Eleven of these youth were under the age of 17 years (curfew age) and died on District streets during mandated curfew hours.
- ◆ **Motive for Fatality** – Motive was obtained from the Metropolitan Police Department. In 2005, motive was known for 30, or 81% of the 37 CFRC youth violence fatalities. Sixteen (53%) of these deaths were associated with disputes/arguments/retaliations as the primary reasons for the Homicides. Drugs and gang activity were noted as the primary motive for eight of the deaths. Self-defense was associated with three 2005 youth Homicide fatalities; all

of these deaths involved an altercation with law enforcement. Accidental shooting was associated with two deaths. Robbery was the reason for one of the 2005 Homicides.

◆ **Other Types of Homicides**

During 2005, there were two Homicides that were categorized as “Other”. This included the following cases:

- ◆ A nine year old, Black/African American male child who was shot while playing outside his home at approximately 9:46 PM on a Thursday. The motive and perpetrator remained unknown at the writing of this Report however this case was not associated with either fatal abuse or youth violence.
- ◆ **Domestic Violence Related Homicide** - During 2005, there was one Homicide that was categorized as domestic violence related. This death involved an 18 year old, Black/African American male, who was struck by his father with a blunt object during a physical altercation. Information from the investigation indicated that the decedent was intoxicated (alcohol) and was behaving violently and aggressively towards other family members prior to the fatal incident and was killed during the father’s attempts to intervene. Because of the decedent’s age (beyond the age of majority for the District), this case is not being categorized as either fatal abuse or youth violence.

“Three 2005 Female Youth Homicide Deaths”

Case 1: On a cold winter day at 2:45 AM MPD responded to the Southeast quadrant of the District based on reports of sounds of gunshots. Upon their arrival they found a female victim sitting in the front passenger seat of a vehicle suffering from a gunshot wound to the right side of her body. The 20 year old was transported to a local hospital where all life saving measures failed and she was pronounced dead at 3:30 AM. The investigation revealed that the victim was shot in another area of the city and transported to the location where found. At the time of the review, the investigation remained open and the perpetrator had not been identified.

Cause/Manner of Death: Gunshot Wound/Homicide

Case 2: On a late fall morning, the MPD received to a report of a shooting in the Northwest quadrant of the city. Officers arrived to find a 17 year old female lying on a bed in the rear of her apartment suffering from a gunshot wound to the face. The victim was transported to a local hospital where she succumbed to her injuries and was pronounced dead at 4:20 AM. The investigation revealed that the decedent was shot by a friend and the motive was related to “negligent handling of an illegal weapon.” The perpetrator was charged with Murder I.

Cause/Manner of Death: Gunshot Wound of Face/Homicide

Case 3: At approximately 5:00 AM in September, while paroling in a Southeast neighborhood, MPD officers reported hearing gunshots. They were also approached by several residents yelling that someone had been shot. The officers responded in the direction of the shooting and found neighbors performing CPR on a female victim lying on the ground suffering from a gunshot wound in the chest. Shortly after medics arrived, it was determined that death was apparent however the 18 year old victim was transported to a local hospital where she was pronounced dead. The investigation revealed that the perpetrator was a previous paramour and the motive was “argument/revenge.” The perpetrator was charged with Murder I While Armed.

Cause/Manner of Death: Gunshot Wound of Chest and Right Hand/Homicide

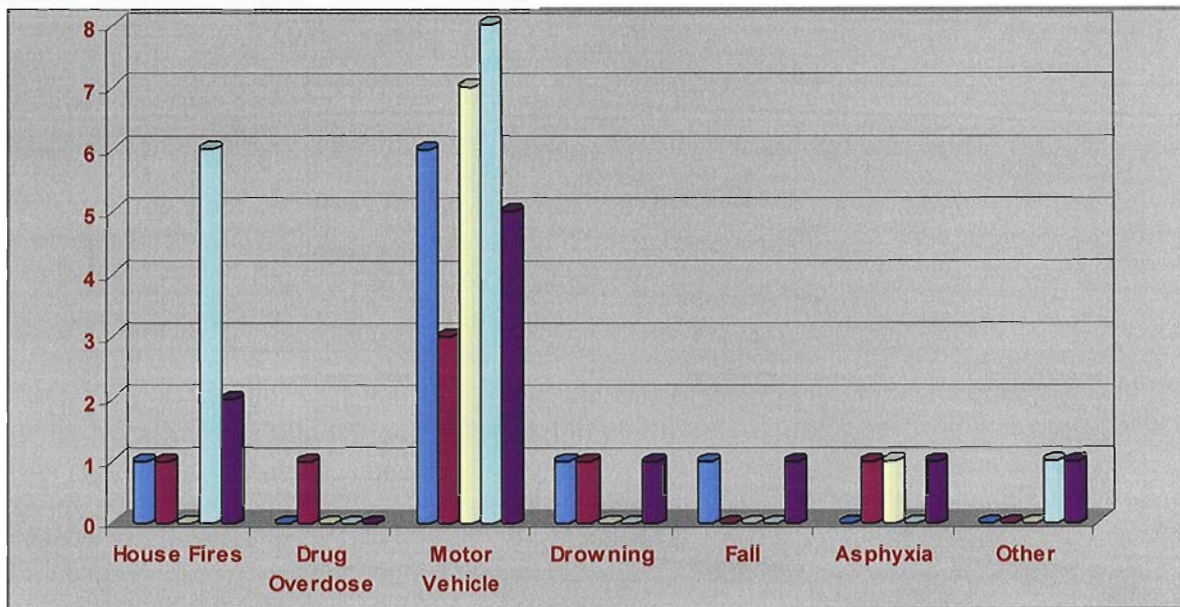
Unintentional Injuries

For the purpose of this report, unintentional injuries are those incidents where the deaths were not the result of deliberate acts. This category may include violent or non-violent conditions that were determined by the autopsy to be accidental. The 11 child/youth fatalities associated with unintentional injuries from calendar year 2005 represent a 27% decrease from the 15 accidental

deaths from 2004. Figure 20 below illustrates accidental child/youth deaths involving District residents over a five year period. As this figure illustrates, the major cause of unintentional District child/youth deaths has been associated with motor vehicle accidents.

Figure 21: CFRC Accidental Deaths

■ 2001 ■ 2002 □ 2003 □ 2004 ■ 2005



- ◆ The ages of the 2005 decedents ranged from less than one day to 21 years.
- ◆ Consistent with the overall 2005 fatality data, the majority of the decedents were Black/African American (n = 8 or, 73%). Three accidental deaths involved two Hispanic and one White child/youth.
- ◆ In 2005, there were slightly more males than female victims (n = 6, or 55%).
- ◆ Consistent with previous years the majority of the 2005 unintentional injuries were associated with motor vehicle accidents (n = 5, or 45%).
- ◆ Although deaths associated with house fires reduced significantly in 2005 (from five in 2004 to three in 2005), these deaths remained the second leading cause of accidental deaths in the District.

Motor Vehicle Accidents

- ◆ Motor vehicle accidents represented 45% (n = 5) of the 11 accidental deaths from calendar year 2005. Four of these incidents involved vehicles and one involve a motorbike/moped. The five 2005 motor vehicle related accidents involved one pedestrian, three passenger and one driver death.
- ◆ The one pedestrian motor vehicle death in 2005 represents 75% decrease from the four pedestrian accidents that occurred in 2004. The 2005 victim was a 17 year old female who was attempting to cross a busy street in the Northeast quadrant of the District. The Traffic Accident Report documented that there was no traffic light at the corner and the victim was not crossing at a crosswalk. Neither speed nor substance use were factors in the accident. The fatal incident occurred in Ward Six which was also the decedent's Ward of residence.

- ◆ Three (n = 60%) of the 2005 motor vehicle related deaths involved victims who were passengers in vehicles. One death occurred in the State of Virginia and two in the District. The ages of the victims ranged from 15 to 21 years, with an average age of 16. All the victims were Black/African Americans; two of the victims were males and one female. The following findings were documented from the CFRC case reviews of passenger deaths:
 - All three of the decedents were riding in striking vehicles in the fatal incident. Excessive speed was noted as a contributing factor for each of the striking vehicles. In one incident the decedent was riding in a stolen vehicle and the driver was attempting to escape police.
 - The two incidents that occurred in the District involved drug use. In one case, both the driver (also died during the accident) tested positive for multiple drugs and the passenger (CFRC decedent) tested positive for marijuana. In the second case the passenger (CFRC decedent) tested positive for marijuana at autopsy however the investigative report noted that alcohol was not a factor for the driver of the vehicle.
 - The investigative reports for the two incidents that occurred in the District indicated that the victims' seatbelts were unfastened at the time of the accidents. The details of the accident that occurred in Virginia are unknown.
 - All three accidents occurred at night, but street lights were on, the weather was clear and roads were dry.
 - Two of the decedents resided in the District in Wards One and Eight. One decedent resided in Maryland at the time of the death; this youth met the CFRC criteria based on the history with the District's child welfare system. Two of the fatal incidents occurred in Ward Six in the District; one occurred in Virginia.
- ◆ One 2005 motor vehicle related accident involved a 17 year old, Black/African American male who crashed his motorbike/moped into a Sports utility vehicle. The victim was a resident of Ward Four however the fatal incident occurred in Maryland. Speed was not a factor in the Accident Report however the decedent tested positive for marijuana at autopsy.

Burns/Smoke Inhalation

- ◆ Three of the 2005 accidental deaths were associated with house fires. This represents a 50% decrease from the six house fire related deaths from 2004.
 - ◆ The ages of the victims ranged from 10 months to four year. Two victims were male; and two were Hispanic and one Black/African American.
 - ◆ All of the fire related fatalities occurred in the homes of the decedents; two apartments in Wards One and Seven and one single family dwelling in Ward Four.
 - ◆ Based on investigative reports, one fire was attributed to the use of candles which were the only source of lighting; and one was attributed to a space heater. One fire was caused by a gas explosion that originated in the laundry room which caused the death of both the two year old child (CFRC decedent) and her mother.
 - ◆ Investigative reports were received for the three house fires. One report indicated that smoke detectors were present and working; one indicated that a smoke detector was present in the home however the report noted that operability was not determined; and one report did not indicate whether smoke detectors were in the home (single family home).
 - ◆ Two of the incidents occurred during sleeping hours (between 3:00 AM and 4:00 AM) and one occurred during the evening hours (5:30 PM). Adults were in the home at the time of all of the fire related deaths.
-

Asphyxia

- ◆ The cause of one 2005 accidental death was Asphyxia. The victim was a 25 day old, Black/African American male. The circumstances involved the infant co-sleeping in a full size bed with the mother and a two year old sibling. The infant was found face down by the mother who observed the two year old lying across the decedent.

Drowning

- ◆ One 2005 accidental death involved a 21 year old Black/African American male who drowned in the bathtub while having a seizure. He had a history of seizure disorder and non-compliance with medication/treatment.

Other

- ◆ One 2005 accidental death involved a 3 hour old, Black/African American female infant who was born prematurely as a result of the mother falling on her abdomen one day prior to delivery. At the time of birth, the infant was 22 weeks gestation, weighed 460 grams, and had APGAR scores of two/two. The cause of death was "Prematurity due to Abruption Placentae due to Maternal Fall."

"Two 2005 Accidental Deaths"

Case 1: On an early winter morning, 2 Black males were unbelted passengers of a vehicle being operated at a high speed by another Black male on a major highway surrounding the District. The driver lost control and the vehicle's passenger front side then collided with a light pole, causing the vehicle to overturn, then roll and slide on its top until it collided with another guardrail on the opposite side of the roadway. Emergency personnel arrived on the scene to find 3 males with injuries that were incompatible with life. Autopsy findings indicated that all the victims were positive for alcohol and multiple drugs. The investigation report indicated that the crash was directly related to driver error, in that the vehicle was traveling at excessive speed which affected the driver's ability to negotiate the curved roadway, causing the vehicle to spin out of control. The driver was partially ejected as the vehicle landed on its roof. The report indicated that the crash occurred at night, street lights were on, the road was dry, the weather was clear, and the road surface was asphalt. There were no traffic controls. Motor vehicle information indicated that the driver's license had been suspended due to tickets and the vehicle was registered to a car dealer in another state. Speed and intoxication were the major contributing factors to the accidental death of three African American males, the youngest of which was a CFRC case.

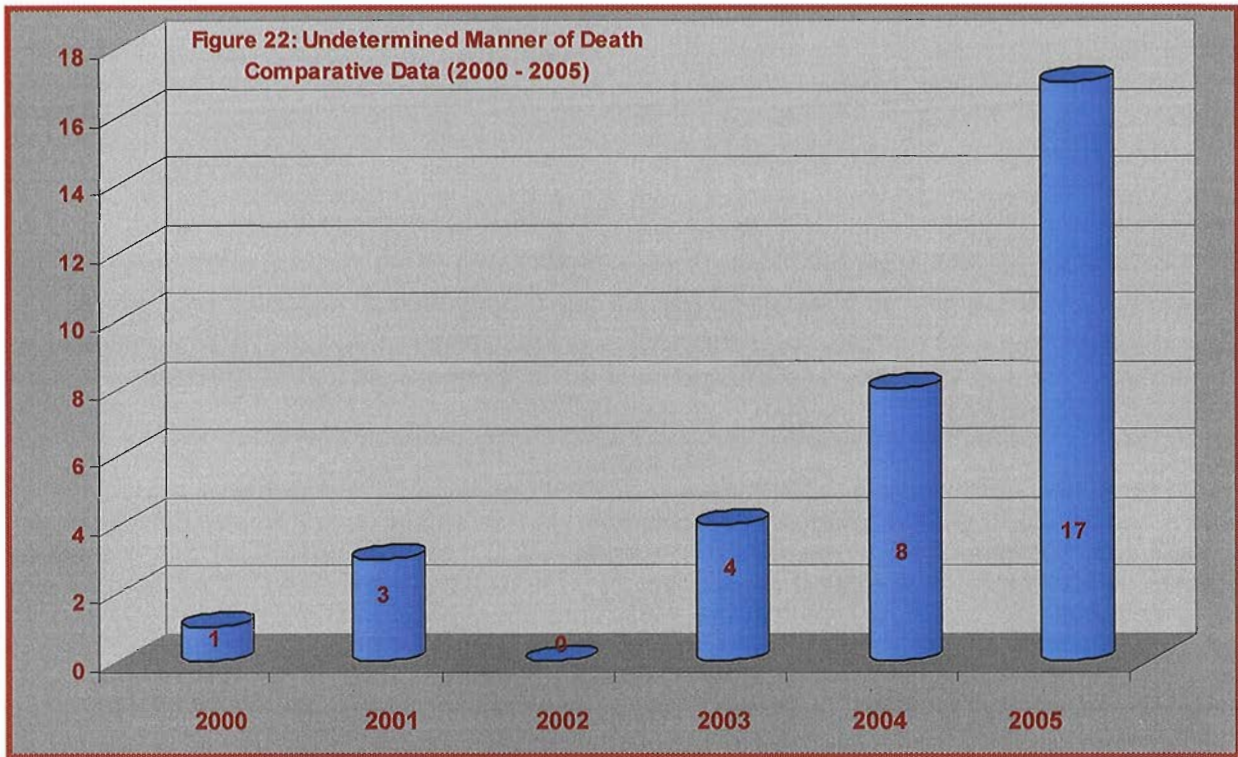
Cause/Manner of Death: Blunt Impact Head Trauma/MVA

Case 2: On an early spring morning, a young mother found her 2 day old infant unresponsive in the bed that they shared. Medics responded to the 911 call and transported the child to a local hospital, where life saving measures failed and the infant was pronounced dead at approximately 4:30 AM. The scene investigation indicated that the home was a 2 bedroom apartment in the SE quadrant of the District. The bedroom where the victim slept was shared by the mother, her children, and several other relatives. The room was furnished with a full and queen size bed; 2 end tables; a TV and at least 3 plastic containers. The room and the other areas of the apartment were noted to be messy and cluttered. The investigative report indicated that the bed where the victim was found had a fitted sheet and quilt, along with a child's game at the far left corner/foot end of the bed and 2 pillows. The mother was reportedly lying on the outside area with the infant lying in the middle/head area of the bed. According to interviews, the mother indicated that she placed the decedent on a folded blanket on the bed at approximately 9:00 PM the day prior. According to a relative, who shares the same room, when she went to bed at approximately 10:30 PM she observed that the older sibling was trying to fall asleep at the foot of the bed; and the mother and decedent were asleep. It was also reported that the mother woke up once during the night and fed the infant; and when she awoke a second time she observed that the older sibling had crawled up the bed and was lying across the decedent.

Cause/Manner of Death: Asphyxia/Accident.

Undetermined Manner of Death

“Undetermined” as a final manner of death is declared when a reasonable classification of manner cannot be established after a full and comprehensive analysis of the post-mortem examination, police and forensic investigation, toxicology screens and any other social, familial, medical and other specific events leading to or surrounding the fatal incident.



In 2005, the number of child fatalities in which the autopsy resulted in an “Undetermined” manner of death increased considerably from previous CFRC years. As Figure 22 illustrates, the more stable incline in Undetermined deaths began in 2003, with the most substantial increase in number of deaths occurring in calendar year 2005. Based on a review of previous CFRC data, prior to 2003, the number of Undetermined deaths ranged from zero to three. Beginning in 2003, the percentage of increase from 2002 was 400% and in 2004 Undetermined deaths increased by another 100%. In 2005 there were 17 child/youth fatalities where the manner of death was Undetermined, representing an unprecedented number of deaths in this category and representing an increase by 113% from the eight Undetermined deaths from calendar year 2004.

As acknowledged in prior CFRC Annual Reports, the steady increase in “Undetermined” fatalities is directly associated with a change in autopsy practice for deaths where the investigations reveals that the infants were co-sleeping or sleeping in inappropriate environments (sofas, floor, etc.) at the time of the fatal event. Prior to the 2004 calendar year, the cause of death for the majority of these deaths were determined to be “Sudden Infant Death Syndrome” with a “Natural” manner of death. The practice change was made by the Office of the Chief Medical Examiner in collaboration with and the support of physicians from the CFRC’s Infant Mortality Review Team. In 2005, paralleled with the increase in the number of Undetermined

deaths, the number of deaths associated with SIDS reduced substantially (n = 0). Based on a review of the 2005 "Undetermined" deaths, the following findings were identified:

- ◆ The ages of the decedents ranged from seven days to 20 years. However the greater majority of the decedents were infants (n = 15, or 88%). Consistent with 2004, all the decedents were Black/African American; however, unlike 2004, the majority of the 2005 decedents were males (n = 10, or 59%).
- ◆ *Undetermined Infant Deaths*
 - Also consistent with 2004, the majority of the infants were born full term (n = 10 or 67% of 15 infants) and the majority had birth weights greater than 1800 grams (n = 14, or 93%).
 - The majority of the causes of death (n = 13, or 87%) was "Sudden Unexplained Death in Infancy". Two of the infant deaths also had "Undetermined" causes of death.
 - Based on a review of death certificates, hospital records and death scene investigations, 11 of the 15 infant death cases documented inappropriate sleep environments (excessive covers/bedding/items); eight documented co-sleeping/bed sharing as a concern and six of these cases documented both. Of the eight cases where infants were co-sleeping, four (n = 50%) had cribs in the home.
 - Of the 15 Undetermined infant cases, only two reported placing their children on their stomachs to sleep; four reported placing the child on the side and eight reported placing infants on their backs.
 - Thirteen of the 15 mothers received some prenatal care, and nine reported that they received regular/routine care; and two mothers reported breastfeeding their infants.
 - Seven women reported substance use as a problem however only two were positive for drug use at birth.
 - One third of the infants were residents of Ward Eight (n = 5), followed by Ward Six (n = 4).
- ◆ *Undetermined Deaths of Children/Youth Over One Year of Age* - The manner of death for two children over the age of one year was Undetermined for 2005. The decedent descriptions, causes of death and circumstances of death were as follows:
 - A one year, nine month old, Black/African American male who was a resident of Ward Eight. Both the cause and the manner of death were "Undetermined."
 - A 20 year old, Black/African American male, who was a resident of Ward Eight. The cause of death was associated with gunshot wound.

Two Undetermined 2005 Fatalities

Case # 1: On 9/1/05, a child welfare social worker reports receiving a “frantic” call from a foster care provider indicating that she had awakened around 4:00 AM to feed the infant, placed the child in bed with her and later awoke and found the 2 month old infant unresponsive. He reported that he last fed the child about 1:00 AM and then placed him in bed with her. The foster care provider stated that police officers from a surrounding jurisdiction were on the scene and that the infant was being transported to a hospital. The child welfare record indicates that the social worker had visited the foster home several weeks prior, and noted that the infant was very congested. At that time, the foster care provider reported he had been sick and fussy throughout the evening prior. The record added that the child had not been enrolled in Medicaid and had not received any medical care related to his symptoms. The worker took the foster parent and the child to a local emergency room, where he was assessed with Upper Respiratory Infection; he was scheduled for and taken for a follow-up visit 4 days later by the agency worker. The worker reports that the infection remained, but indicated that the child was “recovering nicely”. The decedent was scheduled for a well-baby visit on 9/15/05 however there was no documentation noted regarding whether the infant had other well-child visits. The autopsy noted no signs of trauma, no injury and no recognizable natural disease. Toxicology was negative for drugs and alcohol. The investigation, however, showed that the infant was found unresponsive co-sleeping with an adult and overlay could not be ruled out with certainty. The decedent had been placed in foster care several days after his birth due to issues of maternal drug abuse and neglect.

Cause/Manner of Death: Sudden Unexplained Death in Infancy/Undetermined

Case #2: A 30 year old mother with 7 prior pregnancies, 3 term and 4 preterm, delivered an 8th child in the early spring of 2005. Her medical history was significant for STD in 2002 and she had no prenatal care with the 2005 pregnancy. Mother came to the delivery hospital in active labor and was transported to the delivery suite for imminent delivery. Labor advanced and she delivered 1 hour and 30 minutes after hospital arrival. The infant was determined to be preterm (34 weeks gestation); birth weight was 5 lbs/2 ozs; Apgar scores were 8 @ 1 minute and 9 @ 5 minutes. The infant was pink with good cry and was transported to the normal newborn nursery. The infant and mother progressed well and both were discharged 2 days after birth. Prior to going home the mother was given an appointment to follow-up in the Obstetrical Clinic in 4 weeks; and an appointment for the infant to be seen in the Well Baby Clinic in 3 days. Approximately one month later, the mother awakened at approximately 7:00 AM and prepared to get her other children ready for school when she noticed that her infant was blue in color. She rushed next door to her friend’s apartment and called 911. She was instructed by the operator to perform CPR until the medic team arrived. The medic response team arrived timely and observed that the child had no pulse or respiration. CPR was continued and the infant was transported to the emergency room of the nearest hospital. Upon hospital arrival the child was noted to be cold with body temperature of 95.5 degrees. Resuscitation efforts continued but were unsuccessful; the child was pronounced deceased @ 8:00 AM. There were no physical signs of trauma. Based on the investigation, the mother reported that at approximately 1:00 PM the decedent placed on the living room sofa while she sat on the edge of the sofa watching TV. At approximately 1:00 AM the infant was fed, put back to sleep on the sofa on a soft pillow. When the mother prepared for sleep she laid down next to the infant on the sofa. The position of mother and infant was described as the mother lying on the outer edge of the sofa on her left side with the decedent positioned behind her on the left side, facing her back. She indicated that at night the infant normally slept with her on the sofa and that she would sometime position him on her chest. During the day the child slept in a bassinet. The mother stated that she slept on the sofa because the bedroom was cluttered and the TV in the bedroom did not work. On the night prior to the terminal event the mother reported that she had been entertaining friends in her apartment. She and her friends were smoking cigarettes and drinking beers. Medical history indicated that the infant had not been seen for any Well Baby Clinic appointments. The mother reported that the child had a slight cold 5 days prior to the terminal event but was not taking any medication. She used a bulb syringe to aspirate mucus from the infant’s nose. She also reported that the infant had a fall several days prior to the death when her 2-year-old son attempted to pick the child up while she was in the bathroom.

Cause/Manner of Death: Sudden Unexpected Death Associated with Co-sleeping/Undetermined

SUMMARY OF CFRC SUBCATEGORIES

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

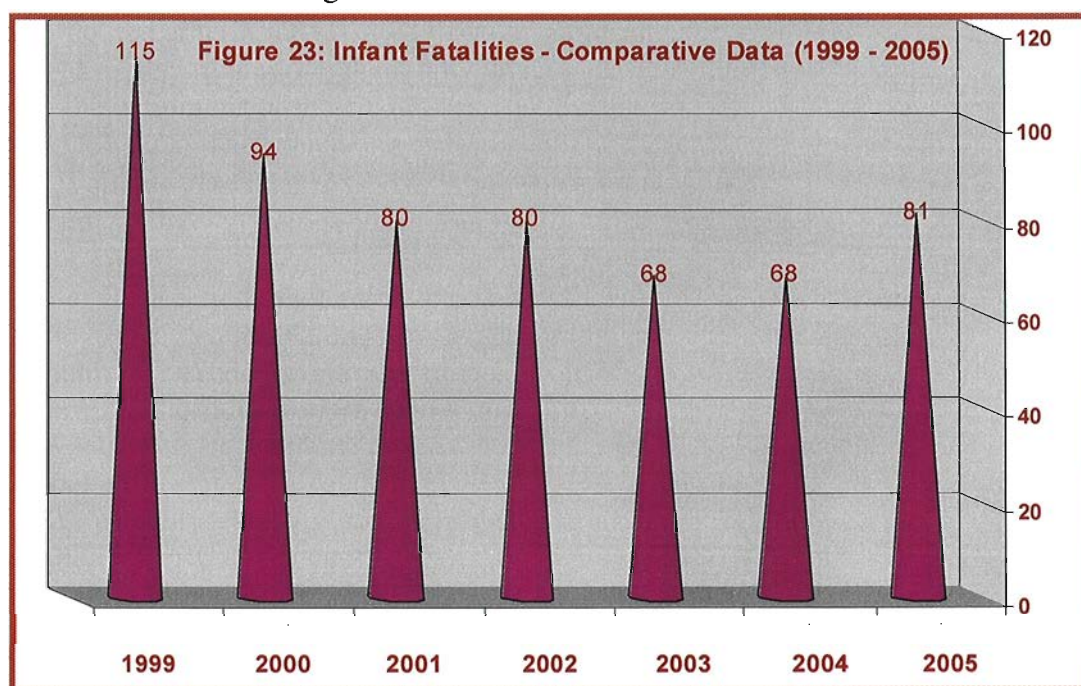
- ◆ Infant Mortality – Decedents under the age of one year.
- ◆ Child Welfare – Decedents whose families were known to the child welfare system within four years prior to the death.
- ◆ Juvenile Justice – Decedents who were known to the juvenile justice system within two years prior to the death.
- ◆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

Table 3 – 2005 Case Type

	<u>#/% of Total</u>
Infant Mortality *	81/53%
Child Welfare *	57/37%
Juvenile Justice *	29/19%
Community	24/16%

*Duplication in all categories except community

Table 3 above illustrates the total number and percentage of deaths for calendar year 2005 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

- During calendar year 2005, the number of infant deaths increased substantially. There were 81 deaths of children under the age of one, representing a 19% increase from the number of infant deaths from calendar years 2003 and 2004. As Figure 23 above

illustrates, this increase represents a significant change in trend after five years of a steady decline (41% decrease from 1999 through 2004) in deaths in this population. The 81 infant deaths from 2005 represent 53% of the total 2005 CFRC child/youth deaths (n = 154).

- In 2005, the ages of the decedents ranged from birth through 11 months. Two thirds (n = 54, or 67%) of the infant population died within the first 28 days of life (neonates) and 50% of these infants (n = 27) died within the first day of life. Table 4 below illustrates comparative data for neonatal deaths for calendar years 2001 through 2004.

Table 4: Decedents' Age At Death					
	2001	2002	2003	2004	2005
Age Range	Birth – 9 Months	Birth – 11 Months	Birth – 9 Months	Birth – 11 Months	Birth – 11 Months
28 Days or Less	59 (74%)	57 (71%)	43 (63%)	40 (59%)	54 (67%)
1 Day or Less	46	45	29	26	27

- As Table 5 illustrates, the number of Black/African American infant decedents has fluctuated during the past five years. In 2005, there was a slight increase in the number of infant deaths that involved Black/African American children. Seventy of the 81 2005 infant decedents were Black/African American, representing a twenty-three percent increase from the 57 infant decedents of the same racial background.
- In 2005, the number of males increased to 47, representing a 38% increase from the 34 male infants who died in 2004. The 47 males from calendar year 2005 represented 58% of the total infant population.

Table 5: Decedents' Race					
	2001	2002	2003	2004	2005
Black	71/ 89%	62/78%	60/88%	57/84%	70/86%
White	4	8	2	3	5
Hispanic	4	9	5	7	6

◆ District Ward of Decedents

As Table 6 illustrates, consistent with the majority of prior CFRC years, there were infant deaths from all Wards of the District during calendar year 2005. Data indicates that the majority of the infant deaths involved residents of Ward Eight (n = 25), followed by Wards Seven (n = 13) and Five (n = 12). The number of deaths for these Wards represented 62% of the total infant death population. Wards Two and Three have consistently represented the lowest number of infant deaths in the District. In 2005, there were two infant deaths that involved residents of Maryland; both were known to the District's child welfare system.

Table 6: Decedents' Ward of Residence					
	2001	2002	2003	2004	2005
Ward 1	5	12	4	11	7
Ward 2	6	9	5	4	2
Ward 3	4	4	0	1	3
Ward 4	10	10	10	9	8
Ward 5	8	8	9	10	12
Ward 6	11	9	6	10	9
Ward 7	11	17	15	13	13
Ward 8	25	11	19	9	25

◆ Gestational Age/Birth Weight

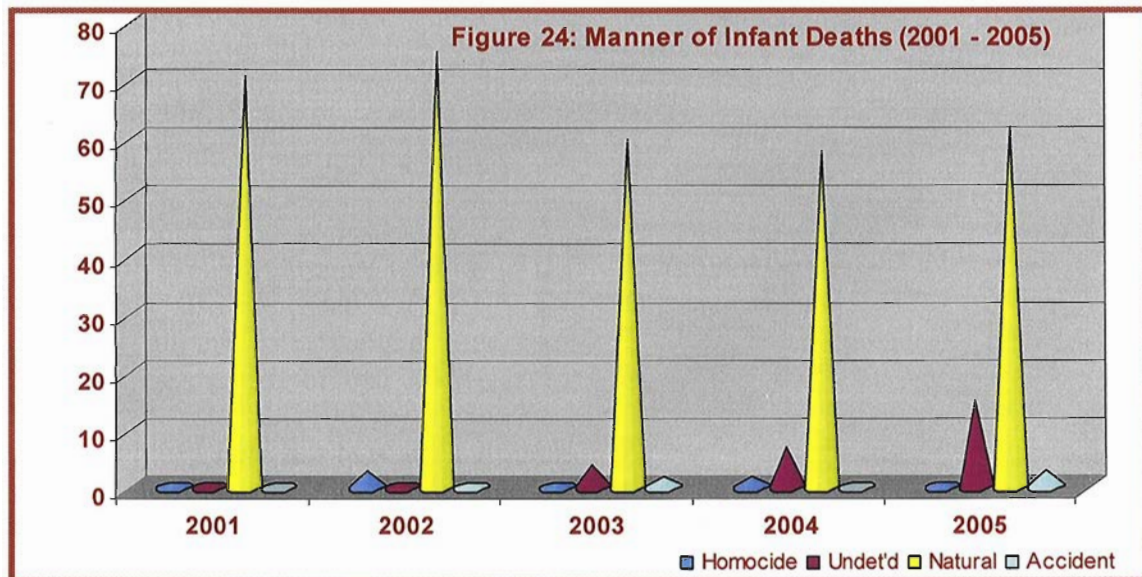
Data from 2005 depicts a change in trend related to the number of deaths that involved infants who were born prematurely. As Table 7 (see next page) illustrates, between 2001 through 2004, the number of infants born prematurely declined consistently. In 2005, this trend reversed with the number of premature births increasing to 59, representing a 31% increase from the 45 fatalities that involved infants who were born prematurely. The 59 deaths from 2005 represent 73% of the total infant death population.

In 2005, consistent with 2004, the number of preterm infants with low birth weight also increased. Of the 59 premature infants, 46 weighed less than 1500 grams and of that number, 16 weighed less than 500 grams and

eleven weighed between 500 and 600 grams. Twenty or 25% of the 2005 infant decedents were full term births. Gestational age and birth weight was not known for two infant decedents.

Table 7: Gestational Age

	2001	2002	2003	2004	2005
< 38 Weeks	66/83%	59/74%	48/71%	45/61%	59/73%
< 23 Weeks	32	31	24	17	20
Low Birth Weight Infants					
< 1500 Grams	59/89%	51/86%	32/67%	33/49%	46/57%
< 500 Grams	23	24	15	16	16



◆ Manner of Death

As with previous years, the majority of the 2005 infants died from Natural causes. Sixty-two children under the age of one year died during 2005 from Natural causes ($n = 76\%$ of the total infant population). In over 70% of the Natural infant deaths, the cause was determined to be associated with prematurity ($n = 44$).

Consistent with the past two CFRC calendar years (2003 and 2004), the second leading manner of 2005 infant deaths was "Undetermined" ($n = 15$). The number of deaths attributed to "Undetermined" manners increased more than 100% in 2005. The official autopsy reports for 13 or 87% of the 15 "Undetermined" infant deaths indicated the cause was "Sudden

Unexpected Infant Death” and over half (n = 7, or 54%) by death certificate directly linked the cause to co-sleeping/bed sharing and inappropriate sleep environments, however investigative reports and hospital records noted four additional cases with the same problems/concerns. Two of these children were in the care of foster care providers and the remaining children were in the care of parents/family members at the time of their deaths. Two Undetermined manners of death also had an “Undetermined” cause of death.

One infant died as a result of Homicide associated with fatal abuse. This death involved a two month old, Black/African American male who died from “Multiple Blunt Impact Injuries” (fatal abuse). There were three accidental infant deaths in 2005. These deaths included two children who died from “Asphyxia”, one associated with overlay and one with a house fire. One accidental death was associated with a pregnant mother falling causing the premature birth of her child.

◆ ***Decedent's Maternal Demographic Data***

- Age of the mother was known for 98% (n = 79) of the 2005 infant deaths. Their ages at the time of the death ranged from 12 to 44 years, with an average age of 27.
- Race was known for 78 mothers. Eighty percent of the mothers (n = 65) were Black/African American, equal number of Hispanic and White mothers experienced infant deaths in 2005 (n = 6 each).
- The majority of the mothers for calendar year 2005 infant deaths (n = 60, or 74%) had never married. Nineteen (n = 23%) mothers were married. Marital status was unknown for two mothers.
- Educational level was known for 55 of the 81 mothers of 2005 infant decedents (68%). Sixty-four percent (n = 35) of the mothers had at least a high school education and 14 of these women had participated in college level educational programs; five of these mothers completed undergraduate level and three had some graduate level education (two completed graduate school). Twenty mothers had less than a high school education, with educational levels ranging from the 5th to 11th grades.
- Of the 62 mothers of 2005 decedents in which employment history was known, 17 were employed and 45 were unemployed at the time of the infant deaths.

“A 2005 Undetermined Infant Death”

A mother called 911 and reported that her 3-month old infant was non-responsive. Paramedics arrived at the home at 7:55 AM and found the infant unconscious in the living room. Life saving measures failed and at 9:55 AM the infant was pronounced dead on the scene. The autopsy indicated that the child was a well-nourished and well-developed Black male infant who weighed 14 pounds and was 23 inches long. There was no apparent evidence of fractures, injury, rashes, or lesions; and no external or internal congenital malformations. The investigation revealed that the mother had last fed the infant a 6 ounce bottle of Enfamil and laid her on the living room sofa, on a pillow, covered with a blanket. The mother watched television while the infant was sleeping next to her in the living room for an undetermined amount of time. She eventually placed the infant on his right side in the bassinet and returned to the living room to prepare for her other children's first day of school. The mother reported that she eventually fell asleep on the living room sofa. When later awakened by the older children, she went to the bedroom to check on the infant and found him lying face down in the bassinette. She picked up the child and found him cold and unresponsive. She ran to the phone while holding the infant to call her mother, who instructed her to call 911. The dispatcher instructed her to place the infant on her back and to begin CPR. She continued CPR until paramedics arrived to take over. The home was described as a 3 bedroom apartment that was cluttered, messy and infested with roaches. Investigators found that the bassinet had at least two stuffed animals, several types of infant clothes, and infant type blankets.

Cause of death: Undetermined/Undetermined

◆ **Maternal Risk Factors**

Based on the review of hospital medical records, birth and death certificates the following data on maternal risk factors were highlighted:

○ **Prenatal Care**

- Prenatal care information was known for 73, or 90% of the mothers. Twelve mothers did not received prenatal care during their pregnancies with the decedents.
- Forty-five (n = 62%) mothers received routine prenatal care, including 24 who entered prenatal care after 12 weeks.
- Sixteen mothers received sporadic prenatal care.
- Thirty-four mothers entered prenatal care after the first trimester of their pregnancy; the weeks of entry ranged from 13 to 34.

○ **Physical Health**

- Of 48 cases where mothers' health status was known, 34 had diagnosed physical health conditions. Some of the health problems included anemia (n = 5), asthma (n = 11), allergies (n = 4), diabetes, cancer, obesity (n = 7), thyroid problems, sickle cell trait (n = 2), fibroids, hypertension (n = 8), GERD, Crohn's Disease, and sickle cell.

○ **Mental Health/Developmental Problems**

- Four mothers had documented histories of mental health disorders, including depression, bi-polar disorder, schizophrenia and suicide ideation.
- Two mothers were diagnosed with mental retardation.

○ **STD/HIV**

- Twenty-three women had prior histories of sexually transmitted diseases.
- Four of these mothers were HIV positive.
- Thirty-one women experienced problems with maternal infections, STDs, and other medical problems during their pregnancies with the decedent (i.e., preeclampsia, urinary track infections, gonorrhea, HIV, Chorioamnionitis, Chlamydia, etc.)

○ **Substance Abuse/Tobacco Use**

- Twenty-four mothers had problems with substance abuse; 10 reported illicit drug use only; eight alcohol and six reported problems with both drugs and alcohol.
- Ten mothers had positive toxicology screens for substances at the time of the decedents' birth.
- Twenty-four mothers also reported tobacco use.

◆ **Sibling Data**

- The majority of decedents from 2005 had siblings. Of the 55 (n = 71% of the 78 cases where information was known) families known to have other children, the number of children ranged from one to seven, with an average of three siblings.

- Ten decedents were part of multiple births; nine were twins and one was a triplet. In one case both twins died however, one died at the end of 2004 and one in the early part of 2005.
- Three mothers also had previous infant/child deaths; one had two prior infant deaths (calendar years 2000 and 2001). Twenty-three women had prior fetal deaths (stillbirths, miscarriages). The number of fetal deaths ranged from one to eight, however the average was 1.6. Thirty-one women reported having had abortions prior to the birth of the 2005 decedent. The number of abortions ranged from one to four with an average of 1.5.

"Three 2005 Infant Deaths- Accidental, Natural and Undetermined"

Case #1: A mother presented to a hospital with vaginal bleeding and spotting. Sonogram revealed bulging membranes, fetal parts in the cervix and a small placental abruption. Neonatology consultation with parents indicated the likelihood of loss of pregnancy. Uterine contractions could not be controlled. Labor advanced rapidly and an emergency C Section was performed. The decedent was determined to be a 22 week non-viable infant, weighing 460 grams, with Apgar scores of 2 @ 1 minute and 2 @ 5 minutes. She died within 1 hour after birth. The prenatal record indicated that the pregnancy was complicated by the mother accidentally falling one day prior to her delivery. Records indicated that she fell onto her abdomen from a squatting position while attempting to lift one of her other children. She was taken to a hospital and was treated for left shoulder dislocation. After delivery, the mother progressed satisfactorily and was discharged home 3 days later. Prior to discharge, she was given an appointment for a 6 week checkup with her private physician and was provided grief counseling and support.

Cause/Manner of Death: Prematurity due to Abruption Placentae due to Maternal Fall/Accident

Case #2: A female infant was born 19 weeks premature, weighing 343 grams with Apgar scores of 2 @ 1 minute and 1 @ 5 minutes. This previable infant was transported to NICU for custodial care with no respiratory effort, no irritability, no tone, no color, fused eyelids and transparent skin. Death occurred within 2 hours of birth. The mother's medical history was significant for morbid obesity and anemia. She was unaware of her pregnancy until the month of the birth because of an IUD placement and continued menstrual flow. Prenatal records indicated that prenatal course was complicated by a possible fetal anomaly from the IUD.

Cause/Manner of Death: Previa Fetus at 19 Weeks Gestation; Premature Delivery, Voluntary Termination of Pregnancy, Fetal Risk from Intrauterine Device/Natural

Case #3: One winter morning, the mother awoke to find her 1 month old infant not breathing in a bed they shared. 911 was called and a relative was instructed to provide CPR. Medics continued resuscitation efforts enroute to a local hospital where the child was pronounced dead at 12:30 PM. The mother reported that the child was last fed at 1:00 AM and rocked back to sleep. The mother reported that she laid the child down on her side on a queen sized bed that they shared with an older sibling. The mother further stated that she awoke at 7:30 AM and checked on the child who appeared to still be sleeping. The mother then returned to sleep. She awakened again at 11:30 AM and noticed that her child "looked strange"; she touched the child and noticed that she felt cool and hard. She then grabbed her baby and ran into the living room to alert a relative who called 911. Medical records indicated that the child was full-term and weighed 6 lbs at birth. She was born by C-Section due to fetal distress during delivery. She was also diagnosed with Asthma and had problems with congestion since birth. Records noted that the infant had both well and sick child medical visits prior to her death.

Cause/Manner of Death: Sudden Unexplained Death in Infancy/Undetermined

Juvenile Justice Fatality Data

Twenty-nine (19%) of the 154 fatalities from 2005 were youth known to the juvenile justice system. Reviews of these cases revealed the following findings:

◆ ***Decedent Demographic Data***

- ***Age/Race/Gender*** - The decedents' ages ranged from 15 through 21 years with an average age of 18 years. Consistent with 2004, one hundred percent of the 2005 juvenile justice decedents were Black/African American and 97% were males (n = 28).
- ***Ward of Residence*** - The majority of the 2005 juvenile justice deaths involved residents of Wards Eight and Seven. Fourteen (n = 48%) decedents were residents of these Wards.
- ***Substance Use/Involvement*** - As with previous years, substance abuse continued to be a major concern in the majority of the 2005 juvenile justice fatalities. Seventy-nine percent of the decedents (n = 23) had known histories of substance use or involvement.
- ***Educational Level*** – Based on review of death certificates two juvenile justice decedents from 2005 had received a high school education. Based on DCPS records, 11 youth had withdrawn from District public schools prior to their deaths. At the times of their withdrawals, their ages ranged from 16 to 20 years and the last grades attended ranged from the eighth to 11th. Thirteen youth were attending school at the times of their deaths. Their ages ranged from 15 to 20 and their grades of enrollment at the times of their deaths ranged from ninth to the 11th. Educational information was unknown for three youth.
- ***Public Services*** – The full population of decedents (n = 29) were known to the District's public assistance program and 17 were actively receiving services at the times of their deaths. All decedents who were active with the public assistance program were receiving medical assistance, three were receiving TANF and six youth were receiving food stamps at the times of their deaths. Additionally, 13 of the juvenile justice youth were also known to the child welfare agency.

◆ ***Manner/Cause of Death***

Ninety percent (n = 26) of the 2005 juvenile justice decedents died from Homicides. The majority of these deaths were caused by firearms (n = 25). The manner for one death was ruled as "Undetermined" however the cause was also associated with firearms. The two remaining fatalities were determined to be Natural and Accidental.

◆ ***Juvenile/Court History***

The majority of the juvenile justice decedents had numerous charges/arrests. Of the 29 decedents from the 2005 calendar year, 23 (80%) had multiple arrests. The types of charges included gun/ammunition possession, drug possession, assault, unauthorized use of a vehicle, and destruction of property. Sixty-two percent (n = 18) of the juvenile justice decedents involved youth who had active cases at the time of the deaths. Twelve of the youth were committed to the District; three were on detained status and in some type of community-based facility under the supervision of the court; and one youth was on probation (the statuses of two youth were unknown). In six of the active cases, the youth were in abscondence from the juvenile system at the time of the death and in one of the closed cases, the youth was in abscondence from the child welfare system at the time of the death.

Child Welfare Fatality Data

Child welfare deaths include those decedents whose families were known to the protective services, foster care and adoption programs. Although the initial entry point for these services is through the public child welfare agency, a range of services is available through public and/or private service providers. During 2005, 56, or 36% of the 154 deaths identified were children who met the definition for review as a child welfare fatality. This data represents a slight decrease from the 58 child welfare decedents from 2004 data. Reviews of the 2005 child welfare fatalities revealed the following:

◆ ***Decedent Demographic***

- ***Age of Decedent*** - The ages of the decedents ranged from birth through 23 years of age, with an average age of nine years. Consistent with overall child fatality data, the majority of the children were infants (n = 23) or older than 14 years of age (n = 24). Combined, these categories represented 84% of the total child welfare fatalities.
- ***Race and Sex of Decedents*** - Ninety-eight percent (n = 55) of the 2005 child welfare deaths represent children/youth of Black/African American descent. One child was Hispanic. Males continued to represent the majority of the child welfare fatality population. Seventy-seven percent (n = 43) of the decedents were males.
- ***Health/Mental Health of Decedents*** - Ten 2005 decedents (18%) had diagnosed chronic health problems/congenital anomalies or physical/developmental disabilities. Fifteen of the decedents had known diagnosed mental health and behavioral disorders. Over 50% of the 2005 child welfare youth over 13 years of age had histories of drug use (n = 14 or 54%). Six of the children under one year of age were born substance exposed in utero.
- ***Educational Level of Decedents*** - Over half (n = 30, or 54%) of the 2005 decedents were school age (age 5 to 21 years). Forty-one percent of these children/youth were over 14 years of age (n = 23) and 10 were over 18 years of age. The educational levels (last grade completed) for the children/youth over the age of 14 ranged from seventh through the 12th grades. At the time of their deaths, two youth had graduated from high school. Eight 2005 school age decedents were enrolled in special education or alternative programs.

◆ ***Cause/Manner of Death***

- The majority of the 2005 child welfare fatalities were attributed to Natural deaths. Twenty two children died from medical related causes and over half of these children were under the age of one year (n = 14, 64%). The eight children who were over the age of one who died from Natural death represented 40% of the overall 2005 population of Natural deaths in this age group (n = 20).
- One third of the child welfare decedents died violently during 2005 (n = 19). Eighteen or 32% of the child welfare deaths were attributed to Homicides and one to Suicide. Two of the child welfare Homicides were caused by parent/caregiver abuse, which represents half of the total fatal abuse deaths for calendar year 2005. These deaths included children under the age of two years; one male and one female; and both were Black/African. Sixteen youth known to the child welfare system died from trauma associated with youth violence (gang, drugs, disputes and criminal behavior). Again, all were Black/African American, the ages ranged from 14 to 23 years and the majority were males (n = 14). The

remaining Homicide involved a nine year old whose death was not associated with either youth violence or fatal abuse.

- Over half of the 11 accidental deaths from 2005 involved children/youth known to the child welfare system (n = 6, or 55%). Four of these deaths resulted from motor vehicle accidents, one from drowning and one from Asphyxia due to overlay.
- Fifty-three percent of the total 2005 “Undetermined” fatalities involved children known to the child welfare system (n = 9). Seven involved infants who were co-sleeping or sleeping in inappropriate sleep environments (two in foster homes) and the cause was determined to be Sudden Unexpected Death in Infancy. One death was caused by gun shot wound and the remaining death involved both the cause and manner being Undetermined.

Number and Reasons for Child Protection Services Referral and Case Status

- ◆ The majority of the 2004 families referred to the child welfare system were reported multiple times (n = 33, or 59%). The number of reports ranged from one to 23, with an average of four reports per family.
- ◆ In 48% of the child welfare fatalities, the decedents were part of the family cases (n = 27).
- ◆ Based on the last child abuse/neglect report received, the primary reason for families being referred was “general neglect”. Forty (71%) families were reported for general neglect issues and physical abuse ranked second (n = 6).
- ◆ At the time of death, 21 (38%) of the 2005 child welfare fatalities were families with active cases.

Family Characteristics

- ◆ Three of the 56 mothers were deceased at the time of their child’s death in 2005.
- ◆ The average age of the 54 living mothers known to the child welfare program was 32 years.
- ◆ Of the 50 living mothers where marital status was known, most were single and had never been married (n = 41, or 82%). Nine of the mothers were married.
- ◆ Thirty-two of the 41 living mothers whose employment history was known were unemployed at the time of the death.
- ◆ Of the 31 cases in which substance abuse history was known, 23 had documented problems with drug and/or alcohol use (74%). Six of these mothers tested positive at the time of their 2005 infant death.
- ◆ Four mothers had prior involvement with the criminal justice system.
- ◆ Six of the 2005 child welfare fatalities documented chronic mental health disorders as problems for mothers.
- ◆ The majority of the 2005 child welfare decedents had surviving siblings (n = 52, or 91%). The number of siblings ranged from one to nine, with an average number of four siblings. Three of the decedents were twins. One of the 2005 child welfare decedents had two prior sibling deaths.

**CFRC SPECIAL REPORT;
WASHINGTON HIGHLANDS FATALITIES**

SPECIAL REPORT: WASHINGTON HIGHLANDS FATALITIES

The purpose of this special report is to highlight the violent deaths that involved youth who were residents of the Washington Highlands neighborhood. This report also highlights some of the critical CFRC recommendations and planned programs that focus on improving outcomes for youth and their families. In its surveillance of child related deaths in the District of Columbia, CFRC found that youth in the Washington Highlands area of Ward Eight have fallen victim to Homicide as a result of the socio-economic and environmental issues present in this small neighborhood. Poverty, substance abuse, school truancy, complicated mental health issues, and criminal activity, are key factors observed by the Committee in youth related Homicides.

“Two 2005 Washington Highlands Youth Homicides”

On a fall day at approximately 3:30 AM, an off-duty police officer and other civilians observed 2 bodies lying in the eastbound lanes of Suitland Parkway. The teenaged victims were unconscious and suffering from multiple gunshot wounds. Reports indicated that injuries were so severe, that it was obvious that the victims were deceased. Autopsy findings revealed that one of the victims was shot a total of 10 times and suffered blunt impact injuries; the second was shot 6 times. The investigation concluded that a 9mm semi-automatic weapon was used in the murder of both teenagers. The manners of death for both youth were determined to be Homicides.

The two teens, described as “very good buddies”, were residents from the Washington Highlands neighborhood in Southeast Washington D.C. Information gathered in public records demonstrates the two teens exhibited similar behaviors and lifestyles that eventually lead to their deaths. Both teens had previous histories with the District’s juvenile justice system and one had an extensive history with the child welfare system. Both had pervasive substance abuse problems, truancy, history of mental illness, and a myriad of issues associated with persons living in poverty. At the time of their deaths, both decedents were in abscondence from juvenile justice services. The older of the two, age 17, was scheduled to be enrolled in a residential drug treatment the day preceding his murder. The other, age 16, was to report for revocation of community electronic monitoring due to his refusal to follow the rules of the family home, and his alleged criminal activities three days following his murder. At the time of this youth’s fatal event, MPD acknowledged that he was responsible for multiple violent crimes. For both teens, drugs, retaliation and revenge were all deemed as motives for their death.

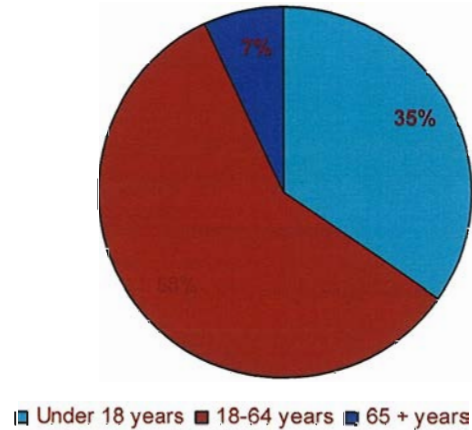
Overview of the Washington Highlands Neighborhood

Washington Highlands is located in the most southern area of the District. North of the neighborhood is Valley Avenue, to the east is Wheeler Road; Southern Avenue runs south, and to the west is South Capital Street. Washington Highlands is a mixed income community, comprised of private, public and subsidized housing. This neighborhood, which also lies within Cluster 39³, is home to several District of Columbia Public Schools. Greater Southeast Community Hospital rests on the southeastern tip of this neighborhood. With an area less than a mile wide, the Washington Highlands neighborhood is a major gateway into the District of Columbia for those traveling from outside jurisdictions (see Map of Washington Highlands neighborhood on Page 44).

³ For the purposes of city planning, the DC Office on Planning has divided the District of Columbia into neighborhood clusters.

Residents of Washington Highlands vary in age. Many persons have resided in this neighborhood for several decades. Data for census tracts located within the Washington Highlands neighborhood (Cluster 39) shows that 98% of the residents are Black/African American⁴. Of the roughly 11,000 housing units, approximately 20% of the residents own their property. The median household income is \$25,017. Recently released data from the US Census Bureau indicates that the poverty line for a family of four equals \$19,971⁵. US Census Data also indicates that the median household income for residents in the District of Columbia is \$44,900.

Figure 25: Ages of Ward 8 Cluster 39 Residents



In a recent workshop held at the Ward Eight Senior Wellness Center, residents of Washington Highlands expressed their concerns about their neighborhood. Residents unanimously agreed that their overall safety was the primary issue faced by the community. Crime, substance abuse and traffic calming measures were all areas of concern for the residents. These are also issues observed by CFRC as contributing factors leading to preventable deaths of children and youth in the District of Columbia.

Metropolitan Police Service Area 706

In February 2004, the District Mayor, in collaboration with other government officials identified Washington Highlands as one of the Violent Crime Focus Areas of the city's Hot Spots Initiative. The Hot Spots Initiative was developed to combat pervasive criminal activity in specified areas throughout the city. Yuma Street, Southeast quadrant was identified as one of the Violent Crime Focus Areas in Police Service Area (PSA) 706. The Yuma Street Hot Spot incorporates Atlantic, Brandywine, Barnaby and 8th Streets SE, all located in the heart of the Washington Highlands neighborhood. For the purposes of this Report, CFRC requested data compiled by the Metropolitan Police Department's (MPD) Geocoded Analytical Services Application. Data obtained from MPD represents the years 2001-2005 regarding this designated Hot Spot area. Analysis of this data provides evidence that Washington Highlands continues to be a neighborhood where crimes, ranging from assault to Homicide, continue to occur at a high rate.

MPD Crime data for the years between 2001 and 2005 provides an overview of the criminal activity within Washington Highlands. During these years, a total of 3,277 criminal offenses occurred within the boundaries of the Washington Highlands neighborhood; about 1.8 criminal acts everyday. In 2005, Assaults with a Deadly Weapon (ADW) led with 131 offenses. This represents a slight increase from 123 ADW offenses in 2004, up 6.5%. Stolen Autos was second, and Robbery was third, with 123 offenses and 89 offenses, both decreased by 13% and 8% respectively⁶ from 2004 data.

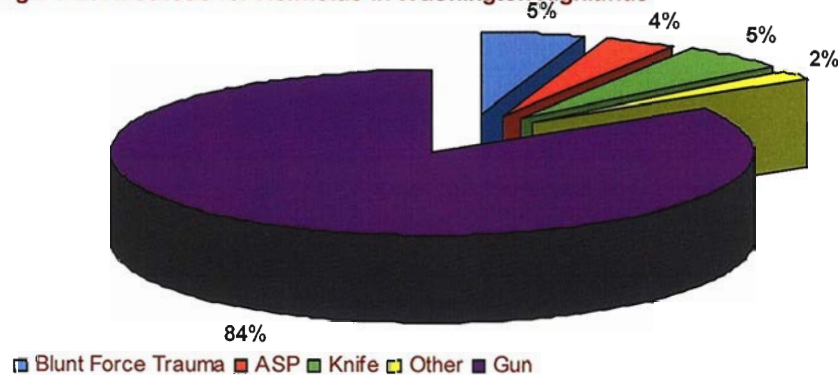
⁴ DC Office of Planning/State Data Center, 2000

⁵ DC Fiscal Policy Institute, August 29, 2006

⁶ MPD Geocoded Criminal Justice Information System data as of September 4, 2006

In 2005, a total of 583 criminal offenses occurred in Washington Highlands, about 1.6 criminal acts per day. Of the criminal offenses occurring in Washington Highlands between 2001 through 2005, 56 were Homicides. Guns were used in 84% of these Homicides, while Blunt Force Trauma and Knives were utilized in 5% of these Homicides (see Figure 26 below).

Figure 26: Methods for Homicide in Washington Highlands



Youth Criminal Activities and Deaths in Washington Highlands

The criminal activity within Washington Highlands has created an unstable environment. In 2005, MPD data reports that 49 juvenile arrests were made in the Washington Highlands neighborhood. These arrests were for a variety of misdemeanor and felony criminal acts. As provided in Figure 27 below, a majority of youths in this neighborhood were arrested for simple assaults, which accounts for 32% of all youth arrests. MPD youth arrests for narcotics were second at 16%, and juvenile custody orders followed at 14%.⁷ Arrests for juvenile custody orders demonstrate these youth were involved with the District of Columbia's juvenile justice system, and violated a provision of their release at the time of their arrest.

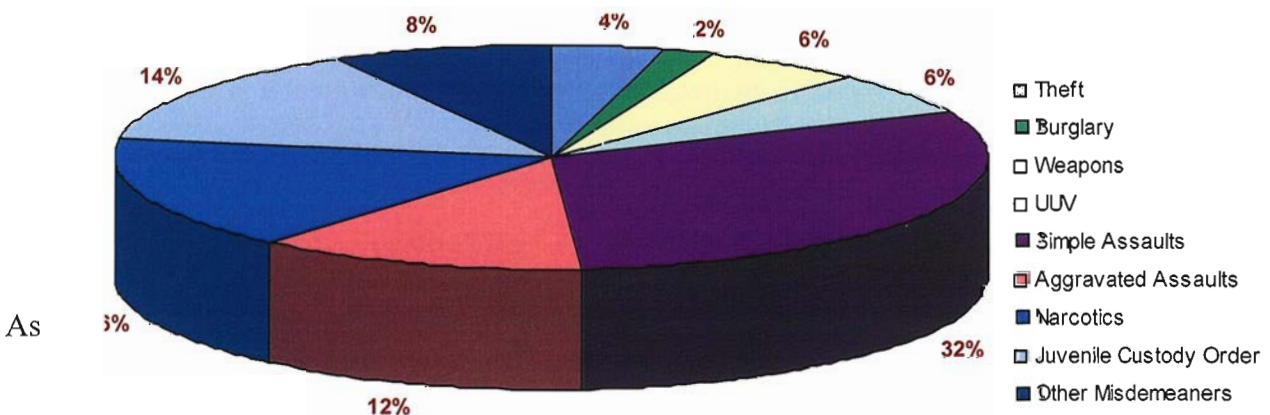


Figure 27: Washington Highlands Youth Arrests 2005

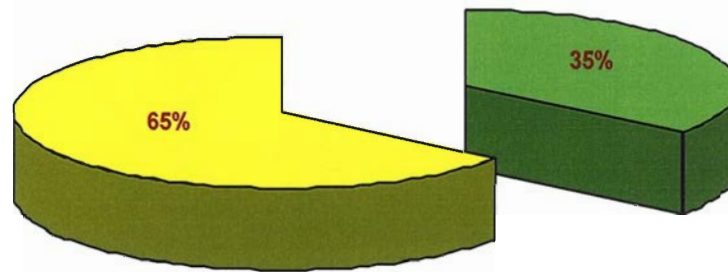
Figure 28 illustrates, during the years 2000 through 2005, the Committee reviewed the deaths of 54 youth age 15 and older, who resided in Ward Eight, and died as a result of Homicide.

⁷ MPD Geocoded CJIS data as of 9/6/06

Nineteen (19), or 35% of the Ward Eight youth Homicide victims were residents of this small neighborhood at the time of their death (see Map of Ward Eight/Washington Highlands deaths on page 45). According to records reviewed from the Office of the Chief Medical Examiner (OCME), 18 of these youth died as a result of gunshot wounds. The remaining decedent died due to stab wounds.

Figure 28: Comparison of Ward 8 Youth Homicides

■ Washington Highlands ■ Other Ward 8 Neighborhoods

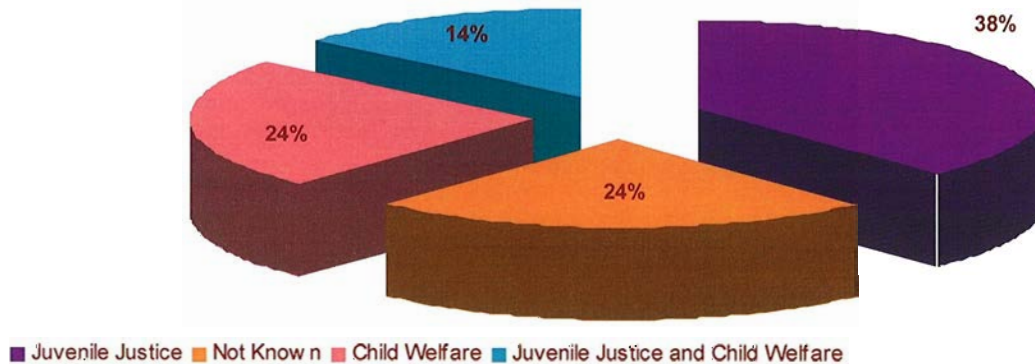


CFRC recognized the following relationships of these decedents at the time of their deaths:

- ◆ All of the youth Homicide victims resided within the PSA 706 Yuma Street Hot Spot area.
- ◆ Most were next-door neighbors, having resided in the community for 2 or more years.
- ◆ Eighteen of the 19 Washington Highland decedents were enrolled in either Ballou Senior High School, or participated in the Ballou Stay Evening School program.

Considering that the Washington Highlands neighborhood is less than one mile wide, CFRC conducted a retrospective review of other Ward Eight youth Homicides. Although the Committee observed a relationship between other Ward Eight youth Homicide victims and their neighborhoods at the times of their deaths, youth Homicides occurred more consistently in Washington Highlands throughout the five year period. This consistency was not observed in other Ward Eight communities during this review period. The youth of the Washington Highlands neighborhood appeared to be involved in retaliatory confrontations with each other; neighbor against neighbor and schoolmate against schoolmate.

Figure 29: Washington Highlands Youth Victims' Public Involvement



A review of public records of the youth Homicide victims from the Washington Highlands area demonstrates a high level of involvement with the District's juvenile justice and/or child welfare systems. Each agency provided and coordinated in-home and community based services for the youth Homicide victims. As Figure 29 above reflects, 38% of the youth Homicide victims were known to the juvenile justice system at the time of their death. Twenty-four percent were known only to the child welfare system. Fourteen percent of the youth Homicide victims were known to both juvenile justice and child welfare at the time of their death. Twenty-four percent of the victims were not known to either agency at the time of their death. Records reviewed demonstrate that all of these Homicide victims were provided with community-based services for narcotic and alcohol abuse, as well as complicated mental health issues. More than half of the Washington Highlands youth Homicide victims received intensive mental health and substance abuse treatment as a result of their prior involvement with child welfare and juvenile justice programs. Additionally, 95% (n = 18) of the Washington Highlands youth Homicide victims were known to the public assistance programs (TANF, Food Stamps and Medical Assistance).

Fatality reviews of these victims have consistently highlighted issues related to public programs failure to appropriately deliver and/or coordinate services to these youth. Some of these issues are outlined as follows:

- ◆ Lack of communication, collaboration and joint planning among all service providers.
- ◆ Most services generated for broad populations of youth were not tailored to fit the specific needs of the targeted youth.
- ◆ Youth offenders were placed with child welfare youth in the same government contracted residential treatment facilities, without recognition of the different needs of these two populations.
- ◆ Youth offenders were "loosely" connected to community based organizations at the end of their commitment. Detailed case management plans delineating roles and responsibilities of each service provider related to treatment, follow-up and reporting progress was not established.
- ◆ Poor oversight of youth offenders who were given court orders to "stay away" from neighborhoods of their original offense.
- ◆ Poor oversight of youth who were not attending school as required by District law.
- ◆ Many adjudicated youth were placed on home-based detention in known "hot spot" neighborhoods.
- ◆ Programs committed to searching for and servicing absconded youth were ineffective in locating youth.

These challenges support that there is a great need for congruent government based programs for at-risk youth, and programs that improve neighborhoods while creating opportunities for the economic empowerment of vulnerable populations. Many of the CFRC youth Homicide victims spent months in residential treatment centers outside of the District of Columbia. However, following a successful discharge from treatment the youth regressed to exhibiting the behaviors that lead to their initial need for government intervention. Twenty-four percent of these Homicide victims were not known to child welfare or juvenile justice agencies. This suggests that the pre-existing socio-economic problems within their neighborhood created an environment where negative conditions could lead to negative outcomes.

Table 8: Ages of Washington Highland Youth Homicide Victims

Age Range	2000 N=3		2001 N=2		2002 N=3		2003 N=2		2004 N=4		2005 N=5	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
15 - 18	3	0	2	0	2	0	1	0	2	1	2	0
19- 23	0	0	0	0	1	0	1	0	1	0	1	2

The Washington Highland youth Homicide victims were all between 15 to 23 years of age during the five-year review period. As shown in Table 8 six or 86% of the Homicide victims were Black/African American males. In 2004, CFRC reviewed the first female youth Homicide victim who resided in Washington Highlands. In 2005, CFRC reviewed the deaths of two Black/African American females who were residents of this neighborhood. Overall the Committee has reviewed the deaths of eight Black/African American female residents of Ward Eight, between 2000 and 2005, or 15% of the Ward Eight youth violence Homicides. This suggests that youth Black/African American females are also experiencing negative outcomes as a result of their home environment. It also suggests that intervention programs should be created specifically for at-risk and socially disengaged female youth in the District of Columbia.

CFRC also recognized the needs of youth Homicide victims' families, friends and neighbors. During crime scene investigations, individuals witnessing these fatal events were left to deal with overwhelming grief and shock of the event, and are not notified of community based mental health services. Mental health professionals agree, that left untreated, post-traumatic stress can lead to further problems, including depression, substance abuse, and disruptions in daily living activities. As previously noted, prior witnessing to violence is a known risk factor for youth Homicide victims

National Trends and Case Review Findings and Recommendations

In the *Program Manual for Child Death Review*, the National Center for Child Death Review reports that youth Homicides represent the greatest proportion of all firearm deaths. The following are trends the National Center for Child Death Review⁸ observed in youth Homicides:

- ◆ Youth Homicide is a problem in large urban areas, especially among Black/African American males.
- ◆ Homicides are the number one cause of death for Black/African and Hispanic teenagers.
- ◆ When socio-economic status is held constant, differences in Homicide rates by race becomes insignificant.
- ◆ Homicides are usually committed by casual acquaintances of the same gender, race and age, using inexpensive, easily acquired handguns.
- ◆ Drug dealing and gang involvement are often the cause of disputes leading to Homicides.
- ◆ Majority of Homicides occur in small pockets of large cities.

Consistent with the National Center for Child Death Review findings, CFRC has also observed the following risk factors in the majority of the youth Homicides reviewed over the past five years:

⁸ *A Program Manual for Child Death Review, Strategies to Better Understand Why Children Die and Taking Action to Prevent Child Deaths*, National Center for Child Review, September 2005

- ◆ Easy availability of and access to firearms.
- ◆ Youth living in neighborhoods with high rates of poverty, social isolation and family violence.
- ◆ Youth active in drug and gang activity.
- ◆ Early school failure, delinquency and violence.
- ◆ Youth with little or no supervision.
- ◆ Prior witnessing of violence.

Based on the above risk factors, CFRC has issued a broad range of recommendations to address issues of prevention and quality of life improvement to several public service delivery systems. Some of the prevention recommendations included, but are not limited to:

- ◆ Instituting MPD “sweeps” (high concentration of activity that focuses on a given location/problem) addressing congregating children and/or youth in identified “hot spots” or other problem areas, as a means of increasing and strengthening enforcement of the District’s curfew law.
- ◆ Re-establishment of the Persons in Need of Supervision program for high-risk youth.
- ◆ Capacity building for related substance abuse and mental health programs.
- ◆ District government sponsorship of youth focused conference on the prevention and reduction of gang behavior and related activities, with special focus on programs proven to be effective with reducing gang related activity.
- ◆ The development of an aggressive and comprehensive conflict resolution program in schools, starting with pre-kindergarten students, that requires participation of all staff. The program curriculum should be system wide, with an incremental approach.

The National Center for Health Statistics considers the Years of Potential Life Lost (YPLL) for persons under the age of 75, which is the average age of life expectancy in the United States⁹. Taking into account that the Washington Highland youth Homicide victims were between 14 and 23 years of age, their deaths, and years of potential life lost, will have lasting negative effects for their families and the neighborhood. The YPLL for the Washington Highland youth Homicide victims is equal to 56.5 years¹⁰. This includes a lost in economic, social and political empowerment for their families. This is a lost generation, who could have been first generation college graduates, business owners or community activist. With neighborhood focused intervention strategies to support better outcomes for these youth, their lives could have prompted economic and social renewal for their families.

In 1996, a Washington Post reporter wrote a series of articles chronicling the life of a family who resided in the Washington Highlands neighborhood. Dash later penned his book *Rosa Lee, A Mother and Her Family in Urban America*¹¹, to further discuss the poor outcomes of those living in environments, such as the Washington Highland youth Homicide victims reviewed by CFRC.

⁹ *Years of Potential Life Lost (YPLL) Reports 1981-1998 Premature Mortality in the United States: Public Health Issues in the Use of Years of Potential Life Lost*. National Center for Health Statistics, Center for Disease Control, December 1986

¹⁰ YPLL=75-midpoint of age group

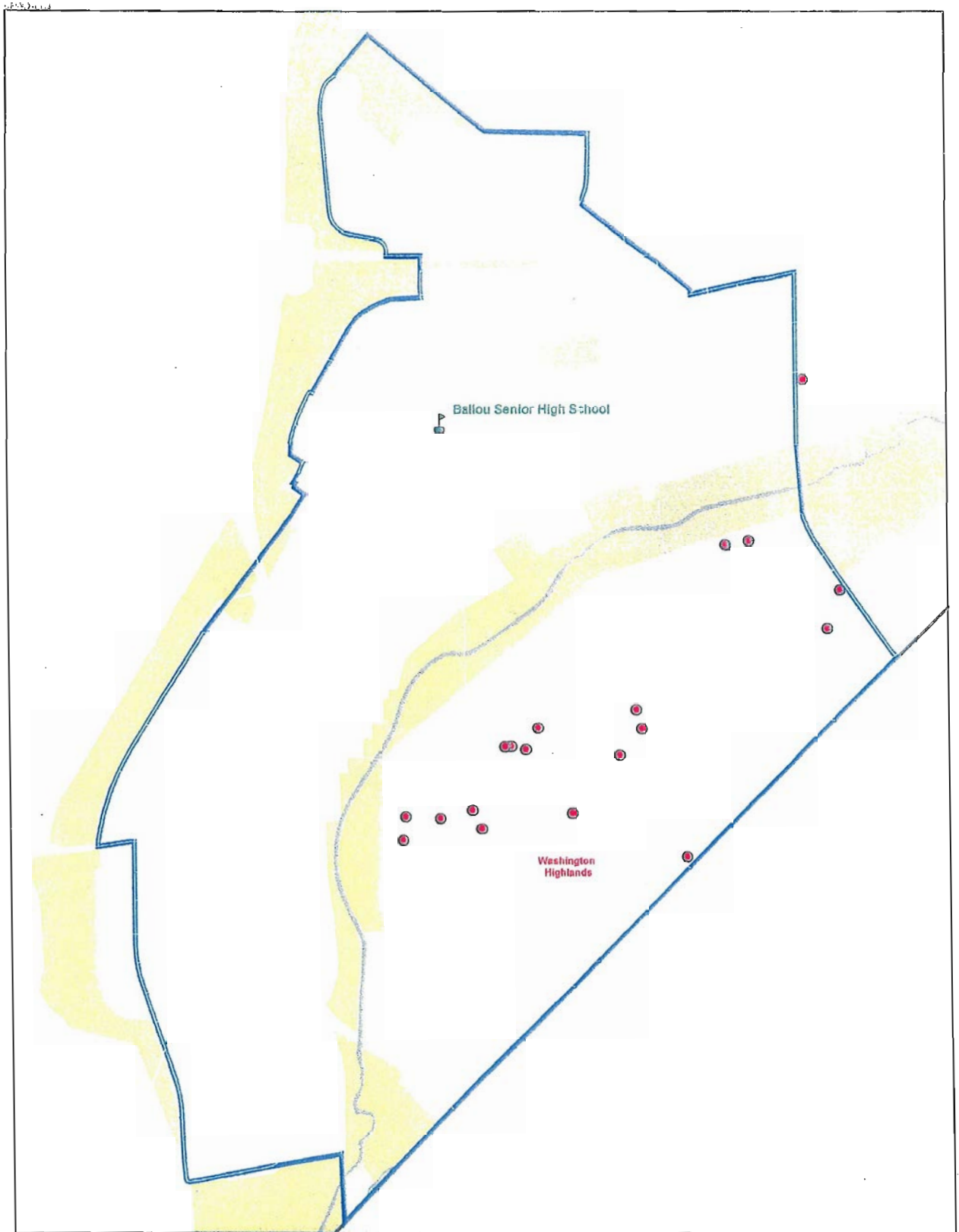
¹¹ Dash, L. (1996) *Rosa Lee, A Mother and Her Family in Urban America*. New York. BasicBooks

Nearly a decade later, families living in the Washington Highlands neighborhood continue to face traumatic events, as a result of their home environment. Grass root efforts to improve the Washington Highlands neighborhood's environment, in collaboration with government sponsored programs, could improve the outcomes for its youth and families.

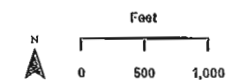
Current District-Wide Intervention Strategies

The Office of the Mayor and the Council of the District of Columbia have worked diligently throughout calendar year 2006 to assess the problems associated with the overall spike in youth violence in the District. As a result of these efforts and the input of youth, numerous community based organizations and youth advocacy groups, a Youth Development Plan was developed in 2005 that included a holistic approach to addressing this problem. In addition to strategies to address the immediate issues of violence, the Plan also includes a range of services to address the developmental and social needs of families that support better opportunities and choices for children/youth in order to increase their levels of functioning and facilitate more productive citizenry.

As part of this plan, the District of Columbia's Children's Youth Investment Trust Corporation has partnered with several community-based organizations to provide programs for youth in this and other Ward Eight neighborhoods. Also, the District has created training and employment opportunities for youth, who are out of school. Such collaborative efforts are necessary to support better outcomes for at-risk youth. Copies of the Mayor's "DC Youth Development Strategy" and Annual Report can be obtained from the Office of the Mayor.



2000 - 2005 Washington Highlands Fatalities

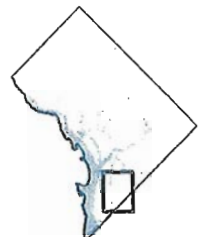


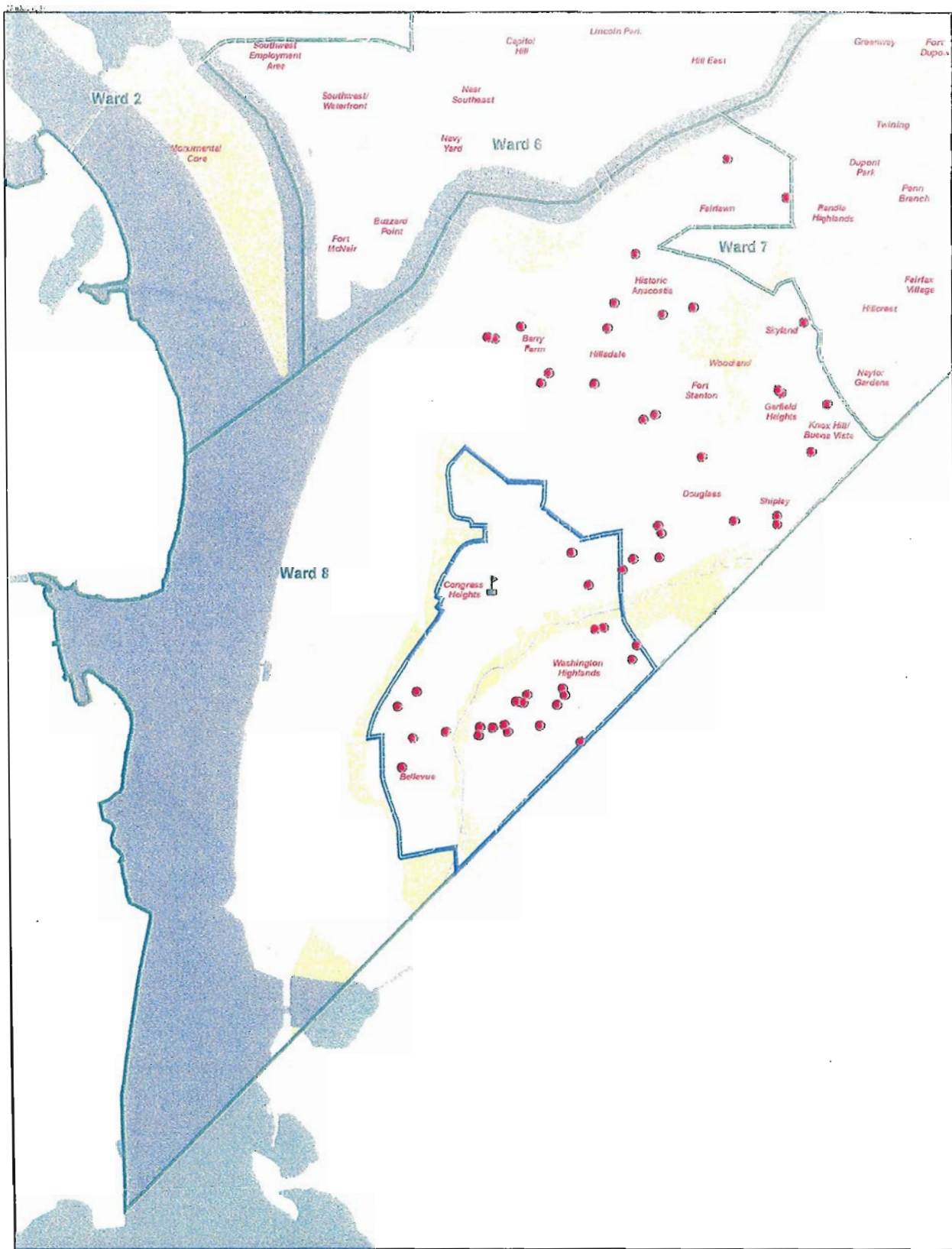
*** Government of the
District of Columbia
Anthony A. Williams, Mayor

Office of Planning ~ December 12, 2006

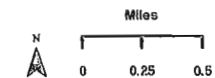
This map was created for planning
purposes from a variety of sources.
It is neither a survey nor a legal document.
Information provided by other agencies
should be verified with them where appropriate.

- 2000-2005 Washington Highlands Fatalities
- Ballou Senior High School
- Neighborhood Cluster 39
- Water
- Parks





Ward 8 Youth Violence Homicides 2000-2005



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

Office of Planning - December 22, 2006

This map was created for planning
purposes from a variety of sources.
It is neither a survey nor a legal document.
Information provided by other agencies
should be verified with them where appropriate.

- Ward 8 Youth Violence Homicides 2000-2005
- 🏫 Ballou Senior High School
- 📏 Neighborhood Cluster 39
- 🗺️ 2002 Wards
- 💧 Water
- 🌳 Parks



APPENDICES

2005 CFRC RECOMMENDATIONS

Improving Health Outcomes

- ◆ In order to encourage and stress the importance of prenatal care, Department of Health (DOH), in collaboration with Managed Care Organizations (MCO), should encourage and/or assist prenatal clinics and other health providers with establishing a mechanism to improve and document outreach efforts (telephone contacts, letters, etc.), when expectant mothers miss prenatal appointments.
- ◆ DOH should ensure that MCO contracts include a standard definition for high-risk mothers with minimum standards of care and timeframes for provision of services. Contracts should also specify consequences for holding accountable those MCO's not properly identifying high-risk women and providing appropriate outreach and or care.
- ◆ DOH, in collaboration with MCO's should mandate that all physicians, clinics and other health care practitioners providing obstetrical services, screen for high risk factors and develop a treatment plan consistent with current standards of care. The treatment plan should include a referral to a perinatologist or an obstetrician with expertise in servicing high-risk women.
- ◆ DOH should determine the availability and adequacy of resources (outpatient and inpatient) available in the District to care for women with high-risk pregnancies and critically ill infants. Resources should include, but not be limited to:
 - Obstetrical and Neonatal Departments that utilize a **team approach** (physician, nurse, social worker, nutritionist, patient educator, discharge planner) to providing family-centered health care which addresses the medical as well as the social factors that may impact the outcome of the pregnancy and care of the newborn;
 - Maternal-Fetal Medicine Specialists to consult and/or manage high risk pregnancies;
 - Diagnostic facilities to appropriately evaluate/monitor high-risk pregnancies and infants;
 - Facilities that participate in research protocols related to decreasing maternal/infant morbidity and mortality;
 - The number of tertiary care beds based on American College of Obstetricians and Gynecologists (ACOG) and American Academy of Pediatrics (AAP) guidelines; and
 - Hospital/medical resources for patient education (importance of folic acid, use of progesterone therapy in preterm labor, relationship of incompetent cervix to premature delivery, benefits of breast feeding, etc.) and follow-up.
- ◆ DOH should enhance collaboration with ACOG, AAP, March of Dimes, DC Medical Association (DCMA), DC Hospital Association (DCHA), Managed Care Organizations, local physicians, and area businesses to establish a functioning Perinatal Association to address issues related to the delivery of obstetrical and pediatric services in our city. DOH should provide funding and administrative support to "fast track" the scheduling of forums and/or other mechanisms of interaction with health care providers to determine barriers to providing optimal obstetrical and neonatal care/follow-up and strategies to address the identified issues.

- ◆ DOH should work with National Institute of Alcohol and Drug Abuse to provide local hospitals, prenatal clinics and other health providers of services to women and children with training and educational materials (video, pamphlets and posters) that highlight the dangers of using drugs and alcohol during pregnancy.
- ◆ In an effort to better enable statisticians and clinicians to perform a comprehensive assessment of the state of infant and maternal health in the District of Columbia, the DOH, as part of its monitoring function, should maintain and the following statistics/data on the factors contributing to high risk pregnancies:
 - Number of documented high risk pregnancies and pregnancy outcomes by Ward,
 - Number of premature and low birth weight infants by Ward,
 - Number of premature and low birth weight infants, neonatal mortality, abortions and stillbirths delivered at each birth hospital/birth center,
 - Incidents of neonatal mortality, abortions and stillbirths for each birth hospital/birth center,
 - Number of transfers of high risk mothers and premature and low birth weight or other high risk infants to tertiary care facilities, and
 - Number of maternal deaths.
- ◆ DOH, MAA should ensure that MCO's screen women with an infant loss for post partum depression and extreme expressions of grief to facilitate the early identification of postpartum depression and referrals for services/supports.
- ◆ DOH in collaboration with MCO's should develop a resource list/database for school personnel and parents, and enhance resources as necessary, for home-based medical services/supports available for families of children with chronic, acute, catastrophic and/or terminal illnesses. Information and resources should include training of caregivers of children with severe, chronic and terminal illnesses; grief support and preparing children and families for death.
- ◆ DC Public Schools and DOH should collaborate with the local chapter of AAP to develop a mechanism to ensure that children receive recommended comprehensive primary pediatric medical and dental care. Too often the emphasis is on providing immunizations rather than assessing the overall health of the child.
- ◆ In view of the identified trend related to the lack of adequate follow-up services to children (especially high-risk) under MCO, DOH should provide CFRC with the results of quality assurance reviews and/or monitoring reports regarding case management services provided in accordance with current contracts.
- ◆ In view of the number of infant deaths reviewed that continue to highlight problems with discharge planning, DOH should work with hospitals and discharge planners to re-assess their discharge education practices for mothers/families to determine if their protocols are comprehensive, as well as culturally and educationally appropriate for the patient populations. Infant discharge information should minimally include the physician's name or place for the well baby visit; information related to Sudden Infant Death Syndrome (SIDS) reduction measures, dangers of bed sharing, discussion on safe sleeping and the importance of having a crib/bassinet, shaken baby syndrome, immunization information and when to seek emergency medical assistance.
- ◆ DOH should partner with Project Safe Child and local radio and television stations to conduct an aggressive media campaign to educate the public on dangers of unintentional

childhood injuries, especially hazards in the home (i.e., TV stands, placement of furniture near windows, blinds, stair gates, etc.). The campaign should also raise awareness about the impact of drugs or alcohol on parents' ability to make sound judgment regarding home safety.

- ◆ In view of the number of cases reviewed during Medical Clusters Reviews conducted in calendar years 2004 and 2005 where the child was known to the District's child welfare system, Child and Family Services Agency (CFSA) should research, develop and implement a more appropriate and effective plan for providing specialized services and supports to medically fragile children in its care. CFSA may benefit from reviewing systems in place by New York and other jurisdictions with specialized medical/special needs units within the child welfare agency. Planning should include:
 - Coordination with DOH/MAA and its special needs contractor, Health Services for Children with Special Needs (HSCSN) for those children enrolled with HSCSN;
 - Immediate development or identification of training for social workers regarding intervening and providing resources, referrals and case planning for children and families with chronic, terminal or catastrophic injury, illness or disease; and
 - Planning for children and families who are not enrolled in HSCSN
- ◆ DOH and DCPS should develop materials and resources to educate parents regarding ways to effectively address and advocate for the health care needs of their children. This should include resources for ensuring routine well child services, accessing comprehensive health services and supports when a child is diagnosed with an illness, education regarding their rights to care/services for Medicaid eligible families, general education regarding healthcare and health resources, etc. This education and/or advocacy process may be similar to or linked to existing DCPS Special Education Advocacy Centers.
- ◆ DOH and DCPS should coordinate to develop school-based resources or resource centers to provide health services (medical, dental exams) for students who are out of compliance with mandated medical/dental care/screening requirements.
- ◆ Given the high number of cases reviewed where mental health problems are documented as unaddressed concerns for decedents and siblings, Department of Mental Health (DMH) should expand the availability of mental health and counseling services that are specifically focused on the needs of youth, especially in the schools.

Improving Child/Youth Safety

- ◆ Department of Parks and Recreation (DPR) should increase bike paths or areas where children and other cyclists can ride bicycles without coming into high-traffic streets or inappropriate areas.
- ◆ DPR should address issues of security and supervision at all centers, especially those with high incidences of violence or which are in areas with high incidences of violence.
- ◆ The District [DPR, Metropolitan Police Department (MPD), DCPS and Department of Transportation (DOT)] should initiate broad public safety campaign/messages and expand use to include schools, recreational centers and general community, regarding:
 - Increase safety public education campaigns to promote/encourage the use of helmets/other safety gear; tips for riding safely on streets; the importance of crossing at crosswalks, etc.

- Invite the community (youth who ride bikes, skateboards, scooters, etc) to participate in designing education strategies that particularly target children and youth;
- Consider providing free helmets, etc, to encourage and promote use
- ◆ MPD should re-establish past practice of assigning safety police to schools to make regular monthly visits (minimally to elementary schools) to meet with students for assembly and in classes to reiterate how to ride bikes, walking safety measures, water safety, etc. There should be related safety messaging for summer months.
- ◆ DOT should develop information/education resources regarding proper use of motorbikes.
- ◆ DC Fire and Emergency Medical Services Department (FEMSD) and MPD should improve relations and establish joint policies and procedures for investigating fires, including:
 - Establishing joint interviewing strategies for children who are survivors of fires.
 - Clearly outlining roles and responsibilities of both agencies at the scene of the fire and outlining the manner in which the scene should be processed.
 - Timeframes for completing final investigation reports.
 - Protocols for the expeditious sharing of information including investigative reports with appropriate District agencies (including OCME and MPD) related to the origin and cause of fires to facilitate expediting the autopsy and criminal investigative processes
- ◆ FEMSD in collaboration with DCPS should implement a school-based fire safety/prevention program that includes:
 - Annual visits to **all** District public schools (particularly elementary and middle schools) to ensure that all children receive fire safety education.
 - Airing public education and fire safety information on DFEMS website and DCPS TV channels to create messages for all ages that can be accessible by all schools and/or individual classes.
 - Programs should target students and parents and should be developed for classrooms, assemblies and PTA meetings

Improving Policy and Practice Standards

- ◆ In view of the high number of school attendance and truancy problems that are highlighted in CFRC meetings, DCPS should require a representative from the Divisional Superintendents' Offices for the schools of decedents' cases being reviewed in order to elevate awareness of the prevalence of the problems and to ensure resolutions.
- ◆ DCPS, CFSA, Department of Youth and Rehabilitation Services (DYRS) and the DC Superior Court, Court Social Services Division (CSSD) should enhance and expand life skills programs for youth to include patterns of risky behaviors. These services should be available to committed and non-committed youth.
- ◆ Given the high number of fatalities reviewed during calendar years 2000 through 2005 where there were issues of poor communication, collaboration and service planning among multiple public agencies involved with children and families, the Committee recommends that the District, through the Safety Net efforts, operating within the ODMCYFE consider the following recommendations:
 - Establish a multi-agency case management system to cover children of all agencies. This system should include a mechanism for identifying and flagging high- risk children and rallying resources, assessing/identifying needs of child/family, immediately initiating,

following-up, and monitoring services, as well as a means of measuring performance, goal achievement and overall process evaluation.

- Create a mechanism to designate a lead responsible agency for the coordination of services and the scheduling of case reviews/planning that includes all parties involved with a family and/or child.
 - Establish a mechanism for conducting multi-agency/multi-disciplinary staffings on high risk or difficult cases where clients are being served by or need services from multiple agencies.
 - Establish a city-wide management information system (database) to include basic information on children and other family members being serviced by any District public agency/program. The system should include a universal referral form to streamline the intake process and capture common pertinent data/information required by multiple agencies.
 - Develop/implement a city-wide mechanism for tracking the utilization and effectiveness of programs, contracts and services.
 - Establish a mechanism to provide joint interagency training/orientation that provides basic information on the programs and services provided by the various public agencies, and the availability and utilization of services (methods of access, contact persons, etc.).
 - Develop and implement the concept of a "Funding Pool" to assist in meeting the costly needs of children, youth and families served by multiple District agencies thereby reducing the gaps in service and/or disconnects due to inadequate funds. Accountability measures should be considered as a component of this concept.
-
- ◆ Given the high number of cases reviewed in which CFSA investigations are inadequately conducted, including failure to make the core contacts or fully investigate allegations, failure to utilize available means to locate alleged perpetrator/neglected children, failure to ensure the safety of all children in the household, etc, CFSA and its Intake Unit should identify a mechanism to better assess the effectiveness of the investigations process and to ensure accountability at all staff levels.
 - ◆ DYRS should ensure that aftercare/transition services/resources are routinely and expeditiously provided to youth scheduled to age out or terminate from the juvenile justice system.

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.

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- (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 related, 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, as the discretion of the investigating authority, if disclosure of the information would compromise a criminal investigation.

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

- (1) The investigation is concluded;
- (2) The investigating authority determines that providing the information will no longer compromise the investigation; or
- (3) The information or records are provided to the Committee.

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

Sec. 4607. Subpoena Power.

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

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

(1) By a special process server, at least 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

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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.

2005 Calendar Year Fatality Listing

<i>Age</i> <i>(Years/Months/Days)</i>	<i>Cause of Death</i>	<i>Manner</i> <i>of Death</i>
0/0/0	Prematurity due to Abruptio Placentae due to Maternal Fall	Accident
0/0/0	Immaturity @ 26 Weeks, Lethal Congenital Abnormalities	Natural
0/0/0	Pneumothorax, Hyaline Membrane Disease, Extreme Prematurity @ 25 Weeks	Natural
0/0/0	Extreme Immaturity @ 22 Weeks, Maternal Chorioamnionitis	Natural
0/0/0	Premature Birth @ 20 Weeks, Preterm Labor and Delivery of Unknown Etiology	Natural
0/0/0	Cardiorespiratory Arrest, Extreme Immaturity, Maternal Cervical Incompetence	Natural
0/0/0	Complications of Premature Birth due to Maternal Preterm Labor and Vaginal Hemorrhage due to Placenta Previa with Abruptio Placentae	Natural
0/0/0	Miscarriage, Premature Rupture of Membranes, Unknown Etiology	Natural
0/0/0	Extreme Prematurity @ 25 Weeks Gestation, Preterm Labor of Unknown Etiology	Natural
0/0/0	Chorioamnionitis, Preterm Labor, Prematurity, Preterm Rupture of Membranes, Etiology Unknown	Natural
0/0/0	Cardiorespiratory Failure, Anencephaly	Natural
0/0/0	Severe Prematurity, Chorioamnionitis	Natural
0/0/0	Previa Fetus, Unknown Etiology	Natural
0/0/0	Prematurity, Preterm Labor, Maternal Cervical Incompetence	Natural
0/0/0	Respiratory and Ventilation Complications, Tracheal Agenesis and Tracheoesophageal Fistula	Natural
0/0/0	Cardio-Pulmonary Failure, Extreme Prematurity, Cervical Incompetence	Natural
0/0/0	Incompatible with Life, 21 Weeks Gestation, Placenta Previa	Natural
0/0/0	Congenital Heart Defect, Chromosome Abnormality, Trisomy 10	Natural
0/0/0	Prematurity @ 18 Weeks, Therapeutic Termination	Natural
0/0/0	Previa Fetus @ 19 Weeks Gestation, Premature Delivery, Voluntary Termination of Pregnancy, Fetal Risk from Intrauterine Device	Natural
0/0/0	Prematurity @ 20 Weeks Associated with Maternal Cocaine Abuse	Natural
0/0/0	Previa Fetus, Unknown Etiology	Natural
0/0/0	Prematurity, Down's Syndrome, Ventriculo-Megaly	Natural
0/0/0	Extreme Prematurity, Chorioamnionitis	Natural
1 Day	Cardiopulmonary Failure, Massive Pulmonary Hemorrhage, Extreme Prematurity	Natural
1 Day	Complications of Maternal Cocaine Abuse	Natural
1 Day	Trisomy 13	Natural
2 Days	Severe pulmonary hemorrhage, prematurity	Natural
2 Days	Respiratory failure due to trisomy 18	Natural
3 Days	Medium-chain ACYL-CoA dehydrogenase deficiency	Natural
5 Days	Pneumothorax- right, anemia secondary to blood loss, persistent pulmonary hypertension	Natural
5 Days	Sepsis due to cellular interstitial pneumonia	Natural
6 Days	Cardiorespiratory arrest, trisomy 18	Natural
6 Days	Overwhelming sepsis, prematurity, premature rupture of membranes of unknown etiology	Natural
7 Days	Sudden unexpected death in infancy associated with bedsharing and soft bedding	Undetermined
7 Days	Respiratory insufficiency, pulmonary parenchymal hemorrhage, prematurity and twin gestation @ 32 weeks	Natural
8 Days	Cardiopulmonary failure, severe atelectasis, extreme prematurity, unknown etiology	Natural
8 Days	Respiratory failure, pulmonary hemorrhage, prematurity, maternal hypertension	Natural
9 Days	Extreme prematurity @ 23 weeks, severe respiratory distress syndrome, unknown etiology	Natural
12 Days	Brain subarachnoid hemorrhage, extreme prematurity born @ 24 weeks	Natural
13 Days	Necrotizing enterocolitis, prematurity, pre-eclampsia	Natural
13 Days	Pulmonary failure, respiratory distress and pneumothorax, extreme prematurity @ 22 weeks, trisomy 21	Natural
14 Days	Necrotizing enterocolitis, prematurity, preterm labor and rupture of membranes of unknown etiology	Natural
15 Days	Sudden death in infancy	Undetermined
17 Days	Bradycardia and cardiac arrest, severe immaturity @ 24 weeks gestation	Natural

18 Days	Bilateral pneumothoraces, mrsa pneumonia and pneumatocoles, mrsa sepsis	Natural
18 Days	Necrotizing enterocolitis, prematurity, twin gestation	Natural
18 Days	Respiratory failure, pulmonary hemorrhage, severe immaturity, maternal incompetent cervix	Natural
24 Days	Septic shock, extreme prematurity, twin gestation, chronic lung disease, patent ductus arteriosus	Natural
25 Days	Asphyxia	Accident
28 Days	Acute renal failure, respiratory failure, bronchopulmonary dysplasia, extreme prematurity	Natural
28 Days	Complications of prematurity	Natural
28 Days	Pulmonary hemorrhage, extreme prematurity @ 24 weeks	Natural
28 Days	Extreme prematurity, chorioamnionitis	Natural
29 Days	Hypotension, multiple organ hemorrhage and congenital anomalies	Natural
1 Month 4 Days	Sudden unexpected infant death associated with co-sleeping with adult	Undetermined
1 Month 6 Days	Sudden unexplained death in infancy	Undetermined
1 Month 11 Days	Undetermined	Undetermined
1 Month 11 Days	Congenital heart disease, s/p Blalock-Taussig shunt, thrombosis, acute hemorrhage	Natural
1 Month 14 Days	Sudden unexpected death in infancy	Undetermined
1 Month 18 Days	Sudden unexpected death in infancy associated with bedsharing	Undetermined
1 Month 19 Days	Sudden unexpected death associated with co-sleeping	Undetermined
1 Month 27 Days	Severe brain damage with cerebellar tonsil herniation, herpes encephalitis	Natural
2 Months	Undetermined	Undetermined
2 Months 1 Day	Necrotizing enterocolitis, severe prematurity, unknown etiology	Natural
2 Months 5 Days	Sudden unexplained death in infancy	Undetermined
2 Months 10 Days	Complication of intestinal intussusception	Natural
2 Months 10 Days	Sudden unexpected death in infancy	Undetermined
2 Months 11 Days	Necrotizing enterocolitis totalis, prematurity @ 24 weeks gestation	Natural
2 Months 13 Days	Pseudomonas sepsis, extreme prematurity, undetermined etiology	Natural
2 Months 14 Days	Multiple blunt impact injuries including recent scalp hemorrhages with subarachnoid hemorrhage and healing rib fractures	Homicide
2 Months 21 Days	Sudden unexpected infant death associated with soft bedding	Undetermined
3 Months 15 Days	Sudden unexplained death in infancy	Undetermined
3 Months 16 Days	Sudden unexpected death in infancy associated with soft bedding and bedsharing	Undetermined
3 Months 28 Days	Sudden unexpected death in infancy associated with co-sleeping and soft bedding and atrial septal defect	Undetermined
4 Months	Bronchopulmonary dysplasia, extreme prematurity	Natural
4 Months 27 Days	Hypoxic ischemic encephalopathy, extreme prematurity, multiple gestation with maternal diabetes mellitus	Natural
7 Months	Right ventricular heart failure, tetralogy of fallot	Natural
9 Months	Wischoff-Aldrich syndrome	Natural
10 Months	Asphyxia due to soot and smoke inhalation	Accident
11 Months 29 Days	Respiratory insufficiency, pneumonia, congenital heart disease	Natural
1 Year 9 Months	Undetermined	Undetermined
1 Year 10 Months	Blunt abdominal trauma including lacerations of liver, adrenal, mesentery with hemoperitoneum	Homicide
2 Years	Blunt head trauma and thermal injuries	Accident
2 Years	Acute bronchopneumonia associated with history of asthma, gastroesophageal reflux and developmental delay	Natural
3 Years	High grade glioma brain tumor	Natural
4 Years	Complications of inhalation of products of combustion and thermal injuries	Accident
4 Years	Multiple blunt force injuries	Homicide
4 Years	Acute exacerbation of bronchial asthma	Natural
6 Years	Intracranial hemorrhage and herniation, cardiac arrest, repair of transposition of great vessels	Natural
6 Years	Acute bacterial meningitis	Natural
6 Years	Multiple injuries including drowning, blunt impact head trauma and asphyxia	Homicide
7 Years	Acute myelocystic leukemia, myelodysplastic syndrome, severe aplastic anemia	Natural
8 Years	Tumor progression in brainstem, brainstem glioma	Natural
9 Years	Gunshot wound of head	Homicide
11 Years	Respiratory failure, pneumocystis pneumonia, acquired immune deficiency syndrome	Natural
12 Years	Unknown- Massive heart attack- MD Death	Natural

13 Years	Complications of seizure disorder of undetermined etiology	Natural
14 Years	Gunshot wound of chest	Homicide
14 Years	Hepatorenal failure, cirrhosis of liver, chronic hepatitis C virus, ante-natal transmission	Natural
15 Years	Septic shock, liver failure, acute monocystic leukemia	Natural
15 Years	Blunt impact head trauma	Accident
15 Years	Gunshot wound of abdomen	Homicide
15 Years	Multiple organ failure, sepsis, staphylococcal pneumonia	Natural
15 Years	Hanging	Suicide
16 Years	Multiple gunshot wounds	Homicide
16 Years	Complications of full thickness burn injury	Accident
16 Years	Gunshot wound of face	Homicide
16 Years	Multiple gunshot wounds	Homicide
16 Years	Multiple gunshot wounds to head	Homicide
16 Years	Diffused lung hemorrhages and left ventricular thrombosis, acute myelogenous leukemia, s/p bone marrow transplant	Natural
16 Years	Gunshot wound of head perforating brain	Homicide
17 Years	Gunshot wound to torso	Homicide
17 Years	Gunshot wound	Homicide
17 Years	Blunt impact to head, pelvis and extremities	Accident
17 Years	Blunt impact injuries of head and torso	Accident
17 Years	Gunshot wound	Homicide
17 Years	Brain swelling and edema with herniation, metabolic disturbances, diabetic ketoacidosis	Natural
17 Years	Multiple gunshot wounds and multiple blunt impact injuries	Homicide
18 Years	Anoxic encephalopathy, status asthmaticus, acute exacerbation of asthma	Natural
18 Years	Multiple blunt impact injuries	Accident
18 Years	Gunshot wounds of abdomen, left arm and right thigh	Homicide
18 Years	Gunshot wounds of torso and upper extremities	Homicide
18 Years	Gunshot wound	Homicide
18 Years	Gunshot wound to head	Homicide
18 Years	Gastrointestinal hemorrhage, cryptococcal meningitis	Natural
18 Years	Multiple gunshot wounds	Homicide
18 Years	Blunt impact head trauma	Homicide
18 Years	Gunshot wound to head perforating brain	Homicide
18 Years	Bronchial asthma	Natural
18 Years	Blunt force head and neck injuries	Homicide
18 Years	Gunshot wound- VA Death	Homicide
18 Years	Gunshot wounds of torso perforating the right iliac artery and the inferior vena cava	Homicide
18 Years	Respiratory failure, adrenoleukodystrophy	Natural
19 Years	Gunshot wound of torso injuring the liver, the aorta and the renal vessels	Homicide
19 Years	Gunshot wound of back perforating lung	Homicide
19 Years	Multiple gunshot wounds	Homicide
19 Years	Gunshot wound of right flank	Homicide
19 Years	Gunshot wound of head perforating brain	Homicide
19 Years	Gunshot wound	Homicide
20 Years	Gunshot wounds of head and torso	Homicide
20 Years	Multiple gunshot wounds	Homicide
20 Years	Gunshot wound of back with injury to right lung, heart and major blood vessels	Homicide
20 Years	Bronchopneumonia, anoxic encephalopathy, congenital hydrocephalus	Natural
20 Years	Multiple gunshot wounds	Homicide
20 Years	Gunshot wounds of head and neck	Homicide
20 Years	Gunshot wound of posterior neck with craniocerebral injuries	Homicide
21 Years	Gunshot wound- MD Death	Homicide
21 Years	Gunshot wound to head and torso	Homicide
21 Years	Gunshot wound	Homicide
21 Years	Gunshot wounds	Homicide
21 Years	Drowning, seizure disorder of undetermined etiology	Accident
21 Years	Multiple gunshot wounds	Homicide
23 Years	Gunshot wound of head	Homicide

* Medical Examiner Cases from other jurisdictions

ACKNOWLEDGEMENT

We wish to acknowledge the dedication and unwavering support of the public servants, private agency/program representatives and community volunteers who serve as members of the District of Columbia Child Fatality Review Committee. It is an act of courage to acknowledge that the death of a child is a community problem. The willingness of Committee members to step outside of their traditional professional roles and examine all the circumstances that may have contributed to a child's death and to seriously consider ways to prevent future deaths and improve the quality of children's 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 dedication to achieving our common goal. A special thanks is extended to the community volunteers who continue to serve the citizens of the District throughout every aspect of the child fatality review process.



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