

DISTRICT OF COLUMBIA
CHILD FATALITY REVIEW COMMITTEE

2004 ANNUAL REPORT



GOVERNMENT OF THE DISTRICT OF COLUMBIA
ANTHONY A. WILLIAMS, MAYOR

EDWARD REISKIN, DEPUTY MAYOR
PUBLIC SAFETY AND JUSTICE

MARIE-LYDIE Y. PIERRE-LOUIS, CHIEF MEDICAL EXAMINER
OFFICE OF THE CHIEF MEDICAL EXAMINER

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CHILD FATALITY REVIEW COMMITTEE***

2004 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 2005

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.

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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 eleventh Annual Report. This Report covers data that resulted from reviews of 155 fatalities from calendar year 2004.

Key Child Fatality Review Findings

Total Number of Child/Youth Fatalities

- ◆ The 155 fatalities reviewed by the Committee from 2004 represent a 33% change in trend from four years of a consistent decline.
- ◆ In 2004 the number of child/youth deaths increased by 17% from the 133 deaths from 2003.

Decedent Demographics

- ◆ The ages of the 2004 decedents ranged from birth to 23 years.
- ◆ The largest population of child fatalities was children under the age of one year. The number of infant deaths remained the same as calendar year 2003 (n = 68, or 44%). The second largest population was youth over the age of 14 years (n = 54, or 35%).
- ◆ Consistent with previous years, the majority of the decedents were Black/African American (140, or 90%).
- ◆ Also consistent with previous years' data, males continued to dominate the child/youth fatality population. There were 99 (64%) male deaths compared to 56 females.
- ◆ The majority of the 2004 decedents were residents of Wards Six, Seven and Eight. The number of deaths from these Wards ranged from 25 to 29 with a total of 81 child/youth fatalities.

Manners of Death

Natural Deaths

- ◆ A review of death certificates indicates that the majority of District children/youth continue to die from natural causes during the 2004 calendar year. There were a total of 77 Natural deaths. As with previous years, children under the age of one year accounted for 75% of 2004 Natural child deaths and the majority of these deaths were associated with prematurity, low birth weight and congenital anomalies.
- ◆ There were two 2004 infant deaths attributed to Sudden Infant Death Syndrome.

Violence Related Deaths

Death certificates attributed 54 fatalities from 2004 to violence related causes. All of these deaths were homicides; there were no suicides in 2004.

Homicides

- ◆ **Fatal Abuse/Neglect** – There were six child deaths during 2004 where the causes were associated with parental/caretaker abuse and neglect compared to three in 2002. The children who died from fatal abuse/neglect during 2004 ranged in age from nine months to seven years.
- ◆ **Youth Violence** – Youth violence continued to be the primary cause of child/youth homicides. In 2004, there were 48 youth who died from violent acts that included gunshot wounds, stab wounds and blunt force trauma. Youth in this category were between eight and 23 years of age. They were primarily Black/African American (100%) and male (90%).

Unintentional Injuries

Accidental or unintentional injuries increased significantly in 2004. There were 15 unintentional deaths in calendar year 2004 compared to eight in 2003. The causes of accidental deaths in all age groups were:

- ◆ Eight Motor Vehicle Accidents,
- ◆ Six Fire Related, and
- ◆ One where an object fell on a toddler.

Undetermined, Unknown and Pending

- ◆ There were eight 2004 deaths where the manner was Undetermined, representing a 100% increase in the four deaths from 2003. 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.). In two of the 2004 Undetermined manners of death the cause was also Undetermined. Six of the deaths had a cause of Sudden Unexplained Death in Infancy.
- ◆ The cause/manner of death is unknown for one District infant. This child died outside the District of Columbia and CFRC was unable to obtain a copy of the death certificate.
- ◆ Similar to 2003, there were no 2004 fatalities where the cause and manner of death remained pending.

Top CFRC Recommendations from Calendar Years 2004

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). However, the following recommendations are provided as a sample of some of significant and wide-ranging issues that are addressed through CFRC reviews and recommendations:

- ◆ Department of Mental Health should take the lead in establishing guidelines for conducting mental health screenings/ assessments and aggressively diagnosing and treating youth in the juvenile justice system.
- ◆ Department of Mental Health should educate the community on depression, the resources available, and the process for obtaining emergency mental health services
- ◆ Department of Youth and Rehabilitation Services (previously Department of Human Services Youth Services Administration) should establish a practice of creating transitional plans for youth who are “aging out” or whose commitments have expired, that include vocational training, life skills, independent living, etc., and ensure that they are connected to these resources prior to leaving the juvenile system.
- ◆ Department of Youth and Rehabilitation Services should acquire legal input and develop or clarify policy related to the determination of the following:
 - Rights of parents to refuse essential recommended health and mental health treatment/medication of juveniles who are committed wards; and
 - Rights of committed juveniles to accept or refuse recommended psychotropic medication.
- ◆ Child and Family Services Agency and other family serving government agencies/ programs should collaborate with the Department of Health to incorporate health education, counseling, and services related to family planning, pre-conception health care, prenatal, post-natal, newborn/pediatric care, and when applicable, drug abuse interventions into their case management or family service plans.
- ◆ Child and Family Services Agency should establish a practice/protocol that requires the agency to contact the state of destination when the physical custody of a child for whom there is an active abuse/neglect investigation/case is being transferred to a relative or third party caregiver in another jurisdiction
- ◆ The Mayor’s Committee on Child Abuse and Neglect, DC Children’s Trust Fund, in partnership with the Child and Family Services Agency should develop a full-scale, aggressive public education campaign that specifically focuses on the non-mandated reporters (general public) regarding signs of abuse and neglect; the importance of reporting and the potential outcome of not reporting.
- ◆ Department of Human Services, Family Services Administration, Emergency Shelter Program should increase the number of shelter programs in the District that are designed to specifically address the needs of homeless families.
- ◆ Department of Health, Addiction Prevention Recovery Administration should establish and implement a comprehensive training curriculum that mandates initial and ongoing training for all case managers. Training should include minimum standards/ requirements for case management practice; prevention and treatment interventions; relevant laws, policies and practice standards related to treatment of addicted individuals, full coordination of

individualize service plans and mandatory child abuse and neglect reporting requirements.

- ◆ Department of Health in collaboration with Child and Family Services Administration should develop strategies related to better integrated service planning for mothers and children who are mutually served by these agencies, including better coordinated home visits to ensure that the home environment is stable for infants and children whose parents are substance abusers.
- ◆ Department of Health, Fire and Emergency Medical Services Department and DC Hospital Association should take immediate steps to address the problems associated with delays in pronouncing decedents.
- ◆ Fire and Emergency Medical Services Department should provide more public service announcements (radio and TV) on appropriate safety and evacuation tips when a fire is discovered in the home
- ◆ DC Public Schools and the Metropolitan Police Department should strengthen current partnerships with all schools including clear delineation of roles and responsibilities and better identification of student protection and safety protocols for critical incidences. Given the known high degree of gang and drug activity among youth/student populations, plans should include police coverage of special activities, identification of the parameters of police/security coverage; and appropriate (confidential) documentation and follow-up for students identified as at risk for violence, etc.
- ◆ DC Public Schools in collaboration with the Office of Attorney General, Child and Family Services Agency (CFSA) and Court Social Services Division (CSSD) should develop stronger working relationships and formal guidelines with reporting protocols to address the persistent problem of truancy and educational neglect.

INTRODUCTION

The Child Fatality Review Committee (CFRC) is a citywide collaborative effort that was authorized by District statute [see Appendix B: Child Fatality Review Committee Establishment Act of 2001 (DC Law 14-028)]. The Committee was established for the purpose of conducting retrospective examinations of the circumstances that contributed to the deaths of infants, children and youth who were residents or wards of the District. 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 (see Appendix C: Summary of CFRC Goals, Objectives and Operating Process).

The District's child death review process is intended to assist in identifying family and community strengths, as well as deficiencies, and improvements needed in service delivery systems, to better address the needs of children and families served. It is an opportunity for self-evaluation, through a multi-agency, multi-disciplinary approach. This process 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 reviews conducted on infant, child and youth fatalities that occurred during calendar year 2004. During calendar year 2004, the Committee identified the deaths of 155 children/youth who met the criteria for review. The ages of these children ranged from birth through 23 years. This Report also includes a ***Special Report on Youth Violence*** as a means of emphasizing many of the issues associated with the escalating problems related to the youth violence epidemic in the District. The ***Special Report*** (page 16) includes expanded data that was captured as a result of the reviews held on deaths of 48 children/youth who were involved in or were innocent victims of youth violence in the city. Additionally, the 2004 Annual Report highlights some of the critical recommendations identified through case review meetings held on fatalities in all manner of death categories along with public and private agencies/organizations' responses (see Attachment C: Agency Responses to CFRC Recommendations).

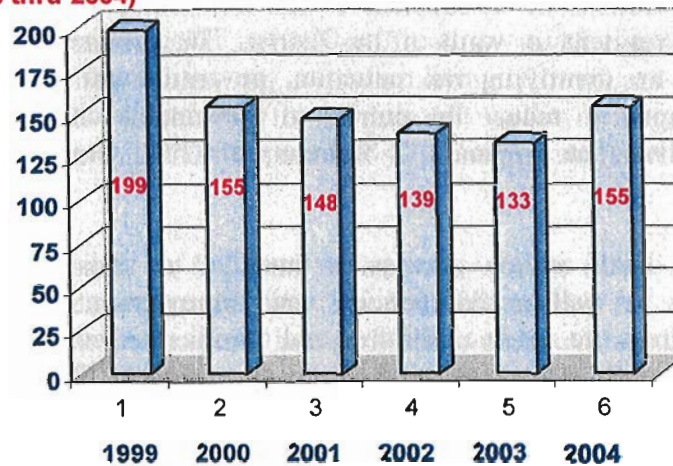
"We Must Continue to Learn from the Death of [A Child] As We Work to Rebuild Government Agencies Responsible for the Care of Our Most Vulnerable Children and Their Families"

Mayor Anthony Williams

2004 CASE REVIEW FINDINGS

SUMMARY OF ALL CHILD/YOUTH FATALITIES¹

**Figure 1: CFRC Total Child/Youth Fatalities
(1999 thru 2004)**



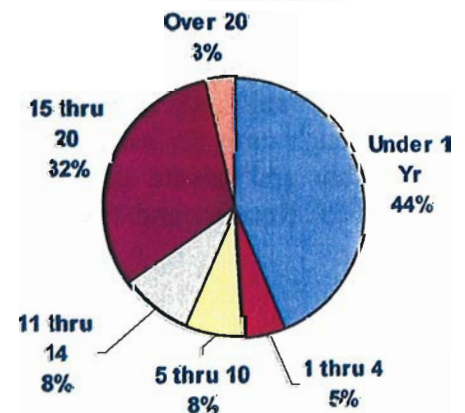
- ◆ After a five year decline in the number of child fatalities identified by the Committee, 2004 data indicates a reverse in trend.
- ◆ In 2004, there were 155 deaths identified by the Committee as meeting the criteria for review.
- ◆ As depicted in Figure 1 above, 2004 data represents a 17% increase (n = 22) from the 133 child fatalities identified from calendar year 2003; but continues to be lower than 1999.

Description of Decedent Population

Ages of Decedents

- ◆ The ages of the 155 decedents ranged from birth through 23 years².
- ◆ As with previous years, the two largest categories of child deaths reviewed from 2004 included infants (under the age of one year) and youth over 14 years.
- ◆ During 2004, the number of children under the age of one

Figure 2: Ages of 2004 Decedents



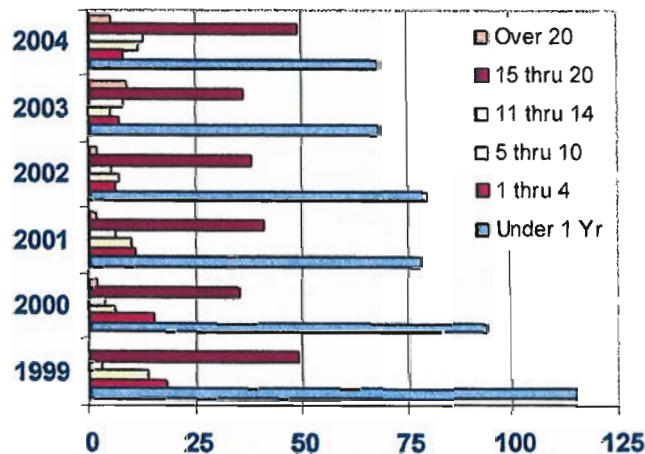
¹ Information presented in all CFRC annual reports represents raw data that results from the case review process and should not be used as the only tool for measuring true changes in child deaths in the District. This information should be evaluated within the context of other statistical measures that are also critical to understanding the overall trends and patterns that are consistently occurring in the child death population. Coupled with other data measures, CFRC data are designed to benefit agencies in determining patterns in family characteristics and needs; and in formulating strategies that may assist in improving programs and services to District residents, i.e., changes in funding and resources and policy/legislative needs.

² Based on established CFRC definitions for child welfare and juvenile justice fatalities, the District's review process can include decedents through the age of 25 years.

year remained the same as calendar year 2003 data (n = 68). The 2004 infant population included 40 neonates (birth through 27 days); 68% (n = 27) of these children died during their first day of life. Twenty-eight infants were post-neonates (from 28 days up to one year).

- ◆ Fifty-four, or 35% of the 2004 fatalities were of youth over the age of 14 years. This population of youth fatalities included 49 decedents 15 through 20 years of age and five who were 21 years or older.

**Figure 3: Age of Decedent
Comparison Data (1999 - 2004)**



- ◆ The remaining 33 decedents were between the ages of one through 14 years of age.

- ◆ When comparing the ages of decedents over a six-year period (1999 – 2004) several trends continue to exist. As Figure 3 illustrates, the numbers of deaths have continued to fluctuate in all age categories. The degree of fluctuation has been greater with the deaths of infants and youth 15 through 20 years of age. Infant deaths have always represented the largest percentage of child deaths; however, the number of deaths in this age group continues to have the

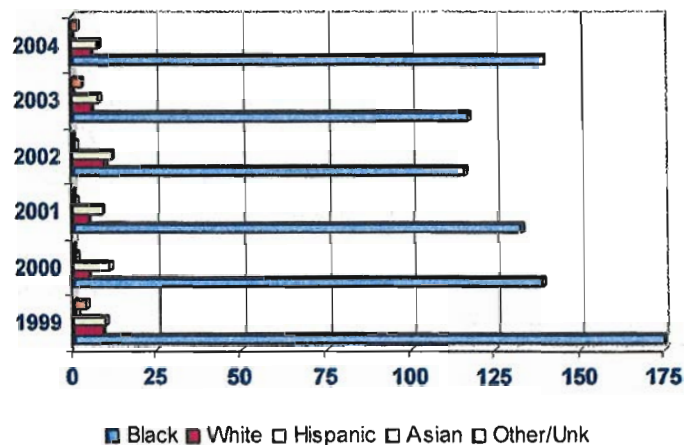
most significant downward trend (41% from 1999 to 2004), with a small increase occurring only between the 2001 and 2002 calendar years. Additionally, although the number of infant deaths remained the same in 2003 and 2004 (n = 68), the percentage of the total number of child deaths for these years was significantly lower in 2004 (infant deaths represented 51% of the total 2003 fatalities and 44% of the 2004 child deaths).

- ◆ Deaths of older youth (over 14 years of age) continued in 2004 to represent the second largest fatality population. However several significant data trends occurred in the 2004 calendar year. Of the 155 deaths from 2004, 54 were youth 15 years of age or older. This represents a 20% increase from the 45 youth deaths from the same age category from 2003. Consistent with previous years, the majority of the decedents in this age category were between the ages of 15 through 20 years of age (n = 49, or 89%). This is the highest number of deaths of youth in this age category since 1999 when the number of deaths was the same. The number of youth over 20 years of age decreased by 44% during 2004 (n = 5).

Race and Gender of Decedents

The District of Columbia child death population continued during 2004 to be dominated by Black/African American male children/youth. The disproportionate representation of this racial and gender group among the child death population continues to be a glaring trend and Committee concern.

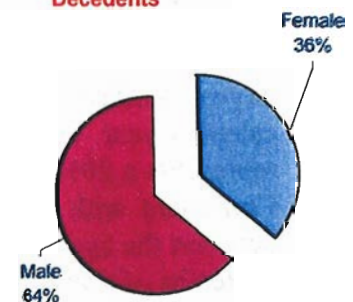
**Figure 4: Race of Decedent
Comparison Data (1999 thru 2004)**



Black/African American children and youth represented 90% of the 155 fatalities identified from calendar year 2004 ($n = 140$). Between 1999 and 2003 calendar years, Black/African American children/youth represented between 83 and 89% of CFRC deaths. Also consistent with other CFRC years, Hispanic and White children have consistently represented the second and third leading child death populations.

Similarly, male children/youth have continued to be over-represented in the fatality data. As Figure 5 illustrates, in 2004, there were 99 males (64%) and 56 females (36%). Additionally, Figure 6 below illustrates the vast disparity in children/youth deaths among Black/African American males within the District.

**Figure 5: Gender of 2004
Decedents**

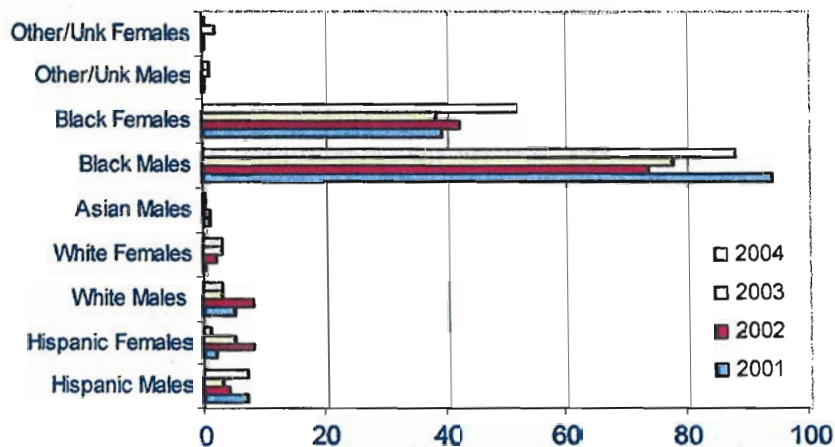


- ◆ In 2004, 88 Black/African American males met the CFRC review criteria. The majority of the Black/African American male child/youth fatality population involved youth over the age of 14 years. Forty-seven or 53% of the 88 Black/African male decedents were 15 years of age or older and 26 (30%) were under one year (infants). The overall average age of Black/African American male decedents was 14 years, however, the average age of decedents under one year of age was 39 days and the average age of youth 15 years and older was 18 years. Unlike previous years, the leading manner of death for Black/African American males for the 2004 calendar year was homicide ($n = 43$, or 49%), followed by natural ($n = 33$, or 38%). Ten (11%) Black/African American males died from unintentional (accidental) injuries. Forty-five

percent (n = 40) of African American male decedents were residents of Wards Seven and Eight and 28% (n = 25) were residents of Wards Five and Six.

- ◆ Black/African American females represented the second leading gender/racial group among 2004 decedents (n = 52). The majority (n = 31, or 60%) of the 2004 Black/African American female decedents were infants and the smallest number of decedents were age 15 years or older (n = 6, or 12%). The leading cause of death was natural (n = 32, or 62%) followed by homicide (n = 9, or 17%). The majority of the decedents were residents of Ward Six (n = 13), followed by equal numbers of deaths from Wards Two, Seven and Eight (n = 8 in each Ward).

Figure 6: Race By Gender of Decedents - Comparison Data (2001 thru 2004)

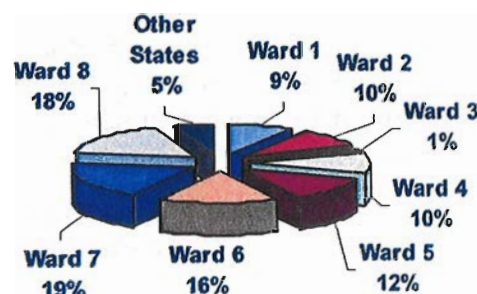


- ◆ Data from calendar year 2004 indicates that the same number of Hispanic and White children died as those in these racial categories in 2003. There were eight deaths of Hispanic children/youth referred to CFRC from calendar years 2003 and 2004, however, the number of Hispanic males increased from three in 2003 to seven in 2004. Eighty-eight percent of these decedents (n = 7) were under the age of one year. Seven children/youth died from natural causes and one died from homicide. Half of the decedents were residents of Ward One (n = 4), three resided in Ward Four and one decedent and his family was homeless.
- ◆ Six deaths of White children/youth occurred in 2003 and 2004 and data from these years indicate that there were equal numbers of male and female deaths. The average age of the 2004 White decedents was four years. The manners of deaths included four natural, one accident and one homicide. The majority of the decedents were residents of Wards One and Three (n = 2 each Ward).
- ◆ Included in the 2004 data was the death of a 43-day old Asian Indian child.

Decedents' Ward of Residency

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

Figure 7: Ward of Residency - 2004 Data



In 2004, eight of the 155 decedents were residents of or residing in other states. These children were known to the child welfare and/or juvenile justice system and based on the families involvement with these programs met the CFRC criteria for review. One 2004 decedent and his family was homeless at the time of the death. As illustrated in Figure 7, the majority of the 2004 decedents were residents of Wards Six, Seven and Eight. The number of deaths for these Wards ranged between 25 and 29, with a total of 81 (52%) decedents from these combined Wards. These Wards were followed by Ward Five with 19 deaths and Ward Two (n = 16). Also consistent with previous years, Ward Three continued to have the smallest number of deaths during calendar year 2004 (n = 2).

"2004 Natural Fatality"

A 12 year old African American male was born to a mother who was drug and alcohol addicted. He was born HIV+ with multiple disorders. He lived most of his life with his mother; however, his illness and life were reportedly compromised by his mother's continued addiction and transient lifestyle, including being abandoned by his mother with other caretakers on more than one occasion. Hospital and medical records indicate that his mother was, at times, non-compliant with the child's medical regime; however, records document that a report of neglect was not made until 2004; not long prior to his death. In February 2004 he was diagnosed with AIDS with Wasting Syndrome. Secondary diagnoses included encephalopathy, chronic abdominal pain, hearing loss, mitral valve prolapse, and Adjustment Disorder with Depressed Mood. He was allergic to several medications. Because of his mother's non-compliance, the child was placed with a maternal relative in Maryland. He was, however, strongly emotionally impacted by both his illness and his mother's inability to provide stability. He began to exhibit angry outbursts, and toward the end of his life, was refusing to comply with medical regimen. He wanted very much to be with his mother during the last months of life, when his mother began in-patient drug treatment, in an attempt to regain his care and custody. In December 2004, Maryland Emergency Medical Services documents indicated that they responded to a 911 call made by the child's home care nurse. He had recently been discharged from a District hospital and began to experience episodes of excessive coughing. Family caretakers notified the home nurse, who contacted the hospital emergency room; the nurse was instructed to give the child Dimetapp. However, the coughing did not improve and he developed respiratory distress. 911 was called however, despite lifesaving efforts, he was non-responsive by the time medics arrived at a Maryland hospital.

Cause/Manner of Death: Acquired Immune Deficiency Syndrome; Mycobacterium Avium Intracellular Infection; Parenteral Nutrition Dependent; Possible Broncho Spasm/Natural

Manner/Cause of 2004 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, death certificates were received for 154 (99%) of the 155 fatalities. CFRC was unable to obtain a death certificate for one District resident. As Figure 8 illustrates, the leading manner of death for calendar year 2004 continued to be Natural (50%) followed by Homicides (35%) and Accidents (10%). The manners of death for eight of the 2004 fatalities were Undetermined. In 2004, there were no deaths attributed to Suicide and there were no causes/manners of death that remained pending.

**Figure 8: Manner of Death
2004 Data**

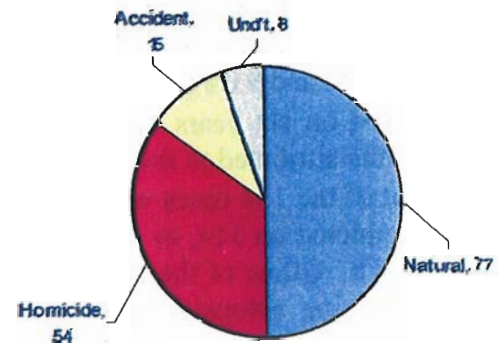
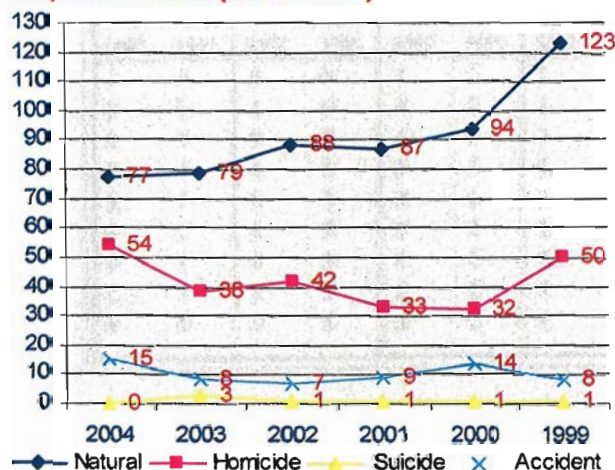


Figure 9 illustrates the manner of death for CFRC fatalities over a six-year period (1999 through 2004). The data from these review years support the following trends/findings:

- ◆ Natural deaths have consistently represented the primary manner of death for District children/youth. These deaths have also represented the most consistent decline during the six year period. Seventy-seven child/youth deaths were attributed to Natural causes. However, due to the overall increase in the number of 2004 deaths, the number of Natural deaths also represented a decrease in the percentage of total fatalities (50% of the 2004 fatalities and 59% of the 2003 fatalities).

**Figure 9: Manners of Death
Comparison Data (1999 - 2004)**



Seventy-seven child/youth deaths were attributed to Natural causes. However, due to the overall increase in the number of 2004 deaths, the number of Natural deaths also represented a decrease in the percentage of total fatalities (50% of the 2004 fatalities and 59% of the 2003 fatalities). Consistent with previous years, in 2004 the majority of the children dying from natural deaths was under the age of one year ($n = 58$, or 75%). The majority of these deaths involved infants who died from medical complications related to pregnancy and/or premature birth.

Nineteen children/youth were one year of age or older, with an average age of 13 years.

- ◆ Homicides remained the second leading manner of death with 54 fatalities from 2004 that fell in this category. As Figure 9 illustrates, the number of child/youth homicides has fluctuated between calendar years 1999 and 2004. Prior to 2004, even with the fluctuation in data, there was an overall decrease in child/youth homicides by 24%. However, 2004 represents a change in trend with a 42% increase in the number of children who died violently between

2003 and 2004. It also represents an increase in the percentage of the total number of 2004 deaths compared to calendar years 2000 through 2003. In 2004, homicides represented 35% of the 155 deaths compared to 30% or less for previous years. Similar to previous years, the majority of the 2004 homicide deaths involved youth over the age of 14 years (n = 44, or 80%). The majority of these deaths were Black/African Americans (n = 52) and males (n = 44).

- ◆ Similar to Homicides, accidental deaths have also fluctuated over the past six years. However, data from calendar year 2004 revealed a significant increase in the number of District children who died of accidental injuries. There were 15 deaths from 2004 that were attributed to accidents, representing an 88% increase from the eight children who died accidentally in 2003. The majority of these children were 14 years of age or younger (n = 10, or 67%) and 93% (n = 14) were Black/African American.
- ◆ Based on six years of CFRC data, 2004 represents the first year in which there were no deaths attributed to suicide.
- ◆ Out of the 154 cases where the manners of deaths were known, autopsies were required and completed on 114, or 74% of the fatalities. Ninety-five of the autopsies were completed by the DC Office of the Chief Medical Examiner (n = 78) and District hospitals (n = 17). The remaining autopsies (n = 19) were conducted by out-of-state facilities and 15 of these autopsies were conducted by the state of Maryland.

Table 1 below, illustrates the Ward of the decedents' residence by manner of death for calendar years 2003 and 2004 (this table does not include one death where the manner remains unknown and one homicide of a child who was homeless at the time of the death).

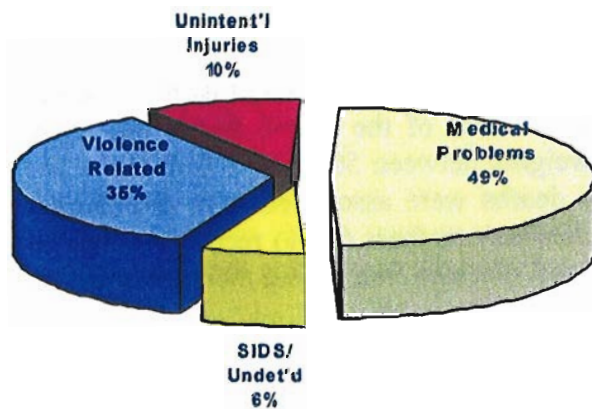
Table 1. Ward of Decedent's Residence By Manner of Death (n = 153)												
Ward	Total		Natural		Homicide		Accident		Suicide		Undet'd	
	2004	2003	2004	2003	2004	2003	2004	2003	2004	2003	2004	2003
One	14	9	11	5	1	2	2	1	0	0	0	1
Two	15	8	9	6	6	1	0	0	0	1	0	0
Three	2	2	2	0	0	1	0	1	0	0	0	0
Four	15	16	8	13	5	2	1	0	0	1	1	0
Five	19	16	9	11	7	5	2	0	0	0	1	0
Six	25	9	13	5	7	2	3	2	0	0	2	0
Seven	29	32	14	17	9	12	3	3	0	0	3	0
Eight	26	31	9	17	14	9	2	1	0	1	1	3
Other State	8	9	2	6	4	3	2	0	0	0	0	0

Cause of Death

In 2004 there were 154 (99%) fatalities where the cause of death was determined. This population includes eight cases where the autopsy resulted in the manner of death being "Undetermined". The cause of the death for the remaining fatality is unknown as the Committee was unable to obtain the death certificate. For the purposes of this Report and to ensure consistency in evaluating Committee data, the causes of death have been grouped in the

following four categories: Medical Conditions, SIDS³, Violence Related, 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 D, 2004 Calendar Year Fatality Listing By Age, Cause and Manner of Death.

Figure 10: 2004 Causes of Death



Medical Conditions - As Figure 10 illustrates, the leading causes of death in the District continued to be associated with medical conditions. In calendar year 2004, of the 154 CFRC deaths where causes were determined/known 75 involved children/youth that died from medically related problems. Data for 2004 revealed two trend changes. The total number of child deaths in this category slightly increased after several years of a steady decline. Due to the significant increase in the number of violence related 2004 deaths, medically related fatalities represented a smaller percentage of the

total deaths for the year. Medically related deaths represented 49% of the 154 deaths for calendar year 2004 which represents a decrease from the 71 deaths from 2003 (53%) that were attributed to medical conditions. The ages of the 2004 medically related decedents ranged from birth through 20 years of age, with an average age of three years.

◆ Children Under One Year of Age

In 2004, data indicates that 56 or 75% of the medically related deaths involved infants (under the age of one year). Seventy-five percent (n = 41) of infant deaths occurred within the first 28 days after birth and 66% of these children died within the first day of life (n = 27). Neonatal data from 2004 represents a reduction from the 43 infant deaths that died within 28 days after birth (83%) and 67% of these children died within the first day of life (n = 29).

"2004 Natural Infant Fatality"

A female infant born at 24 weeks gestation, with a birth weight of 910 grams and APGAR scores of 2 at 1 minute and 5 at 5 minutes, died within 6 hours after birth. At birth he was noted to be cyanotic with extreme bruising and a foul smell. Heart rate was noted to be less than 100. As a result of extensive medical intervention, his heart rate and color improved and he was transported to NICU; although his condition remained critical. Despite continued medical treatment the infant had an acute loss of blood pressure and heart rate with an episode of acute hemorrhage. In view of the diagnosis and severe deterioration, the decision was made with the mother to provide no further intervention. The infant died shortly afterwards in his mother's arms. The mother received prenatal care beginning at 12 weeks. Prenatal course was significant for cerclage placement at 14 weeks and rupture of membranes over a 2 month period. The mother also had a medical history of bronchitis, asthma, obesity, previous STD and numerous prior fetal losses.

Cause/Manner of Death: Pulmonary Hypoplasia with Air Leak due to Chronic Amniotic Fluid and Preterm Delivery/Natural

³ 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

Findings Associated with Medically Related Causes of Infant Deaths

Among the infant deaths, the leading cause was related to prematurity and associated complications. These problems accounted for 48% (n = 27) of the 2004 medical related infant deaths. This represents the same number of infants who died from problems associated with prematurity during 2003, however, in 2004 the percentage of the total medically related infant deaths in this category was slightly lower than 2003 data (n = 52% for 2003). Additionally, based on a review of death certificates, prematurity was noted as a contributor to the deaths of six additional infants, increasing the percentage of deaths in which preterm birth was a significant factor to 59% (n = 33).

- Of the 33 deaths where prematurity was a contributing factor, extremely low birth weight (less than 500 grams) was a factor in 42% (n = 14) of the infant deaths and eight 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 (17, or 52%); fourteen mothers (42%) received either no prenatal care or were late entrants and/or received sporadic care during their pregnancies. Prenatal care was unknown for two mothers.
- Congenital anomalies ranked second with eleven deaths in this category.
- Respiratory system disease and infectious disease (child related) were among the top four leading causes of death with eight infants who died from respiratory disease, followed by seven infant deaths that were attributed to infection.
- Maternal complications were documented on the death certificates of 23 or 41% of infant deaths from 2004 as underlying causes of medically related infant deaths. This represents a slight decrease in the number of deaths that were associated with maternal complications in 2003 (n = 25) Maternal complications included premature rupture of membranes, chorioamnionitis, Group B Streptococcus, placental abruption incompetent cervix, hypertension, etc.

◆ **Children/Youth One Year of Age or Older**

Children over the age of one year have consistently represented a significantly smaller percentage of the medically related deaths. Nineteen, or 25% of 2004 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 12.

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

- Data from calendar year 2004 indicate that the leading cause of medical deaths in this age group was neoplasm (n = 7).
- Infection (child related) ranked second. HIV/AIDS was common to all three of the children/youth who died from infection.
- Respiratory system disease accounted for two deaths of children age one year or older.
- There was one death each that was attributed to prematurity, cardiac disease and blood disease.

"2004 Natural Fatality"

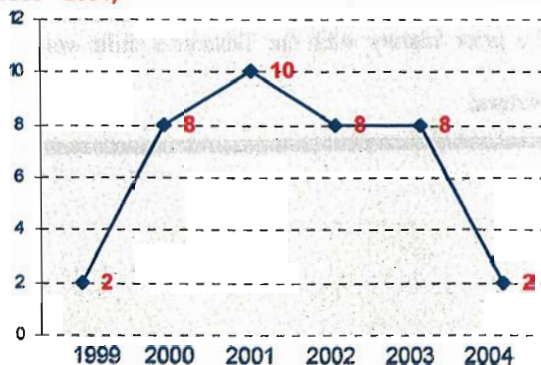
On a winter evening while in the care of his stepfather (at the place of his employment, which was located in a surrounding state), a 14 year old, African American male was discovered in an unresponsive state seated in a chair. Upon the arrival of medics, the youth was treated and transported, first to a hospital in the state where the fatal incident occurred and then to a District hospital, where he died shortly after admission to ICU. The scene investigation revealed empty bottles of liquor along with a half empty bottle of Pedialyte. Additionally, a syringe, insulin, and discarded chicken bones were found on the scene. The investigative report indicated that the stepfather "reeked of alcohol" and that he reported that he had given the decedent a shot of insulin that afternoon. Later he recalled taking him to Popeye's for lunch and bringing him back to his job. While drinking, he noticed the decedent wasn't talking or doing anything; he thought he was asleep. After approximately 1 hour, he tried to awaken him and couldn't; at that time he called 911. He also reported that his stepson usually became fatigued and vomited following insulin injections. The death of this child was investigated by the state where the fatal incident occurred. The results included reports to the DC Police Department and the child welfare agency for follow-up. This state also eventually arrested the mother of the decedent and charged her with "Felony Neglect Contributing to the Death of a Child". She was found guilty at trial and sentenced to 10 years. The family had a prior history with the District's child welfare system, however the case was closed at the time of death and during the time the case was active the record notes that the decedent was healthy, although numerous emergency room visits and other medical records did not support this fact.

Cause/Manner of Death: Diabetic Ketoacidosis due to Insulin Dependent Diabetes Mellitus /Natural

Based on the review of the death certificates, Table 2 depicts the leading and underlying causes of 2004 decedents of all ages (because the majority of death certificates include multiple related causes, the numbers represent the primary cause for the 75 medical related deaths).

<i>TABLE 2: MEDICAL CAUSES OF DEATH AMONG 2004 DECEDENTS</i>			
Primary Causes of Death	Infants < 1 Yr	1 – 20 Yrs	Total
Infections	7	3	10
Neoplasms	0	7	7
Respiratory System Disease	8	2	10
Intraventricular Hemorrhage	0	1	1
Congenital Anomalies	11	0	11
Prematurity	27	1	28
Cardiac Disease	1	1	2
Blood Disorders	1	1	2
Other Conditions	1	3	4

Figure 11: SIDS Deaths - Comparison Data (1999 - 2004)



Sudden Infant Death Syndrome – Two infant deaths from 2004 were attributed to Sudden Infant Death Syndrome (SIDS). As Figure 11 illustrates, based on a review of six years of CFRC data, in 2004, after four years of SIDS deaths ranging between eight and 10, the number reduced significantly. The two SIDS deaths from 2004 represent a reversal in trend to 1999 when the same number of children died from SIDS. This reduction is partly related to the increase in the number of "Undetermined" 2004 child deaths, many of which involved infants

who were co-sleeping or sleeping in inappropriate environments. Reviews of the two 2004 SIDS deaths revealed the following factors:

- ◆ The two 2004 SIDS deaths were Black/African American males, ages one and three months.
- ◆ Both children were the first born and had no surviving siblings.
- ◆ Both infants were born premature. One mother reported that the infant had a history of diarrhea during a two week period prior to the fatal event and one infant had no reported prior medical problems.
- ◆ Both infants were sleeping in an adult bed. One was found at 3:00 AM and was in bed with his mother. The second infant was found at 10:45 AM, in his mother's bed where he had been placed on his back with his head on a pillow and pillows on both sides. Although both children were placed in adult beds, there was a crib in one family's home.
- ◆ At the time of the death, one of the parents was the caregiver in both of the cases (mother in one and father in one).
- ◆ Both children were formula fed. However, one mother breastfed for one month after birth.
- ◆ The mothers of the two SIDS victims were ages 20 and 23 years. Both were single and never married, and were employed at the time of the deaths.
- ◆ One mother received regular prenatal care. Prenatal care information was not known for the other mother.
- ◆ One mother reported no history of substance abuse or tobacco use. Information was not known for the other mother.
- ◆ Both of the children were pronounced after unsuccessful resuscitation in a District hospital. However, the fatal event of one child occurred in the child's home in Ward Five of the District and one (child welfare fatality) occurred in the family's home in the state of Maryland
- ◆ CPR was initiated prior to emergency medical services arrival in both of these SIDS deaths.

"2004 SIDS Death"

In the spring of 2004, at approximately 2:00 AM, in a MD home, a 2 month old infant was placed in bed by his mother. He was last fed approximately 4 hours prior. The mother checked on her infant at approximately 4:00 AM and found him cold and stiff; 911 was immediately called. Prior to medic arrival on the scene the mother and grandmother attempted CPR. The infant was transported to a District hospital and shortly after arrival was pronounced dead. Based on the investigation, the infant was born premature and had had problems with diarrhea since birth. The mother reported that the child appeared to have stomach pains after the last feeding. Although medical assistance was not sought prior to the death, an appointment was scheduled to occur 4 days after the death. The family had a prior history with the District's child welfare system; the case closed in the spring of 2003.

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

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 Annual Report, violence related deaths include homicides and suicides. Based on a review of death certificates for calendar year 2004, there were 54 homicides and unlike previous CFRC years since 1999, there were no suicides of District children/youth.

Homicides

The number of child/youth homicides continues to be a major CFRC concern and has remained the second leading manner/cause of death for District children since 1996. CFRC maintains child/youth homicide data in three categories: youth violence, fatal child abuse/neglect and other. For 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. The "other" category includes those homicides where the child was under the age of 10 and the death was the result of deliberate violent acts by unrelated adults who were not in caretaker roles. In 2004, there were no homicides that fell in the "other" category.

Fifty-four children/youth died from homicides during the 2004 calendar year, representing the highest number of homicides in the history of CFRC. As indicated by Figure 12, CFRC homicide data has continued to be dominated by acts of violence perpetrated by youth on youth (youth violence). Fatal abuse and neglect deaths continued to rank second.

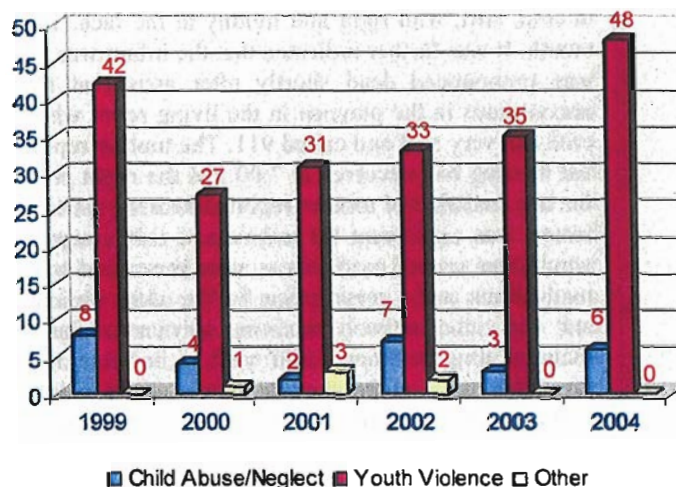
Fatal Abuse and Neglect Fatalities –

Over a six-year period (1999 through 2004), fatal child abuse and neglect deaths have fluctuated, with the lowest number of deaths occurring in 2001 ($n = 2$) and the highest number occurring in 1999 ($n = 8$). In 2004, six children died from injuries associated with fatal abuse/neglect, representing a 100% increase from 2003 data.

2004 Fatal Abuse/Neglect Fatalities

- ◆ The ages of the victims of fatal abuse/neglect were between nine months and seven years, with an average age of three years.
- ◆ Consistent with previous years' data, the majority of the victims of 2004 fatal abuse and neglect were females and Black/African Americans. Eighty-three percent ($n = 5$) of the

Figure 12: Child/Youth Homicides - Comparison Data (1999 - 2004)



victims were females. Four of the six fatal abuse and neglect deaths were Black/African American (67%) and the remaining two victims were White and Hispanic.

- ◆ Four of the fatal incidents occurred within the decedents' homes, in Wards Two, Four, Six and Eight; one incident occurred in a relatives home in Ward Five and one death occurred in a hotel in the state of Arizona.
- ◆ All of the perpetrators were in caregiver roles at the times of the deaths. Three perpetrators were the mothers of the decedents, one was a juvenile relative and one was an unrelated caregiver. The ages of the perpetrators ranged from 14 to 44 years; five were females and five were Black/African American.
- ◆ The causes of five of the deaths were directly associated with physical abuse, including four "Blunt Impact Injuries/Trauma", one "Shaken Baby Syndrome", and one child's death was caused by "Methadone Intoxication".
- ◆ Sixty-seven percent (n = 4) of the decedents' families were known to the child protective services system in the District prior to the fatal event, however half of these cases involved the decedents as reported victims of abuse and/or neglect. One case was open at the time of the death and one had closed approximately one month prior to the death.
- ◆ Four of the perpetrators had documented histories of substance abuse and one had a documented history of mental illness.

A 2004 Fatal Abuse Death

On a spring morning in 2004, medics responded to a District residence and found an unconscious child with no signs of life. The infant was transported to a hospital with CPR in progress. The hospital reported that the child was brought in cold, stiff, with rigor and lividity in the face. The body temperature was low and there was "vomit" in the child's mouth. It was further indicated that the infant was not intubated as the medics could not get her mouth open. The child was pronounced dead shortly after arrival at the hospital. According to the mother, she found the decedent unconscious in the playpen in the living room where she typically slept. She picked her up and noticed that she was cold and very stiff and called 911. The mother reported a typical, uneventful day prior to the fatal incident and that the last feeding had occurred at 7:00 PM the night prior to the fatal event. Although the decedent was not checked after the last feeding, the mother reported hearing the child making "baby type noises" while sleeping. The child's medical history was significant for asthma and cold symptoms; the last "well child check-up" was during the month prior, at which time several medications were prescribed but were never filled. However, at the scene, several over-the-counter medications and a prescription for the older sibling were found. The mother was known to several District agencies and was either actively receiving services or had received services within 6 months prior to the fatal event, that included drug treatment, child welfare, in-home nursing and mental health. Contact with the decedent's primary care physician, revealed the fact that neither of the children were routinely taken for medical appointments or consultations (Neurologist and Geneticist). During the home visit after the death, the sibling was found to be clean and appropriately dressed. He also appeared to be healthy and bonded with his parents. However, based on the circumstances surrounding the death and the mother's history of drug use and non-compliance, the decision was made to remove the child who was later placed with a relative. Approximately, 1 month after the death, the results of the decedent's toxicology screen indicated that the infant's blood was positive for methadone and the case was ruled a homicide. Based on the investigation, the mother felt that the child had been released from the hospital too soon after birth and still appeared to be experiencing withdrawal symptoms, including, excessive crying, irritability, squirming, tremors, vomiting, diarrhea and runny nose. The mother was eventually arrested and pled guilty to voluntary manslaughter and 1st degree cruelty to children.

Cause/Manner of Death: Methadone Intoxication/Homicide

SPECIAL REPORT ON 2004 YOUTH VIOLENCE RELATED HOMICIDES

This Special Report on Youth Violence is being included in the CFRC 2004 Annual Report for the purpose of highlighting the issues and escalating problems related to the youth violence epidemic in the District. As with other statistical data in this Report, the information presented in this section is based on the fatality review meetings conducted over the past three years that focused specifically on youth homicides and youth violence in our community. These reviews revealed very enlightening information regarding demographics associated with the youth, their families and perpetrators. They also exposed very powerful information about the number of decedents who were involved with the District's public service delivery systems and the ability of the government to effectively meet the needs of these citizens, with a goal of ensuring the ultimate in quality of life. This report emphasizes recommendations that resulted from numerous youth homicide cluster reviews that were held during 2004 that highlighted the Committee's continued concern related to youth homicides with little to no change in circumstances, service interventions, presenting issues and youth and family histories of both the victims and perpetrators. It serves as the first step of an ongoing plan to highlight and elevate concerns related to the problem of youth violence. It also supports recommendations made in the past that the Committee hopes will be the beginning towards initiating change in the lives of vulnerable children/youth who are or may be exposed (directly or indirectly) to the violence in our community.

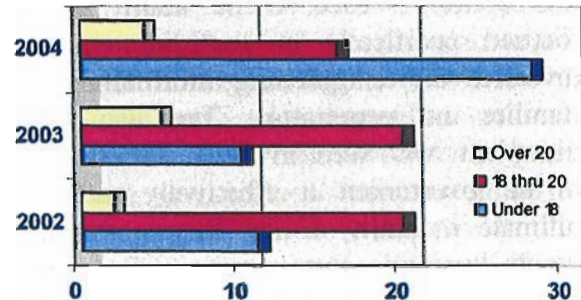
Youth violence, fatal and non-fatal, is not a problem that is unique to the District. It is a highly visible and high priority concern in many areas of this country, and in many communities and neighborhoods. Nationally, it affects families of all races and socio-economic statuses. This problem resonates throughout communities and families leaving devastating and lasting scars on victims, families, friends and perpetrators, as well as entire communities. Although research and relevant literature supports the fact that since 1993 there has been a nationwide decline in youth violence, it also acknowledges that the number of adolescents involved in violent behavior and are exposed to violence remains disconcertingly high.

The intent of this section of the Annual Report is to focus on the violent behavior of District youth and possible risk factors highlighted through the District's CFRC. The CFRC data presents some common as well as unique factors associated with the deaths of youth in the District compared to those occurring in other states and cities. One glaring unique factor is although nationally homicide is the second leading manner of death among youth ages 15 to 19 years it continues to be the leading manner of death for District youth. Another unique factor is the race of the youth dying from violence in the District. Although the Black/African American child/youth population continues to decrease in the District, the race of the youth dying violently continues to range from 95% to 100% in this population. This Report presents for the first time a full analysis of the data and information that has resulted from youth violence deaths over the last three years. It will provide not only information on the characteristics of the decedent population but it will also provide information related to circumstances surrounding the death, the causes and associated risk factors, many of which are common to national data on youth in the same age category.

Decedent Characteristic

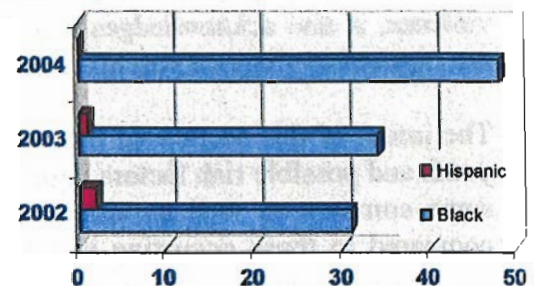
- ◆ **Age** – During 2004, the ages of the youth who died from youth violence related homicides ranged from eight through 23 years. The majority of the youth were under the age of 21. During 2004, there were two significant changes in trend regarding the decedents' ages. First, unlike 2002 and 2003, the largest population of youth dying violently was under the age of 18 years. Additionally, unlike previous years, this population included youth who were younger than 14 years of age, with the youngest being eight years old. The 28 children/youth from calendar year 2004 who were under the age of 18 years of age represents a 155% increase from the 11 decedents in this same age category from 2002 and a 180% increase from the 10 decedents from 2003. During 2004, among the 18 through 20 year old category, the number of youth deaths decreased by 20% (n = 16) from the 20 deaths in the same age category during 2002 and 2003 (n = 20 each year).

Figure 13: Age of Youth Violence Decedents (2002 thru 2004)



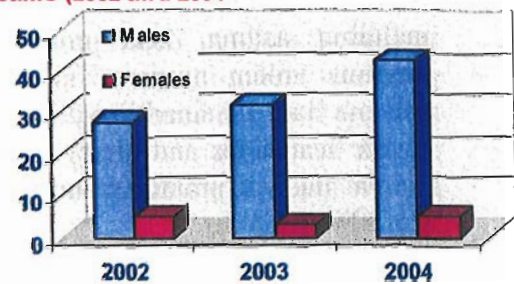
- ◆ **Race** – A report issued by the Surgeon General in 2001, “Youth Violence: A Report of the Surgeon General”, indicates that, based on confidential interviews with youths, “race and ethnicity have little bearing on the overall proportion of racial and ethnic groups that engage in *non-fatal* violent behavior”. It further indicates that based on supporting data, “there are racial and ethnic differences in homicide rates.” Although Black/African American children have historically been disproportionately represented in the District’s child death population, this problem has been more prevalent and apparent in the homicide area than other manners of death categories. Additionally, within the homicide category Black/African Americans are even more likely to be victims in the District. Based on historical CFRC data, youth violence homicides have been limited to Black/African American and Hispanic victims. As Figure 14 illustrates, the number of Black/African American victims of youth violence represented 94% of the total youth violence fatalities in 2002, 97% in 2003 and 100% in 2004. Consistent with all previous CFRC years, there were no fatal youth violence incidents that involved White or Asian youth.

Figure 14: Race of Youth Violence Victims (2002 thru 2004)



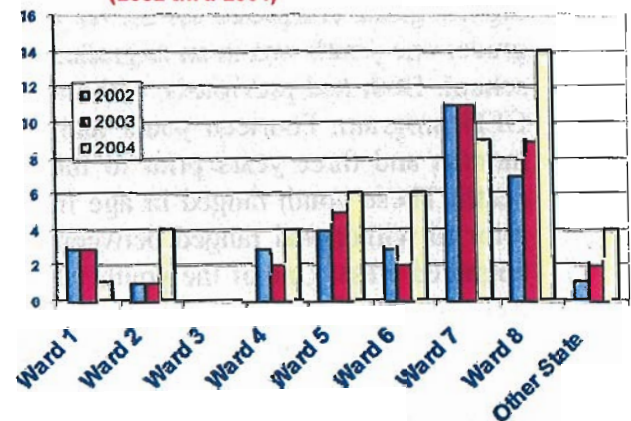
- ◆ **Gender** – Male victims have also historically dominated youth violence fatalities in the District. Eighty-five percent of the 2002 victims of youth violence homicides were males ($n = 28$). The percentage of male victims increased in 2003 to 91% ($n = 32$) and decreased to 90% in 2004. In 2002 and 2004, five of the youth violence victims were female and in 2003 three were females.

Figure 15: Gender of Youth Violence Victims (2002 thru 2004)



- ◆ **Ward of Residence** – As Figure 16 illustrates, the majority of the decedents from calendar years 2002, 2003 and 2004 were residents of Wards Seven and Eight. The combined total for Wards Seven and Eight deaths represented 55% ($n = 18$) of the total number of youth violence deaths from 2002, 57% ($n = 20$) from 2003 and 48% ($n = 23$) from calendar year 2004. During 2004, Wards Five and Six ranked third with equal numbers of youth homicides ($n = 6$). Consistent with previous CFRC years, there were no youth homicide fatalities that involved decedents from Ward Three.

Figure 16: Victim's Ward of Residence (2002 thru 2004)



- ◆ **Substance Use/Histories** – The majority of the 2002 through 2004 decedents had a prior and/or current history of substance abuse. In 2004, 33 youth (69%) had a known history of drug and/or alcohol use. Twenty-two of these youth were known for drug use only and five of these youth admitted to multiple drug use. Four of the 2004 decedents had histories of alcohol use only and seven had histories of both drug and alcohol use. Twenty-three, or 66% of the 2003 decedents and 23, or 70% of 2002 youth had histories of substance abuse.

- ◆ **Mental Health Histories/Behavioral Problems** – Thirty-three, or 69% of the 48 decedents from calendar year 2004 had documented histories of mental health or behavioral problems. The majority of these youth ($n = 19$, or 58%) had mental health diagnoses and had documented behavioral problems within the home and the community. Twelve of the 33 youth had histories of behavioral problems only; and two decedents had only diagnosed mental health problems with no known or documented behavioral issues. The most common mental health diagnoses included depression and conduct disorder ($n = 15$, or 45%). Other diagnoses included Oppositional Defiant, Impulse Disorder, and Bipolar Disorder. Four of these youth had histories of prior suicide attempts or ideation; one had attempted suicide three times prior to his death. Three of the 2004 decedents had been victims of previous shootings, two had an illegal firearm at the time of their deaths, three had been linked to previous District shootings and eight had known histories of gang involvement. Seventeen, or 49% of the 35 victims of youth violence from calendar year 2003 and 15, or 45% of the 2002 victims had known histories of mental health and behavioral problems.

- ◆ **Medical Problems** – Ten of the 2004 decedents had documented medical problems, including asthma, heart problems, sleeping/eating disorders, allergies, appendicitis, and previous violent injuries. Three of these decedents had suffered from prior gunshot wounds and one had sustained head/brain injuries from a motor vehicle accident that left him with severe headaches and dizzy spells. Four of the 2003 and two of the 2002 decedents had known medical problems and the most common for both years was asthma. One decedent was HIV positive.
- ◆ **Education Level** – The primary source of educational information for CFRC decedents is the DC Public School System. However, in the event that information cannot be obtained from DCPS, other sources were used such as child welfare, juvenile justice or DC Superior Court records. In situations where no information was available on decedents' educational history, the last grade completed was obtained from the death certificate. According to documents reviewed, most of the youth decedents were academic underachievers. The highest grade completed for the 48 youth violence decedents ranged from the first to the 12th grade; one youth was in an ungraded program. A total of two youth had graduated from high school. Both had previously withdrawn from public school but enrolled in and completed a GED program. Fourteen youth had withdrawn from a District public school between two months and three years prior to their deaths and one was expelled two years prior to his death. These youth ranged in age from 15 to 23 years of age and the last grade completed prior to withdrawal ranged between the seventh and 10th grades; and one youth was in an ungraded class. One of the youth who withdrew was in special education programs and two were in an alternative educational program. Two of the youth who withdrew from school were enrolled in Job Corp at the time of their deaths.

Of the 32 youth who were actively enrolled in school at the times of their deaths, six were enrolled in special education programs, two of these youth were placed in age appropriate grades, three were placed below age/grade level and one was in an ungraded class. One youth was placed in an alternative program and below age level. Eighteen of the 32 youth were enrolled in regular educational programs and the educational type was unknown for seven youth. Fourteen of these youth were in age-appropriate grades at the times of their deaths, while eleven were in one to three grades below their ages.

Of the 35 youth violence fatalities reviewed from calendar year 2003, educational information is not known for three of the decedents. The highest grade completed for the remaining 32 decedents (ages 15 through 22 years) ranged from the sixth to the 12th grades. Eight of the youth had graduated from high school or received a GED. Twelve youth (ages 18 and 22) remained in a withdrawn status at the time of their deaths. The remaining 12 youth (ages 15 to 19 years old) were actively enrolled in schools; five of these youth were enrolled in age-appropriate grades and seven were enrolled in grades from two to four grades below.

Education information is not known for two of the 33 youth violence decedents from the 2002 calendar year. Of the remaining 31 youth, 12 (ages 15 through 22 years) remained in a withdrawal status at the times of their deaths; three had received special education services;

and the highest grades completed for all these youth were eighth through eleventh. Three decedents had graduated from high school. Sixteen youth (ages 15 through 19 years) were enrolled in school at the times of their deaths and three were in age-appropriate grades.

- ◆ **Unexcused Absences/School Truancy** – Truancy or unexcused absences from school, has been linked in the literature to serious delinquent activity and other negative behavior among youth. It has been associated with substance abuse, and involvement in gang and criminal activities. Excessive absences/truancy has been a long recognized problem of the fatalities reviewed by the District's CFRC. Not only has this problem been consistently highlighted as issues with decedents, excessive absenteeism is also routinely documented as a concern for siblings or other family members. Information from calendar years 2002 through 2004 supports the fact that truancy is a serious problem that needs to be closely monitored and addressed in the District. Although capturing educational information has been a historical part of CFRC practice, prior to 2004, it was obtained only on CFRC cases that received a multi-agency review. However, in 2004, because of the concerns related to school attendance, attendance information was requested on all school age children/youth. Therefore, the information provided below is more complete for calendar year 2004.

As Table 3 illustrates, 2004 records document the fact that 33, or 80% of the 41 cases where attendance information was known and/or obtained, involved decedents with attendance problems during the last year of school attendance. The number of days absent (unexcused) ranged from 11 to 92, with an average of 48 days of unexcused absences. The largest group of youth had over 15 unexcused absences (n = 27).

Youth's Age	# Days Absent		
	10 – 15	16 – 30	31 & over
13 – 15	2	4	2
16 – 17	2	7	2
18 – 20	2	4	5
21 – 23			2
Total	6	15	12

Based on 2003 data, out of the 21 cases in which attendance information was known/obtained, 18, or 86% of the youth had histories of excessive absences/truancy problems. The number of days absent ranged from 14 to 160 and the average number of absences was 42 days. In 2002, of the 24 youth whose educational information was known/obtained, 15, or 62% of these youth had histories of attendance problems. The number of unexcused absences ranged from 11 to 96, with an average of 34 days.

- ◆ **Decedents Known to the Child Welfare and Juvenile Justice Systems** – Thirty-nine, or 81% of the 48 youth violence fatalities from 2004 involved decedents who were known to the District's child welfare and/or juvenile justice systems. Fourteen of these youth had histories with both systems and six were known to both systems during the same time period and records noted no efforts to collaborate in regards to planning and/or treatment.
 - **Child Welfare System** – Twenty (42%) of the 2004 youth homicide decedents were known to the child welfare system. The number of reports received on each family ranged from one to 26, with an average of four per family. A minimum of at least one report was substantiated for abuse and/or neglect on 14 of the families referred. Six families had only unsubstantiated reports and most of these families (n = 4) were reported

once to the child welfare system. Based on the last report of suspected abuse and/or neglect, the majority of the 20 families were reported for general neglect (n = 11, or 55%); the remaining nine families were reported for issues of child abuse (n = 8) and left alone (n = 1). The majority of the cases for the 2004 child welfare youth violence fatalities were closed at the time of the fatal incidents (n = 16, or 80%). The closure dates for these cases ranged from 15 days through four years prior to the death, two of the decedents were in abscondence at the time that the cases closed.

Four of the cases were active at the time of the deaths, three of these youth were either committed or in shelter care status and one was in a non-committed status (investigation was ongoing at the time of the death). Two of the decedents of active cases resided with a parent (including one under court ordered protective supervision). The three youth who were in some form of commitment status were on abscondence at the times of their deaths, totaling five child welfare decedents who were in abscondence when they died or their case closed. The non-committed youth had issues of generational neglect in that his mother grew up in the District's foster care system. Six of the 14 child welfare decedents who were also known to the juvenile justice system had open cases during the same time periods and two of these youth were in a commitment status.

- **Juvenile Justice System** - Thirty-three youth violence fatalities involved decedents who were known to the juvenile justice system within two years of their deaths. The ages of these youth ranged from 13 to 23 years, with an average age of 18. The ages of the decedents at the time of their first arrest ranged from 10 to 17 years. All of the decedents had multiple arrests, with 21 decedents being arrested more than twice. Although the most frequent charge for first and second arrests was possession of drugs (n = nine), followed by unauthorized use of vehicles (UUV) with seven deaths, five youths' first charges involved possession of or assault with a dangerous weapon. Other charges included simple assault, sexual abuse/assault, burglary/theft, destruction of property and truancy. The second arrest for 12 decedents was related to drug possession, while five decedents were arrested a second time for UUV and four for weapons charges.

Twelve of the decedents' juvenile justice cases were active at the times of their deaths. Five were committed, five were on probation, one was detained and one had an active consent decree. Twenty-one of the 33 juvenile justice homicides involved decedents whose cases had closed/terminated within two years prior to the youths' deaths. This included three cases where all charges were dismissed/not petitioned. Six juvenile justice youth were previously on probation, five were in a detainee status, four had been previously committed to the District and two had consent decrees that terminated prior to their deaths. The reason for termination was not known for one youth. Three of the juvenile justice decedents with active cases were in abscondence at the times of their deaths and one of the youth with a closed case was in abscondence at the time the case terminated.

- ◆ **Public Assistance Program** – Consistent with prior CFRC years, most families of decedents were known to the District's public assistance programs and the majority of these families

were receiving services at the times of their deaths. Of the 48 youth violence fatalities from calendar year 2004, 44, or 92% of the decedent's families were known to the District's public assistance program. Thirty-eight of these families were either receiving services at the time of the youth's deaths or within two years prior to the death. Of the 30 families who were actively receiving public assistance at the time of the deaths, the most common service received was medical assistance (n = 30), followed by food stamps (n = 11, or 37%) and TANF (n = 7, 23%). Seven of the active families were receiving all three services (TANF, medical assistance and food stamps). Similar to 2004, in 2003 and 2002, 77% and 82% respectively of the homicide victims were either receiving public assistance at the times of the deaths or within two years prior to the death (n = 27 for each year).

- ◆ **Caregivers at the Time of Death** – The majority of the 48 youth who died during calendar year 2004 resided with parents at the times of their deaths (n = 26, or 54%). Twenty-two youth resided with their mothers; two with their fathers and two resided with both parents. Twelve youth were independent; their ages ranged from 18 to 23 years. Five youth resided with relatives at the times of their deaths and two with non-relatives. Two were residing in juvenile justice facilities and one youth was homeless at the time of his death (although the death certificate provided his sister's address as decedent address). This youth was committed to the District and at the time that his commitment terminated, records documented that he had no known place of residence.
- ◆ **Family Risk Factors** - Based on nationally recognized risk factors the following existed with the 2004 decedents and their families:
 - Thirty-four, or 69% of the mothers of decedents were single, never married and were the heads of the household. Six youth had parents who were deceased (three mothers and three fathers).
 - Two of the 2004 decedents had siblings who had also died from youth violence related incidences during prior CFRC years.
 - Of the 46 mothers who were alive at the time of their child's death, employment history was known for 32. Fifteen or 47% of the 32 mothers whose employment history was known were unemployed. Fourteen of these mothers were known to the District's public assistance program. Of the 17 mothers who were employed, 10 had previous histories with the public assistance program.
 - Four of the 48 decedents were committed to the child welfare and/or juvenile justice system at the times of their deaths and were placed in facilities or relatives through these programs. Of the 26 who were in the care/custody of parents, 22 were residing with their mothers in single heads of households and at least 20 of these youth had little to no involvement with their fathers. Two decedents resided with their fathers and two with both parents. The remaining 19 decedents included five who resided with relatives, one with a non-relative, 11 were independent and one was homeless at the time of his death (just released from a juvenile justice detention facility with no address).
 - The average age of the mothers at the time of the death was 42 with the average age of the decedent being 17.
 - Eight of the mothers had documented substance abuse problems, three had diagnosed mental illnesses and four had documented chronic medical concerns.

- The average number of surviving siblings was three; however, 15 decedents had four or more siblings, with the largest number of siblings being 12.

◆ **Circumstances Surrounding the Death**

- **Month of Fatal Incident** – As Figure 17 illustrates, the months that the fatal incident occurred varied among calendar years. Youth were killed during every month of each year with the exception of 2004. During 2004, there was no youth violence homicide during the month of November and a minimum of three youth were killed during 10 of the remaining months. Also during 2004, the highest number of deaths (over 4) occurred during the months of January, May, July and October.

A monthly average of four District children/youth were killed during 2004, with the highest number of deaths being nine and the lowest being one. During 2002 and 2003, there were no months where the number of deaths exceeded six and the average number of deaths per month was three.

- **Time of Fatal Incident** – Based on death certificates and the police Death Reports, the majority of the fatal incidents that were associated with youth violence deaths for calendar years 2002, 2003 and 2004 occurred between 7:00 PM and 6:00 AM (n = 71% for 2004, 66% for 2003 and 73% for 2002). Twenty of the 2004 youth violence victims were under the age of 17 years (curfew age) and 12 of these youth died on District streets during mandated “curfew hours”. Nine of these deaths occurred during school months and on the early morning of a school day.

**Figure 17: CFRC Youth Homicides
Month of Fatal Injury**

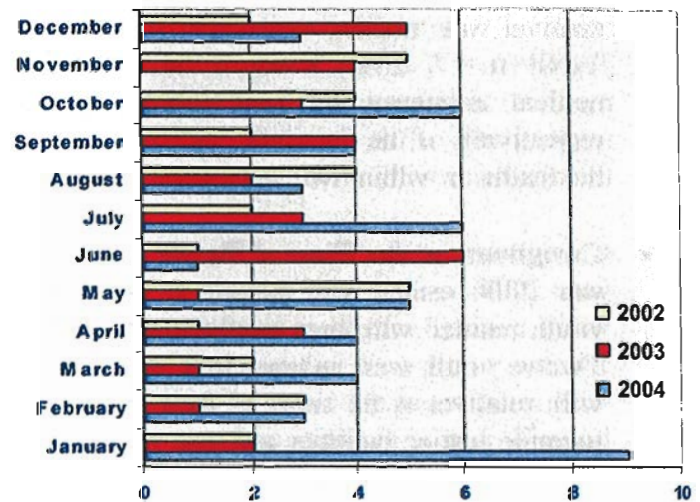
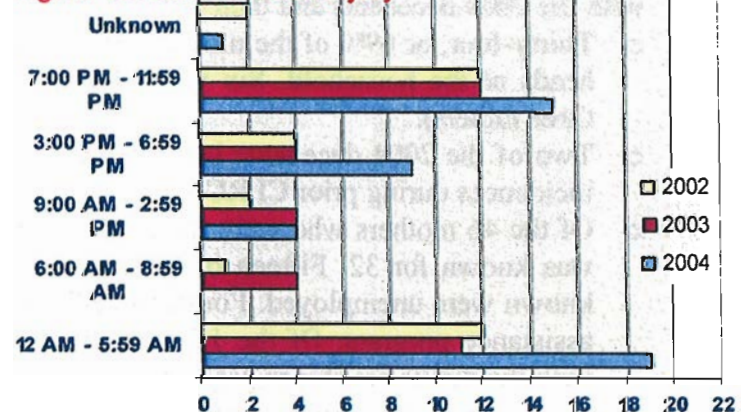


Figure 18: Time of Fatal Injury



- **Ward of Fatal Incident** - The Ward of incident refers to the location of the fatal injury. As Table 4 illustrates, the majority of the youth violence related fatal incidents are occurring in Wards Five, Seven and Eight. For calendar years 2002, 2003 and 2004, over 65% of the violent incidents occurred in these Wards. Many of the incidents occurred within the neighborhoods or in close proximity to the neighborhood where the decedent resided (14 in 2002, 13 in 2003 and 14 in 2004). According to MPD, the locations of many of the incidents were known for criminal activity. In 2004, 57% (n = 28) of the youth violence fatalities occurred in District neighborhoods that were known for drugs, gang and/or other types of criminal activities (car theft, assaults, etc.). (See page 24 for a map that depicts the Ward where the fatal incident occurred for youth violence homicides that occurred between calendar years 2002 and 2004.)

Table 4: Incident Ward

	2002	2003	2004
Ward 1	2	3	0
Ward 2	2	0	1
Ward 3	0	0	0
Ward 4	2	1	4
Ward 5	7	7	11
Ward 6	3	2	3
Ward 7	10	8	9
Ward 8	5	11	12
Other/State	2	3	8

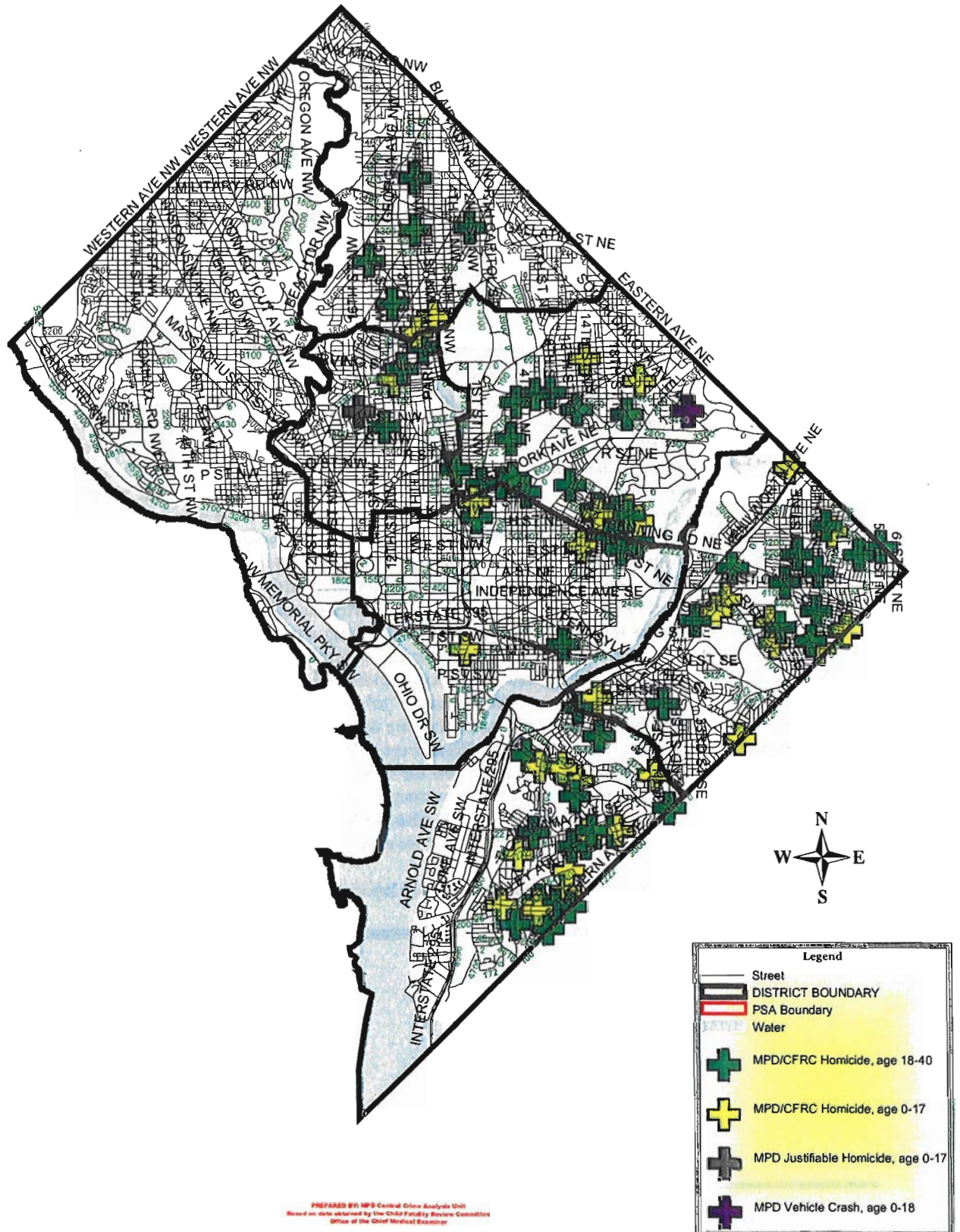
"Two 2004 Youth Violence Homicides"

On a weekend in February 2004, at approximately 2:00 AM, a radio call was received reporting the sounds of gunshots in the NE quadrant of the city. While responding to the location they received another call reporting a shooting and a traffic collision in the same area. Upon arrival on the scene, they observed a vehicle that had run off the road and had collided into a tree. The MPD observed two victims in a late model vehicle, one seated in the driver's seat and one in the front passenger's seat, both appeared to be unconscious. The DC Fire Department responded to the scene and extricated the victims from the vehicle. One showed no signs of life and was pronounced on the scene; the second was transported to a local trauma hospital and was pronounced dead after unsuccessful medical intervention. The drivers of both vehicles were traveling at an excessive rate of speed. The decedent's car exited the main roadway and entered onto the service lane. Shortly thereafter, the vehicle mounted the south side curb, traveled across the grassy median and collided with a tree. The investigative report indicated that the road conditions were dry, the weather clear and although the event occurred at night, the street was well lit with streetlights. Witnesses on the scene indicated that the passengers/drivers of both vehicles were exchanging gunfire prior to the collision, "which was undoubtedly a contributing factor to the crash". The report further recorded that neither the driver nor the passenger "suffered gunshot wounds", and that "their deaths were caused by Blunt Force Trauma" resulting from the impact with the tree. Neither victim was wearing a seatbelt nor did the vehicle have air bags. It was determined that the driver of the vehicle was 18 years of age and the passenger was 17 years old. The vehicle was unregistered and the driver had a Learner's Permit. Records also indicated that the driver was known to the juvenile justice system and had numerous arrests that involved drugs, firearms, assault, driving infractions and UUV.

Cause/Manner of Death: Multiple Blunt Impact Injuries of Head, Chest and Abdomen/Homicide



Child Fatality Review Committee Juvenile Homicides, 2002-2004



- **Location of the Fatal Incident** – The majority of the victims were found by MPD or emergency medical services personnel either in public areas (streets/alleys/sidewalks), inside of or on the premises of private property (homes, apartments, private parking lots, etc.) or in vehicles. In calendar years 2002, 2003 and 2004, the number of youth who were found on public streets of the District represented 48%, 51%, and 31% respectively. The number found in vehicles represented 30%, in 2002, 11% in 2003 and 33% in 2004. Of the 16 youth who were found fatally injured in vehicles, nine had documented criminal histories that included “unauthorized use of a vehicle.” The number of youth found on school grounds fluctuated from two in 2002 to one in 2003 to three in 2004.

The majority of the decedents were pronounced dead at District hospitals. In calendar years 2004 and 2003, 29 (59%) and 20 (57%) died in local hospitals, while 14 (29%) and 12 (34%) died on the scenes and were never transported to a hospital. Six of the 2004 and three of the 2003 decedents died in hospitals in other states. A slightly larger percentage of youth died on the scene in 2002 (n = 13, or 39%); three of the 20 youth who died in hospitals, died in other state facilities.

◆ **Autopsy**

- **Cause of Death** - Based on causes of deaths among District youth, violence can be directly linked in large part to the problem of easy access to firearms. Gunshot wounds caused the majority of the District’s child/youth deaths associated with youth violence. Other causes included Blunt Impact (associated with motor vehicle incidents) and fatal assaults and stab wounds.

Gunshot wounds (GSW) have historically been the leading cause of youth violence deaths. In calendar years 2002 through 2004, the number of youth who died from gunshot wounds represented from 100% to 91% of CFRC youth violence fatalities. In 2004, four (4) decedents died from injuries associated with Blunt Impact and the deaths of three of these youth were the result of motor vehicle incidents, however, due to the circumstances surrounding the deaths they were determined to be homicides. One blunt impact death was associated with a fatal assault (beating). Forty-three 2004 homicides were from gunshot wounds and one decedent died from injuries associated with both GSW (n = 6) and multiple stab wounds (n = 5).

Table 5: Type of Causes of Death			
	2002	2003	2004
Gunshot Wounds	33	33	43
Stab Wounds	0	2	0
Combination (GSW/Stab)	0	0	1
Blunt Impact	0	0	4

While the majority of the 2004 firearm victims (n = 22, or 46%) were shot once fatally in a major part of their bodies (head, chest, abdomen, etc), many were shot multiple times. Table 6 illustrates the number of victims by the number of gunshot wounds. The highest number of gunshot wounds for a 2004 victim was 19 while two additional victims had 11. During calendar years 2002 and 2003, the highest numbers of gunshot wounds were 15 and 19 respectively.

Table 6: Number of Wounds			
# GSWs	2002	2003	2004
1	14	16	22
2 – 5	14	12	11
6 – 10	3	1	8
Over 10	2	4	3

- **Toxicology Screen** - Based on the results of toxicology screens conducted at the time of autopsy, the number of decedents who were positive for drugs and/or alcohol use declined between calendar years 2002 and 2004. In 2002, 20 of the 33 decedents (61%) were positive for drug and/or alcohol use. Of this number, 13 had positive screens for illicit drugs (three were positive for multiple drugs), two were positive for alcohol only and five for both drugs and alcohol. The types of drugs used included PCP, marijuana, cocaine, heroin and methamphetamine.

In 2003, 16 of the 35 decedents (46%) were positive for drugs and/or alcohol, which included 10 for drugs only, 4 for alcohol only and 2 for both drugs and alcohol. The drugs of choice included marijuana and PCP. In 2004, the number of decedents who tested positive for drugs and alcohol reduced to 29% (n = 14 of 49 youth homicide deaths). Five of these youth were positive for drugs only, six for alcohol only and three for both drugs and alcohol. The types of drugs used included PCP and methamphetamine. When combining the number of youth who had a documented prior history of drug and alcohol use with the number who had positive toxicology screens at the time of their deaths, the numbers at-risk due to substance use increases significantly. In 2004, 33 youth (67%) had a history of drugs and/or alcohol use and/or tested positive at the time of death; in 2003, 22 (63%) and in 2002, 23, or 70% of youth had substance abuse histories.

The toxicology screen results for calendar year 2004 also revealed 12 youth who were positive for tobacco use (nicotine) and four of these youth were under the age of 18 years.

"A 2004 Youth Violence Homicide"

A 17 year old, African American male was the driver of a vehicle with at least 2 other passengers. He was shot while traveling in the Northwest quadrant of the city. The vehicle proceeded down the street striking multiple cars and finally crashed into a tree. Upon the arrival of the MPD, the victim was suffering from a gunshot wound to the head. He had no signs of life and therefore remained on the scene until he was pronounced dead at approximately 8:00 PM. The 2 other victims were transported to a local hospital suffering from non-life threatening injuries. According to the juvenile justice program, the decedent was driving a stolen vehicle. He had left the group home earlier that day to visit his mother. The investigation was completed on 12/04 and the perpetrator was identified and arrested. He was a Black, male and in his 20's. The motive for the murder was retaliation (he had allegedly been a victim of a robbery committed by the decedent). The perpetrator was known to the criminal justice system and had a prior history of drug involvement. The MPD report also noted that the decedent had a prior history of drug and gang activity.

The decedent had a 4 year history with the juvenile justice system that included multiple arrests for weapons charges, assault, drug possession and receiving stolen goods. At the time of his death he was committed and placed in a group home and was considered a model resident. The decedent was also briefly known to the child welfare system approximately 4 years prior to his death based on 1 report made by a mental health professional that involved allegations of physical abuse by his stepfather. Based on the investigation which indicated that there was no physical evidence of abuse, the report was unsubstantiated. The decedent's involvement with the mental health system began in 2000 based on his history of running away and defiant behavior. He had several psychiatric hospitalizations with numerous diagnoses. He was determined to be of low average intelligence with poor judgement and insight. His educational history included an early special education determination. He received special education services through elementary school, however, was not enrolled in special education when promoted to the junior high school level. His history of running away from home and truancy began in the 7th grade and at the time of his death his enrollment in school could not be verified.

Cause/Manner of Death: Gunshot wound to the head/Homicide

Death Investigations

The following data is based on information obtained from the Metropolitan Police Department and from the US Attorney's Office website.

- **Motive** – In 2004, motive was known for 34, or 70% of the 48 CFRC youth violence fatalities. Twenty-five (74%) of these deaths were associated with disputes/arguments/retaliations as the primary reasons for the homicides, with drugs and gang activity being specifically noted as the secondary reason for five of these deaths. In 2003, of the 31 cases where motive was known, the police investigations indicated that disputes/arguments/retaliations were the primary reasons for the 2003 homicides (n = 23, or 74%). Twelve of these cases were associated with drugs and gang activity. In 2002, motive was obtained for 22 (66%) of the 33 homicides. The primary motive for 15 of these cases dealt with disputes/arguments/retaliations and two were associated with hate crimes, two domestic violence and three related to gang activity.

Robbery was the reason for six of the 2003 homicides and one in 2002. There were no 2004 deaths that were associated with robbery. Self-defense was associated with one fatality from 2003 and two from 2004; all of these deaths involved an altercation with law enforcement.

Also, in 2002 and 2004, four of the homicides (two for each year) were determined to be accidental. For one death in each of these years, the decedents were not the intended victims.

- **Perpetrator Findings**

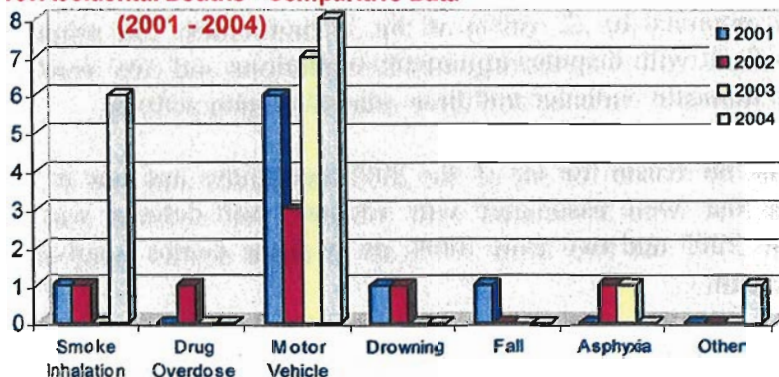
- **Age** - Investigation data from 2004 youth violence homicides indicate that the ages of the perpetrators of these violent acts ranged from 16 to 55 years, with an average age of 23. The majority of the perpetrators were 21 years of age or younger (n = 18). Two perpetrators were over the age of 34. Both were law enforcement officers and the incidents were associated with self-defense. Of the 13 homicides from 2003 where perpetrator information was known, the average age was 24, with the age range being 15 to 37. Five of the perpetrators were under age 22 and eight were between the ages of 22 and 30 years. The average age of the 17 perpetrators identified from 2002 was 17 years, with the youngest being 14 and the oldest being 35 years of age. The majority of the perpetrators were 21 years of age or younger (n = 12).
- **Race/Gender** – The perpetrators for all three calendar years were males and the majority were Black/African American (n = 16, or 94% of 17 identified from calendar year 2002; 12, or 92% of the 13 from calendar year 2003 and 24, or 96% of the 25 from calendar year 2004).

This concludes the *Special Report on Youth Violence*. It is the hope of the Committee that by providing a more comprehensive view of the issues associated with youth violence and death, we will succeed in broadening our understanding of the needs of the affected population that will generate more thoughtful and focused changes in funding, services and programs that better address these issues.

Unintentional Injuries

For the purpose of this report, unintentional injuries are those incidents where the death was not deliberate. This category may include violent or non-violent conditions that were determined by the autopsy to be accidental. The number of children who died from unintentional injuries increased significantly in 2004. There were fifteen accidental deaths that occurred during calendar year 2004. Figure 19 illustrates a comparison of the number and types of accidental child/youth deaths involving District residents over a four-year period. As this figure illustrates, the causes of unintentional deaths from 2004 were associated with motor vehicle accidents, house fires and a falling object ("Other" category).

Figure 19: Accidental Deaths - Comparative Data



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

- ◆ The 15 accidental deaths from 2004 represent an 88% increase from similar deaths that occurred during 2003 ($n = 8$), a 114% increase from 2002 ($n = 7$) and a 67% increase from the nine that occurred in 2001.
- ◆ The ages of the 2004 decedents ranged from two to 21 years.
- ◆ Consistent with overall 2004 fatality data, the majority of the decedents were Black/African American ($n = 14$, 93%). One accidental death involved a White youth.
- ◆ The majority of the decedents were males ($n = 11$).

Motor Vehicle Accidents

- ◆ The major cause of 2004 deaths from unintentional injuries was motor vehicle accidents. Of the 15 accidental deaths, eight, or 53% were caused by motor vehicle incidents. Although the total number of motor vehicle related accidents is higher for 2004 the percentage of the total number of deaths in this category is lower than 2003 ($n = 7$, or 88% of 2003 unintentional injuries were motor vehicle related).
- ◆ Half ($n = 4$) of the motor vehicle accidents involved pedestrian fatalities and four involved decedents who were drivers.
- ◆ Five of the motor vehicle accidents involved motorcycles/all terrain vehicles ($n = 4$) or a bicycle ($n = 1$). Three accidents involved automobiles.
- ◆ The ages of the victims of pedestrian accidents ranged from five to 18, with the average age being 12 years. Three of the victims were Black/African Americans and one was White; all of the victims were males. Of the four pedestrian related accidents, three involved pedestrian error/violations that contributed to the fatal incident. Two of the victims in these cases had

extensive mental health histories with injurious behavior and/or suicide ideation and abscondence. One youth had a history of seizure disorder and drug use. Two of these incidents occurred between 9:00 AM and 3:00 PM and one occurred between 12:00 midnight and 6:00 AM (had absconded from foster home). The fourth pedestrian related motor vehicle accident where driver error was an issue, occurred between 3:00 PM and 7:00 PM and involved a youth driving a motorcycle at high speed on a paved walkway, striking a group of preschool age children. It was not known whether substance abuse was a factor as the perpetrator left the scene of the accident and was not arrested until two days later. Two of the pedestrian related accidents occurred in the District (Ward Two and Eight) and two occurred in Maryland foster care facilities.

"Two 2004 Accidental Deaths"

In the winter of 2004, at approximately 4:00 AM, the MPD and the FEMSD responded to a call for a fire in a 2 story home located in the southeast quadrant of the District. Investigative reports indicated that a total of 4 individuals were discovered and removed from the home, 3 showed no signs of life and were pronounced dead on the scene. This included two African American children, ages 6 and 12 years; and a 31 year old African American adult. All were discovered on the "main floor of the home". The 4th victim was transported to a local hospital where he was also pronounced dead. Reports indicate that the fire originated on the "first floor below grade" and in the "common room den, family room, living room, or lounge". The report further indicates that the fire was confined to the building of origin and the source of the fire was described as "heat from powered equipment." The Report indicates that the cause of the ignition was unintentional and the material that first ignited was "bedding, blanket, sheet or comforter." The material that contributed most to the flame spreading was "interior wall covering" (including drapes, wood or paper). The investigation concluded that there were smoke detectors in the home and that the detection system was battery operated and operable. The detector(s) alerted occupants and the occupants responded". The estimated property damage/loss was \$150,000.00. On the same day of the fire, the Fire Department conducted outreach efforts within a 4-block radius, which consisted of door-to-door contact to distribute information and answer questions related to fire safety. They also, months later, conducted fire safety outreach events at schools where the children or relatives attended.

Causes/Manners of Death: Asphyxia due to Soot and Smoke Inhalation/Accident (1st death)
Soot and Smoke Inhalation/Accident (2nd death)

- ◆ Four of the motor vehicle accidents involved the decedents as drivers. The victims' ages ranged from 13 to 21 years with an average age of 17. All were Black/African American males. Three of the victims were driving motorcycles/all terrain vehicles and one was riding a bicycle at the time of death. All of the accidents involved victim (driver) error. Reviews of these deaths indicated that victims had not complied with traffic and safety laws/recommendations. None of the victims were wearing helmets at the times of their deaths. Speed was a factor in three of the deaths; and traffic violations were factors in three deaths (victims not stopping at stop signs and red traffic lights). All of the deaths occurred during daylight hours. Atmospheric conditions were not factors in the deaths. Of the three older victims (age 16 and over), one had a learner's permit, one had an expired driver's license and one had no license or learners permit. Drug and alcohol consumption were not factors in any of the fatalities. All of the deaths occurred in the District in the same Wards where the victims resided (Wards Four, Five and Seven).

Burns/Smoke Inhalation:

- ◆ The number of burn/smoke inhalation related deaths increased significantly during 2004. There were five house fires that involved six deaths of District children/youth. Compared to

previous CFRC data, the 2004 deaths attributed to burn/smoke inhalation increased by 500% over the one death that occurred in 2001 and 2002 and by 600% from calendar year 2003 when there were no deaths attributed to these causes. The ages of the decedents ranged from four through 13 years with an average age of eight. All of the decedents were Black/African American and equal numbers were male and female. Based on the reviews of the five house fires, the following findings were identified:

- All of the fire related fatalities occurred in family residences. Four of the decedents died in their homes and two died in the homes of relatives. Four of the dwellings were single family and one was a public housing apartment complex.
- Four of the house fires occurred in the District, with equal numbers occurring in Wards Six and Seven. Two incidents occurred in Maryland.
- Two of the deaths occurred during one house fire.
- Three of the fires were attributed to the use of space heaters, causing four child deaths.
- Investigative reports were received for four of the five house fires. All reports indicated that smoke detectors were present in the home (one wired and four battery), however, only two indicated that the smoke detectors were working at the times of the fire.
- Two of the decedents had at least a single past incident of playing with matches but were not documented as firesetters. Neither of these fires was attributed to space heaters.
- Four of the children died in fires that occurred during sleeping hours (between 1:00 AM and 4:00 AM). and
- Four of the fires occurred while adults were in the home; one occurred during the evening while younger children were being supervised by a teenage sibling.

Other

- ◆ One 2004 accidental death involved a 23-month old Black/African American female child being hit by a 27-inch television, as the child attempted to pull up on an unstable stand, where the television was placed along with other audiovisual equipment.

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 2004, there were eight child deaths in which the manner of death was Undetermined. This represents a significant increase in the number of fatalities in the Undetermined manner of death category. Based on a review of previous CFRC data, the number of children whose deaths were determined to be “Undetermined” ranged from one to four. This increase in the number of 2004 “Undetermined” fatalities was directly associated with a change in practice for those deaths where infants were determined to be 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 decision to change practice was made by the Office of the Chief Medical Examiner in collaboration with physicians from the CFRC’s Infant Mortality Review Team. Based on a review of the 2004 “Undetermined” deaths, the following findings were identified:

- ◆ The majority of the decedents were infants ($n = 7$), with ages that ranged from one to four months and an average age of two months. One of the eight decedents was two years of age. All the decedents were Black/African American and the majority were females ($n = 6$, or 75%).
- ◆ The majority of the infants were born full term ($n = 6$) and all had birth weights greater than 1800 grams.
- ◆ The majority of the causes of death ($n = 6$) was “Sudden Unexplained Death in Infancy” with two death certificates noting co-sleeping and/or bed sharing as a concern. However, based on a review of hospital records and death scene investigations, caregivers for five of the six infants reported that the decedents were co-sleeping at the time of the fatal event. Three of the caregivers reported placing and finding the infants on their stomachs and two reported placing and finding the infant on their back.
- ◆ Two of the “Undetermined” manner of deaths also had an Undetermined cause of death. These children were one month and two years of age respectively.

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 7 – Case Type

	2004 #/%
Infant Mortality *	68/44%
Child Welfare *	58/37%
Juvenile Justice *	35/23%
Community	23/15%

*Numbers and Percentages include duplication in all categories except community

Table 7 above illustrates the total number and percentage of deaths for calendar year 2004 for each CFRC category. The following provides a summary of the findings and data elements collected on the CFRC subcategories.

Infant Mortality Data

◆ Decedent/Family Demographics

- Between 1999 and 2004, the number of infant deaths in the District has been on a steady decline. During this six-year period, infant fatalities decreased by 41%. During 2004, although the number of 2004 infant deaths remained the same as 2003 (n = 68), there was a decrease in the percentage of the total child death population. In 2004, the 68 infant deaths represented 44% of the total deaths and the 68 infants who died in 2003 represented 51% of the total population.
- In 2004, the ages of the decedents ranged from birth through 11 months. Over half (n = 40, or 59%) of the infant population died within the first 28 days of life (neonates) and two thirds of these infants (n = 27, or 68%) died within the first day of life. Table 8 illustrates comparative data for neonatal deaths for calendar years 2001 through 2004.

Figure 20: IMR Comparative Data (1999 - 2004)

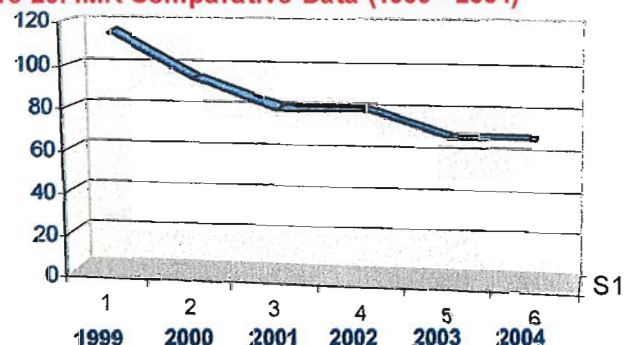


Table 8: Decedents' Age At Death

	2001	2002	2003	2004
Age Range	Birth – 9 Months	Birth – 11 Months	Birth – 9 Months	Birth – 11 Months
#/% Deaths W/in 1 st 28 Days	59 or 74%	57 or 71%	43 or 63%	40 or 59%
# Deaths W/in 1 st Day	46	45	29	26

- The number of Black/African American infant deaths reduced slightly during 2004. Fifty-seven (84%) of the 2004 infant deaths were Black/African American, representing a five percent decrease from the 60 infant deaths in calendar year 2003. In 2004, seven decedents were Hispanic, three were White and one was Asian Indian. In 2003, eight decedents were of other racial backgrounds (Hispanic, White and Asian)

Table 9: Decedents' Race

	2001	2002	2003	2004
Black	71/89%	62/78%	60/88%	57/84%
White	4	8	2	3
Hispanic	4	9	5	7

- Males and females were equally represented among the infant decedents in 2004 (n = 34 each). In 2003 and 2002, males represented over half of the total infant death population (n = 40, or 59% in 2003 and 44, or 55% in 2002).

◆ District Ward of Decedents

As Table 10 illustrates, there were infant deaths from all Wards of the District during calendar year 2004. Data indicates that the majority of the infant deaths involved residents of Ward Seven (n = 13). Ward One ranked second with 11 child deaths, followed by Wards Five and Six with 10 deaths each. Wards Four and Eight also had an equal number of child deaths. The nine deaths from Ward Eight represented a significant decrease (53%) from the 19 infant fatalities from 2003.

Table 10: Decedents' Ward of Residence

	2001	2002	2003	2004
Ward 1	5	12	4	11
Ward 2	6	9	5	4
Ward 3	4	4	0	1
Ward 4	10	10	10	9
Ward 5	8	8	9	10
Ward 6	11	9	6	10
Ward 7	11	17	15	13
Ward 8	25	11	19	9

◆ Gestational Age/Birth Weight

The number of infants born prematurely has steadily declined over the past four years. Based on the review of the 2004 birth certificates, 45 (61%) of the infant decedents were born prematurely (under 38 weeks gestation). Seventeen of the preterm births occurred prior to 23 weeks gestation. In 2004, the number of preterm infants with low birth weight increased slightly. Of the 45 premature infants, 33 (49% of the total infant population) weighed less than 1500 grams and of that number, 16 weighed less than 500 grams and three weighed between 500 and 600 grams. Nineteen, or 28% of the 2004 infant decedents were full term births. Gestational age and birth weight was not known for four infant decedents.

Table 11: Gestational Age

	2001	2002	2003	2004
< 38 Weeks	66/83%	59/74%	48/71%	45/61%
< 23 Weeks	32	31	24	17

Table 12: Low Birth Weight Infants

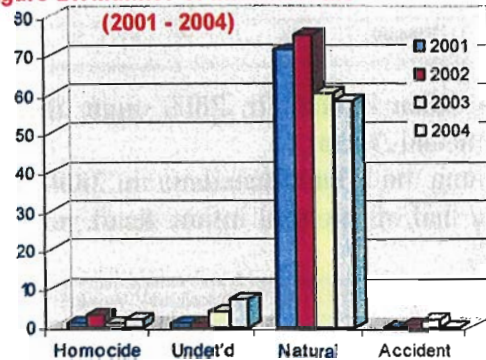
	2001	2002	2003	2004
< 1500 Grams	59/89%	51/86%	32/67%	33/49%
< 500 Grams	23	24	15	16

◆ Manner of Death

Death certificates were received for 67 of the 2004 infant deaths (99%). As with previous years, the majority of the 2004 infants died from Natural causes. In 85% (n = 58) of the 2004 infant deaths the manner was determined to be associated with prematurity, congenital anomalies and other medical problems.

Consistent with calendar year 2003, the second leading manner of 2004 infant deaths was “Undetermined” (n = 7). The official autopsy reports for six of these deaths indicated the

Figure 21: Manner of Infant Deaths (2001 - 2004)



causes were “Sudden Unexpected Infant Death” and five involved co-sleeping/bedsharing as noted on the death certificate or in investigative reports. One “Undetermined” death also had an undetermined cause of death.

Two infants died of Homicides associated with fatal abuse. These deaths included an 11-month old female who died from “Methadone Overdose” and a six-month old female who died from “Blunt Impact Head Trauma”. There were no accidental infant deaths in 2004.

◆ ***Decedent’s Maternal Demographic Data***

- Age was known for 67 of 68 mothers of the 2004 infant deaths. The ages of the mothers at the time of the death ranged from 15 to 43 years, with an average age of 26.
- The majority of the mothers for calendar year 2004 infant deaths (n = 58, or 85%) had never married. Eight mothers were married. Marital status was unknown for two mothers.
- Educational level was known for 52 of the 68 mothers of 2004 infant decedents. Thirty-six mothers (69%) had at least a high school education and nine of these women had either completed college (two completed graduate school) or had some undergraduate level education. Sixteen mothers had less than a high school education, with educational levels ranging from the 4th to 11th grades.
- Of the 58 mothers of 2004 decedents in which employment history was known, 17 were employed and 40 were unemployed at the time of the infant deaths. One mother was deceased at the time of the death.

◆ ***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***

- Fourteen of the 62 mothers where prenatal care information was known did not receive prenatal care during their pregnancies with the decedents.
- Seventeen mothers entered prenatal care after the first trimester of their pregnancy; the weeks of entry ranged from 13 to 38.
- Thirty-two mothers received routine prenatal care, including five who entered prenatal care after 12 weeks.
- Sixteen mothers received sporadic prenatal care, including 11 who also were late entrants into care.

- **Physical Health**
 - Thirty-one mothers had diagnosed physical health conditions. Some of the health problems included asthma, allergies, diabetes, cancer, obesity, hepatitis, lupus, fibroids, heart murmur and sickle cell.
 - Fourteen mothers had problems related to obesity.
 - Five mothers had histories of hypertension.
- **Mental Health Problems**
 - Nine mothers had documented histories of mental health problems, including depression, post-partum depression, bi-polar disorder, suicide ideation, etc.
- **STD/HIV**
 - Twenty-seven women had prior histories of sexually transmitted diseases and/or maternal infections.
 - One mother was HIV positive.
- **Substance Abuse**
 - Fourteen mothers had problems with drug use; and six of these women also used alcohol.
 - Eight mothers had positive toxicology screens for substances at the time of the decedents' birth.
- ◆ **Sibling Data**

The majority of decedents in 2004 had siblings. Of the 41 (60%) families known to have other children, the average number of siblings was three. Nine of the 2004 decedents were twins and in one family both twins died. Two mothers of 2004 infant deaths also had a previous child death.

"2004 Undetermined Infant Death"

At 8:07 AM, Fire Department medics responded to a District home and found a relative performing CPR on a 2 month old, male infant. The infant was transported to a local hospital and was subsequently pronounced dead at 8:50 AM. The mother reported to the police that she went to bed at approximately 11:30 PM. She awoke at about 5:00 AM, fed her infant and placed her back in bed. The child began to cry and she rocked her back to sleep and, as she attempted to lay her down, she again began to cry. The mother reports that she then laid her down on her back and placed the infant on her chest. The mother awakened up several hours later and noticed that her child was cold and had mucus and blood coming from his nose and mouth. She awakened the father who calls 911 and immediately began CPR. The mother reported that the child was born full term, with a birth weight of 6 lbs and 13 ozs. She had no complications with her pregnancy and received regular prenatal care. The infant had several well child visits, with no medical concerns noted. The child was being formula and breast fed.

Cause/Manner of Death: Sudden Unexpected Infant Death/Undetermined

Juvenile Justice Fatality Data

Thirty-five (23%) of the 155 fatalities from 2004 were youth known to the juvenile justice system. Reviews of these cases revealed the following findings:

◆ ***Age of Decedent***

The average age of the 2004 decedents was 18 years. The youngest CFRC decedent involved with the juvenile justice system was 13 and the oldest was 23 years of age.

◆ ***Gender/Race of Decedent***

One hundred percent of the 2004 juvenile justice decedents were Black/African American and 97% were males. One 2004 juvenile justice decedent was female.

◆ ***Substance Abuse***

As with previous years, substance abuse continued to be a major concern in the majority of the 2004 juvenile justice fatalities. Seventy-four percent of the decedents (n = 26) had known histories of substance use or involvement.

◆ ***Educational Level of Decedent***

- Two juvenile justice decedents from the 2004 calendar year had received a high school education by obtaining a GED. One youth based on the death certificate alone completed the 12th grade however no supporting documentation was received related to the youth's graduation.
- Twelve youth were known to have withdrawn from District public schools from two months to three years prior to their deaths. At the times of their withdrawals, their ages ranged from 15 to 23 years and the last grades attended ranged from the seventh to the eleventh. One youth was in an alternative educational program and was in an ungraded status and two youth were enrolled in special education programs at the times of their withdrawal.
- Twenty youth were attending school at the times of their deaths. Their ages ranged from 15 to 21, with an average age of 17 years. The grades of enrollment for 19 of these youth at the times of the deaths ranged from the ninth to the 11th. One youth (21 year old) was enrolled in a GED program at the time of his death.

◆ ***Public Services***

- Fourteen youth were also known to the child welfare agency.
- Thirty-two youth were known to the District's public assistance program and 23 decedents were actively receiving services at the times of their deaths. All decedents who were active with the public assistance program were receiving medical assistance and four of these youth were receiving TANF and food stamps, while two were receiving food stamps and medical assistance only.

◆ ***Ward of Decedents Residence***

The majority of the 2004 juvenile justice deaths involved residents of Ward Seven (n = 9) followed by Wards Eight and Five which had equal numbers of fatalities (n = 7 in each

Ward). Ward Six had four and Ward Four had three deaths. Two decedents were residents of Maryland, but committed to the District's juvenile justice system.

◆ ***Manner/Cause of Death***

Ninety-four percent (n = 33) of the 2004 juvenile justice decedents died from homicides. Thirty of these deaths were caused by firearms. Although three deaths were the result of a motor vehicle accident, based on the events leading to the fatal injury the fatalities were ruled as Homicides. The manner of death for two of the juvenile justice fatalities was Accident. Both fatalities involved the decedents riding a motorcycle/mini-bike and the fatal incidents were attributed to speed, recklessness, lack of helmets and violation of traffic laws.

◆ ***Juvenile/Court History***

○ ***Number of Arrests***

The majority of the juvenile justice decedents had numerous charges/arrests. Of the 35 decedents from the 2004 calendar year, 30 (86%) had multiple arrests. The most recent arrest for three of the juvenile justice decedents was for adult charges. The types of charges included gun/ammunition possession, drug possession, assault, sexual abuse, unauthorized use of a vehicle, discharging missiles and destruction of property.

○ ***Status of Case At Time of Death***

Thirty-four percent (n = 12) of the juvenile justice decedents involved youth who had active cases at the time of the deaths. Seven of the youth were committed to the District, three were on probation, one had an active consent decree and one was on a detainee status. In three 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 at the time of closure. The cases of the remaining 23 juvenile justice decedents had closed within two years of the deaths.

"Two 2003 Juvenile Homicides"

At 11:18 PM, MPD received a call regarding the sound of gun shots in the northeast area of the District. Once on the scene officers located an individual lying at the end of a walkway in an unconscious state. He was transported by emergency medical services to a local hospital, where he was pronounced dead at 12:47 AM. The autopsy revealed 5 gunshot wounds, 2 to the right upper arm, 1 to the left chest area, 1 to the mid-sternum, and 1 to the left upper arm. The victim was a 21 year-old African American male and was the third child of five. He began using drugs at age 13; but denied using alcohol. Several years prior to his death, he was involved in a serious motorcycle accident and received a traumatic brain injury, which based on his family, caused severe personality changes. He was often found sitting in a dark room, unable to lift his head. He began to exhibit poor impulse control and explosive, violent outbursts. He reported to a caseworker that his head hurt 80% of the time, that he had dizzy spells and a sense of extreme heaviness in his head. Records indicate that he was born and reared in the District and was known to multiple public service programs in the city, including child welfare (multiple neglect reports), juvenile justice (multiple arrests), mental health, public schools and public assistance. After the sixth grade, the victim's educational history was plagued with truancy and academic problems. Although his death certificate indicates that he completed the 12 grade, records reviewed through 2002 indicate that he did not complete high school. An evaluation pointed out that all of the people in his environment were women and that he had no healthy male role models in his life. The victim reported enjoying football and bike riding. He described himself as a nice person who likes to be responsible. He reported wanting to do positive things in life while acknowledging that it had been difficult to do so.

Cause/Manner of Death: Gunshot Wound to Chest Perforating Heart and Aorta/Homicide

Child Welfare Fatality Data

Child welfare deaths include those decedents whose families were known to the protective services, foster care and adoption programs. Although the initial entry point for these services is through the public child welfare agency, a range of services is available through public and/or private service providers. During 2004, 58, or 37% of the 155 deaths identified were children who met the definition for review as a child welfare fatality. This data represents a 71% increase from the 34 child welfare fatalities identified from calendar year 2003 child deaths. Reviews of these cases revealed the following:

Age of Decedent

The ages of the decedents ranged from birth through 22 years of age, with an average age of 10 years. Consistent with overall child fatality data, the majority of the children were infants (n = 15) or older than 14 years of age (n = 24). Combined, these categories represented 67% (n = 39) of the total child welfare fatalities.

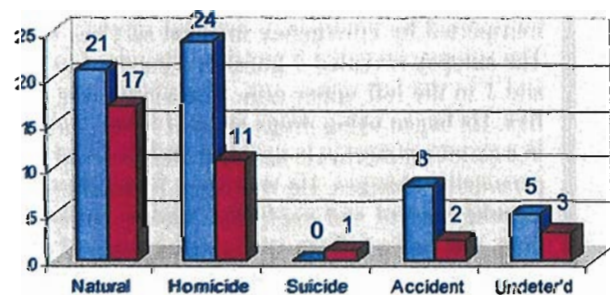
Race and Sex of Decedents

- ◆ Ninety-seven percent (n = 56) of the 2004 child welfare deaths represent children/youth of African American descent. The remaining children/youth included one Hispanic and one White.
- ◆ Males again represented the majority of the child welfare child fatality population. Sixty-seven percent (n = 39) of the decedents were male children/youth.

Cause/Manner of Death

- ◆ Unlike 2003 and other CFRC years, the majority of the 2004 child welfare fatalities were attributed to violence. The number of homicides involving children/youth known to the District's child welfare system increased by 118% during 2004. The manner of death for 41% (n = 24) of the 58 child welfare decedents was homicide. The child welfare homicides represent 50% of the total number of the children/youth who died from homicides during 2004. Four of the child welfare homicides were caused by parent/caregiver abuse, which represents two third (67%) of the total fatal abuse deaths for calendar year 2004 (n = 6). These children were between the ages of 10 months and seven years. The seven year old died from abuse that occurred when she was under one year of age. The majority of the decedents who died from fatal abuse were Black/African American (n = 2) and female (n = 3). Twenty youth known to the child welfare system died from trauma associated with youth violence (gang, drugs, disputes and criminal behavior). Child welfare youth violence deaths from 2004 represent 42% of the overall total number of deaths in this category (n = 48). Again, the majority of the youth were over the age of 14 (n = 17), Black/African American (n = 20) and males (n = 17).

**Figure 22: Manner of Death (2003 - 2004)
Child Welfare Fatalities**



- ◆ Twenty-one child welfare fatalities were attributed to natural causes. One of the natural deaths was caused by SIDS and 20 were caused by medical conditions. Eight of the 19 medically related deaths were associated with prematurity, low birth weight and congenital anomalies. Five deaths were associated with infections and three of these decedents had been diagnosed with HIV/AIDS; and three were associated with neoplasms.

"A 2004 Child Welfare Death"

A 9 year old, African American, male was struck and killed by a truck, at approximately 3:51 AM, while attempting to cross a busy highway in the state of Maryland, where he was placed in a foster home. The accident report indicates that a truck was traveling northbound when the victim ran across the southbound lanes and into lane #1 of northbound traffic and was struck by the vehicle. The report also notes that the victim was "wearing dark clothing and "was not in a crosswalk or crossing at an intersection." He was transported to a MD hospital where he died a short time later. His remains were taken to the Maryland Medical Examiner. The driver of the truck was not injured. It was also determined that the driver was not at fault, thus was not charged in the death. Although, the decedent had a history of abscondence and acting out behavior, the foster mother was unaware that he had absconded from her home. During the month prior to his death, the foster mother reported that the decedent exhibited episodes of self-abusive and other escalating inappropriate behavior at home and school. The decedent and his family had a long history with the child welfare, mental health and public schools systems. The child welfare history dates back to 1991. Eventually, the decedent was removed from his mother's care along with his two siblings, and placed together in a traditional foster home. However, several years later, due to his therapeutic needs and aggressive/acting out behavior, he was separated from his sibling and prior to his death he had a total of three more foster home placements. While in foster care he received early intervention and therapeutic services. Therapeutic services partially focused on his concerns about his mother's death and his inappropriate behaviors. Based on records reviewed, it appears that his behavior began to deteriorate in 2003. He repeatedly left school grounds without permission and his negative behavior resumed and even escalated at school and at home. The foster mother reported that the decedent's inappropriate behavior increased when he was afraid, confused or stressed. His social worker observed that when he was not concerned with placement and family visitation issues he appeared more stable. The worker attributed his escalating behavior problems to relative's failure to assume legal guardianship of him and the foster mother's failure to follow through with his adoption. His most recent diagnosis was Oppositional Defiant Disorder, Reactive Attachment Disorder, and Attention Deficit and Hyperactive Disorder. He was in the 4th grade and was enrolled in a Maryland school at the time of his death. Although he had been in a special education program during his earlier academic history, he was not enrolled in a special education program at the time of his death. It was noted in records that despite his acting out behavior and problems with social skills, he was academically able to maintain an average level of functioning. One day after his death, the decedent was scheduled to see his psychiatrist, to address his escalating and uncontrollable behaviors.

Cause/Manner of Death: Multiples Injuries to Head/Accident

- ◆ Eight (53%) of the 15 accidental deaths from 2004 involved children/youth known to the child welfare system. Four of these deaths resulted from motor vehicle accidents, three from house fires and one as a result of a television falling on a 23 month old child. Caregiver negligence was determined to be a contributing factor in one of the accidental deaths and victim/driver negligence in the other.
- ◆ The manners of five child welfare deaths were "Undetermined". In one case, both the cause and manner were undetermined and in four cases the cause was determined to be "Sudden Unexplained Infant Death", with two cases involving issues of co-sleeping.

Health/Mental Health of Decedents

- ◆ Seventeen 2004 decedents (29%) had diagnosed chronic health problems/congenital anomalies or physical/developmental disabilities. Some of the health problems included Asthma, Sickle Cell, Diabetes, heart and respiratory disorders, allergies and HIV. One child was mentally retarded.
- ◆ Five of the 2004 decedents had diagnosed mental illnesses.
- ◆ One third of the 2004 child welfare youth 13 years of age or older had histories of drug use (n = 10). Three of the children under one year of age were born substance exposed in utero.

Educational Level of Decedents

- ◆ Over half (n = 36, or 62%) of the 2004 decedents were school age (age 5 to 21 years). Sixty-one percent of these children/youth were over 14 years of age (n = 22) and four were over 18 years of age. The educational levels (last grade completed) for the children/youth over the age of 14 ranged from 7th through the 12th grades. However, at the time of their deaths, only one youth had graduated from high school.
- ◆ Nine 2004 school age decedents were enrolled in special education or alternative programs.

Number and Reasons for Child Protection Services Referral

- ◆ The majority of the 2004 families referred to the child welfare system were reported multiple times (n = 31, or 53%). The number of reports ranged from one to 26, with an average of four reports per family.
- ◆ In over half of the child welfare fatalities, the decedents were part of the cases (n = 37, or 64%).
- ◆ Based on the last child abuse/neglect reports received, the primary reason for families being referred was “general neglect”. Thirty (52%) families were reported for general neglect issues. Physical abuse ranked second to neglect reports (n = 16).
- ◆ Based on the outcome of the intake investigations, allegations on at least one of the reports of suspected abuse and/or neglect were supported and the case was opened by intake in over 80% of the cases (n = 47).

Case Status

- ◆ At the time of death, 25 (43%) of the 2004 child welfare fatalities were families with active cases. The remaining cases had closed within four years prior to the death, with 13 closures occurring within one year prior to the death.
- ◆ Some of the reasons for case closure included the decedent aging out, adoption finalized, parental care improved, children placed with a relative, family referred for community services, the family failed to follow through with services, the whereabouts of decedent unknown or in abscondence or the last report was unsupported/inconclusive.

Family Characteristics

- ◆ The average age of the mothers known to the child welfare program of where age was known (n = 57) was 35 years.
- ◆ Of the 58 mothers, most were single and had never been married (n = 50). Six of the mothers were married and four of these women were married to the decedents' fathers.

- ◆ Thirty-two of the 45 mothers whose employment history was known were unemployed at the time of the death.
- ◆ Three of the 58 mothers known to the child welfare program were deceased.
- ◆ Of the 43 cases in which substance abuse history was known, 24 had documented problems with drug and/or alcohol use (56%).
- ◆ Eight mothers had prior involvement with the criminal justice system.
- ◆ Eight of the 2004 child welfare fatalities documented chronic mental health issues of the mother as a problem.
- ◆ The majority of the decedents had surviving siblings ($n = 50$, or 86%). The number of siblings ranged from one to twelve, with an average number of three siblings. Two of the decedents were twins and both twins of one family were 2004 fatalities. One of the 2004 child welfare decedents had two prior sibling deaths.

"A 2004 Death of Child Known to Multiple Public Service Agencies"

On an autumn day in 2004, at approximately 12:41 AM, a 911 call was made reporting an unconscious child. The Fire Department dispatched several units to the scene. MPD also responded to the scene and discovered a 3 month old African American female infant not breathing with dried blood around her mouth and nose and on the left side of her cheek. The teenage mother reported to medics that she found her baby not breathing; down time was unknown. The mother denied a history of allergies or medications and indicated that the baby had no complications at birth. The medics assessed the patient and began resuscitation efforts and transport to the hospital. The hospital was notified of a priority 1 transport. Despite aggressive life saving efforts that continued at the hospital, the infant died shortly after arrival and the child was transported to the OCME for autopsy. The physician reported that the child had no marks or bruises on her body. The decedent's pupils were clear; and there appeared to be no signs of head trauma. It was also reported that the child's temperature at the time of arrival was 36 degrees. Hospital records indicated that the mother reported that a person in the household "was shaking the baby and the baby was unresponsive." The decedent's great aunt reported that she attempted to give the baby CPR but got no response. The mother reported to MPD, that the child was placed in her bed at approximately 11:00 PM by one of her cousins. She stated that a short time later, the same cousin went into the room where the decedent was placed and was the first to notice that the decedent wasn't breathing. The mother went into her aunt's room and they both returned and found the child cold and not breathing. The aunt stated to MPD that she carried the child to her bedroom and proceeded to give her CPR. She indicated that when she would blow into the child's mouth, blood like fluid emitted from her mouth. The mother reported that the decedent was healthy but that she had a fever approximately 2 weeks prior to her death. She indicated that the child was taken to a local pediatric hospital for the fever and was taken for a wellness visit approximately one month prior to the death.

The home where the fatal event occurred belonged to a relative who did not live in the home. The scene was described by investigators as a 3 bedroom row house with a basement and enclosed rear porch. The incident occurred in the upstairs bedroom directly at the top of the stairs. The room consisted of a bed and a child bassinet. The investigative report describes the entire home as "filthy with exposed trash and food about the entire house". The home was infested with an "assortment of bugs and insects" and was also "infested with large rats." Several dangerous electrical outlets, which were overloaded, were also observed. In the basement, a propane burner/turkey fryer was next to a full size bed. There were large rat holes about the walls and steps. The home was occupied with 14 children and 8 adults. Six or 7 of the children were found sleeping "like puppies" on a mattress on the floor. When the children were removed, the detectives discovered a fifty-year-old mentally challenged male sleeping underneath a pile of soiled clothing. Additionally, the aunt reported that earlier in the day, another child (relationship unknown), who is mentally challenged, babysat for the decedent and during that time, the aunt was not home nor was adult supervision provided.

The death of this African American infant unfolded a very complicated history that involved multiple families who were involved with multiple agencies and programs for over 2 decades in the District and other states. According to research with the public assistance and child welfare program, the matriarch of the family had 10 children. At least 7 of her children had between 2 and 8 children. Further investigation of all the families noted previous and extensive histories of multiple complex problems, including medical, psychological, financial, criminal, and child neglect and abuse. Further investigations also revealed long histories of contacts with the District's child welfare, health, educational, criminal justice and public assistance systems for all the above families. The majority of the referrals to the child welfare system mirrored the problems found in the home at the time of the death: inadequate, unsafe and overcrowded living conditions, child sexual abuse, general neglect, lack of supervision, and unaddressed learning disabilities. The majority of the family members received SSI. There was also documentation that several of the adult males and females in the families had criminal backgrounds that included incarcerations.

Cause/Manner of Death: Undetermined/Undetermined

Appendices

2004 CFRC RECOMMENDATIONS

RECOMMENDATIONS

Policy and Practice Standards

Department of Mental Health (DMH) should take the lead in establishing guidelines for conducting mental health screenings/assessments and aggressively diagnosing and treating youth in the juvenile justice system.

Department of Youth and Rehabilitation Services (DYRS) should establish a practice of creating transitional plans for youth who are "aging out" or whose commitments have expired, that include vocational training, life skills, independent living, etc., and ensure that they are connected to these resources prior to leaving the juvenile system.

Child and Family Services Agency (CFSA) and other family serving government agencies/ programs should collaborate with the DOH (DOH) to incorporate health education, counseling, and services related to family planning, pre-conception health care, prenatal, post-natal, newborn/pediatric care, and when applicable, drug abuse interventions into their case management or family service plans.

CFSA should establish a practice/protocol that requires the agency to contact the state of destination when the physical custody of a child for whom there is an active investigation/case is being transferred to a relative or third party caregiver in another jurisdiction.

Fire and Emergency Medical Services Department (FEMSD) should collaborate with all District agencies that provide services to families and children (CFSA, DMH, DOH and DHS) should establish a practice of referring siblings of "fire setters" and children surviving fires to the District's Fire Setters Program.

Office of the Chief Medical Examiner (OCME) should ensure that viral tests are a routine part of the autopsy process for infants when circumstances are suggestive of an infectious process and a bacterial etiology cannot be identified.

Existing Service Improvements and Expansions

DOH, FDEMSD and DC Housing Authority (DCHA) should take immediate steps to address the problems associated with delays in pronouncing decedents, including:

- Legally authorizing and training emergency medical services staff, as first responders to the scene, to pronounce;
- Developing protocols/criteria that clarifies when a child should be pronounced on the scene or be taken to the hospital for pronouncement; and
- Enforcing hospitals' requirement to pronounce.

DOH in collaboration with local hospital associations and hospitals should develop standards of care for discharging and providing ongoing medical treatment/follow-up of infants who are born addicted or drug exposed that include:

- Guidelines for identification of symptoms/signs of withdrawal and other medical/developmental problems that should be monitored as a part of routine well child pediatric care;
- Development or identification of state of the art treatment programs/techniques to treat the unique neurological needs of drug exposed infants, including massage and other sensory approaches; and
- Guidelines for identification of indicators for referring families for home nursing, community support, parenting and/or child welfare intervention.

DOH, Addiction Prevention and Recovery Administration (APRA) should evaluate/investigate the current

methods of distributing methadone to ensure consistency with the strict requirements for other controlled substances, including the dosage and quantity distributed.

DOH (APRA, Maternal and Family Health Administration and Medical Assistance Administration) in collaboration with CFSA should develop strategies related to better integrated service planning for mothers and children who are mutually served by these agencies, including better coordinated home visits to ensure that the home environment is stable for infants and children whose parents are substance abusers.

DC Public School (DCPS) and the Metropolitan Police Department (MPD) should strengthen current partnerships with all schools including clear delineation of roles and responsibilities and better identification of student protection and safety protocols for critical incidences. Given the known high degree of gang and drug activity among youth/student populations, plans should include police coverage of special activities, identification of the parameters of police/security coverage; and appropriate (confidential) documentation and follow-up for students identified as at risk for violence, etc.

DCPS in collaboration with the Office of Attorney General (OAG), CFSA and Court Social Services Division (CSSD) should develop stronger working relationships and formal guidelines with reporting protocols to address the persistent problem of truancy and educational neglect. The guidelines/protocols should include clearly identified triggers for referral for school-based intervention, reporting educational neglect (CFSA), and for truancy court (CSSD).

Department of Corrections (DOC) in collaboration with DOH should assess and improve the quality of medical care provided to incarcerated women to ensure that a range of services are available, including routine and comprehensive medical assessment and treatment; prenatal and post-partum care; birth control/family planning; and HIV/STD treatment/monitoring. Services should be provided based on a comprehensive plan and standards of care.

The Deputy Mayors for Child, Youth, Families and Elders and Public Safety and Justice, in collaboration with appropriate District Agencies (OAG, DHS, CFSA, DMH and DOH) should establish a city-wide plan of services to comprehensively address the problems associated with domestic violence, including:

- The establishment of an office/program to focus on providing comprehensive and coordinated services to victims of domestic violence;
- The identification of appropriate resources and services that support and protect victims of domestic violence;
- The development of a screening tool to assist in identifying signs of domestic violence and protocols requiring broad use throughout public service agencies that have direct contact with families/children, i.e., IMA, CFSA, DYRS, RSA, MRDDA, FSA, etc.;
- The identification of legal barriers to ensure better protection of victims and prosecution of perpetrators; and
- The establishment of an ongoing public education campaign to increase awareness of the issues of domestic violence and how to seek assistance.

Training and Public Education

DMH should educate the community on depression, the resources available, and the process for obtaining emergency mental health services

The Mayor's Committee on Child Abuse and Neglect (MCCAN), DC Children's Trust Fund, in partnership with CFSA should develop a full-scale, aggressive public education campaign:

- To provide education and outreach that specifically focuses on the non-mandated reporters (general public) regarding signs of abuse and neglect; the importance of reporting and the potential outcome of not reporting.
- To educate parents on responsible measures that can be taken when they are unable to care for their child and the responsible community resources that are available, i.e., respite, day care, safe havens, CFSA, etc.

FEMSD should provide more public service announcements (radio and TV) on appropriate safety and

evacuation tips when a fire is discovered in the home.

DCPS should ensure that fire safety education is available for all grades in school settings.

DOH should work with local birth hospitals and the American Academy of Pediatrics to discuss the high number of decedents who were co-sleeping at the time of their deaths and the need to educate new parents about the potential dangers and associated risk factors and provide information on how to safely co-sleep.

DOH, APRA should establish and implement a comprehensive training curriculum that mandates initial and ongoing training for all case managers. Training should include minimum standards/requirements for case management practice; prevention and treatment interventions; relevant laws, policies and practice standards related to treatment of addicted individuals, full coordination of individualized service plans and mandatory child abuse and neglect reporting requirements.

Legislative and Regulatory Improvements

DYRS should acquire legal input and develop or clarify policy related to the determination of the following:

- Rights of parents to refuse essential recommended health and mental health treatment/medication of juveniles who are committed wards; and
- Rights of committed juveniles to accept or refuse recommended psychotropic medication.

DYRS should acquire legal input and develop or clarify policy related to the determination of the following:

- Rights of parents to refuse essential recommended health and mental health treatment/medication of juveniles who are committed wards; and
- Rights of committed juveniles to accept or refuse recommended psychotropic medication.

Resource Development

DHS, Family Services Administration (FSA), Emergency Shelter Program should increase the number of shelter programs in the District that are designed to specifically address the needs of homeless families. Additionally, FSA should enhance services/practices to residents of these shelters to include the following:

- Collaboration with DOH to ensure the provision of routine education to mothers regarding appropriate sleeping positions environments for infants and children, highlighting SIDS and other risk factors;
- Provision of and monitoring the use of cribs;
- Collaboration with DOH to develop and implement protocol/practice that requires a nurse to provide routine assessments, immunizations and referrals for pediatric care. Protocol should include the performance of assessments within a reasonable time period after arrival at the shelter;
- Collaboration with DHS, Early Intervention Program/Child Find to provide developmental assessments and, when applicable, enrollment in Healthy Start or daycare; and
- Collaboration with the DMH to provide assessments and referrals for depression and domestic violence, and to provide anger management intervention and stress reduction strategies for residents and staff.

DOC in collaboration with CFSA, Greater Southeast Community Hospital and DOH should develop a Memorandum of Understanding to address the comprehensive planning needs of incarcerated pregnant women and their infants; including, referral to appropriate community resources when they are released during pregnancy, planning for the custodial care and concrete needs of the infant when they will remain incarcerated after delivery. This MOU should identify rules and responsibilities for all (agency) partners.

DCPS should reinstate the Attendance Officers positions at all schools to ensure appropriate individualized service planning for students with attendance problems and their families.

APPENDIX B

XLVI. CHILD FATALITY REVIEW COMMITTEE

Sec. 4601. Short title.

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

Sec. 4602. Definitions.

For the purposes of this title, the term:

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

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

Sec. 4603. Establishment and purpose.

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

(b) The Committee shall:

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

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

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

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

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

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

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

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

(1) Department of Human Services;

(2) Department of Health;

(3) Office of the Chief Medical Examiner;

(4) Child and Family Services Agency;

(5) Metropolitan Police Department;

(6) Fire and Emergency Medical Services Department;

(7) D.C. Public Schools;

(8) Department of Housing and Community Development; and

(9) Office of Corporation Counsel

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

(1) Superior Court of the District of Columbia;

(2) Office of the United States Attorney for the District of Columbia;

(3) District of Columbia hospitals where children are born or treated;

(4) College or university schools of social work, and

(5) Mayor's Committee on Child Abuse and Neglect.

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

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

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

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

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

Sec. 4605. Criteria for case review.

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

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

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

- (1) Multidisciplinary review of individual fatalities;
- (2) Multidisciplinary review of clusters of fatalities identified by special category or characteristic;
- (3) Statistical reviews of fatalities; or
- (4) Any combination of such approaches.

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

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

- (1) Those children known to the juvenile justice system;
- (2) Those children who are known to the mental retardation/developmental disabilities system;
- (3) Those children for which there is or has been a report of child abuse or neglect concerning the child's family;
- (4) Those children who were under the jurisdiction of the Superior Court of the District of Columbia (including protective service, foster care, and adoption cases);
- (5) Those children who for some other reason, were wards of the District and
- (6) Medical Examiner Office cases.

Sec. 4606. Access to information.

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

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

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

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

(4) Information made confidential by section 20 of the Vital Records Act of 1981, effective October 8, 1981 (D.C. Law 4-34; D.C. Official Code § 7-219); section 512 of the Mentally Retarded Citizens Constitutional Rights and Dignity Act of 1978, effective March 3, 1979 (D.C. Law 2-137; D.C. Official Code § 7-1305.12); section 302 of the District of Columbia Mental Health Information Act of 1978, effective March 3, 1979 (D.C. Law 2-136; D.C. Official Code § 7-1203.02); section 203 of the Prevention of Child Abuse and Neglect Act of 1977, effective September 23, 1977 (D.C. Law 2-22; D.C. Official Code § 4-1302.03); section 306 of the Prevention of Child Abuse and Neglect Act

of 1977, effective October 18, 1979 (DC Law 3-29; D.C. Official Code § 4-1303.06); section 28 of the Health Maintenance Organization Act of 1996, effective April 9, 1997 (D.C. Law 11-235; D.C. Official Code § 31-3426); and D.C. Official Code §§ 16-2331, 16-2332, 16-2333, and 16-2335.

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

(c) Notwithstanding subsection (a)(1) of this section, information and records concerning a current law enforcement investigation may be withheld, 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 Counsel or his or her designee in the name of the District of Columbia. Subject to the availability of an appropriation for this purpose, any fines collected pursuant to this section shall be used by the

Committee to fund its activities.

Sec. 4612. Persons required to make reports; procedure.

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

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

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

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

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

Sec. 4613. Immunity from liability for making reports.

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

Sec. 4614. Failure to make report.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 4621. Fiscal impact statement.

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

CFRC Goals, Objectives and Operating Process

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

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



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

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

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

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

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

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

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

Review Participants

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

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



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

The Review Meeting

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

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

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

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

APPENDIX D

2004 Calendar Year Fatality Listing

<i>Years/Months/Days</i>	<i>Cause of Death</i>	<i>Manner of Death</i>
0/0/0	Prematurity @ 17 weeks due to prolonged premature rupture of membranes due to preterm labor of unknown etiology	Natural
0/0/0	Prematurity due to maternal acute chorioamnionitis and funisitis due to maternal incompetent cervix	Natural
0/0/0	Extreme prematurity @ 22 weeks due to premature rupture of membranes due to maternal cervical incompetence	Natural
0/0/0	Preterm labor, previable fetus via vaginal delivery due to unknown etiology	Natural
0/0/0	Extreme prematurity @ 21 weeks due to maternal essential severe hypertension and end stage renal disease	Natural
0/0/0	Hypoplastic left heart syndrome	Natural
0/0/0	Bilateral pulmonary hypoplasia due to bilateral pleural effusion due to abdominal ascites, etiology unknown	Natural
0/0/0	Extreme prematurity @ 21 weeks, non-viable fetus due to preterm labor due to twin gestation	Natural
0/0/0	Prematurity of unknown etiology	Natural
0/0/0	Cardio-respiratory failure and arrest due to multi-system failure due to extreme prematurity @ 22 weeks due to abruptio placentae	Natural
0/0/0	Extreme prematurity @ 22 weeks due to preterm labor of undetermined etiology	Natural
0/0/0	Non-viability @ 18 weeks gestation due to substance abuse	Natural
0/0/0	Extreme prematurity @ 21 weeks, non-viable fetus due to preterm labor due to twin gestation	Natural
0/0/0	Extreme prematurity due to prolonged premature rupture of membranes, etiology unknown	Natural
0/0/0	Spontaneous premature birth @ 21-23 weeks gestation due to maternal acute chorioamnionitis	Natural
0/0/0	Cardio-respiratory failure and arrest due to multi-system failure due to immaturity @ 22 weeks	Natural
0/0/0	Previa due to extreme prematurity due to preterm labor due to premature rupture of membranes of undetermined etiology	Natural
0/0/0	Previa due to unknown etiology	Natural
0/0/0	Severe prematurity due to premature aminorrhexis due to bacterial infection due to trichomoniasis	Natural
0/0/0	Extreme prematurity @ 22 weeks	Natural
0/0/0	Prematurity due to sepsis due to maternal premature rupture of membranes due to multi-gestation pregnancy	Natural
0/0/0	Respiratory failure following spontaneous premature delivery @ 22 weeks gestation due to maternal chronic substance abuse	Natural
0/0/0	Severe prematurity, gestational age 22.5 weeks due to maternal incompetent cervix	Natural
1 Day	Pulmonary hypoplasia due to oligohydramnios	Natural
1 Day	Respiratory distress syndrome due to prematurity @ 24 weeks due to preterm labor and delivery of undetermined etiology	Natural
1 Day	Massive pneumopericardium due to pneumomediastinum eventration due to right hemidiaphragm	Natural
1 Day	Complications of prematurity due to preterm delivery of twin gestation with maternal cervical incompetence	Natural
2 Days	Multi-organ failure due to birth asphyxia due to maternal cardiorespiratory arrest due to hypertensive and arteriosclerotic cardiovascular disease	Natural
3 Days	Trisomy 13	Natural
4 Days	Perinatal asphyxia due to rupture of the maternal uterus due to complications of vaginal birth after cesarean section	Natural
4 Days	Pulmonary congestion due to aspiration of meconium	Natural
5 Days	Septic shock due to group B beta streptococcal sepsis	Natural
8 Days	Severe hydrocephalus of unknown etiology	Natural
15 Days	Cardiorespiratory failure and arrest due to multi-system failure and disseminated intravascular coagulation due to sepsis and necrotizing enterocolitis	Natural

15 Days	Necrotizing enterocolitis due to prematurity due to placenta abruption	Natural
15 Days	Intestinal perforation due to extreme prematurity @ 24 weeks gestation	Natural
16 Days	Bacterial sepsis of newborn, unspecified due to neonatal cardiac failure	Natural
17 Days	Hyperkalemia due to necrotizing enterocolitis due to prematurity @ 30 weeks gestation due to twin gestation	Natural
20 Days	Sepsis due to necrotizing enterocolitis due to prematurity of unknown etiology	Natural
21 Days	Septic shock due to systemic candidiasis with meningitis due to extreme prematurity due to twin gestation with preterm labor	Natural
28 Days	CV collapse due to sepsis	Natural
29 Days	Multi-organ dysfunction syndrome due to hypoplastic left heart syndrome	Natural
1 Month 2 Days	Severe micro-encephaly due to hepto-splenomegaly due to congenital anomalies of unknown etiology	Natural
1 Month 5 Days	Sudden death in infancy with pancreatic cysts	Natural
1 Month 5 Days	Sudden Infant Death Syndrome	Natural
1 Month 11 Days	Cardiopulmonary arrest and cardiovascular collapse due to chronic renal failure due to posterior urethral valves	Natural
1 Month 12 Days	Sudden unexpected infant death	Undetermined
1 Month 14 Days	Bronchopulmonary dysplasia due to extreme prematurity	Natural
1 Month 14 Days	Complex congenital heart disease	Natural
1 Month 17 Days	Unknown	Unknown
1 Month 18 Days	Undetermined	Undetermined
1 Month 26 Days	Sudden unexpected infant death while co-sleeping with adult and with inappropriate bedding for an infant	Undetermined
2 Months	Sudden unexpected infant death	Undetermined
2 Months 2 Days	Sudden infant death associated with co-sleeping	Undetermined
2 Months 11 Days	Necrotizing enterocolitis totalis due to sepsis	Natural
3 Months	Probable viral pneumonia, etiologic agent undetermined	Natural *
3 Months 2 Days	Chronic multi-focal atrial tachyarrhythmia due to hypoplastic left heart syndrome	Natural
3 Months 23 Days	Liver failure due to necrotizing enterocolitis due to sepsis and septic shock due to bronchopulmonary dysplasia due to extreme prematurity	Natural
3 Months 28 Days	Sudden Infant Death Syndrome	Natural
4 Months	Sepsis due to fungus due to extreme prematurity	Natural
4 Months	Sudden unexpected death in infancy	Undetermined
4 Months	Bronchopulmonary dysplasia due to liver failure and bowel resection due to necrotizing enterocolitis due to extreme prematurity	Natural
4 Months 15 Days	Complications for the treatment of pulmonary sling due to anomaly and tracheal stenosis	Natural
4 Months 26 Days	Sudden unexpected death in infancy	Undetermined *
6 Months 27 Days	Cardiorespiratory arrest due to trisomy 13	Natural
9 Months	Blunt impact head trauma with fracture of skull, epidural and subdural hemorrhage in the longitudinal sulcus, brain contusion	Homicide
9 Months	Meningitis due to septicemia due to premature birth	Natural
10 Months 25 Days	Methadone intoxication	Homicide
1 Year 17 Days	Multiple blunt impact injuries	Homicide
1 Year 8 Months	Seizure disorder with pneumonia and otitis media due to premature birth of undetermined etiology	Natural
1 Year 10 Months	Blunt impact head trauma	Accident
2 Years	Undetermined	Undetermined
2 Years	Asphyxia (according to Arizona)	Homicide *
2 Years	Pulmonary hemorrhage due to acute myeloblastic leukemia	Natural
4 Years	Complications of inhalation of products of combustion	Accident
4 Years	Multiple blunt trauma	Homicide
5 Years	Blunt impact head trauma including skull fracture subdural subarachnoid hemorrhage, contusions and edema of brain	Accident
5 Years	Asphyxia due to soot and smoke inhalation	Accident
7 Years	Complications of inflicted head trauma	Homicide *
7 Years	Thermal injuries and soot and smoke inhalation	Accident *
8 Years	Carbon monoxide intoxication	Accident
8 Years	Pneumocystosis carinii pneumonia and respiratory syncytial virus infection due to acquired immune deficiency syndrome	Natural
8 Years	Cardiomyopathy due to chronic rejection (history of cardiac transplant) due to pulmonary atresia with intact ventricular septum	Natural

8 Years	Acute lymphoblastic leukemia	Natural
8 Years	Gunshot wound to head with perforation of brain	Homicide
9 Years	Multiple injuries	Accident *
10 Years	Acute exacerbation of bronchial asthma	Natural
10 Years	Acquired immune deficiency syndrome due to mycobacterium avium intracellular infection due to parenteral nutrition dependent due to possible broncho spasm	Natural *
11 Years	Asphyxia due to smoke and soot inhalation	Accident
11 Years	Bone marrow embolization into lungs complicating posterior spine due to arthrodesis procedure performed for treatment of scoliosis	Natural
12 Years	Saccular aneurysm of the right posterior cerebral artery with subarachnoid hemorrhage	Natural
13 Years	Smoke inhalations and thermal injuries	Accident *
13 Years	Gunshot wound to chest and left arm	Homicide *
13 Years	Blunt impact trauma to torso and head	Accident
14 Years	Gunshot wounds to neck and chest with injury to spinal cord, lung and heart	Homicide
14 Years	Diabetic ketoacidosis due to insulin dependent diabetes mellitus	Natural
14 Years	Recurrent pneumonia and aspiration due to long standing encephalopathy due to human immune deficiency disease	Natural
14 Years	Complications of brainstem glioma	Natural
14 Years	Multiple gunshot wounds	Homicide *
14 Years	Multi-organ failure due to graft versus host disease due to acute myeloid leukemia	Natural
14 Years	Severe chronic bronchial asthmatic changes with acute exacerbation	Natural
15 Years	Cardiogenic shock due to pulmonary edema due to mediastinal large B cell lymphoma with metastasis	Natural
15 Years	Gunshot wound to head	Homicide
15 Years	Gunshot wound to back injuring lung and vasculature	Homicide
15 Years	Gunshot wounds to head and neck	Homicide
15 Years	Gunshot wound to head perforating brain	Homicide
15 Years	Multiple injuries to head, torso and extremities (from car accident)	Homicide *
15 Years	Cardiomyopathy, idiopathic	Natural
15 Years	Gunshot wound to head with penetration of brain	Homicide *
16 Years	Multiple gunshot wounds	Homicide *
16 Years	Multiple gunshot wounds	Homicide
16 Years	Gunshot wounds to head perforating brain	Homicide
16 Years	Gunshot wound to chest perforating lungs, vena cava, bronchus and aorta	Homicide
16 Years	Gunshot wound of head perforating major blood vessels	Homicide
16 Years	Multiple gunshot wounds and stab wounds	Homicide
16 Years	Gunshot wound to head perforating brain	Homicide
16 Years	Blunt impact torso trauma	Accident
16 Years	Gunshot wounds to head and chest	Homicide
17 Years	Multiple gunshot wounds	Homicide *
17 Years	Multiple gunshot wounds	Homicide
17 Years	Gunshot wound of head injuring brain and brainstem	Homicide
17 Years	Gunshot wounds to torso and extremities perforating heart	Homicide
17 Years	Respiratory failure, pneumonia	Natural
17 Years	Gunshot wounds of head, right shoulder, right hip and right thigh	Homicide
17 Years	Gunshot wound to head penetrating brain	Homicide
17 Years	Multiple blunt impact injuries head, chest and abdomen	Homicide
17 Years	Gunshot wound to back perforating lung and arm	Homicide
17 Years	Gunshot to head perforating the brain	Homicide
17 Years	Head injuries with complications	Accident *
18 Years	Gunshot wound to pelvis injuring iliac vessels with exsanguination	Homicide
18 Years	Chronic cor pulmonale due to pulmonary hypertension due to multiple small pulmonary embolism due to deep vein thrombosis due to sickle cell anemia	Natural
18 Years	Multiple gunshot wounds	Homicide *
18 Years	Blunt impact head, torso and extremity trauma	Accident
18 Years	Gunshot wound to chest perforating heart and aorta injuring lungs and spinal cord	Homicide
18 Years	Gunshot wound of neck with injuries to the cervical spinal cord, the left carotid artery and left jugular vein	Homicide
18 Years	Gunshot wounds to torso and upper extremities	Homicide
18 Years	Multiple blunt impact injuries of head, chest and abdomen	Homicide
18 Years	Gunshot wound to chest	Homicide
18 Years	Gunshot wound of chest perforating left lung and aorta	Homicide

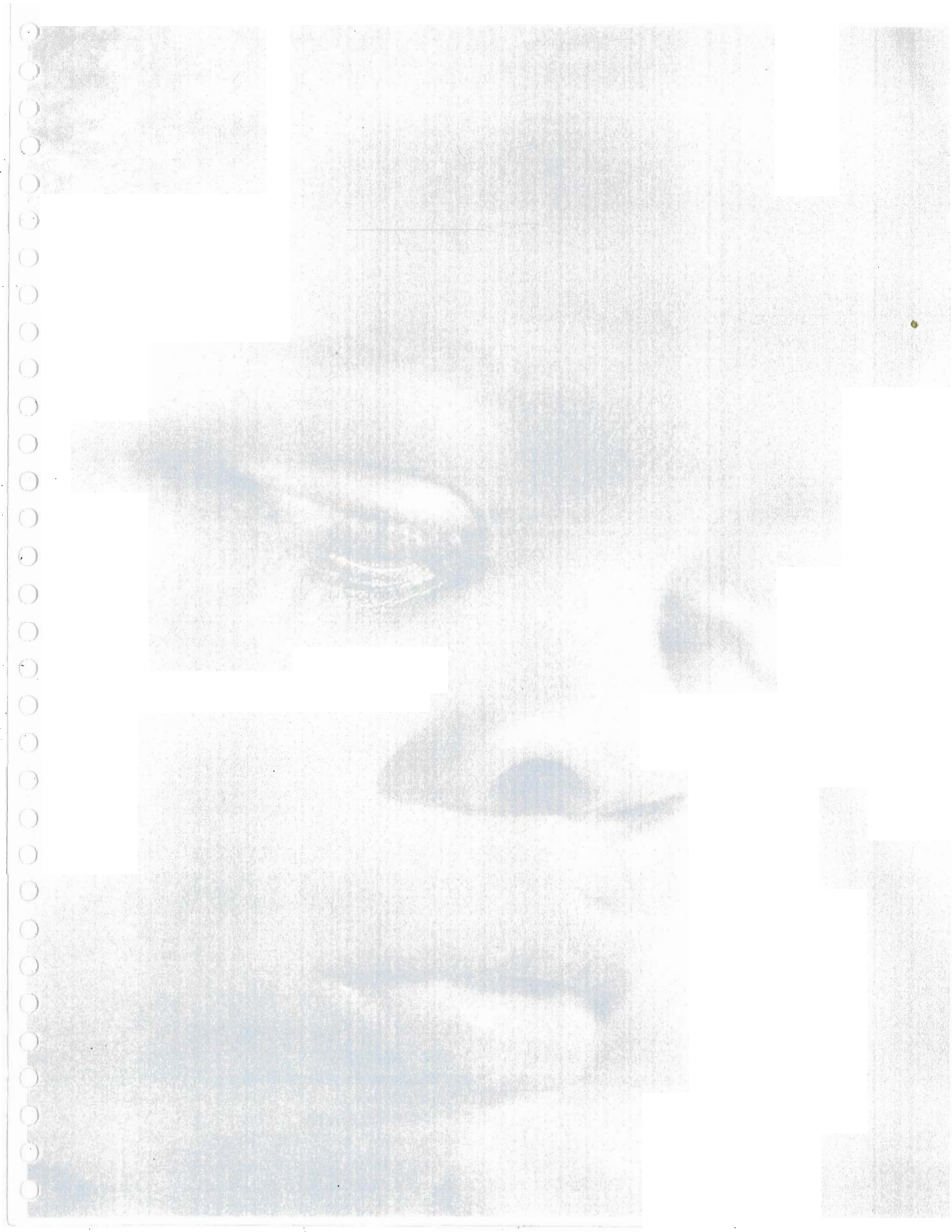
18 Years	Gunshot wound to torso with injuries to spinal cord, right lung and superior vena cava	Homicide
18 Years	Multiple injuries	Accident *
19 Years	Multi-organ failure due to septic shock associated with urinary tract infection	Natural
19 Years	Gunshot wound of torso perforating lungs and lacerating aorta	Homicide
19 Years	Gunshot wound to chest with perforation of aorta, lung and spinal cord	Homicide
19 Years	Gunshot wounds to back	Homicide
19 Years	Gunshot wound to head with perforation of brain	Homicide
19 Years	Gunshot wound of head penetrating brain	Homicide
19 Years	Multiple gunshot wounds	Homicide *
20 Years	Multiple gunshot wounds injuring major blood vessels, right lung, liver, gastrointestinal tract and bladder	Homicide
20 Years	Acute Leukemia	Natural
21 Years	Gunshot wound to chest perforating heart and aorta	Homicide
21 Years	Multiple blunt impact trauma	Accident
21 Years	Gunshot wounds to torso	Homicide
22 Years	Gunshot wound to neck with perforation to carotid artery and lung	Homicide
23 Years	Gunshot wounds to head, neck and torso	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 unwavering dedication to achieving our common goal. A special thanks is extended to the community volunteers who continue to serve the citizens of the District throughout every aspect of the child fatality review process.



GOVERNMENT OF THE DISTRICT OF COLUMBIA, OFFICE OF THE CHIEF MEDICAL EXAMINER
CHILD FATALITY REVIEW COMMITTEE (CFRC)

1910 MASSACHUSETTS AVENUE, S.E. ♦ BUILDING 19 ♦ SUITE 212

WASHINGTON, D.C. 20003

TELEPHONE 202-698-9099 ♦ FAX 202-698-9108

♦ FOR ADDITIONAL COPIES OF THE ANNUAL REPORT, CONTACT CFRC ♦