DISTRICT OF COLUMBIA GOVERNMENT
OFFICE OF THE CHIEF MEDICAL EXAMINER

CHILD FATALITY REVIEW COMMITTEE

2015 ANNUAL REPORT

DISTRICT OF COLUMBIA
CHILD FATALITY REVIEW COMMITTEE
2015 ANNUAL REPORT

PRESENTED TO:

THE HONORABLE MURIEL BOWSER, MAYOR, DISTRICT OF COLUMBIA

THE COUNCIL OF THE DISTRICT OF COLUMBIA
AND
THE RESIDENTS OF THE DISTRICT OF COLUMBIA

DECEMBER 2016

DISTRICT OF COLUMBIA
CHILD FATALITY REVIEW COMMITTEE
2015 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.

CHILD FATALITY REVIEW COMMITTEE MEETING CO-CHAIRS

ROGER A. MITCHELL, JR. MD FASCP
CHIEF MEDICAL EXAMINER, OCME
CO-CHAIR, CHILD FATALITY REVIEW COMMITTEE

CYNTHIA G. WRIGHT, ESQ.
ASSISTANT US ATTORNEY - HOMICIDE SPECIAL VICTIMS UNIT, USAO
CO-CHAIR, CHILD FATALITY REVIEW COMMITTEE

OFFICE OF THE CHIEF MEDICAL EXAMINER FATALITY REVIEW UNIT

JENNA BEEBE-ARYEE, MSW
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JACQUELINE CORBIN-ARMSTRONG, MSW, MSM
FATALITY REVIEW PROGRAM SPECIALIST

ANDRE MULLINGS
OUTREACH PROGRAM SPECIALIST

TOYA BYRD
STAFF ASSISTANT

SIDONIE HEUMEN, MSN
STAFF ASSISTANT

DISTRICT OF COLUMBIA
CHILD FATALITY REVIEW COMMITTEE
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GREETINGS FROM THE CHIEF MEDICAL EXAMINER
ROGER A. MITCHELL JR., MD

Over the last year, the Child Fatality Review Committee CFRC) and the Fatality Review Unit at the Office of the Chief Medical Examiner remained focused on improving the Fatality Review Process. We have been successful in obtaining $100,000 in grant funding dedicated to supporting this critical work. Our grant programs in 2015 focused on the hiring of an Outreach Specialist who is dedicated to interfacing with the public surrounding the committee and our findings.

We are excited about the progress we are making! Our role as the Medical Examiner is not limited to the determination of cause and manner of death. Equally as important is the work we do within our fatality review committees. The Child Fatality Review Committee is committed to developing systemic recommendations that can be used to inform evidence-based programs and policy.

This report is intended to provide a snap shot into the deaths of District of Columbia children and infants. The analysis of mortality data and the recommendations contained within this report are critical to understanding risk factors surrounding preventable deaths of the children who reside in the District of Columbia.

Thank you to the membership of the CFRC, participant Agencies and Community Members who contributed to this report. We will continue to serve as a voice for those lost, while working toward sustainable system change.

Yours in Truth and Service,

Roger A. Mitchell, Jr. MD
Chief Medical Examiner
District of Columbia Office of the Chief Medical Examiner
Co-Chair – Child Fatality Review Committee

CYNTHIA G. WRIGHT, ESQ., CFRC CO-CHAIR

I am thrilled to share that the vitality of the Child Fatality Review Committee (CFRC) has been greatly enhanced through *improved* case reports produced by the D.C. Medical Examiner's office and the *improved* attendance and participation by all Committee members.

The coordination of the monthly meetings by OCME's fatality review staff lend to a more reflective and comprehensive synopsis of all aspects surrounding a child's death. We have embraced technology and are now reviewing reports through our secure web portal in advance of the meetings. This provides all Committee agencies charged with the welfare, education and protection of children the opportunity to carefully evaluate where there may have been systemic failures which could have been corrected. The strong reports have been used effectively by our dedicated and faithful Committee members, who graciously manage to take time from their busy schedules to review reports, research facts in advance of the meetings, and thoughtfully make recommendations for wide-spread improvements to all systems involved with protecting our children. Hopefully, the CFRC's case reviews will help to eliminate all unnecessary child deaths. We are all committed to educating our communities through the education of safe sleep practices, proper utilization of car seats, and keeping our children and youth safe from gun violence and substance abuse.

Additionally, one of the greatest benefits of the Committee is the chance to "network" with individuals genuinely concerned about the welfare of our children and youth who are directly engaged in the day-to-day advocacy of our most vulnerable residents. These contacts help to build trust and create effective bonds which enable members to exchange critical information and share resources in real time.

I am honored to serve on the Committee and have greatly benefited by learning so much from the awesome, dedicated members of the Committee. Working on this Committee with so many committed professionals restores my hope that by working together, we really can improve the lives of children everywhere and make a difference in our community.

Sincerely,

Cynthia G. Wright

Cynthia G. Wright, Esq.
Assistant U.S. Attorney
District of Columbia –
Homicide Section
Special Victim's Unit
Co-Chair CFRC

DISTRICT OF COLUMBIA
CHILD FATALITY REVIEW COMMITTEE
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DEDICATION

This Annual Report is dedicated to the memory of the children and youth of the District of Columbia who lost their lives due 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 these children, we can succeed in positively affecting the future of our infants, children and youth by reducing the number of preventable deaths and promoting quality of life for all residents.

THE INFANT MORTALITY REVIEW TEAM (IMRT)

Committee members and participants of the IMRT convene on the 1st Tuesday of each month. In 2015, members and meeting participants represented the following District Government agencies, medical providers, and community based organizations:

The American College of Obstetrics and Gynecologist

AmeriHealth Caritas DC

Child and Family Services Agency

Children's National Medical Center

A DC Midwife

Department of Health

Howard University Hospital

March of Dimes

Office of the Chief Medical Examiner

Providence Hospital

Unity Health Care

US Attorney's Office of the District of Columbia

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THE CHILD FATALITY REVIEW TEAM (CFRT)

The CFRT convenes on the 3rd Thursday of each month. In 2015, members represented the following District Government agencies, medical providers and community-based organizations:

AmeriHealth Caritas DC

Center for the Study of Social Policy

Child and Family Services Agency

Children's National Medical Center

DC Fire and Emergency Medical Services

DC Public Schools

Department of Behavioral Health

Department of Health

Department of Health Care Finance

Department of Youth Rehabilitative Services

Howard University School of Social Work

Metropolitan Police Department

Office of the Attorney General

Office of the Chief Medical Examiner

Office of the State Superintendent for Education

Residents of the District of Columbia

Superior Court of the District of Columbia

Superior Court of the District of Columbia's Court Social Services Division

US Attorney's Office for the District of Columbia

THE WORK OF THE CFRC…A CALL TO ACTION

The death of an infant, child or youth resident of the District of Columbia initiates a call to action for District government public safety and human services cluster agencies. The District's child fatality review process is the only formally established mechanism within our city's government for assessing the circumstances surrounding the deaths of infants, children and youth and evaluate associated risk factors. This process assists in identifying family and community strengths, as well as deficiencies and improvements needed for service delivery systems to better address the needs of those children and families served by our local government. The process provides a wealth of information used to enhance services and systems in an effort to reduce the number of preventable deaths and improve the quality of children and youth's lives.

The Child Fatality Review Committee (CFRC or Committee) is divided into two teams; the Infant Mortality Review Team (IMRT) reviews the deaths of District infants from birth through 12 months. The Child Fatality Review Team (CFRT) reviews the deaths of children ages 1 through 18 years old, and youth between the ages of 18 and 25 years old who were known to child welfare and/or juvenile justice programs. In accordance with DC Official Code §4-1371.04, Committee membership is multidisciplinary, representing public and private child and family servicing agencies and programs. Most important, Committee membership includes community members representing the District of Columbia's Wards.

When an infant, child or youth dies in the District of Columbia, the Committee is notified through several established sources. Upon notification, the Committee staff obtains copies of the decedent's birth and death certificates, copies of records from the medical examiner and other public agencies, hospitals and human services cluster agencies. Records are reviewed, and the Committee's staff composes a comprehensive summary developed for presentation to the Committee during monthly case review meetings. All fatality review meetings are confidential.

This annual report summarizes data collected from 35 infant, child and youth fatalities reviewed by the Committee during calendar year 2015. The statute mandates the publishing of an annual report reflecting the work of the Committee during the year of review. In 2015, the IMRT and the CFRT convened for a total of 18 meetings. During these meetings, each team discussed the intricate details surrounding the events leading to the fatality. Members also received information pertaining to the decedent's social, educational, and medical history – providing a holistic story of the decedent. The information shared during the course of these meetings provides an opportunity for our city's decision makers to learn what works in the realm of public safety and human services for our most vulnerable residents.

EXECUTIVE SUMMARY

The District of Columbia's Child Fatality Review Committee (CFRC) is pleased to present its 20th Annual Report. This Report covers data from the 35 fatality cases reviewed by the Committee in 2015**.** These cases represent infant, children and youth deaths that occurred in 2012, 2013 and 2014.

The CFRC is a citywide collaborative effort authorized by the Child Fatality Review Committee Establishment Act of 2001 (see Appendix B: DC Code, § 4-1371.01 *et. seq*.). This committee was established for the purpose of conducting retrospective reviews of the circumstances contributing to the deaths of infants, children and youth who were residents of the District of Columbia, or were known to the child welfare or juvenile justice systems of the District. The primary goals of the District's child death review process are to: 1) identify risk reduction, prevention and system improvement factors, and 2) recommend strategies to reduce the number of preventable child deaths and/or improve the quality of life of District residents.

KEY CHILD FATALITY REVIEW DATA FINDINGS

DECEDENT DEMOGRAPHICS

The age of the 35 decedent cases reviewed by the CFRC in 2015 ranged from birth to 20 years of age. Select demographic information is bulleted below:

- Sixty percent (60%, 21 cases) of the decedents were infants.
- Seventy-four percent (74%, 26 cases) of the decedents were African American.
- Sixty-six percent (66%, 23 cases) of the decedents died of natural causes.

Natural Deaths

Twenty-three (23) natural death cases involving infants, children and youth were reviewed in 2015. Seventeen (17, 74%) of these cases involved infants. Complications of prematurity was the leading cause of death observed during the review of infant cases (8, 35%), and heart disease was the leading cause of natural death case reviews involving children and youth (4, 17%).

Homicide

Six (6) fatalities of children and youth whose deaths resulted from acts of violence were reviewed. Two (2) of these cases involved the fatal abuse of children.

Accidental Deaths

Four (4) accidental deaths involving infants, children and youth were reviewed. The circumstances leading to these accidental deaths included asphyxia due to overlay and motor vehicle collisions.

Undetermined Deaths

Two (2) of the infant fatalities reviewed were deemed as undetermined following a comprehensive medical and forensic investigation.

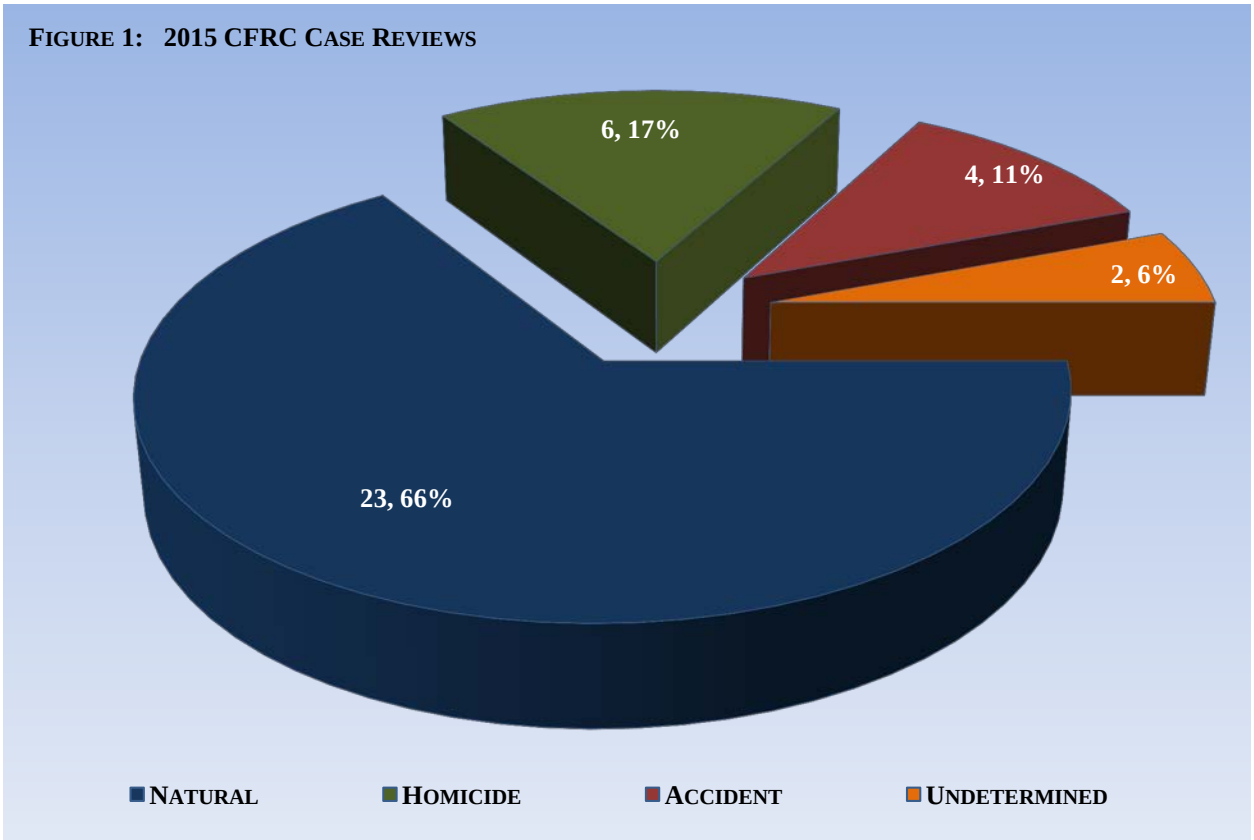
CHILD FATALITY REVIEW COMMITTEE - TOTAL CASE REVIEWS

The five manners of death are as follows: Natural, Homicide, Accidental, Undetermined and Suicide. The manner of death is determined based on circumstances surrounding the death as well as findings observed during the autopsy or examination of the decedent.

In 2015, the Committee reviewed 35 cases of child fatalities that occurred in 2012, 2013, and 2014.

- Twenty-three (23) cases involved infants, children and youth who died of natural causes.
- Six(6) cases involved infants, children and youth whose manner of death was homicide.
- Four (4) cases involved infants, children and youth whose deaths were accidental.
- Two (2) cases involved the deaths of infants where the cause was undetermined.

FIGURE 1: 2015 CFRC CASE REVIEWS



SECTION I:

SUMMARY OF TEAM FINDINGS

INFANT MORTALITY REVIEW TEAM (IMRT) FINDINGS

In 2015, the IMRT reviewed twenty-one (21) infant mortality cases of deaths that occurred in 2012, 2013, and 2014.

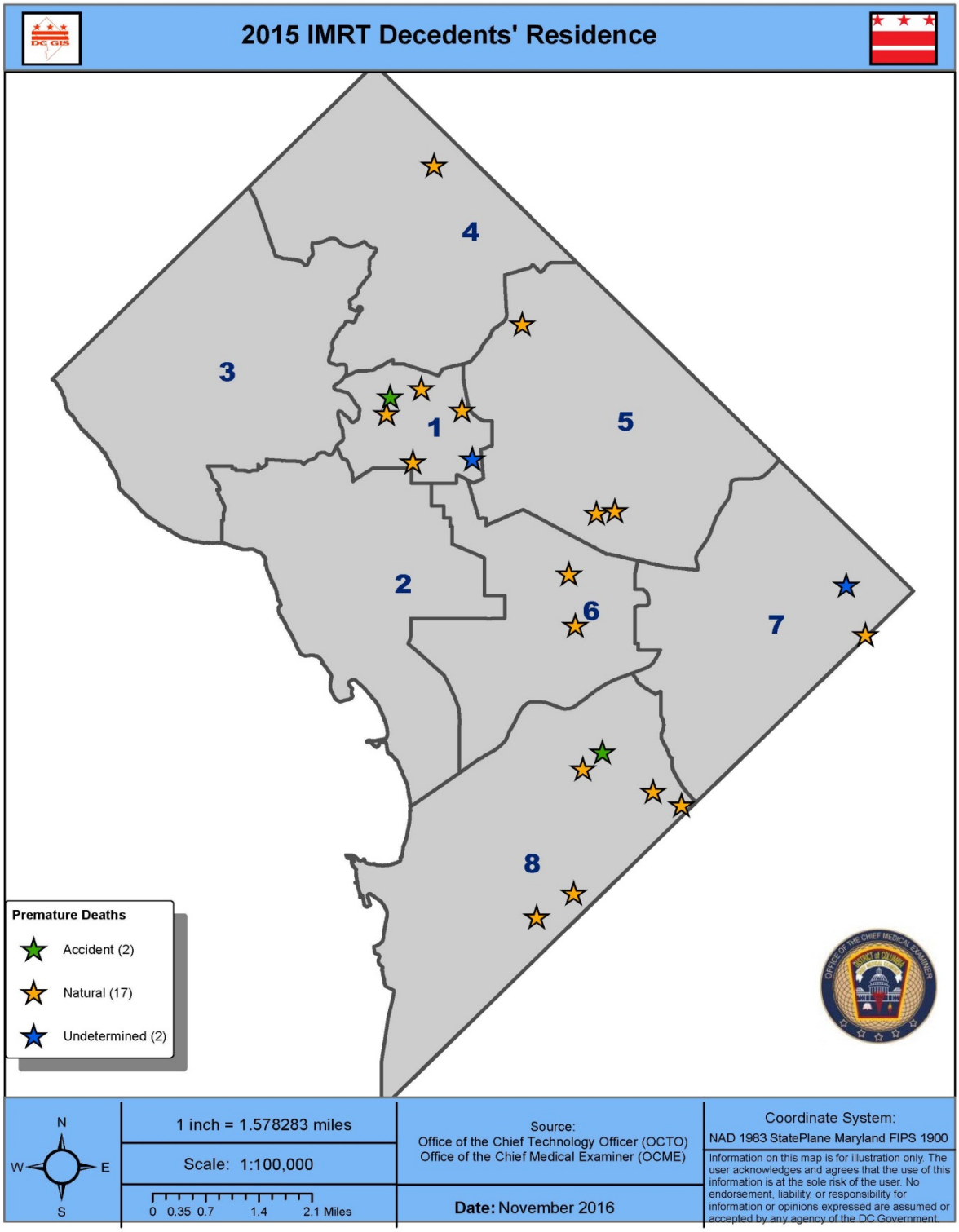
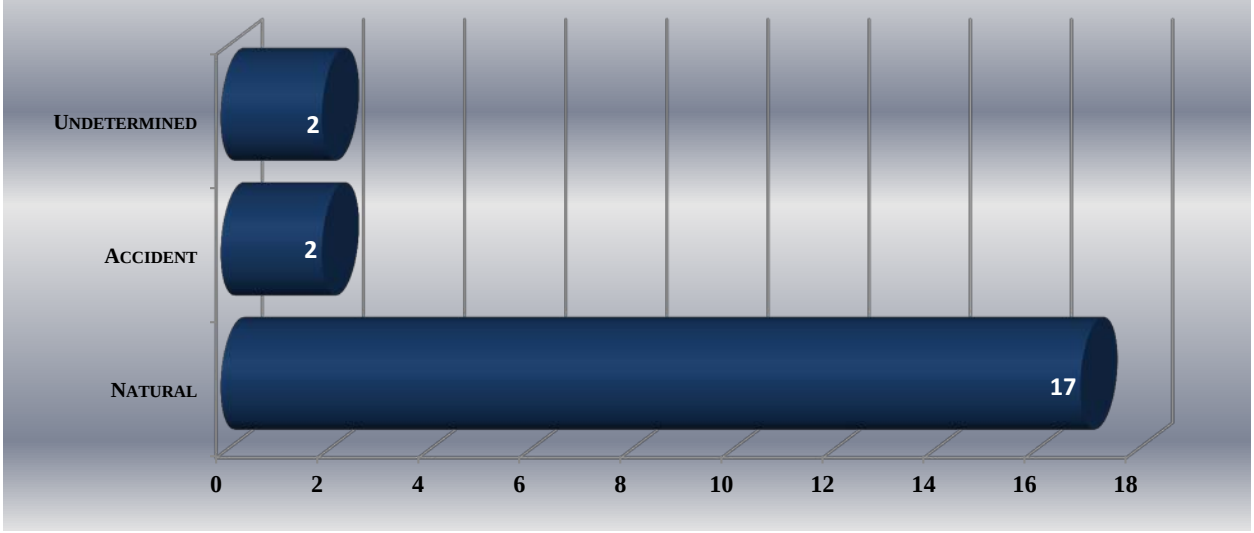


FIGURE 2: IMRT CASE REVIEW MANNERS OF DEATH



As indicated in *Figure 2*, seventeen (17, 81%) of the cases reviewed by the IMRT were natural deaths. The team reviewed two cases each in which the deaths were certified as undetermined and accidental. Records indicate fourteen (14, 67%) of the decedents were recipients of Medicaid. As illustrated in *Figure 3*, the majority of decedents reviewed by the IMRT were Black/African American males and females (14, 67%).

FIGURE 3: IMRT DECEDENT GENDER AND RACE

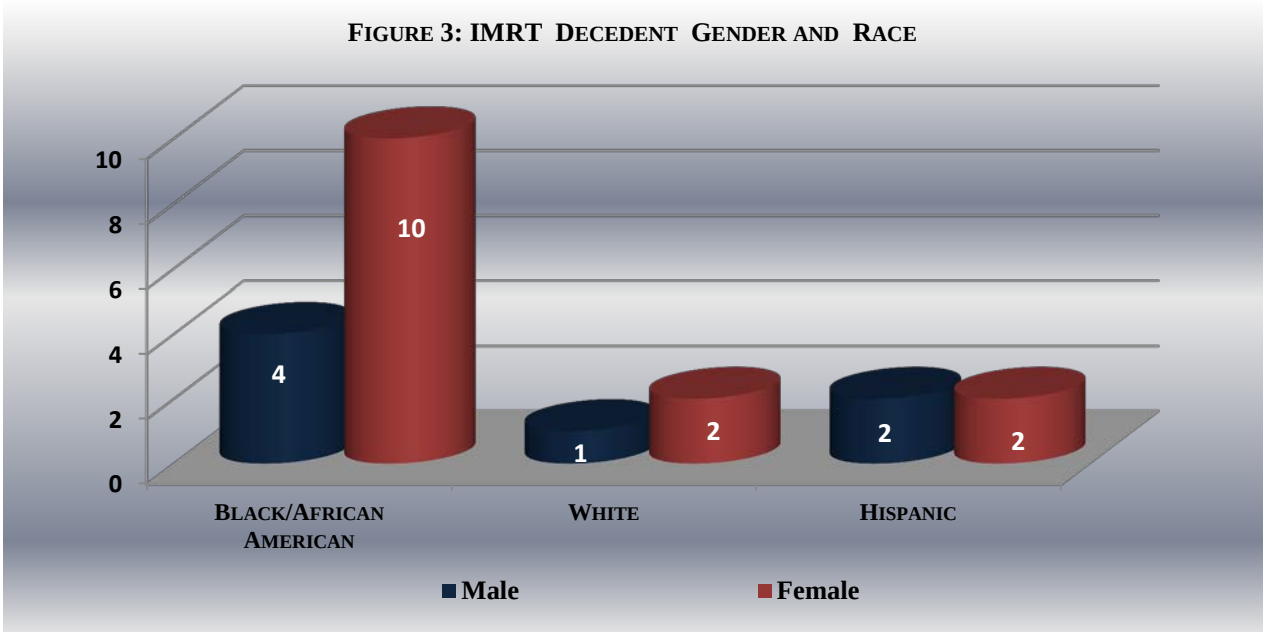


FIGURE 4: IMRT DECEDENT AGE AND MANNER OF DEATH

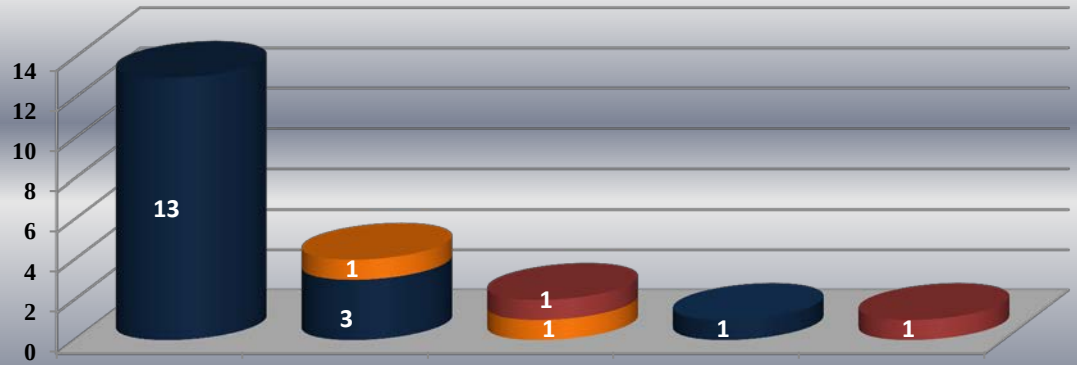


Figure 4 depicts the decedents' ages in comparison to the manner of death. Thirteen (13, 62%) of the IMRT decedents were under 1 month of age.

TABLE 1: IMRT CASE REVIEWS CAUSES OF DEATH	
CAUSES OF DEATH	**NUMBER OF CASES REVIEWED**
NATURAL CASES	
COMPLICATIONS OF PREMATURITY	**8**
CONGENITAL ANOMALIES	**3**
CENTRAL NERVOUS SYSTEM ISSUES	**3**
RESPIRATORY SYSTEM ISSUES	**1**
CARDIOVASCULAR ISSUES	**1**
RENAL SYSTEM ISSUES	**1**
ACCIDENTAL DEATHS	
ASPHYXIA DUE TO OVERLAY	**2**
UNDETERMINED DEATHS	
SUID (Associated with sleep environment)	**2**

The majority of the cases reviewed by the IMRT featured infants whose deaths were due to complications of extreme prematurity (8, 38%). According to the World Health Organization, infants who complete less than 28 weeks gestation prior to birth are considered extremely premature, which is a leading cause of infant mortality (World Health Organization, 2015). Congenital anomalies and medical issues related to the central nervous system were identified as causes of deaths in three cases, (3, 14%). In addition to prematurity, the infant's sleep environment also played a significant role in the cases reviewed by the IMRT including cases

certified as Asphyxia and Sudden Unexpected Infant Death (SUID).

PREMATURITY AND INFANT MORTALITY

The American Academy of Pediatrics defines a pre-term birth as any delivery, regardless of birth weight, that occurs before thirty-seven (37) completed weeks of gestation from the first day of the mother's last menstrual period. Infant mortality increases in infants born less than thirty-two (32) weeks of gestational age, as these infants have not had an opportunity to fully develop. Fourteen (14, 67%) of the IMRT cases involved infants who were born pre-term. Nine (9) of these infants who died of natural causes weighed less than 1000 grams at birth. In eight (8, 38%) of these cases reviewed, the premature birth of the infant was associated with the cause of death. Of these infants, six (6) were Black/African American, one (1) was White and one (1) was Hispanic.

MATERNAL AND INFANT RISK FACTORS

One of the key tenets of the IMRT is to identify and discuss the risk factors associated with infant mortality during case review meetings. The leading risk factors associated with infant mortality are categorized as a maternal risk factor or as an infant risk factor. Maternal risk factors are disclosed through the review of the mother's pregnancy/delivery health records, and public service records. Infant risk factors include gestational age at birth, weight, and diagnosis of congenital or chronic disease at birth. As observed through death scene investigations, the infant's environment may also show risk potential. The following are the maternal and infant risk factors identified during the 2015 IMRT case review meetings:

PRENATAL CARE

All of the IMRT case reviews indicated the expecting mothers whose infants were born premature received some prenatal care from their medical providers. The American College of Obstetricians and Gynecologists (ACOG) recommendations for prenatal care are as follows:

- During the first and second trimesters, (between the 1st and 28th week of gestation) mothers should expect to complete monthly visits with the health care provider.
- During the third trimester, the mothers should expect to visit their health care provider every two weeks.
- After completing the 36th week of gestation, mothers should expect to see their health care provider every week until giving birth to the infant.

The IMRT agrees that the mother's participation in regularly scheduled prenatal care visits is crucial to the infant's overall development, as well as the health of the expecting mother. All expecting mothers, particularly those whose pregnancy is deemed high risk – including but not limited to teenagers, women 35 years or older, and women with chronic medical conditions- benefit from regularly scheduled prenatal care visits.

PREMATURE RUPTURE OF MEMBRANES (PROM)

The spontaneous rupture of the amniotic membranes is a natural course of the pregnancy; however, the premature rupture of membranes (PROM) requires immediate medical attention. PROM is diagnosed when the amniotic membrane that surrounds the infant ruptures prior to the completion of the 37th week of gestation. When PROM occurs, the infant may be at risk of infection. PROM was the cause of the infant's premature birth in four (4, 24%) of the natural death infant cases reviewed by the IMRT.

INFECTION

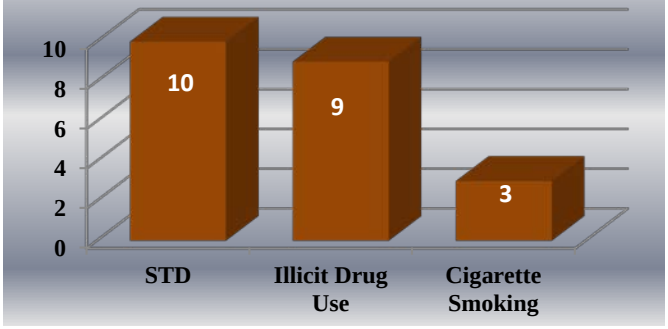
Infection during pregnancy places the unborn fetus at risk. Sources of infection include sexually transmitted diseases and group B streptococcus. Chorioamnionitis is an infection of the amniotic fluid and membranes that can lead to serious illness and death in newborn infants. Nine (9, 53%) of the IMRT mothers were diagnosed with chorioamnionitis infection at the time of delivery.

OBESITY

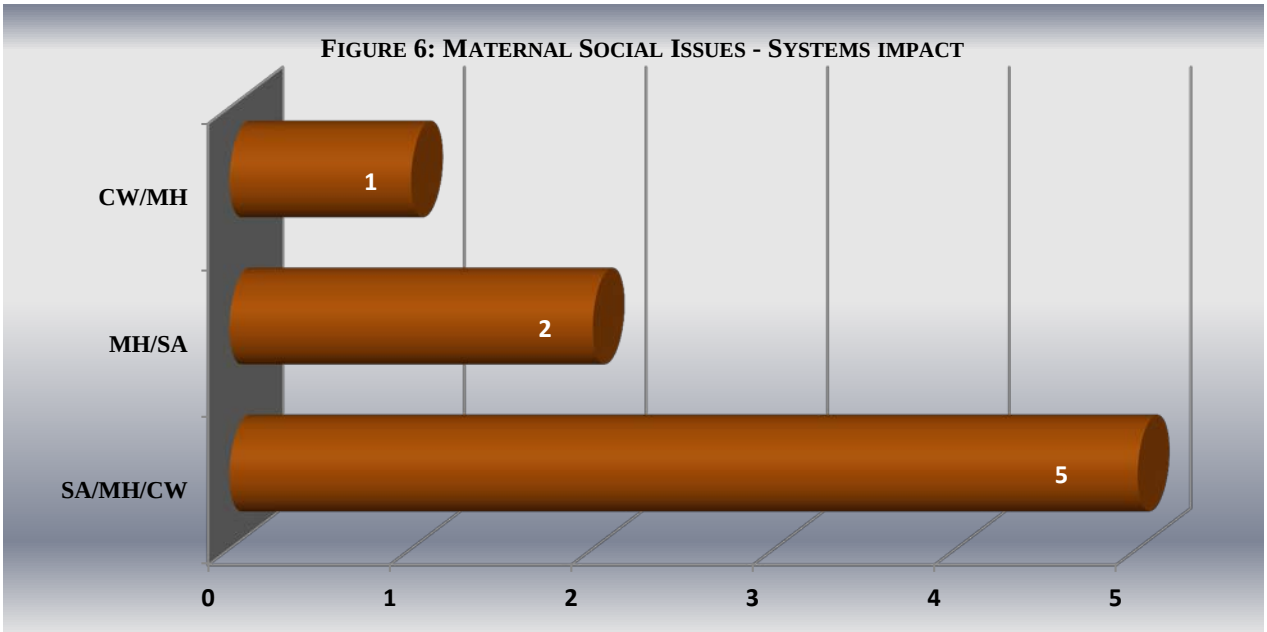
Maternal obesity is a risk factor addressed in the medical records in eight (8, 47%) of the natural death cases reviewed by the IMRT. Several studies indicate obesity can have a negative impact on the outcome of a pregnancy. According to an opinion issued by ACOG in January 2013, maternal obesity leads to negative consequences for both the mother and the unborn fetus. Obese mothers are at risk of complications during the pregnancy, including gestational diabetes, and pre-eclampsia. Complications for infants include premature birth, and still birth. As a proactive intervention, the preconception consultation can help women address obesity, nutrition and goals for weight loss. (Dimes, 2013)

MATERNAL SOCIAL AND ENVIRONMENTAL RISK FACTORS OBSERVED IN IMRT CASE REVIEWS

FIGURE 5: SOCIAL RISKS IDENTIFIED IN IMRT CASE REVIEWS



Medical records reviewed for IMRT cases provided additional information related to the mother's social risk factors associated with all manners of death. As illustrated in *Figure 5*, sexually transmitted disease (STD) was the leading risk factor in ten (10, 48%) of the cases reviewed, followed by illicit drug use (9, 43%) and cigarette smoking (3, 14%).

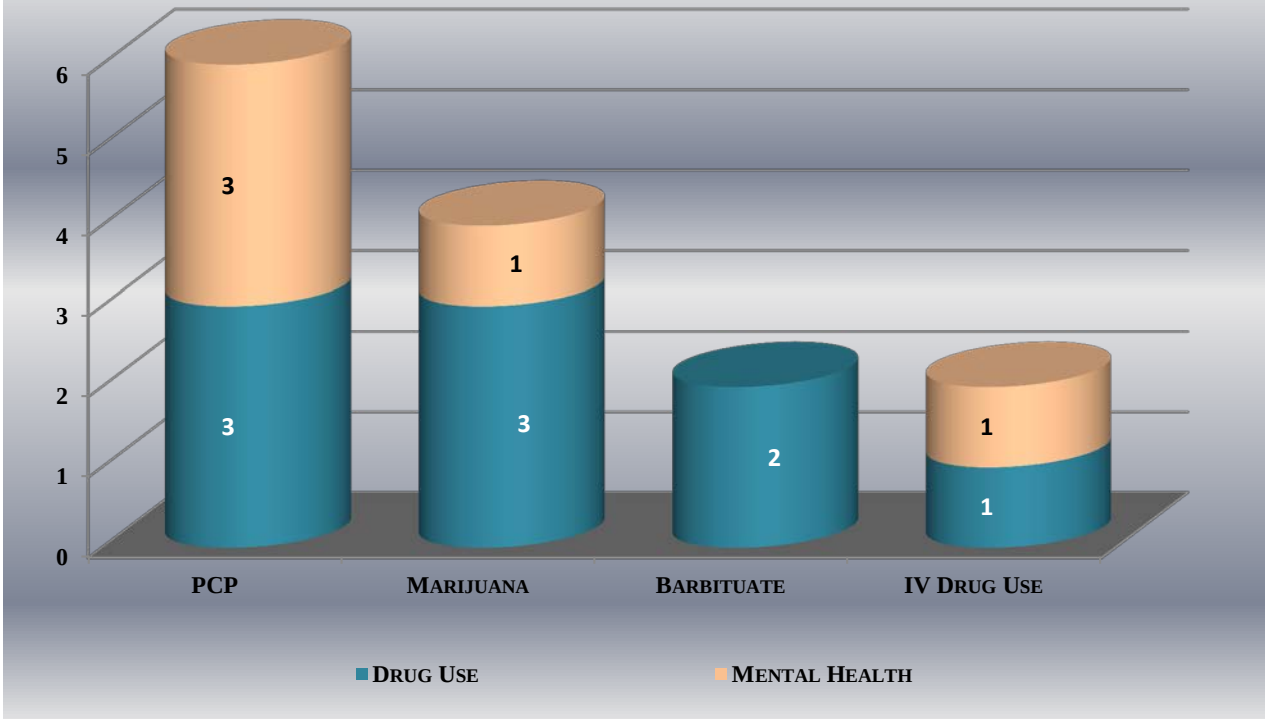


The IMRT case reviews also shed light on maternal behavioral issues and the need for crisis intervention at the time of the pregnancy and postpartum. Eight (8, 38%) of the cases reviewed indicated the mothers were diagnosd with a mental health disorder. In seven (7) of these cases, the mother's co-occuring susbtance abuse impacted the pregnancy and the mother's overall well being. In six cases (6, 29%) child welfare intervention was required to address the family's critical needs. This indicates there is an opportunity to address the mother's mental health needs during preconceptual conferences and/or prenatal care visits, as recommended by the National Institute of Health. (NIH, 2016). Also, direct service providers in the fields of child welfare and mental health have the opportunity to address the special needs of pregnant and postpartum women. Health providers are encouraged to assist women with identifying changes in their mood and behavior, while women are encouraged to contact their health provider when they experience psychosocial changes such as:

- Mood swings
- Experiencing difficulty with caring for self and infant
- Loss of interest in activities once enjoyed
- Abnormal eating or sleeping habits

As previously stated, mental health issues with co-occurring substance abuse was also observed in the cases reviewed by the IMRT. Phencyclidine (PCP) and marijuana use was indicated in three cases each (3, 14%). Barbituate use was indicated in two (2, 10%) cases. One mother was identified as an IV drug user. *Figure 7* compares the maternal substance abuse and mental health disorders as observed in IMRT case reviews.

FIGURE 7: MATERNAL DRUG USE AND MENTAL HEALTH DIAGNOSES



Maternal mental health is internationally recognized as an issue women may endure during their pregnancy and postpartum. The mother's mental health significantly impacts positive outcomes for both the mother and the infant. Improving maternal mental health world-wide is a goal of the World Health Organization as discussed in their Sustainable Development Goals (WHO2015). According to the WHO, women are at a higher risk of experiencing mental health problems when pre-existing social determinants, including substance abuse and economic instability exist. Economic instability was a significant concern revealed through IMRT case reviews. Fourteen (14, 67%) of the mothers were recipients of Medicaid and eight (8, 38%) were recipients of Temporary Assistance for Needy Families (TANF). Housing was an expressed need among four mothers (4, 20%).

UNDETERMINED INFANT DEATHS

Although a thorough forensic death investigation and examination was conducted immediately following the infant's death, a definitive cause of death could not be determined in two (2, 10%) infant mortality cases. In one case, the undetermined death was attributed to SUID associated with unsafe sleeping conditions.

In cases reviewed by the IMRT, such unsafe sleeping conditions included the following:

- Infants placed to sleep on adult mattresses
- Infants placed to sleep on air mattresses
- Infants placed to sleep with adults and/or children

The above unsafe sleep conditions were observed in IMRT cases; this is not a complete list of risks associated with SUID deaths. Nationally, education surrouding safe sleep practices are commonly provided through the Centers for Disease Control, the National Institute of Child Health and Human Development, and the American Academy of Pediatrics, to name a few organizations invested in the prevention of infant mortality. In the District of Columbia, both public and private agencies, including CFRC member agencies, are collaborating to continue to improve upon programs that currently address prevention efforts to curb the incidence of SUID-related fatalities.

Table 2 provides information related to the IMRT undetermined deaths. This information was gathered during the Office of the Chief Medical Examiner's medical legal investigation conducted immediately following the infant's death.

TABLE 2: IMRT UNDETERMINED INFANT DEATHS

DECEDENT DEMOGRAPHICS	SLEEP ENVIRONMENT	MEDICAL HISTORY PRIOR TO DEATH	SOCIAL ISSUES
7 week old Black-AA/Female	Infant placed to sleep supine on adult bed	Full Term Infant No Prior Medical Issues	Child Welfare History
5 month-old/ Black-AA/Male	Infant placed to sleep on adult chest and later found on floor between air mattress and couch	Premature birth History of heart murmur	Child Welfare History

ACCIDENTAL INFANT DEATHS

Two (2, 10%) of the IMRT decedents died of accidental deaths with the cause of death identified as asphyxia due to overlay. *Table 3* provides information related to these fatalities as provided by the case review and the OCME medical legal investigation of the death:

TABLE 3: IMRT ACCIDENTAL INFANT DEATHS

DECEDENT DEMOGRAPHICS	SLEEP ENVIRONMENT	MEDICAL HISTORY PRIOR TO DEATH	SOCIAL ISSUES
2 months, 15 days old Hispanic/Female	Infant placed prone on pillow in an adult bed with parent (bed sharing)	Full Term Infant No Prior Medical Issues	No Prenatal Care Uninsured
1 month old/ Black-AA/ Female	Infant placed to sleep with parents in adult bed (bed sharing)	Full Term Infant No Prior Medical Issues	Child Welfare History Maternal Marijuana Use Infant Positive Tox Screen

The infant's sleep environment, more specifically bed sharing, was a risk factor associated with these accidental deaths. Parents/caretakers often choose to share the adult bed with the infant as a means to bond and nurture the infant. The family's personal economic needs may also factor in this decision making, as infants are placed in beds to share with family members due to limited living space. The practice of bed sharing also provides the mother with easy access to the infant for breastfeeding. As bed sharing presents the risk of accidental overlay, the practice of co-sleeping – placing the infant in a separate sleep environment yet in the same room as the infant – provides easy access for bonding, nurturing and breastfeeding.

The IMRT continues to discuss the practice of bed sharing vs. co-sleeping during the course of SUID case review meetings. Advocates agree either method may formulate and establish a nurturing bond between the infant and parents/caretakers when practiced in a safe environment.

CHILD FATALITY REVIEW TEAM FINDINGS

In 2015, the CFRT reviewed fourteen (14) fatalities involving children and youth in which the death occurred in 2012, 2013 and 2014.

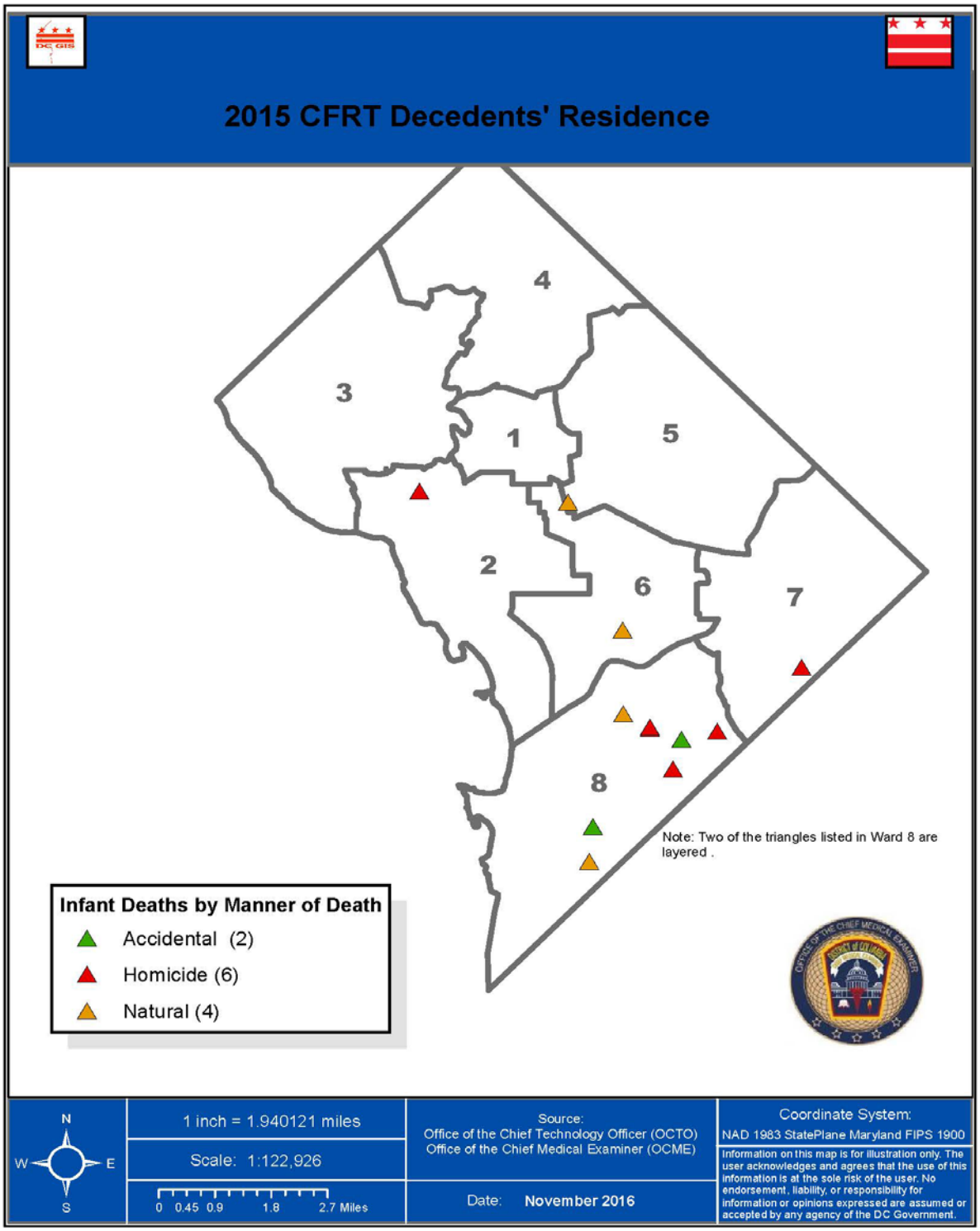
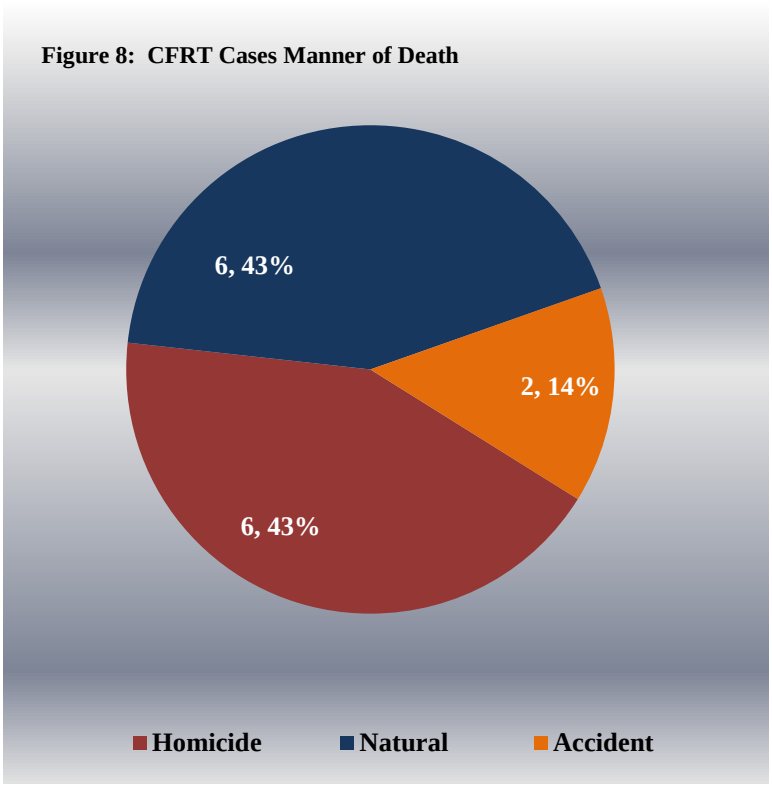
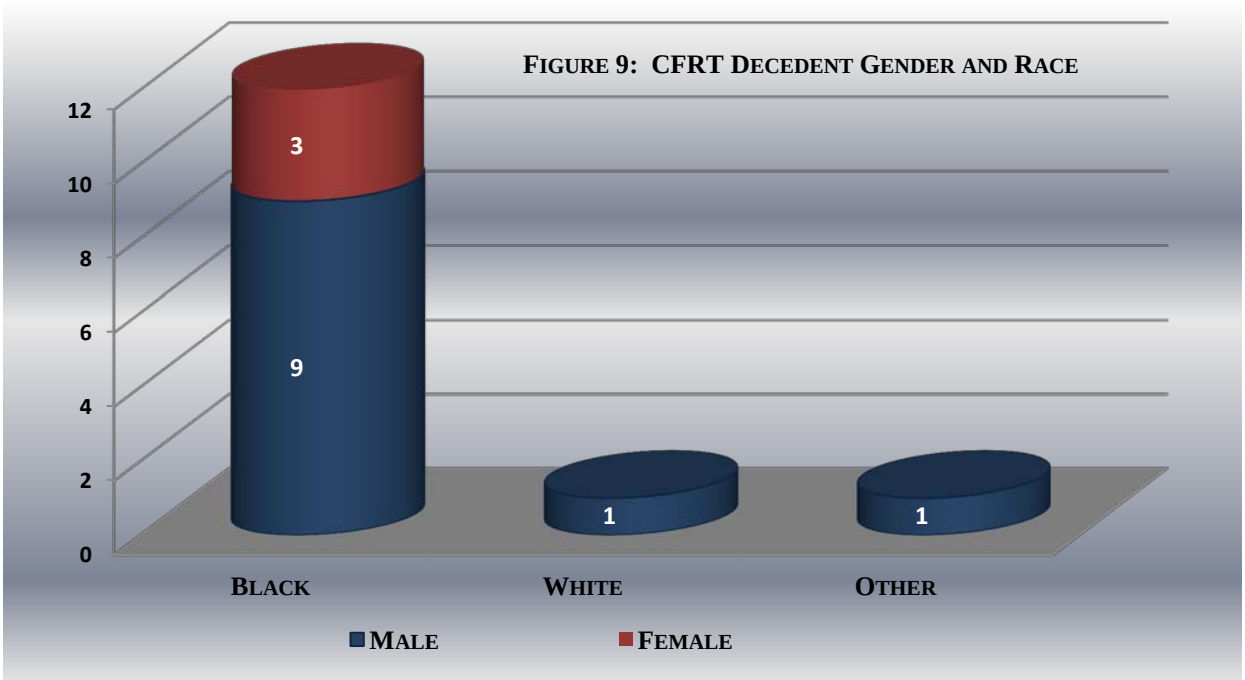


Figure 8: CFRT Cases Manner of Death



As detailed in *Figure 8*, the CFRT reviewed an equal number of deaths attributed to homicide and natural causes (6, 43%). Two (2) of the homicide cases involved the fatal abuse of two children ages 18 months and 3 years old. The remaining two (2) cases reviewed involved children who died of accidental causes.

Figure 9 indicates the majority of cases reviewed by the CFRT in 2015 involved Black/African American males and females (12, 86%). Of the cases reviewed, eleven involved male decedents (11, 79%), and three involved female decedents (3, 21%).



CFRT HOMICIDE CASE REVIEWS

The CFRT reviewed six (6) homicides, two (2) of which were attributed to fatal child abuse. The Committee categorizes homicide case reviews in the following manner:

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

TABLE 4: CFRC YOUTH HOMICIDE DECEDENT DEMOGRAPHICS - CAUSES OF DEATH AND RISKS

DECEDENT DEMOGRAPHICS/ WARD OF RESIDENCE	CAUSE OF DEATH	ASSOCIATE RISK FACTORS
18-year-old/ Black – AA/ Male Ward 8	Gunshot Wound of Back	• Diminished Economic Opportunities • Family History of Economic Instability
17-year-old/Black – AA/ Male Ward 7	Multiple Sharp Force Injuries	• Diminished Economic Opportunities • School Truancy • History of Involvement with Child Welfare • Family History of Economic Instability
18 – year old/Black-AA/ Female Ward 8	Gunshot Wound of Torso	• Diminished Economic Opportunities • School Truancy • History of Involvement with Child Welfare • History of Involvement with Juvenile Justice • Decedent substance abuse • Family History of Economic Instability
20-year-old/Black – AA/ Male Ward 8	Multiple Gunshot Wounds	• Diminished Economic Opportunities • School Truancy • History of Involvement with Child Welfare • History of Involvement with Juvenile Justice • Decedent Substance Abuse • Family History of Economic Instability

As shown in *Table 4*, youth homicide cases reviewed by the CFRT involved youth ages 17 years of age and older. The case reviews revealed how the decedent's environmental risk factors are similar to nationally recognized risk factors defined by the National Center for the Review and Prevention of Child Deaths (NCRPCD, 2016).

Children and youth residing in neighborhoods with few economic opportunities, as well as children and youth of families experiencing economic instability are at risk. Truant youth, and those with frequent child welfare or juvenile justice contacts, are also at greater risk. This indicates an opportunity for the collaboration of child welfare and juvenile justice agencies to proactively collaborate and address the needs of this high risk population of children and youth.

The CFRT reviewed two (2) cases involving the fatal abuse of children. *Table 5* provides insight on the cases reviewed by the CFRT in 2015.

TABLE 5: CFRT FATAL ABUSE HOMICIDE VICTIMS

DECEDENT DEMOGRAPHICS	CAUSE OF DEATH	SIGNIFICANT SOCIAL HISTORY
18 – month- old/ White /Male	Complications Following Ingestion of Exogenous Substance Containing Butylchloride	None identified in case reviews
3–year-old/ Black-AA/Male	Multiple Blunt Force Injuries	Involvement with child welfare Family history of economic instability Family history of substance abuse

In one (1) case the adult perpetrator is unknown. In the other case, the mother of the decedent was charged with three counts of first-degree cruelty to children, and two counts of first degree murder - felony murder.

CFRT NATURAL DEATHS CASE REVIEWS

As shown in *Table 6*, the CFRT reviewed six (6) cases involving the natural deaths of children. Five of the natural death cases involved Black/African American males and females. One (1) case involved a male of Ethiopian decent.

TABLE 6: CFRT CASE REVIEWS OF NATURAL DEATHS

DECEDENT DEMOGRAPHICS	CAUSE OF DEATH	MEDICAL HISTORY
2-year-old Black-AA/ Male	Complications of Lymphocytic Myocarditis	No significant medical history
17-year-old Black-AA/ Female	Acute on Chronic Myocarditis-Probable Viral Etiology	No significant medical history
17-year-old Black-AA/ Male	Sudden Death due to Myocarditis and Cerebral Vasculitis Complicating Syphilis Infection	Newly diagnosed with HIV
1 year old Ethiopian/Male	Heart Failure due to Congenital Heart Disease	Congenital Heart Disease
9 year old Black-AA/Female	Gastrointestinal Hemorrhage	Cerebral Palsy
3 year old Black-AA/Male	Respiratory Failure due to Hypoxic Ischemic Encephalopathy	Global Developmental Delays

CFRT ACCIDENTAL DEATH CASE REVIEWS

The CFRT reviewed two (2) cases of Accidental Deaths. Both cases involved motor vehicles. *Table 7* provides details of these deaths.

TABLE 7: CFRT ACCIDENTAL DEATH CASE REVIEWS

DECEDENT DEMOGRAPHICS	CAUSE OF DEATH	CIRCUMSTANCES SURROUNDING THE DEATH
3 year old/ Black-AA/Female	Multiple Blunt Force Injuries	Child ran into oncoming traffic
15 month old/ Black- AA/Male	Multiple Blunt Force Injuries	Child car seat not utilized

CFRC Decedents Known to Child Welfare and Juvenile Justice Programs

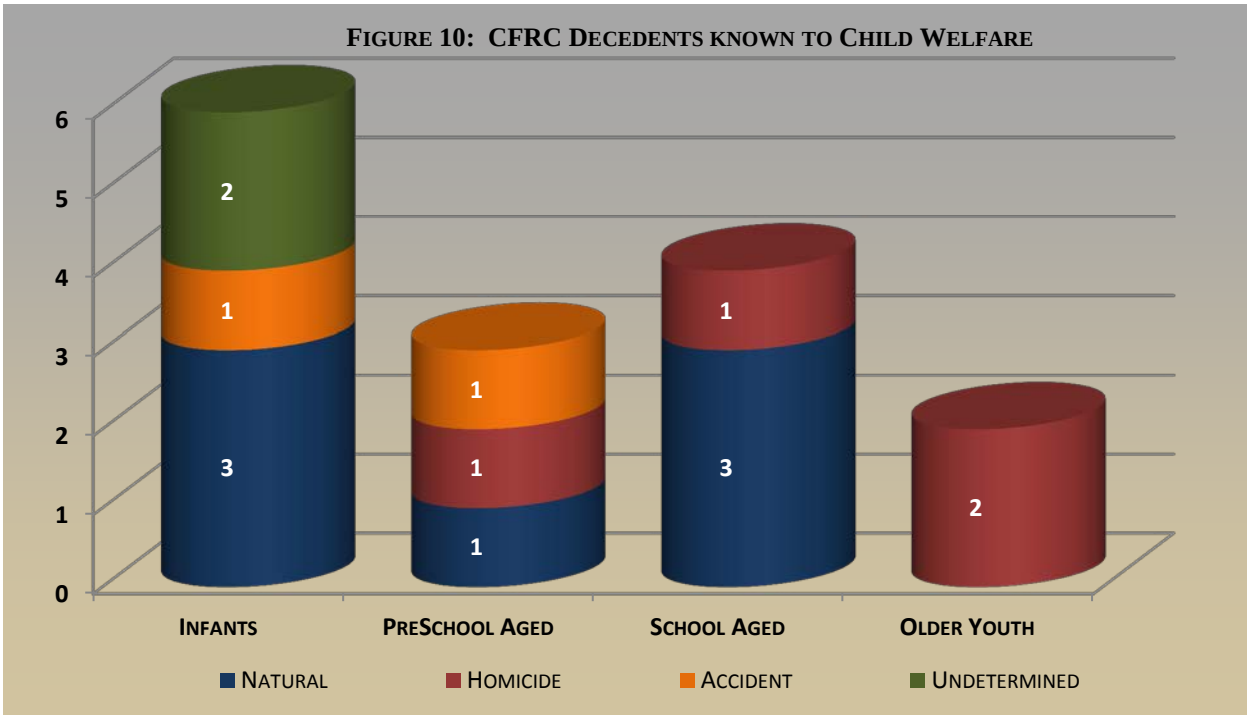
The CFRC is mandated to review the fatalities of children and youth known to the District of Columbia's child welfare and juvenile justice programs. Children and youth involved in these systems of care often have contacts with multiple public providers (e.g. mental health, education, or community resources). This provides the Committee with the opportunity to learn how the system collaborated to improve outcomes for this at-risk population. Children and youth with child welfare and juvenile justice involvement are at risk particularly due to their adverse life experiences (CDC-Kaiser ACE Study, 2016). Such adverse life experiences – which may include child maltreatment, exposure to violence, substance /alcohol exposure and abuse, and poor educational outcomes – may have long lasting negative effects on their individual overall health and social outcomes. As the ACE study concludes, the key to improving outcomes for this subset of infants, children and youth is to prevent their exposure to such adverse life experiences.

Two of the decedents, both Black-African American males, were known to both child welfare juvenile justice programs. As indicated in *Table 8*, the CFRT's review of these cases revealed the decedents' shared adverse life experiences - substance abuse, school truancy, unresolved mental health issues, and family history of economic insecurity – may have a negative impact. This presents an opportunity for the intervention of direct service providers and advocates throughout the system of care.

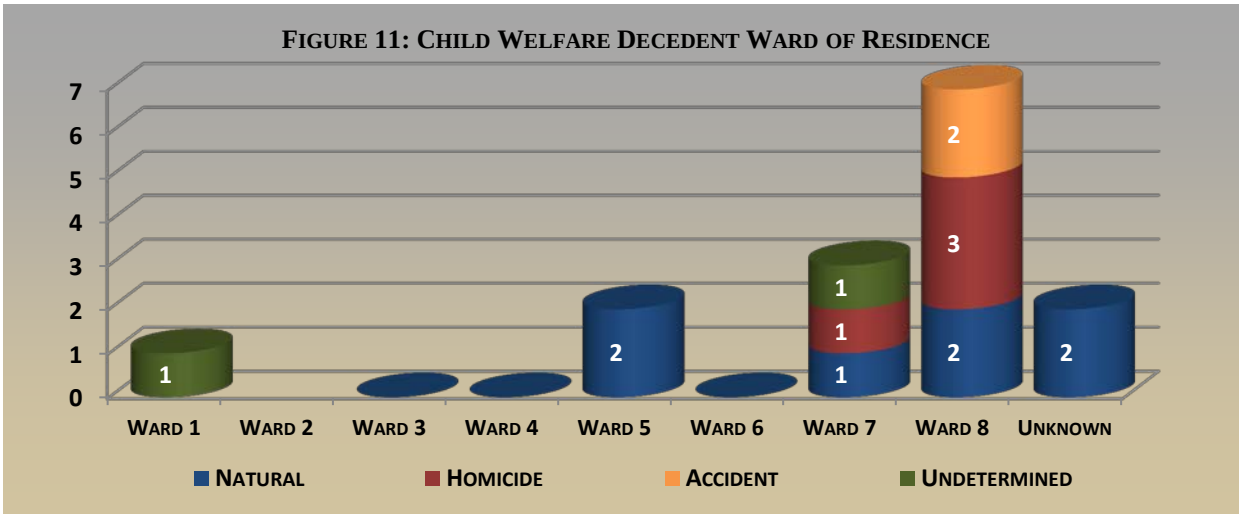
TABLE 8: JUVENILE JUSTICE DECEDENT RISK FACTORS

DECEDENT DEMOGRAPHICS	MANNER OF DEATH	CAUSE OF DEATH	ASSOCIATED RISK FACTORS
18 year old/ Black- AA/ Male/ Ward 8	Homicide	Gunshot Wound of Torso	• pre-teen drug abuse (marijuana) • family child welfare Involvement • school truancy – high school drop out • unresolved mental health issues • multiple juvenile offenses leading to commitment • family history of economic insecurity
20 year old/ Black – AA/ Male/ Ward 8	Homicide	Multiple Gunshot Wounds	

During the 2015 review year, the CFRC reviewed 15 cases (43% of the total cases reviewed) involving infants, children and youth who were known to the District's child welfare program within four years of the fatal event.



As shown in *Figure 10*, six (6) infants and nine (9) children and youth between the ages of 3 to 20 years old were known to child welfare, all of whom were Black/African American males and females. The leading manner of death among the child welfare decedents was natural death (7, 47%), followed by homicides (4, 27%).



All of the child welfare decedents were participants in the Temporary Assistance to Needy Families (TANF) Program and were recipients of Medicaid. As observed in *Figure 11*, the majority of the child welfare decedents resided in Ward 8 (8, 53%), and Ward 7 (3, 20%)[1].

The leading risk factor observed in all of the child welfare cases reviewed by both the CFRT and the IMRT was maternal substance abuse (8, 53%). Although maternal mental health issues were not evident in cases involving children and youth known to child welfare between the ages of 3 and 20 years old, maternal mental health issues were identified as the second leading risk factor (4, 27%) among all of the cases reviewed involving infants known to child welfare. *Table 8* and *Table 9* outline the causes of death and the associated risk factors Committee members identified during case review meetings.

TABLE 8: CHILD WELFARE DECEDENT CAUSE OF DEATH AND ASSOCIATED RISKS

CHILD WELFARE CASE REVIEWS	CAUSE OF DEATH/ NUMBER OF CASES	ASSOCIATED RISKS
Infants 40% of child welfare case reviews	Extreme Prematurity (Natural Death – 2 cases)	Maternal Substance Abuse Maternal Mental Health History History of Domestic Violence[2] Maternal Criminal Offenses Maternal Health Complications
	Cardiovascular Issues (Natural Death – 1 case)	Maternal Substance Abuse Maternal Mental Health Issues Maternal Health Complications
	Asphyxia due to Overlay (Accidental Death 1-case)	Maternal Substance Abuse Maternal Health Complications Maternal Mental Health Issues Bed Sharing with Adults
	Undetermined (2 cases)	Maternal Substance Abuse[3] Maternal Health Complications Unsafe Sleep Environment Maternal Mental Health Issues Family History of Domestic Violence

[1] The Ward of residence is unknown for two (2) decedents. One decedent resided in a foster care placement at the time of the fatal event. The address of the other decedent no longer exists in the District of Columbia.

[2] Domestic Violence and Maternal Criminal Offenses was observed in one (1) of the two extreme prematurity cases.

[3] Maternal Substance Abuse was identified in one of the undetermined cases.

TABLE 9: CHILD WELFARE DECEDENT CAUSE OF DEATH AND ASSOCIATED RISKS

CHILD WELFARE CASE REVIEWS	CAUSE OF DEATH/NUMBER OF CASES	ASSOCIATED RISKS
Children and Youth 3 to 20 years old 60% of child welfare case reviews	Acute on Chronic Myocarditis Probable Viral Etiology (Natural Death – 1 case)	Decedent Substance Abuse Foster Care Placement Teen Mother
	Sudden Death due to Myocarditis and Cerebral Vasculitis Complicating Syphilis Infection (Natural Death – 1 case)	Multiple Sex Partners
	Gastrointestinal Hemorrhage (Natural Death – 1 case)	Maternal Substance/Alcohol Abuse Medically Fragile Child
	Respiratory Failure due to Hypoxic Ischemic Encephalopathy (Natural Death – 1 case)	Maternal Substance Abuse Maternal Foster Care History
	Multiple Blunt Force Injuries (Accidental Death – 1 case)	None noted outside of child welfare history
	Gunshot Wounds (Homicide - 2 cases)	Co-involvement with juvenile justice Decedent Substance Abuse School Truancy
	Multiple Sharp Force Injuries (Homicide – 1 case)	School Truancy
	Multiple Blunt Force Injuries (Fatal Abuse Homicide – 1 case)	Maternal Substance Abuse

The risk factors identified within the child welfare cases indicate there are opportunities for intervention throughout the spectrum of human services providers. Some behavioral risks nationally associated with infant and child fatalities include:

- Maternal and/or decedent substance abuse - ten (10, 67%) of child welfare cases
- School truancy and/or youth criminal activity –five (5, 33%) of child welfare cases
- Infants placed to sleep in unsafe environments – three (3, 20%) of child welfare cases

The Committee's current discussions focus on child welfare's response and interventions to cases where nationally recognized risk factors are observed during case review meetings.

SECTION 2:

COMMITTEE DISCUSSIONS

CHILD FATALITY REVIEW COMMITTEE DISCUSSIONS

Discussions held during the monthly Committee meetings help to identify the systemic issues and risk factors associated with infant, child and youth fatalities in the District of Columbia. As in previous years, infant mortality associated with premature birth, and youth violence homicides continue to be the leading concerns of Committee members.

ONGOING IMRT DISCUSSIONS

The implementation of maternal interviews, a nationally-recognized practice advocated by ACOG and the National Fetal and Infant Mortality Review, may provide information to the Committee not available in records reviewed for the fatality review meetings. The maternal interview process may also provide information regarding the infant's social environment, as well as the mother's personal antepartum experiences with providers and social service agencies. OCME is collaborating with the DOH and community based providers to implement the maternal interview process that will report its findings to the IMRT. It is the expectation that the maternal interview will enhance the IMRT's case review and assist with the development of sound recommendations to address the needs of expecting families in the District of Columbia.

The IMRT continues to discuss cases in which the medical record indicates the infant would be non-viable at birth. In its efforts to improve outcomes for infants and their families, the IMRT will charge a subcommittee of medical experts and community-based providers to review the circumstances leading to the death of infants who were medically deemed non-viable at birth, yet resuscitated. In 2015, nine (9, 43%) of the IMRT cases reviewed indicated the infant weighed less than 1000 grams, and was deemed non-viable. These infants were born within 17 to 24 weeks gestation. The IMRT agrees it is important to collect data and discuss the findings of these infant fatalities, as they significantly impact the District of Columbia's overall infant mortality rate.

Ongoing CFRT Discussions

The CFRT case review findings and discussion included what appears to be an increase in the number of natural deaths among children associated with pediatric myocarditis. Myocarditis causes inflammation of the heart muscle and can lead to heart failure (NIH, NIH Genetic and Rare Diseases Information Center, 2016). This rare condition can be caused by infections, allergic reactions to medication, as well as environmental exposures. The Committee is collecting information related to these natural deaths, including the underlying medical conditions and viruses that lead to the diagnosis of pediatric myocarditis. The findings from these case reviews may help to develop risk factors associated with pediatric myocarditis.

The Committee also reviewed a number of deaths in which the ongoing health needs of the District's teenagers were paramount. Teenage pregnancy, the transmission of sexually transmitted diseases, and the availability of substance abuse treatment for the District's youth required further discussion and presentations from government agency policy makers and stakeholders. The Committee was impressed to hear about ongoing practices and initiatives implemented by the following agencies:

- The Department of Health's Teen Pregnancy Prevention Program
- The Department of Behavioral Health Youth Substance Abuse Prevention Campaign and Community-Based Treatment providers
- The collaboration between DC Public Schools and the Department of Health creation of on-site student health centers, as well as the Unity Health Clinic onsite student health centers

In 2015, OCME was awarded a $100,000 grant from the Office of Victims Services and Justice Grant for the CFRC to engage in community outreach and improve its recommendations process. Community outreach and the dissemination of the Committee's efforts to improve the outcomes of the District's most vulnerable residents is a strategic tenet within the Committee's spectrum of advocacy activities. The Fatality Review Unit at the OCME hired an Outreach Program Specialist, whose task is to directly interact with District residents and community leaders and address the issues discussed in the annual report. The Outreach Program Specialist will also act as the liaison between the Committee and the District community at-large. This is a clear opportunity to create an open dialogue and actively engage with District residents. The goal is to ensure that the safety and health of our communities remain within the forefront of all District residents.

The Committee will also embark upon improving its recommendation process to address the need for systemic change in District government practices and policies that effect the at-risk population served by the CFRC. The Committee will engage with nationally-recognized authorities to learn about best practices among the child death prevention community. Through improved data collection, robust case discussions and community outreach, the District's Child Fatality Review Committee will be recognized as a leading voice in the prevention of child deaths.

ACKNOWLEDGMENT

MEETING ADJOURNED…

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

We also wish to thank OCME's Forensic Epidemiologist, Chikarlo R. Leak, DrPH, and Executive Assistant, SaVern M. Fripp for their assistance with the compilation of this report.

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