

CHILD FATALITY REVIEW COMMITTEE

2020 ANNUAL REPORT





MISSION OF CFRC

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

Kristinza Gieze, MD

Deputy Medical Examiner, OCME

Co-Chair, Child Fatality Review Committee

Erica McClaskey, MD

Bureau Chief; Co-Chair, Child Fatality Review Committee

OFFICE OF THE CHIEF MEDICAL EXAMINER FATALITY REVIEW DIVISION

Jenna Beebe-Aryee MSW

Fatality Review Program Manager

Tracie T. Martin MSW

Senior Fatality Review Program Specialist

Jackie Corbin-Armstrong, MSW, MSM

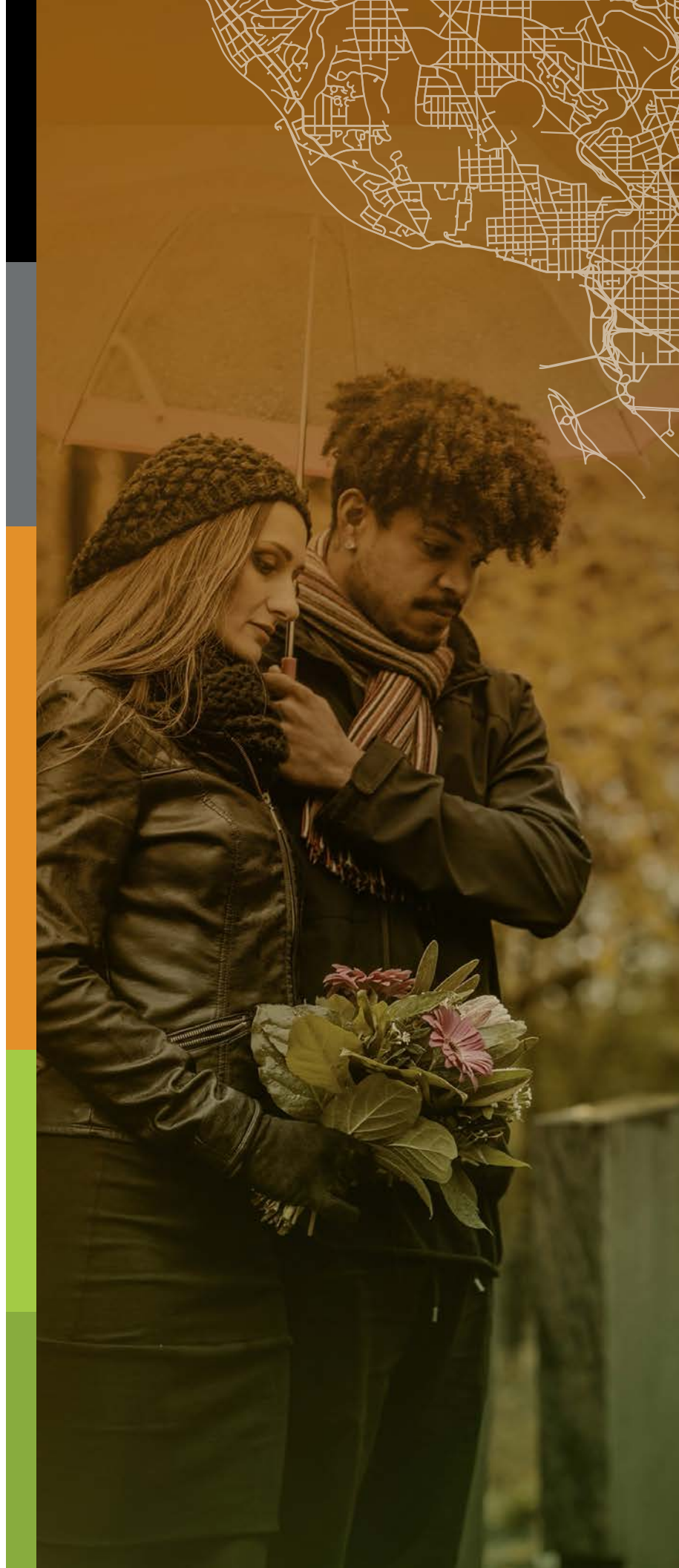
Fatality Review Program Specialist

Katherine Barnes, MPH

Fatality Review Program Specialist

Toya Byrd

Staff Assistant





CHILD FATALITY REVIEW COMMITTEE

2020 ANNUAL REPORT

THIS REPORT IS PRESENTED TO:

The Mayor of the District of Columbia
The Council of the District of Columbia
The Residents of the District of Columbia

DECEMBER 2021

CONTENTS

2

GREETING FROM THE CHIEF
MEDICAL EXAMINER

3

GREETINGS FROM CFRC
CO-CHAIRS

4

DEDICATION AND COMMITTEE
COMPOSITION AND
MEMBERSHIP

6

INTRODUCTION: THE DC CHILD
FATALITY REVIEW COMMITTEE

8

EXECUTIVE SUMMARY

10

SECTION 1: SUMMARY
OF TEAM FINDINGS

11

INFANT MORTALITY REVIEW
TEAM FINDINGS

34

CHILD FATALITY REVIEW TEAM
FINDINGS

40

SECTION 2: COMMITTEE
RECOMMENDATIONS AND
AGENCY RESPONSES

44

ACKNOWLEDGEMENT



GREETINGS FROM THE CHIEF MEDICAL EXAMINER

As the newly appointed Chief Medical Examiner of the District of Columbia, I understand the city's commitment to the prevention of child fatalities.

The COVID-19 pandemic presented challenges to our daily lives; yet we should commend the work of the Child Fatality Review Committee. Both the IMRT and the CFRT continued to convene and strategize, utilizing the lens of public health, to address this difficult task.

The CFRC members are our public servants, all multidisciplinary experts and child advocates for the children of the District of Columbia. This unique opportunity to look retrospectively at past events and develop recommendations for systemic improvements, the District of Columbia's Child Fatality Review Committee stands above the rest. I am proud and appreciative of their work.

We proudly present the 2020 Child Fatality Review Committee Annual Report. We hope that this report will help to inform our public servants and community advocates.



Sincerely,

Francisco J. Diaz

Francisco J. Diaz, MD, FCAP

Chief Medical Examiner
Office of the Chief Medical Examiner
Washington, DC.





GREETINGS FROM THE CO-CHAIRS

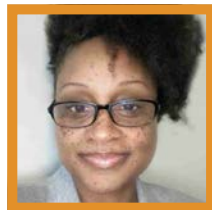
As the appointed co-chairs of the District of Columbia's Child Fatality Review Committee, we are continuously grateful for the opportunity to address systemic barriers that impede healthy outcomes for the infants, children, and youth of the District of Columbia.

COVID-19 presented challenges to the CFRC's ability to convene face-to-face, however the Committee continued to thrive by expanding the members' knowledge of agency programs implemented to foster healthy lives for this vulnerable population.

The CFRC's collaboration with the District of Columbia's Violence Fatality Review Committee to address youth violence and homicides in the District of Columbia was ground-breaking, and recent funding provided to broaden the scope of the District's Infant Safe Sleep programs shows our continued commitment to break barriers through our unified communication throughout the care continuum.

We proudly present the 25th Child Fatality Review Committee Annual Report. We thank and appreciate the CFRC members, participants and OCME staff for their hard work and commitment to the children and families of the District of Columbia.

Sincerely,



Kristinza Giese

Kristinza Giese, MD

Deputy Medical Examiner, Office of the Chief Medical Examiner



Erica McClaskey

Erica McClaskey, MD, MS, FAFP

Family Health Bureau Chief, DC Health



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, acts of violence, accidents, and suicide.

Our vision is that as we learn lessons from circumstances surrounding the deaths of our infants and children, we can successfully reduce the number of preventable deaths while improving the quality of life of all residents.

THE INFANT MORTALITY REVIEW TEAM (IMRT)

Committee members and participants of the IMRT convene on the first Tuesday of each month. In 2020, members and meeting participants represented the following District Government agencies, medical providers, and community-based organizations.

- Amerihealth Caritas DC
- Center for the Study of Social Policy
- Children's National Medical Center
- DC Health
- Department of Behavioral Health
- Department of Health Care Finance
- DC Housing Authority
- Department of Human Services
- George Washington University Hospital
- Howard University Hospital
- Metropolitan Police Department
- National Institutes of Health- Children's Health and Human Development
- Office of the Chief Medical Examiner
- Office of the Attorney General
- Residents of the District of Columbia
- Trusted Health Plan
- Office of the US Attorney of the District of Columbia
- Washington Hospital Center

THE CHILD FATALITY REVIEW TEAM (CFRT)

The CFRT convenes on the third Thursday of each month. In 2020, members and meeting participants represented the following District Government agencies, medical providers, and community-based organizations:

- AmeriHealth Caritas
- Center for the Study of Social Policy
- Child and Family Services Agency
- Children's National Medical Center
- DC Fire and Emergency Medical Services
- DC Health
- DC Housing Authority
- DC Public Schools
- Department of Behavioral Health
- Department of Health Care Finance
- Department of Human Services
- Department on 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 of Education
- Office of the US Attorney for the District of Columbia
- Residents of the District of Columbia
- Superior Court of the District of Columbia
- Superior Court of the District of Columbia Court Social Services Division





INTRODUCTION

The death of infants, children, or youth residents of the District of Columbia affects their families, neighbors, daycare operators, schoolmates, and the community at large. This is a public health issue and a call to action for District Government agencies that once provided services to these families.

The fatality review process identifies family and community strengths, as well as deficiencies and improvements needed to serve our community better. The process provides a wealth of information used to enhance public services and systems utilized to reduce the number of preventable deaths and improve the overall quality of life for residents of the District of Columbia.

The District of Columbia's Child Fatality Review Committee (CFRC) provides our community with the unique opportunity to address the critical needs of our most vulnerable infants, children, and youth through the retrospective death review process. The CFRC 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 District children ages 1 through 18 and youths older than 18 who were involved with the District's child welfare services within four (4) years of their death, or juvenile justice programs within two (2) years of their death. Membership is multi-disciplinary and inclusive of public and private child servicing agencies, medical providers, academia, legal professionals, and child advocates. Most importantly, residents representing neighborhoods throughout the District have a seat at the table to ensure those most impacted have a say.

When an infant, child, or youth dies in the District of Columbia, the CFRC is notified through several established sources. Upon notification, the OCME Fatality Review Division staff obtains copies of the decedent's birth and death certificates, records from the medical examiner, public

THIS ANNUAL REPORT SUMMARIZES DATA COLLECTED FROM INFANT, CHILD, AND YOUTH FATALITIES REVIEWED BY THE CFRC DURING THE 2020 CALENDAR YEAR. THIS REPORT IS COMPRISED OF TWO SECTIONS:

► SECTION 1

Summary of Team Findings

A compilation of data derived from the Infant Mortality Review Team and the Child Fatality Review Team monthly meetings.

► SECTION 2

Committee Recommendations

Recommendations adopted by the CFRC and submitted to District Government agencies, medical providers, community-based partners, and their responses are published in this section.



and private child welfare, education, health and public safety agencies, and area hospitals. A comprehensive report is developed for presentation to the CFRC during monthly case review meetings. All fatality review meetings are confidential.

During the onset of the COVID-19 pandemic, in addition to the normal duties of the fatality review division staff, the Fatality Review Division Manager and Fatality Review Program Specialists were detailed to support the development and implementation of the Virtual Family Assistance Center (VFAC) alongside the leadership of the Department of Behavioral Health (DBH), DC Public Schools (DCPS)- School-Based Mental Health, the Department of Human Services (DHS), and the Mayor's Office of Community Relations (MOCRS). Staff from each area were the first Navigators to engage with the COVID-19 decedent next of kin and their families to provide them with support and resources.

The Bowser Administration established the Virtual Family Assistance Center (VFAC) to serve as a collaborative, streamlined system to engage and assist those who lost loved ones to COVID-19. Trained professionals provided support in many areas, and ensured individuals received the resources available to them during this difficult time.

VFAC Navigators provided a listening ear, responded to, and connected individuals to needed District services and resources.

These services included, but were not limited to:

- Burial and funeral assistance
- Delivery of food and other essential items
- Connection to vital records and other documents
- Connection to public benefits for food, employment/unemployment, health insurance, and cash assistance
- Rental, utility, and house cleaning/disinfecting assistance and support
- Mental health and grief support
- Support for seniors
- Support for students

During the public health emergency, the Fatality Review Division continued to coordinate and plan meetings, offering members and participants a platform for engagement. Informal meetings were held, offering participants an opportunity to present real-time information about the services or programs they were providing to support District residents during these challenging times.



EXECUTIVE SUMMARY

The District of Columbia's Child Fatality Review Committee (CFRC) is pleased to present its twenty-fifth Annual Report. The CFRC 2020 Annual Report covers data from the 47 cases reviewed by the committee in 2020. These cases represent infant, children, and youth deaths that occurred in 2018, 2019, and 2020.

The CFRC is a citywide collaborative effort authorized by the Child Fatality Committee Establishment Act of 2001 (see Appendix B: DC Official Code, §4-1371.01 et seq). This committee was established to conduct 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.

The primary goals of the child death review process are to 1) identify risk reduction, prevention, and system improvements factors, and 2) recommend strategies to reduce the number of preventable child deaths and/or improve the quality of life of our residents. The CFRC also considers adverse environmental factors – relevant in cases involving premature births, youth homicides, and the sudden unexpected death of an infant.

TABLE 1 Manners of Death

MANNERS OF DEATH	CFRC ANNUAL REPORT DEFINITION
Natural Death Case Reviews	Death caused by the natural disease process and not an accident or act of violence.
Homicide Case Reviews	The deliberate and unlawful killing of a person by another person.
Undetermined Case Reviews	Following a thorough medical and legal investigation, a conclusive manner of death is not determined.
Accidental Death Case Reviews	Deaths caused unintentionally rather than by natural causes, suicide, or murder.
Suicide Case Reviews	Deaths caused by self-inflicted behavior with the intent to die.

KEY CHILD FATALITY REVIEW COMMITTEE DATA FINDINGS DECEDENT DEMOGRAPHICS

The ages of the 47 decedent cases reviewed by the CFRC in 2020 ranged from birth to 20 years of age. Select demographic information is bulleted below:

► **80%**
(80%, 38 cases) of the decedents were infants.

► **85%**
(85%, 40 cases) of the decedents were identified as African American/Black.

► **65%**
(65%, 31 cases) of the decedents died from natural causes

FIGURE 1 CFRC 2020 Decedent Manner of Death

- Thirty-one cases involved infants and children whose deaths were classified as natural causes.
- Eight cases involved youth whose deaths were classified as homicides.
- Six cases involved infants whose deaths were classified as accidents.
- Two cases involved the deaths of infants whose deaths were classified as undetermined.

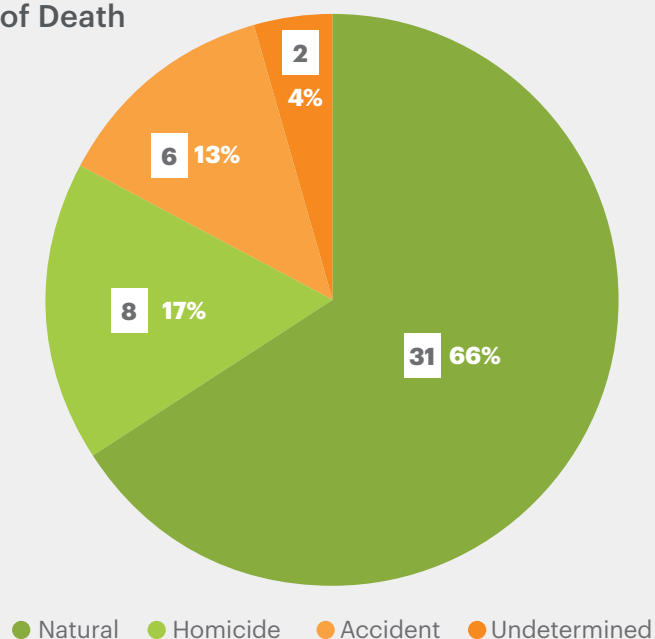
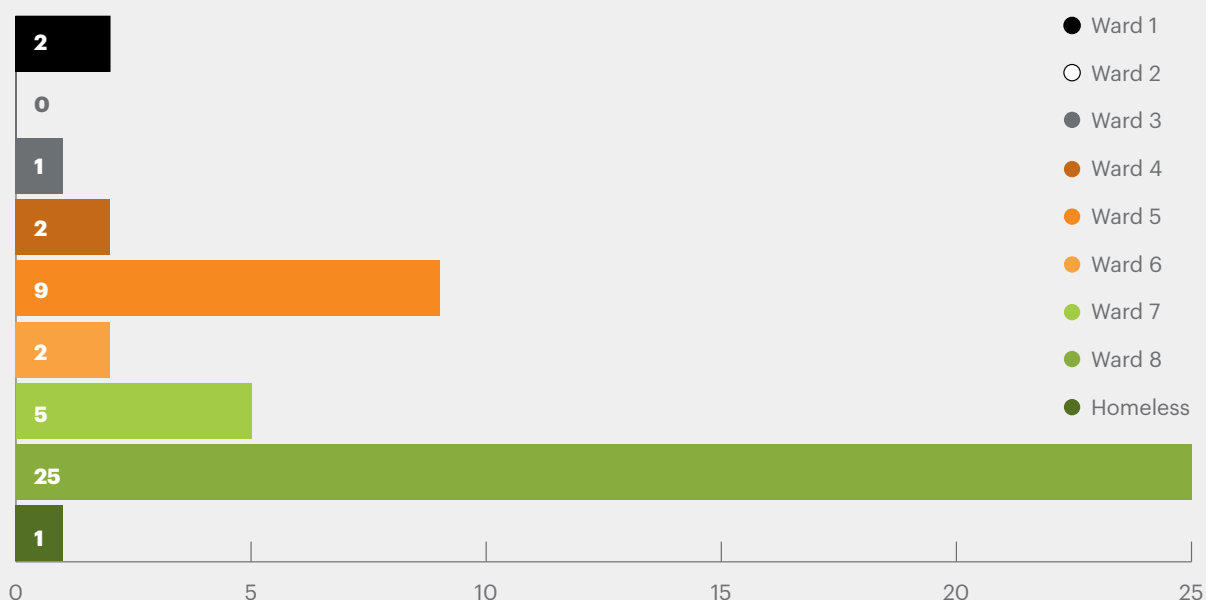


FIGURE 2 CFRC 2020 Decedent Ward of Residence



The CFRC reviewed the deaths of twenty-five decedents who resided in Ward 8 at the time of the fatal event (53% of cases reviewed). One youth was identified as having “no fixed address.” Historically, the Child Fatality Review Committee has reviewed more deaths of infants, children, and youth who reside with their families in Ward 8.

A romantic couple is shown from behind, embracing each other in a lush park. The woman has long, wavy brown hair and is wearing a dark, long-sleeved top. The man is wearing a dark jacket. They are standing on a grassy path with trees and foliage in the background. The scene is bathed in the warm, golden light of a sunset, creating a soft, bokeh effect in the background.

SECTION I

SUMMARY OF TEAM FINDINGS



INFANT MORTALITY REVIEW TEAM FINDINGS

The Infant Mortality Review Team (IMRT) met three times before the Coronavirus Pandemic prohibited the ability to conduct case reviews due to the state of emergency issued by the Mayor of the District of Columbia.

When the IMRT resumed meeting virtually via the secure WebEx platform, the first three meetings were informational, as the District of Columbia's appointed Boards and Commissions were not permitted to conduct formal business. The IMRT received exceptional reports from the Child and Family Services Agency, The Department of Human Services, MedStar Washington Hospital Center, and Evermore. A brief description of the information is included in this Annual Report.

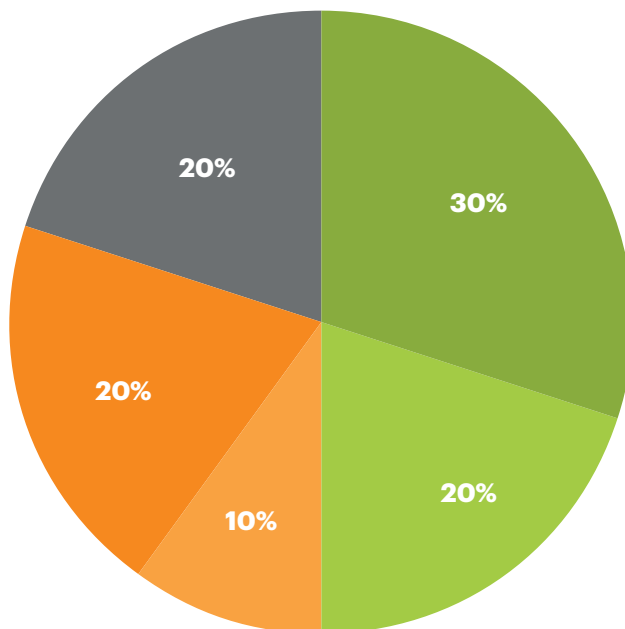
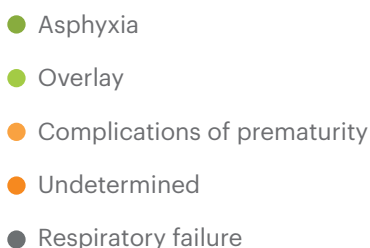
The IMRT resumed formal case reviews in September 2020 and conducted three more meetings, only canceling the November 4, 2020 meeting due to the unprecedented nature of the 2020 Presidential Election also being on the same date.

The IMRT completed nine (9) full case reviews in 2020, with an average of 31 participants at each meeting.

The Infant Mortality Review Team showed exceptional commitment to the case review process during the Coronavirus pandemic in concert with their other duties as physicians, nurses, social workers, attorneys, administrators, and community members.

In the 2020 review of fatalities, which all occurred in 2018, the Manner of Death for the fatalities was: 6 were classified as Accidental deaths (67%), two were classified as Undetermined (22%), and one as a Natural death (11%). The leading Cause of Death for the reviewed fatalities was observed to be evenly distributed with; overlay, undetermined and respiratory failure all at 20% (N=2) and Asphyxia observed at 30% (N=3). **See Figure 3.**

FIGURE 3
IMRT Decedent
Cause of Death



The average gestational age was 37 weeks, with an average of seven pre-natal appointments attended by the decedents' mothers. The average BMI for the decedents' mothers was 32, and the decedents' father's average BMI was 28. Eight of the nine decedents belonged to a Managed Care Organization, and only one was a Fee-For-Service beneficiary. Four decedents had a positive toxicology at birth, and four decedents had a NICU admission.

Most of the decedents resided in Ward 8 (N=6). All nine decedents were black, and five of the decedents were male. **See Figure 4.**

Substance use was observed by both the decedents' mother and father in the cases reviewed. Seventy-seven percent of mothers used marijuana, and sixty-six percent used alcohol and tobacco products. **See Figure 5.**

Forty-four percent of decedents' fathers used marijuana and tobacco products, and thirty-three percent utilized alcohol and cocaine substances. **See Figure 6.**

FIGURE 4 Ward of Fatality

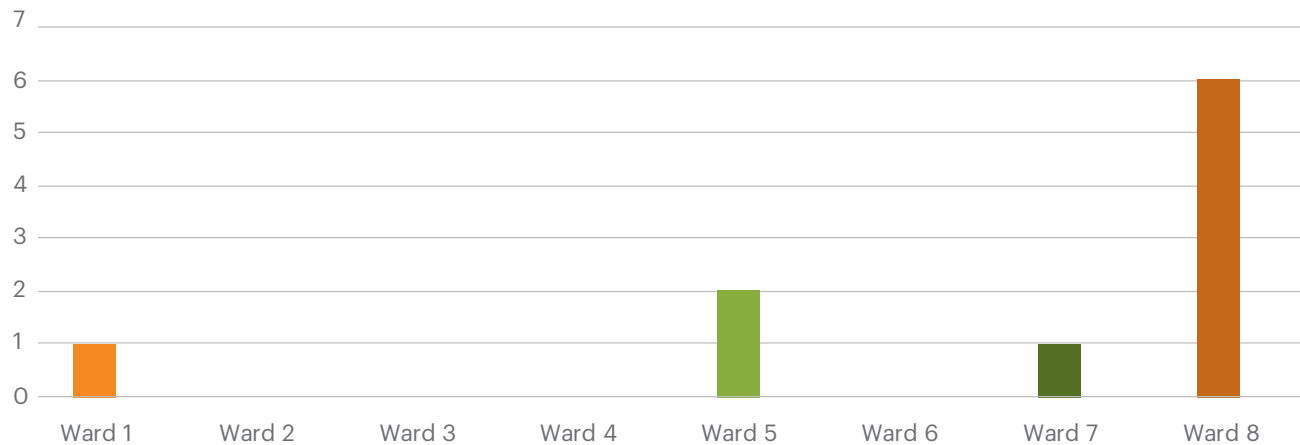


FIGURE 5 Mother Substance Use

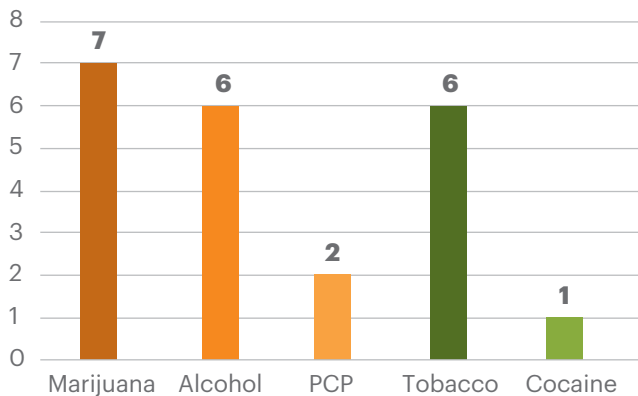
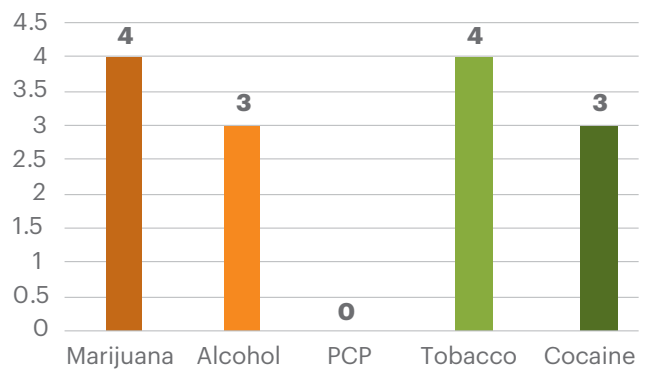


FIGURE 6 Father Substance Use



The greatest maternal risk factor noted was the mother’s history of previous Cesarean sections for delivery, fifty-five percent. **See Figure 7.**

As most families were involved with government based social service programs, the IMRT observed the family’s involvement with government social service agencies. Housing and food insecurity and mental health treatment were the leading factors impacting these families. **See Figure 8.**



FIGURE 7 Maternal Risk Factors

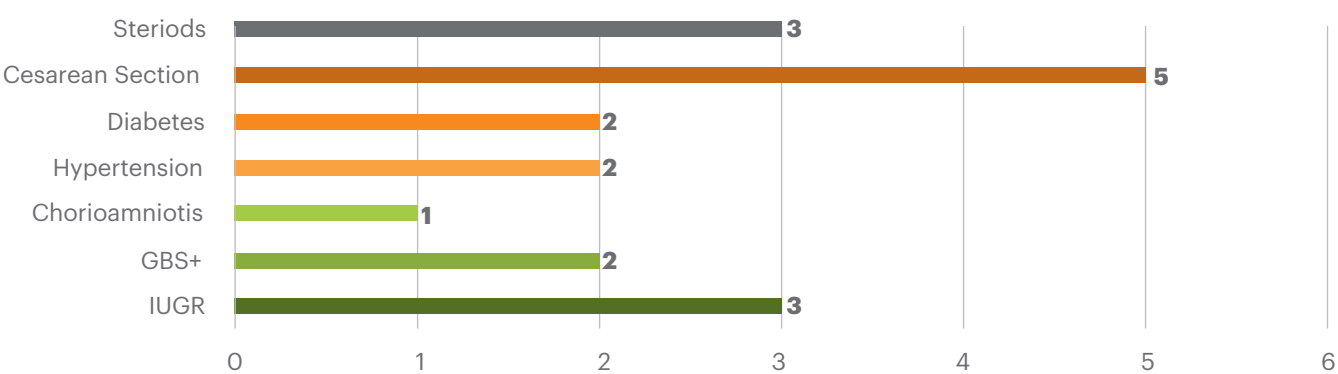
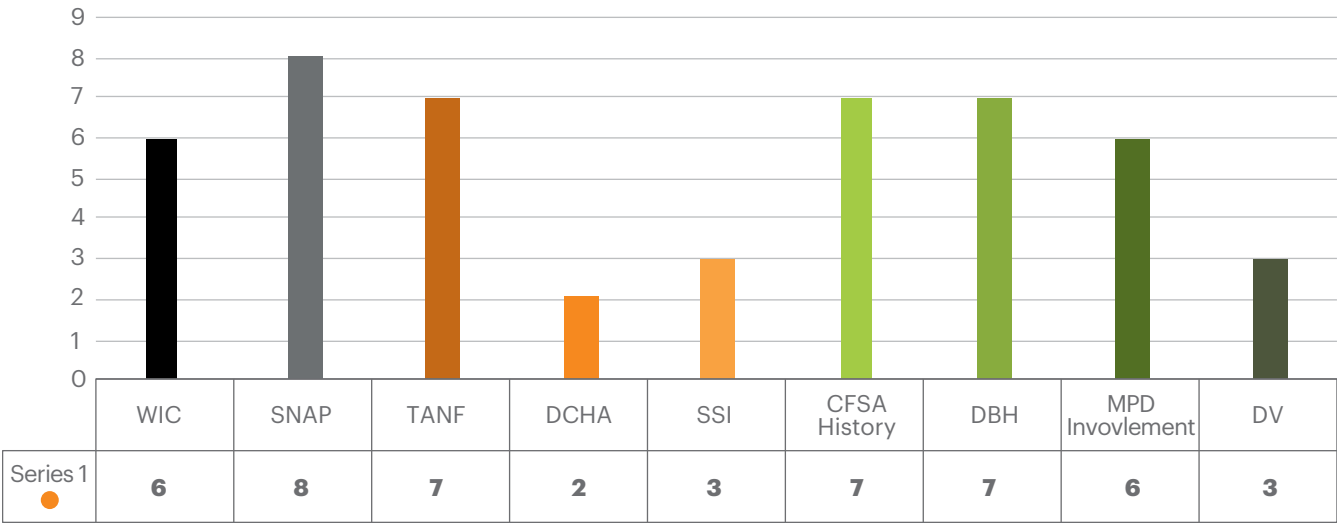


FIGURE 8 Social Service Involvement



UNSAFE SLEEP ENVIRONMENT

As noted in previous Child Fatality Review Committee Annual Reports, unsafe sleep continues to be the leading contributory factor for Undetermined or Accidental infant deaths in the District of Columbia. Out of the nine (9) full case reviews completed in 2020, seven (7) decedents did not sleep in their own AAP-approved crib or sleep environment, were not alone in the bed, and slept on an adult mattress. Those seven cases also had an AAP-approved safe sleep environment, “pack and play,” or “cribette” found on the premises during the medico-legal investigation, which was not in use at the time of the fatality.

As mentioned, Unsafe Sleep environments as a contributory cause of death have been observed in Undetermined and Accidental infant deaths and have been steadily increasing during the review of cases.

The following trends were noted in a retrospective of the information collected for the Annual Reports between 2017 and 2020.

In the 2017 review of infants who died in 2015, **six fatalities (35%)** had an Unsafe Sleep Component.

In the 2018 review of infants who died in 2015 and 2016, **ten fatalities (30%)** had an Unsafe Sleep Component.

In the 2019 review of infants who died in 2017, **fourteen fatalities (66%)** had an Unsafe Sleep Component.

In the 2020 review of infants who died in 2018, **eight fatalities (88%)** had an Unsafe Sleep Component. (Due to COVID-19 restrictions, full case reviews only occurred in five months during 2020).

Total number of full case reviews completed by the Infant Mortality Review Team

- 2017- 17 full case reviews
- 2018- 33 full case reviews
- 2019- 21 full case reviews
- 2020- 9 full case reviews

The 2020 review of infant fatalities revealed:

- Five families experienced housing insecurity.
- Five families had a history of untreated mental health.
- Seven families had a history of child welfare involvement.
- Eight families experienced financial insecurity- receipt of government resources: TANF, SNAP, WIC, SSI, or Housing Assistance
- Seven infants were exposed to tobacco products.
- Seven mothers reported using marijuana and tobacco during pregnancy and at the time of the fatality

INFANT MORTALITY REVIEW TEAM CASE DISCUSSION:

Several themes were discussed during the abbreviated meeting schedule conducted in 2020.

1. Prosecuting cases when the Manner of Death is determined to be an Accident or Undetermined, from the perspective of the United States Attorney’s Office (USAO) and the Office of the Attorney General (OAG), was discussed when contributory conditions –overlay, unsafe sleep environment, lack of supervision, or caregiver impairment are present. The USAO and the OAG indicated their offices have minimal impact in pursuing criminal charges in these cases. The IMRT continued to discuss the lack of a clear negligence statute in the District of Columbia, which can only be addressed by members of the City Council. Presently the District of Columbia has a First-Degree Cruelty to Children Statute, which is used to prosecute cases.

2. The IMRT indicated a better risk stratification process could help determine how best to move towards prevention practices in the community before a fatality situation develops, especially in preventable deaths. The team observed that when agencies contemplate “touchpoints” as a means of access for families, the interventions should be perceived as helpful and supportive, not punitive by the individuals receiving the attention.

3. The IMRT is excited to work with Thrive by Five and the larger health and welfare community to provide Safe Sleep Interventions and engage with families and caregivers. The Infant Mortality Review Team is committed to using information gathered from focus groups and surveys to determine what could be said or done with families to aid them in their decisions to exercise safe sleep practices and not bed share with their infants.

4. The IMRT discussed that no extensive research had been conducted on why caregivers choose not to use the “Pack and Play” even though families have them in the home at the time of the fatality. One of the suggestions from the Infant Mortality Review Team that was implemented was, when the Medical Examiner investigates fatalities with an unsafe sleep environment component if there was a “Pack and Play,” crib or another safe sleep environment present at the scene, to ask if it was being utilized for infant safe sleep and if not, what was the rationale for not using it. This line of questioning will enable investigations and thereby the IMRT to obtain real-time data regarding this concern, versus assuming, to identify patterns and trends upstream in the caregiver’s decision-making process.

5. The IMRT discussed that in-bed bassinets and sleepers are not regulated by the United States Consumer Product Safety Commission. Although this equipment is marketed as “safe,” they are not recommended, or safety approved by the American Academy of Pediatrics (AAP). Anything besides the approved crib mattress with a fitted sheet creates a safe sleep risk to an infant.



6. The IMRT continued to review fatalities where the infant sleep environment was a contributory cause in the fatality. The team discussed whether the proper messaging was being delivered regarding infant safe sleeping and if the information being given at well-child visits needs to be reevaluated to ensure understanding and synthesis by the receiver. The Infant Mortality Review Team acknowledged that education and training regarding infant safe sleep practices provided to caregivers might differ based on the training or methodology of the person giving the education. In the review of fatalities with an unsafe sleep component, the Infant Mortality Review Team noted that parents appeared to retain the information to “place the infant on their back” regarding safe sleep education. However, caregivers are not placing infants “alone” and in their own crib, bassinet, or approved safe sleep environment. The need for whole family education was identified as a need when providing infant safe sleep education.

7. The IMRT reflected on the cases where educational neglect was identified by Child and Family Services Agency (CFSA) as an indicator that something else is amiss in the home; and if educational neglect can be used as a trigger in the CFSA for a broader and more comprehensive review of family systems that are also impacted to include unsafe sleep situations, even if the infant is not the focus of the neglect allegation.

8. The IMRT identified chronic stress and the social determinants of health as several of the components affecting the families of all the reviewed decedents. Providing peer support and coaching to families to strengthen the “Back to Sleep” message and practice, encouraging caregiver’s efforts, and reinforcing safe sleep education was identified as a critical component in the equitable provision of resources and services to the families in the District of Columbia.

IMR 2018 NATURAL DEATH STATISTICAL REVIEWS

The Child Fatality Review Committee (CFRC), Infant Mortality Review Team (IMRT) staff identified 29 cases applicable for review of infants who died of natural causes in the calendar year 2018. These infants lived up to a matter of minutes, hours, and days. None lived longer than 17 days. The following is a summary of statistics obtained from the review of these cases utilizing information gathered from the DC Health (DOH) Vital Statistics- Certificate of Live Birth and Certificate of Death.

DECEDENT INFORMATION

Of the 29 decedents reviewed, 52% (N=15) were male, and 48% (N=14) were female. **See Figure 9.**



FIGURE 9
2018 IMR Statistical Decedent Gender

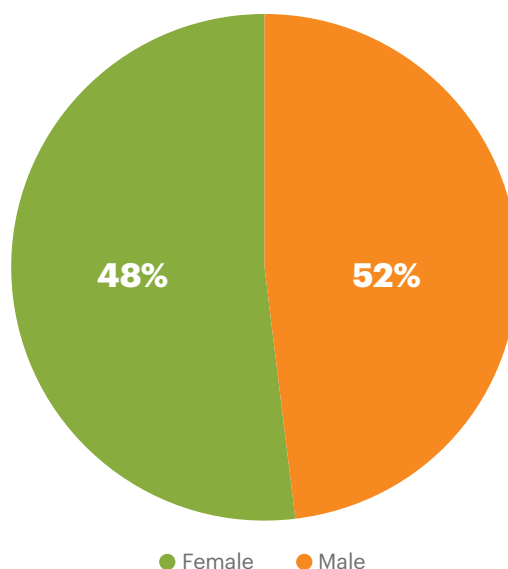


FIGURE 10 2018 IMR Statistical Decedent Race

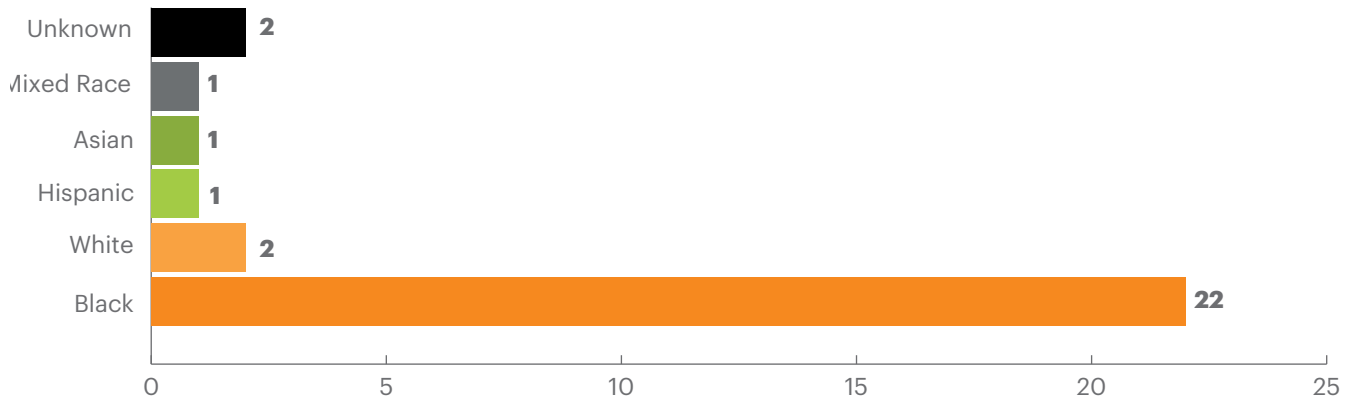
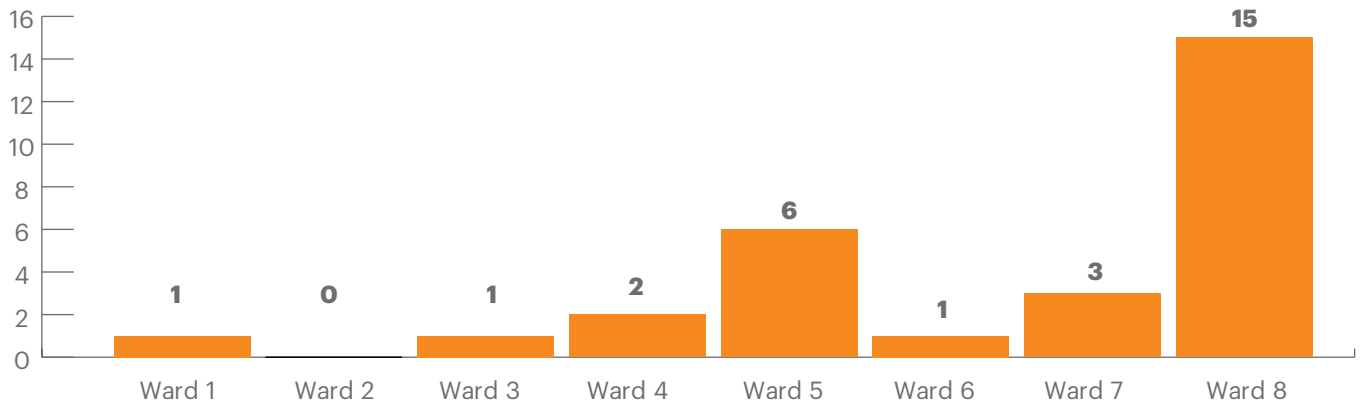


FIGURE 11 2018 IMR Statistical Decedent Ward of Residence

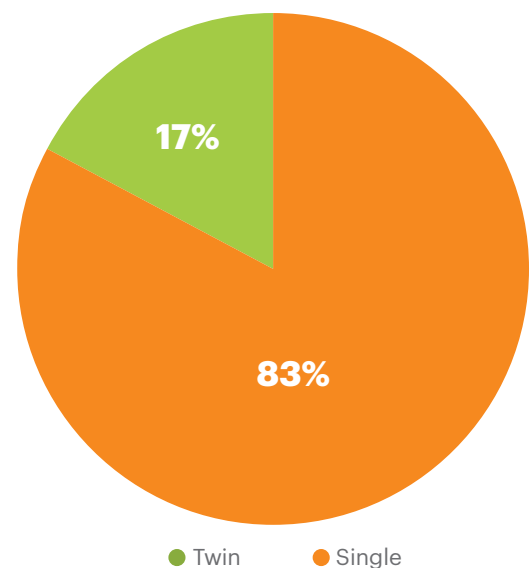


Of the races identified on the Certificate of Live Birth, 76% (N=22) of the decedents were Black and 7% (N=2) were White. One decedent each was Hispanic, Asian, and biracial. The race of two (2) decedents was not identified on the Certificate of Live Birth. **See Figure 10.**

Wards 5, 7, and 8 had the most infant deaths which accounted for 83% of the decedents in this statistical review. Ward 8 was the highest with 52% of decedents. **See Figure 11.**

Eighty-three percent (83%, N=24) of decedents were born as a singleton pregnancy, and 17% (N=5) were born as a twin pregnancy. None of the decedents were born outside of this jurisdiction. **See Figure 12.**

FIGURE 12
2018 IMR Decedent Birth Plurality



The number of decedents who were born and died was highest in March. Six (6) decedents, or 21% of the total number of decedents born in this sample, died during that month. **See Figure 13.**

Fifty-five percent of decedents (N=16), lived between 1-18 hours, with an average number of ten decedents who lived for 1.5 hours. Thirty-four percent (N=10) of decedents lived between 1-17 days, with an average of six decedents having

lived for three (3) days. Lastly, three (3) decedents lived between 17 and 29 minutes - an average of 20 minutes. **See Figure 14.**

Sixty-nine percent of these births occurred during the second trimester, with an average gestational age of 23 weeks. There were 31% third trimester cases, with a maximum gestation of 41 weeks. **See Figure 15.**

FIGURE 13 2018 IMR Statistical Decedent Month of Death by Frequency

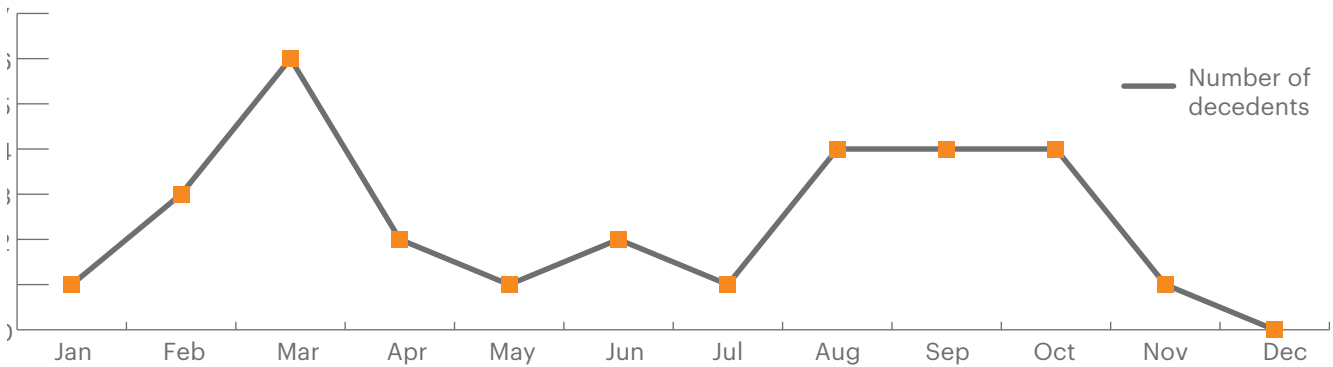


FIGURE 14
2018 IMR Statistical Decedent Age at Death

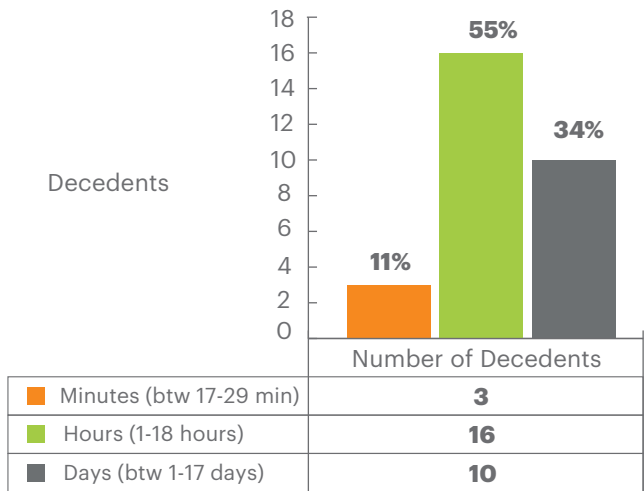
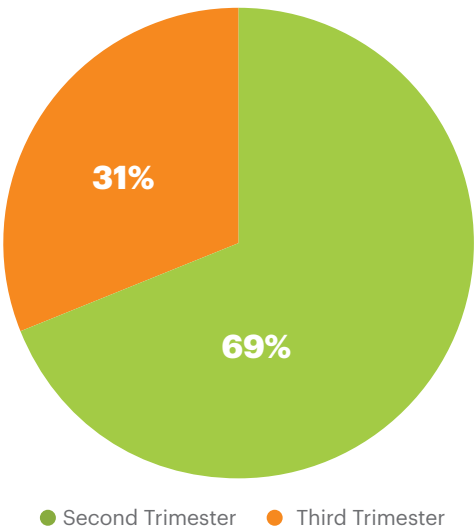


FIGURE 15
2018 IMR Statistical Decedent Gestational Age at Birth



GESTATIONAL AGE AND WEIGHT AT BIRTH

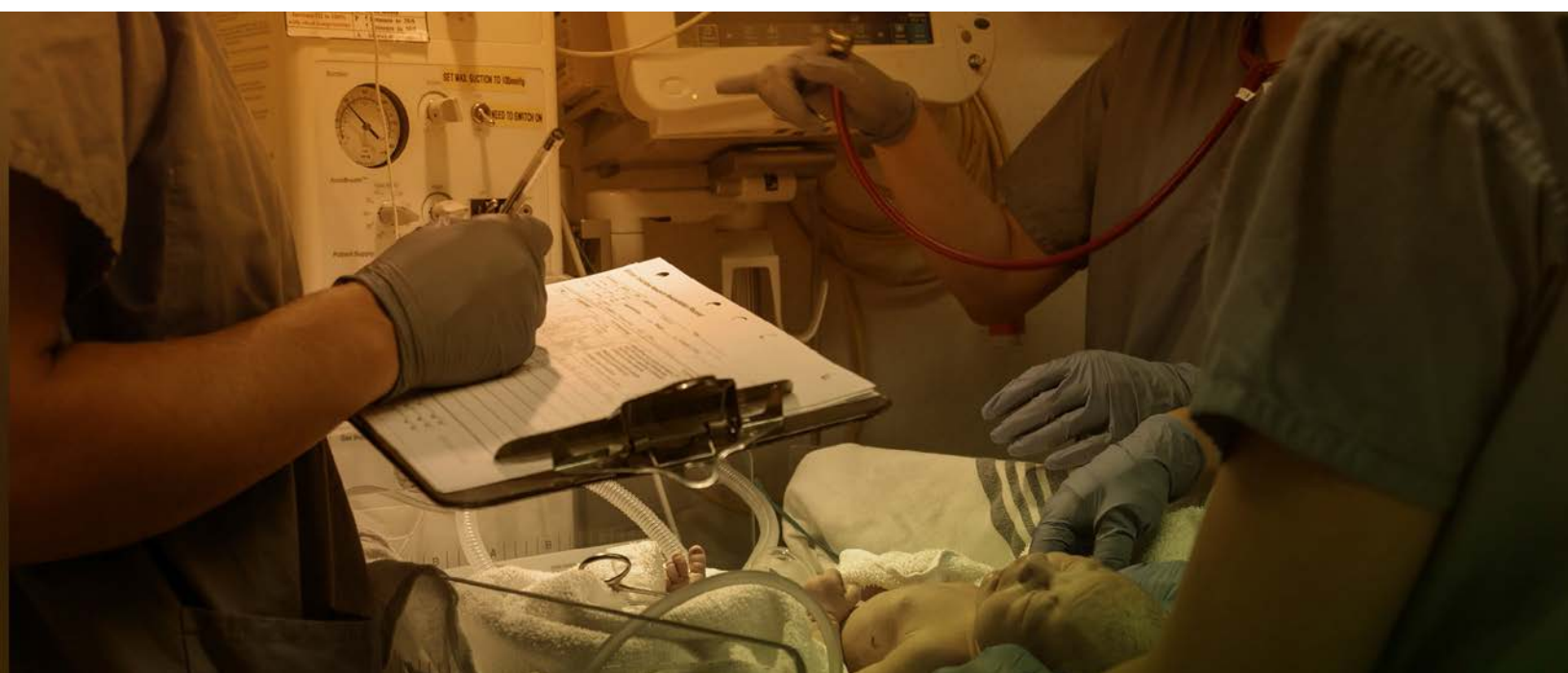
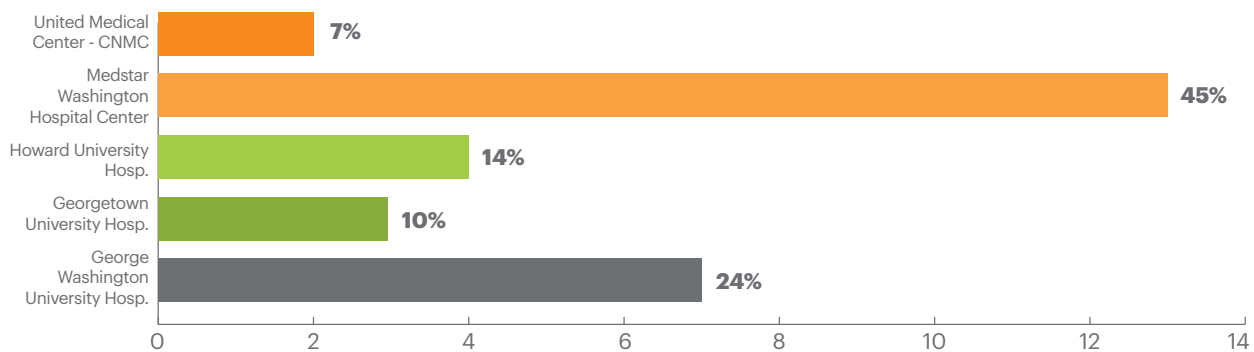
Fifty-five percent (N=16) of the decedents weighed more than the expected birth weight for gestational age. Forty-one percent (N=12) of the decedents weighed less than the expected birth weight for gestational age. One decedent's birth weight was not recorded on the Certificate of Live Birth.

Previable and Perivable Cases: These decedents were less than 28 weeks gestation and weighed less than 1000 grams at birth.

- 19 – 21 weeks gestation fetuses are previable – the fetuses in this category are not sustainable. No medical interventions could have saved them.
- 22 – 27 weeks gestations fetuses are perivable – the fetuses in this category have a higher probability of survival at birth. However, their survival is not optimized.
- Gestational age and birth weight relate to a fetus's survivability at birth.

Most decedents, 45% (N=13), were born at the MedStar Washington Hospital Center, followed by 24% (N=7) born at the George Washington University Hospital. Fourteen percent (N=4) were born at Howard University Hospital. Ten percent (N=3), were born at Georgetown University Hospital. Seven percent (N=2) of these decedents were born at the United Medical Center. **See Figure 16.**

FIGURE 16 2018 IMR Statistical Decedent Hospital of Birth





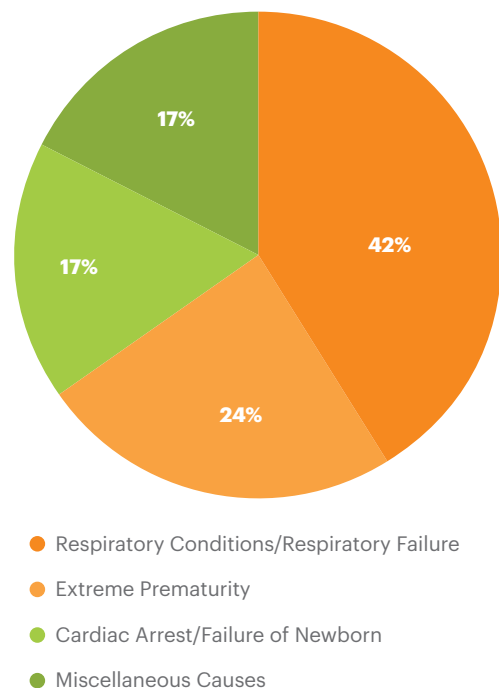
Forty-one percent (N=12) of decedents died of disorders related to respiratory conditions originating in the perinatal period. Twenty-four percent (N=7), of the decedents' cause of death was from a short gestation and low birth weight. Cardiac arrest/failure of newborns accounted for 17% (N=5), which was the third largest cause of decedent deaths. **See Table 2 and Figure 17.**

Respiratory conditions/respiratory failure was the leading condition contributing to the cause of death in the cases reviewed for this statistical summary. Extreme prematurity was the second leading condition, contributing to the cause of deaths for decedents reviewed in this statistical summary.

TABLE 2
2018 IMR Decedent – Immediate Causes of Death by ICD-10 Code

IMMEDIATE CAUSE OF DEATH BY ICD-10 CODE	FREQUENCY (NUMBER OF DECEDENTS)
Other respiratory conditions originating in the perinatal period (P28)	12
Disorders of the newborn related to short gestation and low birth weight, not elsewhere classified (P07)	7
Cardiac arrest/failure of newborn (P29.81)	5
Brain Damage (P91.6)	3
Congenital Anomalies (Q89.7)	1
Hepatic Failure (K72)	1

FIGURE 17
2018 IMR Statistical Decedent Conditions Leading to Cause of Death



According to the Certificate of Live Birth, sixty-two percent (N=18) of decedents were born in the cephalic position and twenty-four percent (N=7) were born in a breech position. Three percent (N=1) were born in a categorized position indicated as “Other”. Eleven percent (N=3) of the decedent’s fetal presentation was not reported. **See Figure 18.**

Most decedents, 65% (N=19), were delivered by spontaneous vaginal delivery. Thirty-five percent (N=10) of decedents were delivered by Cesarean section. There were no Vaginal/Forceps or Vaginal/Vacuum deliveries

noted. Of the ten decedents delivered via Cesarean section, 100% underwent a cesarean delivery without attempting a trial of labor. **See Figure 19.**

Of the Apgar scores recorded at 1 minute, 55% (N=16) of decedents had no Apgar score recorded. Fourteen percent (N=4) of decedents had an Apgar score of 2 at one (1) minute. Ten percent (N=3) of decedents had an Apgar score of 1 at one (1) minute. Seven percent (N=2) of each decedent had an Apgar score of 3 and 8 at one (1) minute.

FIGURE 18
2018 IMR Statistical Decedents’ Fetal Presentation at Birth

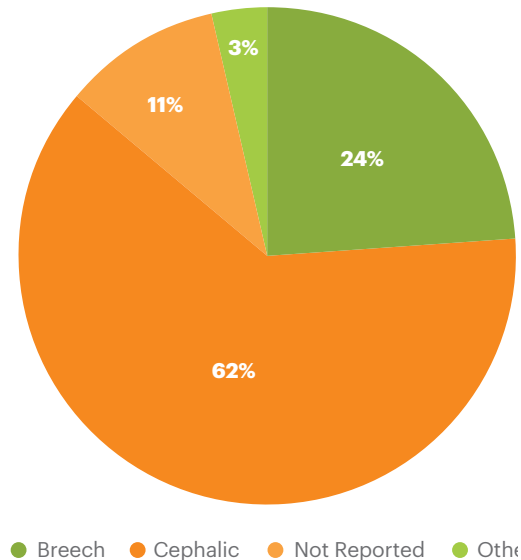


FIGURE 19
2018 IMR Statistical Decedent Method of Delivery

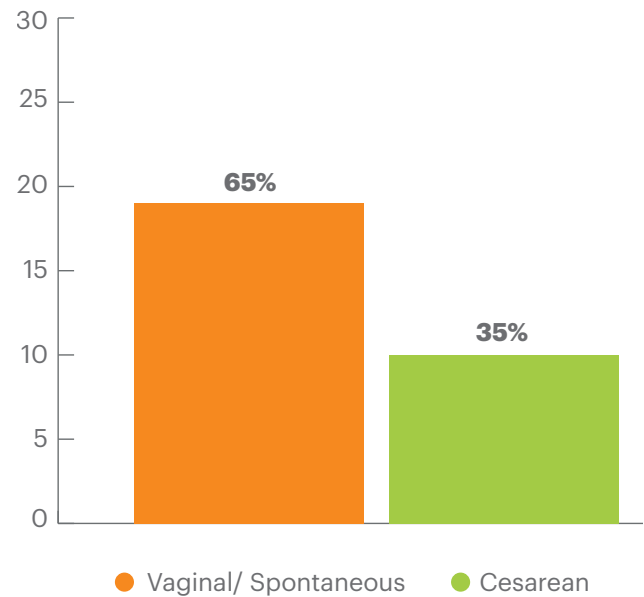
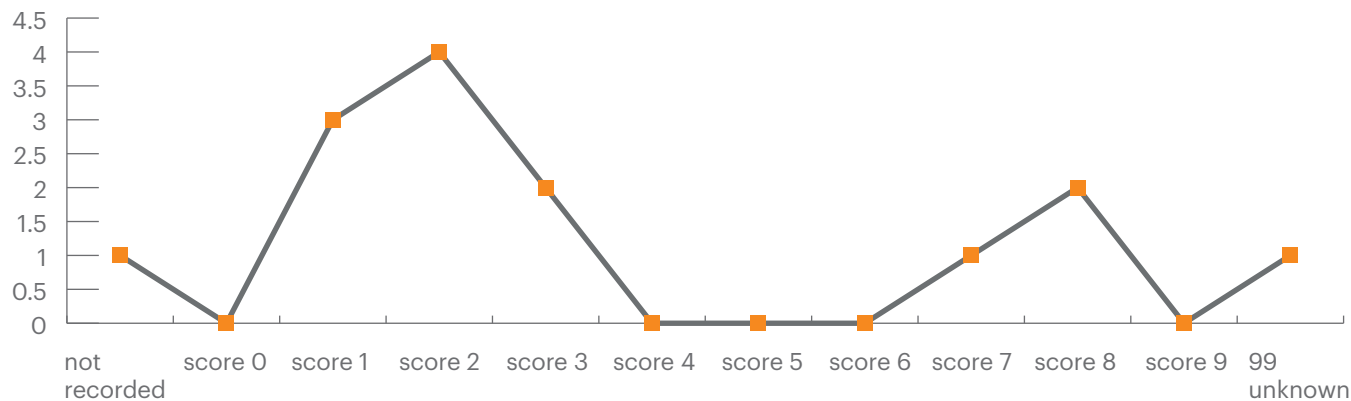


FIGURE 20 2018 IMR Statistical Decedent Apgar Score at 1 Minute





Most decedent's Apgar scores were first entered at the 5-minute time mark. Twenty-eight percent (N=8) of decedents had an Apgar score of 1. Fourteen percent (N=4) of decedents had an Apgar score of 2 at five (5) minutes; 10% (N=3) of each decedent had an Apgar score of 5 and 7 at five minutes; seven percent (N=2) of each decedent had an Apgar score of 3, 4, and 9; and three percent (N=1) of each decedent had an APGAR score of 6, 99 (unknown), and not recorded. **See Figure 21.**

At the 10-minute time mark, fourteen percent (N=4) of decedents had an Apgar score of 1; 10% (N=3) of decedents had an Apgar score of 0; seven percent (N=2) had an Apgar score of 3 at ten (10) minutes; and three percent (N=1) had an Apgar score of 4, 6, and 7 at ten (10) minutes. Twenty-four percent (N=7) of decedents had Apgar scores that were not recorded at ten (10) minutes. Thirty-four 34% (N=10) of the decedents had an Apgar score of 99 (unknown). **See Figure 22.**

FIGURE 21 2018 IMR Statistical Decedent Apgar Score at 5 Minutes

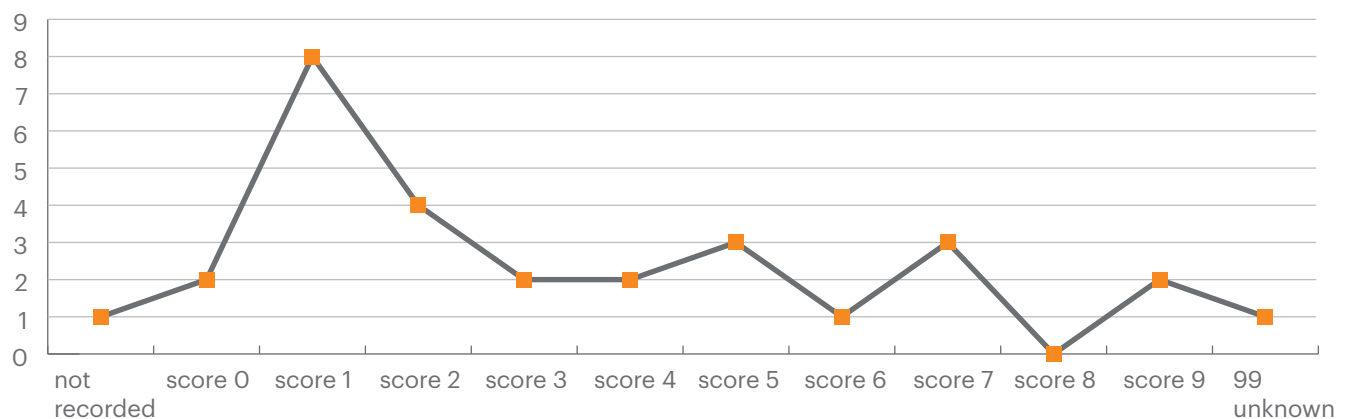
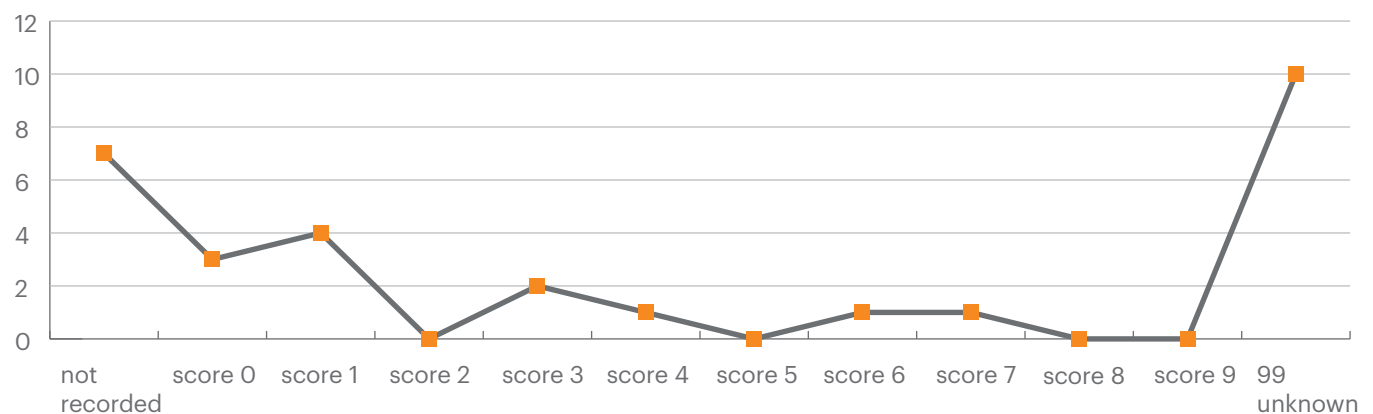


FIGURE 22 2018 IMR Statistical Decedent Apgar Score at 10 Minutes



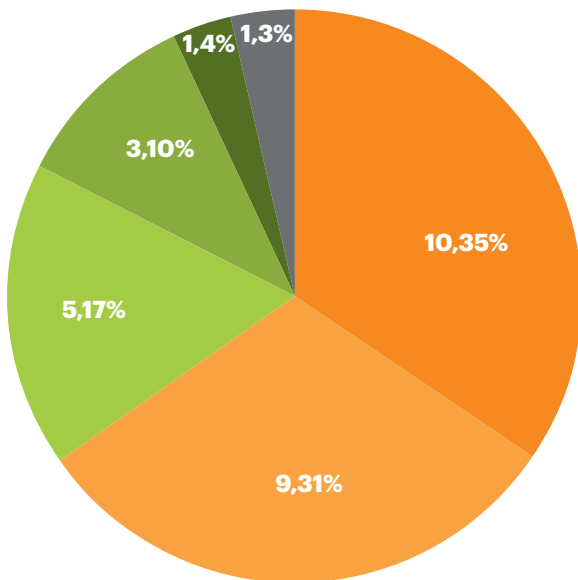


The Certificate of Live Birth tracks the abnormal conditions of newborns. Thirty-five percent (N=10) of decedents required assisted ventilation immediately following delivery. Thirty-one percent (N=9) of decedents had a NICU admission immediately following their birth. Seventeen percent (N=5) of decedents did not have any abnormal conditions indicated on the Certificate of Live Birth. Eleven percent (N=3) of decedents had prematurity listed as an abnormal condition. One decedent was born with Acute Chorioamnionitis as an abnormal condition following delivery, and one decedent had nothing recorded. **See Figure 23.**

Seventy-two percent of the decedents (N=21) did not have any congenital anomalies listed in these categories on their Certificate of Live Birth. Two (2) decedents did not have any information recorded on their Certificate of Live Birth. There were five noted categories with one decedent each with various congenital anomalies indicated on their Certificate of Live Birth, including Dandy Walker Deformity, Exencephaly, Hepatosplenomegaly, Hypospadias, Multicystic Dysplastic Kidney, and Severe prematurity.¹ **See Figure 24.**

FIGURE 23

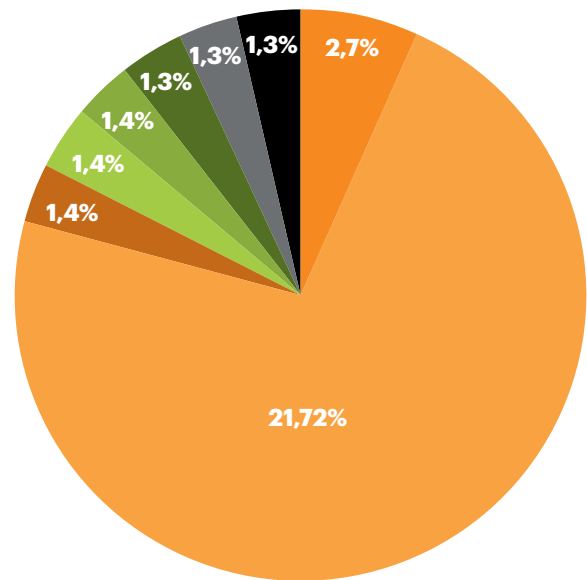
**2018 IMR Statistical Decedents-
Abnormal Conditions of the Newborn**



- Assisted Ventilation
- Prematurity
- NICU Admission
- Acute Chorioamnionitis
- None
- Not recorded

FIGURE 24

**2018 IMR Statistical Decedent
Method of Delivery**



- No Record
- None
- Dandy-Walker
- Exancephaly
- Hepatoplenomegaly
- Hypospadias
- Multicystic Dysplastic Kidney
- Severe Prematurity

<https://www.empowher.com/media/reference/dandy-walker-syndrome>
<https://radiopaedia.org/articles/exencephaly>
<https://healthh.com/hepatosplenomegaly>
<https://www.nationwidechildrens.org/conditions/multicystic-dysplastic-kidney>
<https://www.mayoclinic.org/diseases-conditions/premature-birth/symptoms-causes/syc-20376730>



Sixty-two percent (N=18) of the decedents were not breastfed at the time of discharge, as most were never discharged from the hospital nor ever left the hospital's labor and delivery unit. Thirty-eight percent (N=11) of decedents were breastfed at the time of discharge, most having moved to the hospital's neonatal intensive care unit (NICU). **See Figure 25.**

MATERNAL INFORMATION

Although there were twenty-nine (N=29) decedents included in this statistical review, there were twenty-seven (N=27) mothers counted in the maternal information sections of this report. There were five sets of twins. However, two (2) sets of twins (four decedents) were discussed individually in this report.

FIGURE 25

Statistical Decedents Breastfed at Discharge

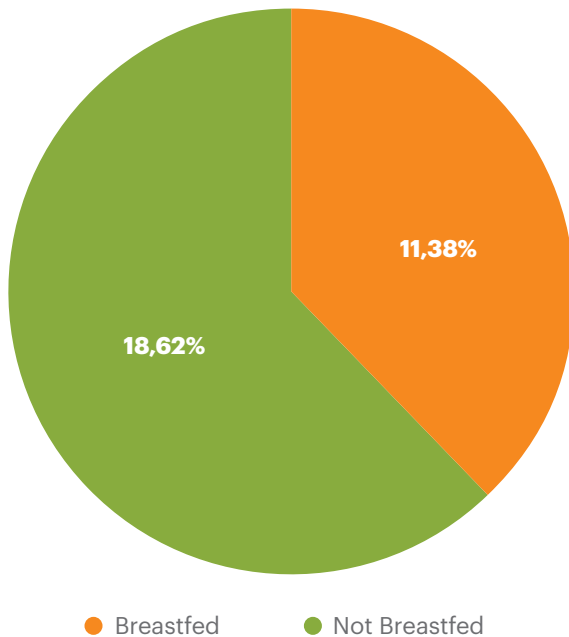
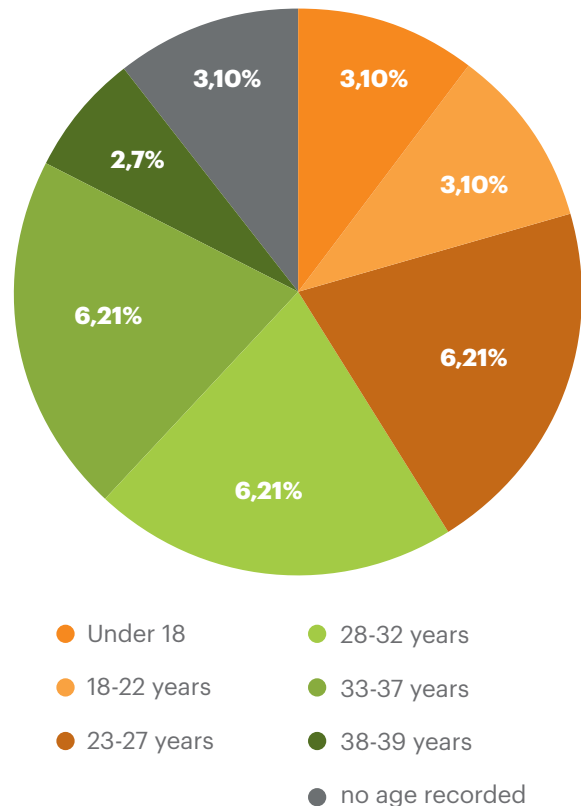


FIGURE 26

2018 IMR Statistical Decedents-Abnormal Conditions of the Newborn



The youngest mother in this statistical sample was 17 years old, and the oldest mother was 39 years old. The average age of all mothers in this statistical review was 28 years old. Ten percent of the mothers had no age recorded on the Certificate of Live Birth. **See Figure 26.**

As indicated on the Certificate of Live Birth, 81% (N=22) of the mothers were Black. Seven percent (N=2) were Hispanic (one mother identified as Guatemalan, and the other identified as Dominican). Four percent (N=1) identified as White, and four percent (N=1) identified as Other, Asian (Nepali). Four percent (N=1) was not recorded. **See Figure 27.**

Most of the mothers completed high school, received a GED, or furthered their education. Thirty percent (N=8) of the mothers received a high school diploma or a GED. Eighteen percent (N=5) attained some college credits, and four percent (N=1) obtained an associate degree. Seven percent (N=2) of mothers obtained their bachelor's degree, and four percent (N=1) of mothers obtained their master's degree. Fifteen percent (N=4) of mothers attended school during their 9th to 12th grade years yet did not obtain a diploma. Four percent (N=1) of the mothers attended less than the eighth-grade year of school, and 18% (N=5) of the mothers' educational status was not recorded on the Certificate of Live Birth. **See Figure 28.**

FIGURE 27
2018 IMR Statistical Decedent
Method of Delivery

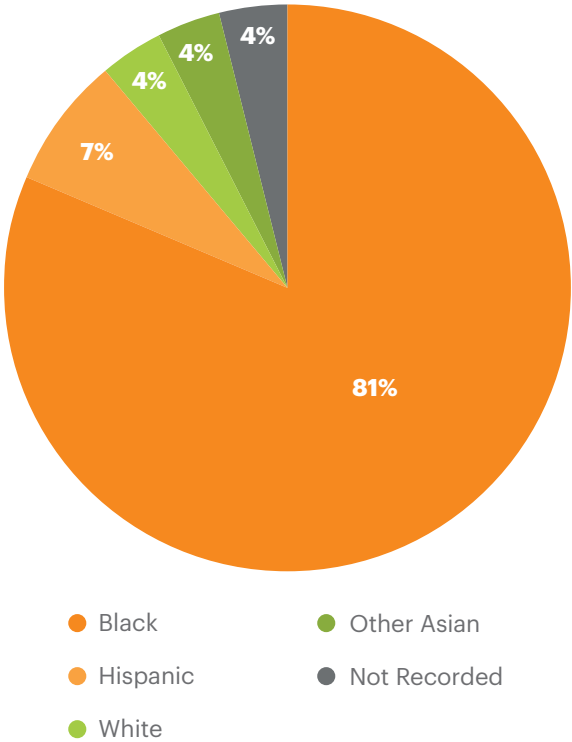
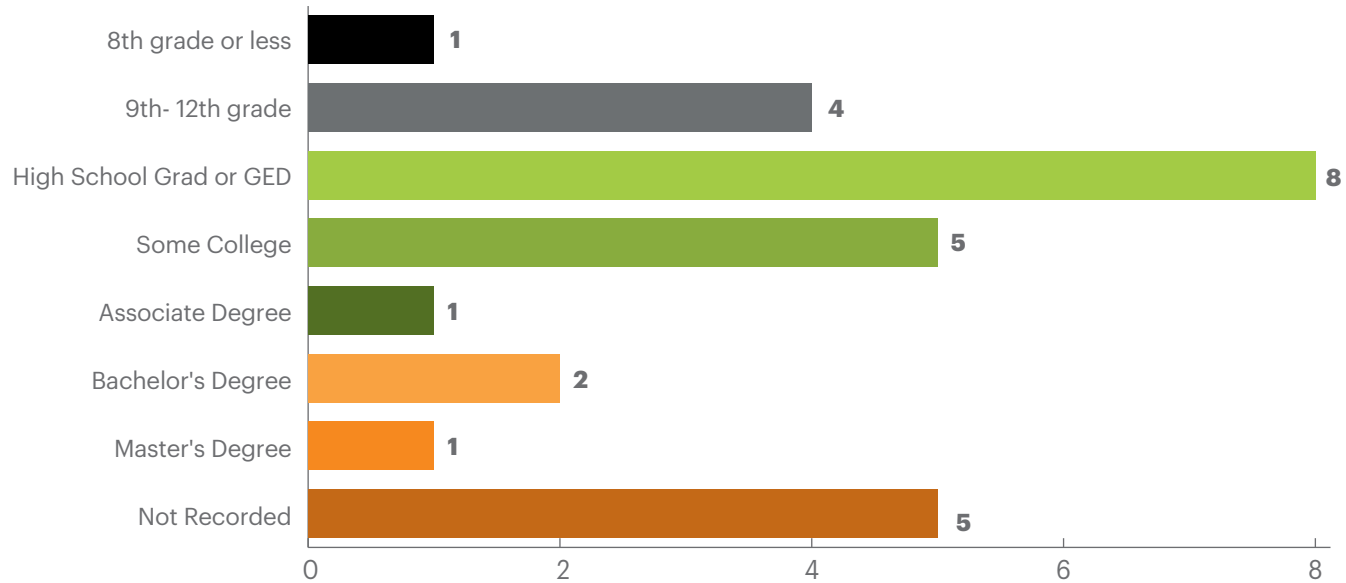


FIGURE 28 2018 IMR Statistical Decedent Maternal Education Status



The Certificate of Live Birth indicated 74% (N=20) of mothers were not married at birth, conception, or prior to the fatal event; and 26% (N=7) of mothers were married. **See Figure 29.**

According to the Certificate of Live Birth, and the Death Certificate, fifty-six percent (N=15) of the decedent’s mothers received prenatal care. Twenty-six percent (N=7) did not receive prenatal care, and 18% (N=5) were not recorded. Whether the mothers’ care was supplemented or altered to prevent the decedent’s death or provide adequate care throughout the pregnancy was not captured. **See Figure 30.**

In the statistical review, 81% (N=22) of mothers were DC Medicaid Beneficiaries. Fourteen percent (N=4) of mothers had private insurance, and three percent (N=1) were enrolled in the Amerihealth DC Medicaid Managed Care Organization. Seven percent (N=2) of the mothers’ insurance status was not reported. **See Figure 31.**

FIGURE 29
2018 IMR Statistical Decedents’
Maternal Marital Status

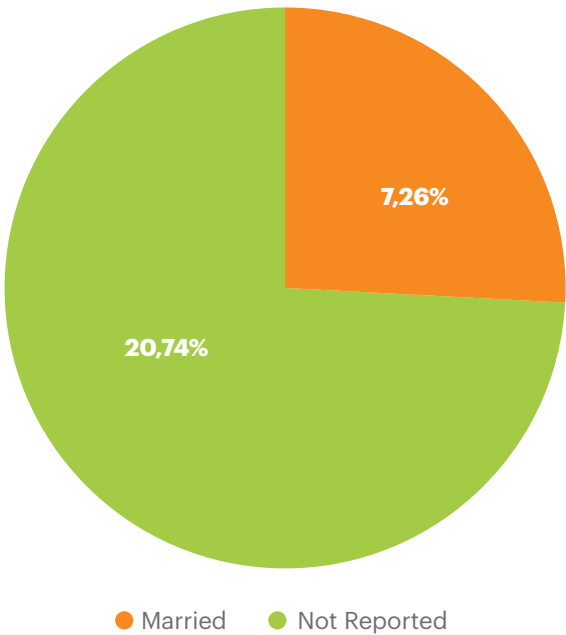


FIGURE 30
2018 IMR Statistical Decedent’s
Maternal Prenatal Care

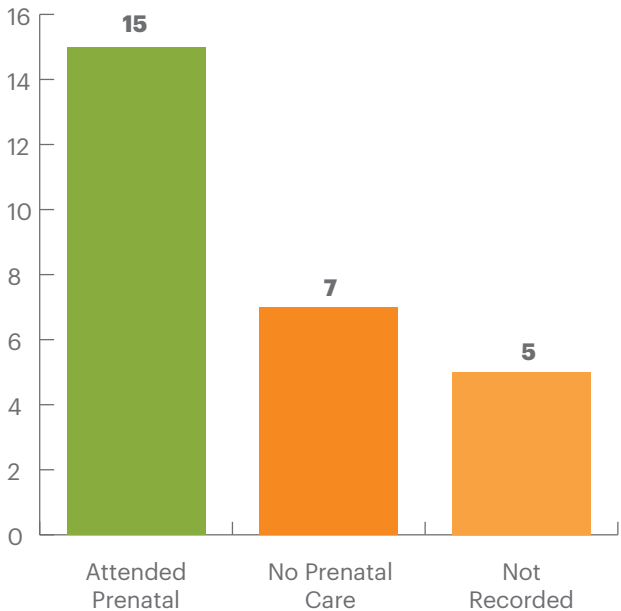
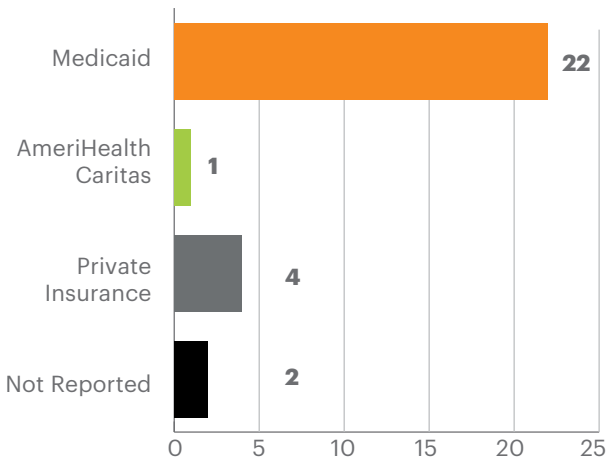


FIGURE 31
2018 IMR Statistical Decedent’s Maternal
Health Insurance Participation



Of the 16 mothers who were known to have received pre-natal care, 22% (N= 6) attended their first pre-natal visit on or before their eighth week of pregnancy. Thirty-seven percent (N=10) of the mothers began pre-natal care at nine weeks or after. Nineteen percent (N=5) of the mothers did not receive prenatal care, and 22% (N=6) of the mothers' information was not recorded. **See Figure 32.**

The average height of all mothers was 5 feet 2 inches tall, with the shortest maternal height indicated as 5 feet 0 inches tall and the tallest as 5 feet 9 inches tall. The maternal height of three mothers were either unknown or unrecorded. **See Figure 33.**

FIGURE 32 2018 Frequency of IMR Statistical Decedents' Maternal Prenatal Care 1st Visit

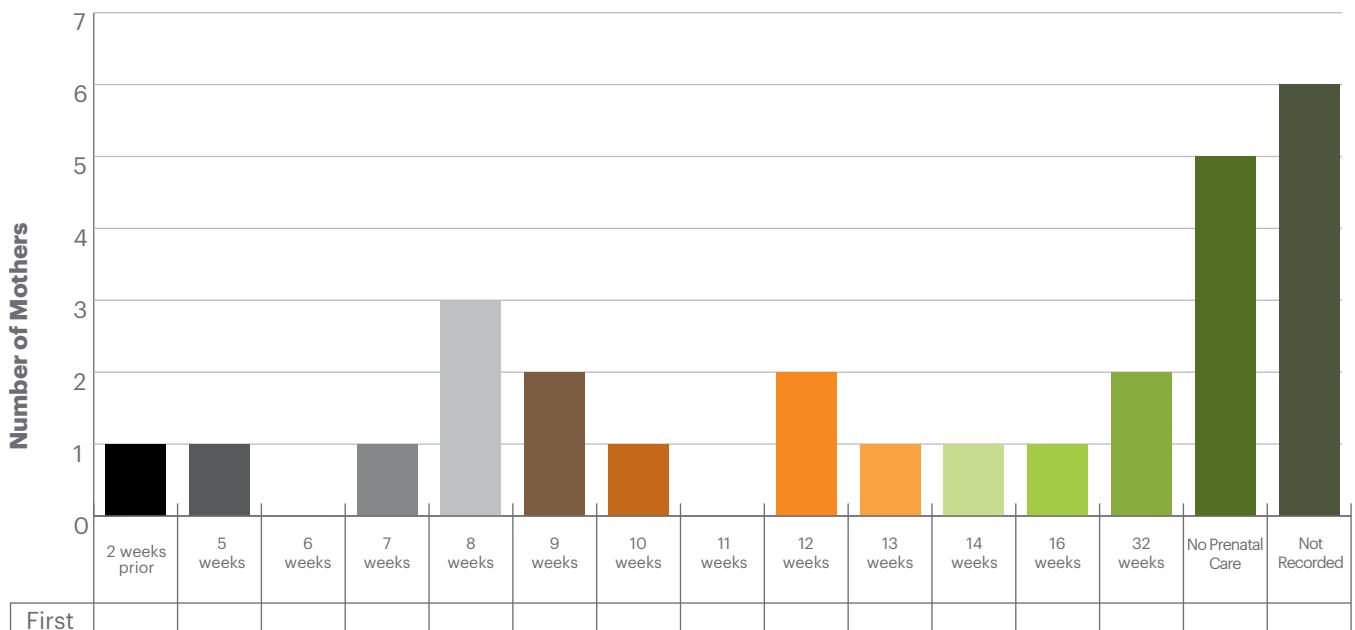
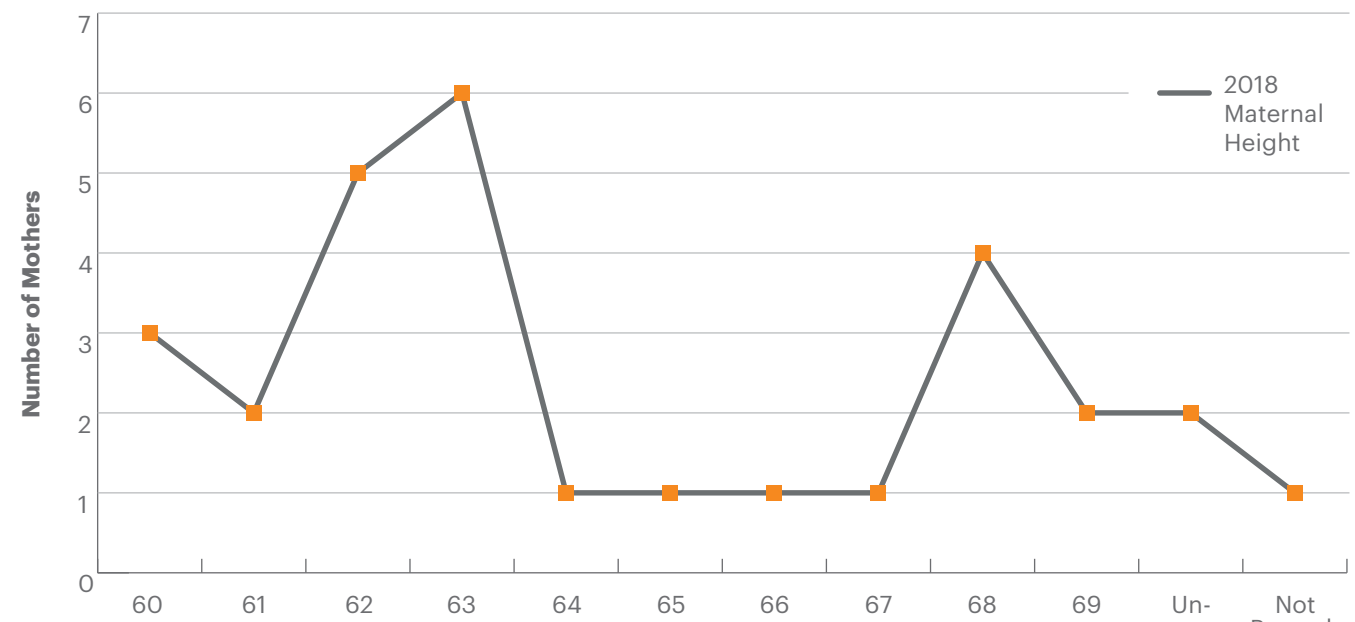


FIGURE 33 2018 IMR Statistical Decedent's Maternal Height



The average maternal pre-pregnancy weight of all mothers in this statistical review was 182 pounds, with the lowest maternal pre-pregnancy weight being 120 pounds and the highest weight being 315 pounds. There was one mother whose pre-pregnancy weight was not recorded and three mothers whose pre-pregnancy weights were unknown. **The average pre-pregnancy BMI of all mothers was 31.**

BMI CATEGORIES:²

Underweight = <18.5

Normal weight = 18.5–24.9

Overweight = 25–29.9

Obesity = BMI of 30 or greater

Note: there are both CDC and ACOG Guidelines: Pre-Pregnancy BMI > or equal to 30. Per Link Pregnancy Complications | Maternal and Infant Health | CDC.³

TABLE 3

2018 IMR Statistical Decedent's Maternal Pre-Pregnancy Weights

Maternal Pre-Pregnancy Weight	Number of Mothers	Maternal Pre-Pregnancy BMI	Number of Mothers
120-140 pounds	5	21.0 – 24.8	5
141-160 pounds	6	22.8 – 29.9	6
161-180 pounds	3	30.0 – 32.6	3
181-200 pounds	2	29.5 – 36.8	2
201-220 pounds	3	31.2 – 37.2	3
221-240 pounds	2	41.2 – 43.0	2
241-260 pounds	1	38.9	1
261-280 pounds	0		
281-300 pounds	0		
301-320 pounds	1	47.9	1
321-340 pounds	0		
341-360 pounds	0		
Not reported	1	Not reported	1
Unknown	3	Unknown	3
Total:	27	Total:	27

² https://www.nhlbi.nih.gov/health/educational/lose_wt/BMI/bmicalc.htm

³ <https://www.cdc.gov/reproductivehealth/maternalinfanthealth/pregnancy-complications.html>

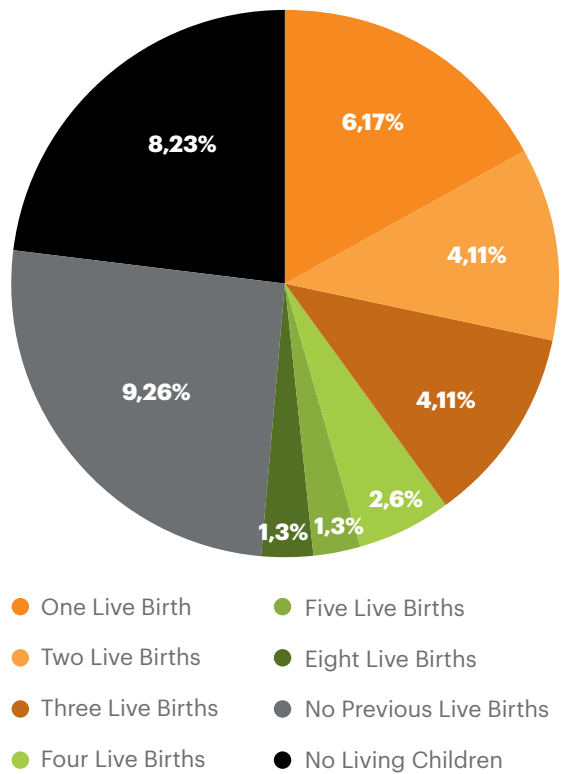
Thirty-three percent (N=9) of mothers did not have any previous live births. Twenty-two percent (N=6) of mothers had given birth to one (1) child previously. Fifteen percent (N=4) of mothers had given birth to two (2) children previously, and fifteen percent (N=4) of mothers had given birth to three (3) children previously. Seven percent (N=2) of mothers had given birth to four (4) children previously, and four percent (N=1) where each of the mothers gave birth to five and eight children, respectively. Thirty percent (N=8) of mothers did not have any other living children.

See Figure 34.

Ninety-two percent (N=25) did not have any deceased children. Four percent (N=1) of mothers had one (1) deceased child, and four percent (N=1) did not have information recorded on the Certificate of Live Birth.

This statistic looked specifically at the number of spontaneous or induced losses or ectopic pregnancies mothers had experienced with previous pregnancies. Sixty-two percent (N=17) of mothers reported experiencing no previous induced losses or ectopic pregnancies. Twenty-two percent (N=6) of mothers reported experiencing one (1) previous induced loss or ectopic pregnancy. Four percent (N=1) of each of the mothers reported experiencing two (2) and four (4) previous induced losses or ectopic pregnancies, and one (1) was not recorded. Four percent (N=1) of mothers reported experiencing eight (8) previous induced losses or ectopic pregnancies.

FIGURE 34
2018 IMR Statistical Previous Number of Live Births



The Certificate of Live Birth provides a list of possible risk factors in this pregnancy, and to select all that apply:

Diabetes

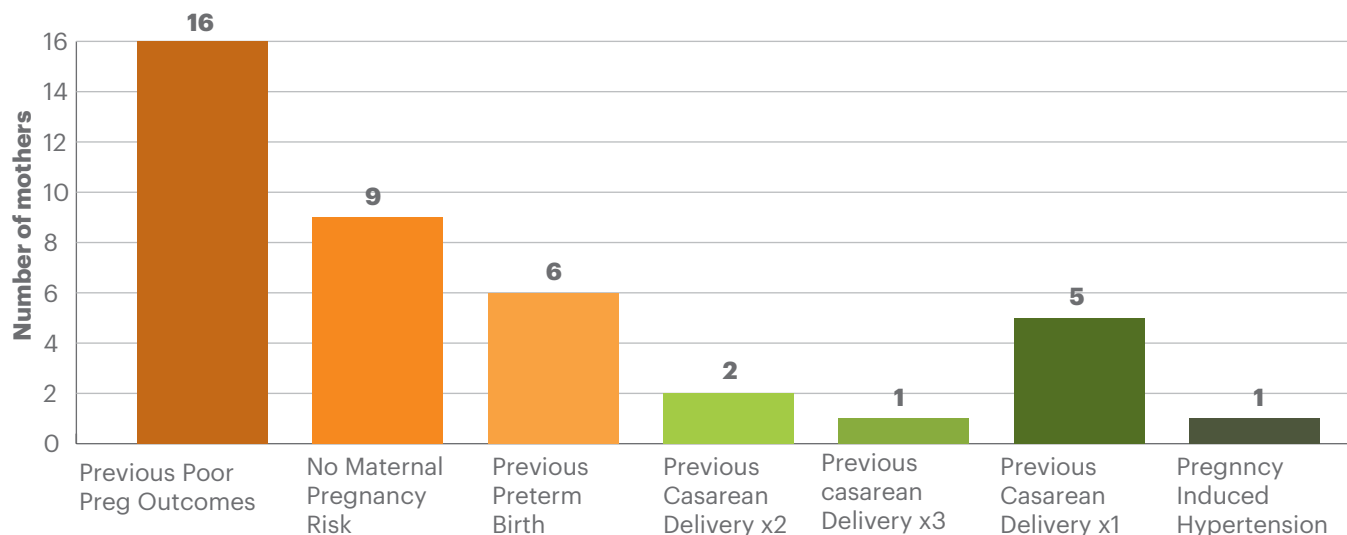
- Pre-pregnancy (Diagnosis before this pregnancy)
- Gestational (Diagnosis in this pregnancy)

Hypertension

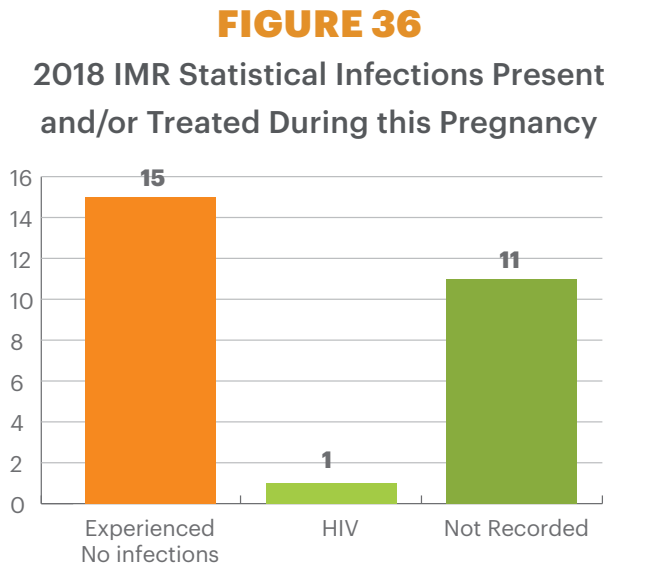
- Pre-pregnancy (Chronic)
- Gestational (PIH, preeclampsia)
- Eclampsia
- ☐ Previous preterm birth
- ☐ Other previous poor pregnancy outcomes (includes prenatal death, small-for-gestational age/intrauterine growth, restricted birth)
- ☐ Pregnancy resulted from infertility treatment-If yes, check all that apply:
 - Fertility-enhancing drugs, Artificial insemination, or Intrauterine insemination
 - Assisted reproductive technology (e.g., in-vitro fertilization (IVF), gamete intrafallopian transfer (GIFT))
- ☐ Mother had a previous cesarean delivery
 - If yes, how many _____
- ☐ None of the above

The information regarding maternal risk factors in this pregnancy recorded on the Certificate of Live Birth reported 60% (N=16) of the mothers had previous poor pregnancy outcomes. Thirty-three percent (N=9) of the mothers had no maternal pregnancy risk factor for this pregnancy reported on the Certificate of Live Birth. Twenty-two percent (N=6) of the mothers reported previous preterm birth on the Certificate of Live Birth. Nineteen percent (N=5) of the mothers reported previous Cesarean delivery x 1 on the Certificate of Live Birth. Seven percent (N=2) of the mothers reported previous Cesarean delivery x 2 on the Certificate of Live Birth, and 4% (N=1) of the mothers reported previous Cesarean delivery x 3 on the Certificate of Live Birth. Eleven percent (N=3) of the mothers reported hypertension (pregnancy chronic), and four percent (N=1) of the mothers reported pregnancy induced hypertension on the Certificate of Live Birth. **See Figure 35.**

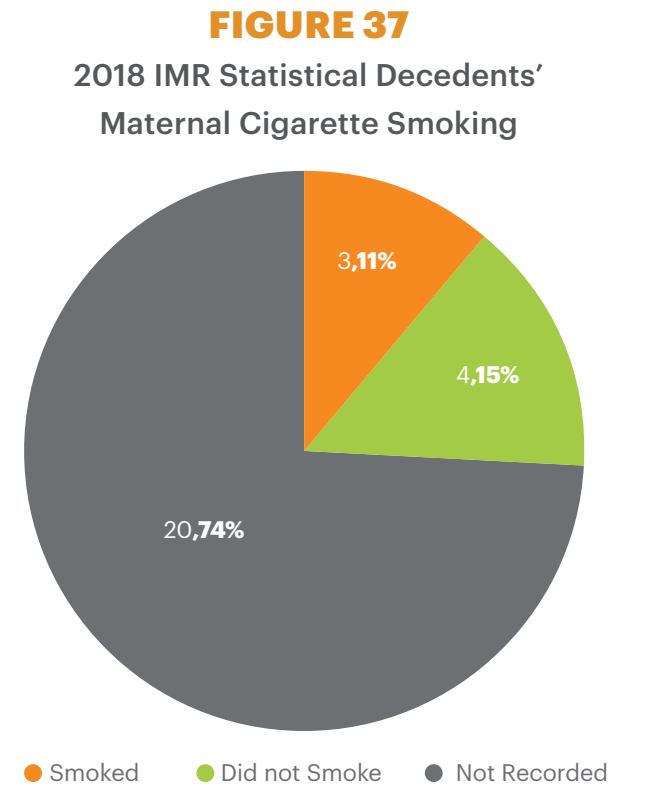
FIGURE 35 2018 IMR Statistical Maternal Risk Factors In This Pregnancy



The Certificate of Live Birth indicated that 56% (N=15) of mothers did not experience any infections during this pregnancy. Forty-one percent (N=11) of the mothers did not have any information recorded, and HIV was indicated for one mother. **See Figure 36.**



Seventy-four percent (N=20) of mothers reported not smoking cigarettes before or during their pregnancy. **See Figure 37.**



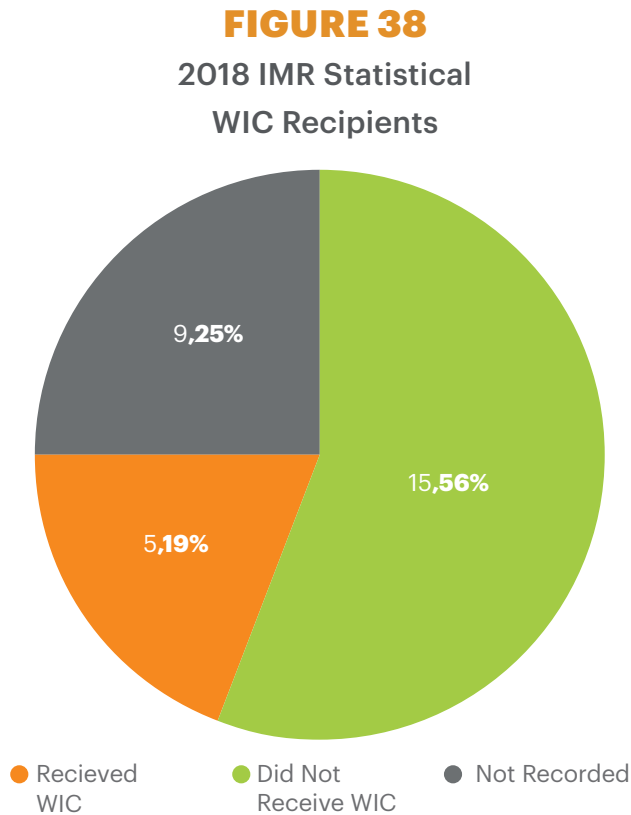
Thirty percent (N=8) of mothers did not exhibit any characteristics of labor and delivery. Antibiotics received by the mother before delivery was the most frequently reported characteristic of labor and delivery and accounted for 15% (N=4) of mothers. **See Table 4.**

TABLE 4

2018 IMR Statistical Maternal Characteristics of Labor and Delivery

Characteristics of Labor and Delivery	Number of Affected Mothers
None	8
Antibiotics used by mother	4
Augmentation of labor	3
Epidural or spinal anesthesia during labor	3
Induction of labor	3
Not recorded	2
Monitored Anesthesia Care (MAC)	1
Moderate heavy meconium staining of the am-niotic fluid	1
PTL, clinical chorioamnionitis diagnosed during labor or maternal temperature >= 100.4°F	1
Steroids for fetal lung maturation received by mother prior to delivery	1
Total	27

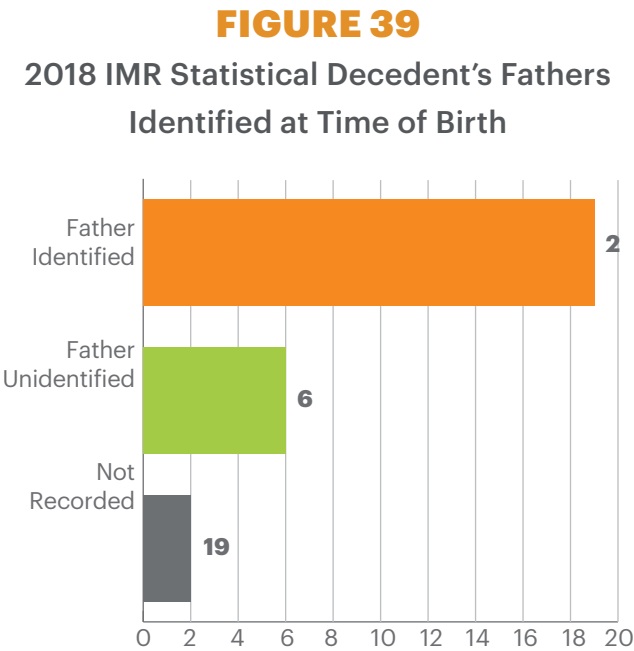
Fifty-six percent (N=15) of mothers did not receive WIC for themselves for this pregnancy, and 19% (N=5) of mothers received WIC for themselves for this pregnancy. See **Figure 38**.



PATERNAL INFORMATION

Although there were 29 decedents included in this statistical review, there were 27 fathers counted in the paternal information sections of this report as there were five sets of twins represented in the statistical data. All other twins in this statistical review were two of a set. However, they were counted individually.

Seventy percent (N=19) of fathers were identified, and their information was recorded on the Certificate of Live Birth. Twenty-two percent (N=6) of fathers were indicated as “Unknown,” and seven percent (N=2) were “Not Recorded.” See **Figure 39**.





Fifty-one percent (N=14) of the fathers did not have their age recorded on the Certificate of Live Birth. The most frequent age range of fathers was between 26-35 years old, with an average age of 30 years old. The youngest father was 21 years old, and the eldest father was 49 years old. **See Figure 40.**

Fifty-five percent (N=15) of paternal race information on the Certificate of Live Birth was “Not Recorded.” Thirty-three percent (N=9) of fathers were Black, four percent (N=1) each were Hispanic (of Dominican decent), White, and of Other-Asian (Nepali) descent.

Fifty-two percent (N=14) of the fathers’ educational status was indicated as not recorded, and four percent (N=1) was unknown on the Certificate of Live Birth. Four percent (N=1) of fathers had attended school during the 9th through 12th grade yet did not obtain a diploma. Fifteen percent (N=4) attained a high school diploma/GED without further education. An additional eleven percent (N=3) of fathers received some college credits. Seven percent (N=2) of fathers obtained their associate’s and master’s degrees. **See Figure 41.**

FIGURE 40
2018 IMR Statistical
Paternal Age

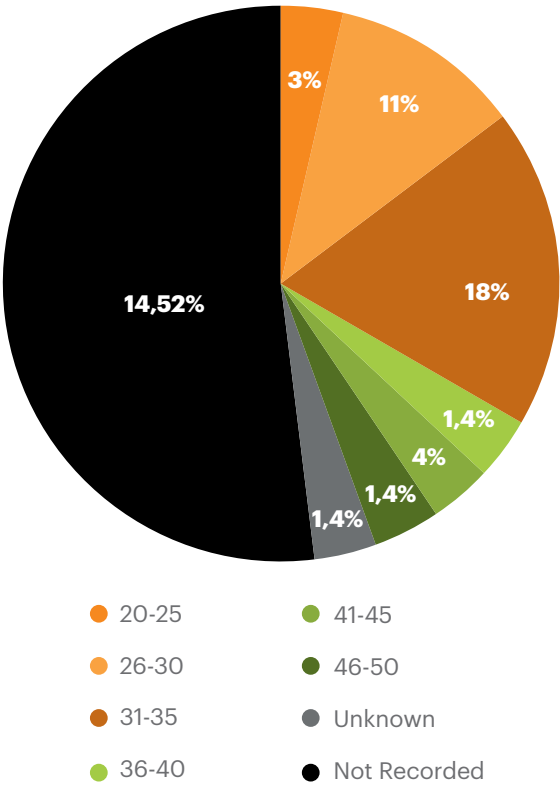
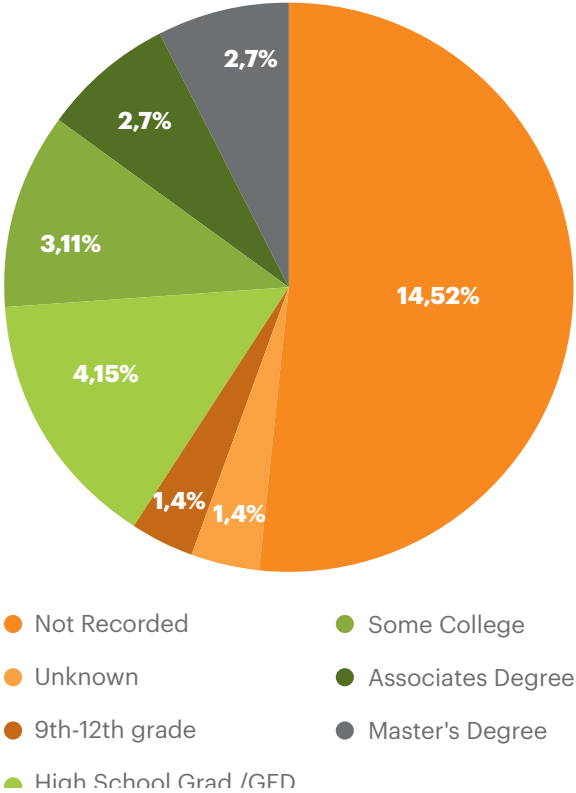


FIGURE 41
2018 Statistical Paternal
Education Status





CHILD FATALITY REVIEW TEAM FINDINGS

In 2020, the CFRT reviewed nine (9) fatalities involving youths whose death occurred in 2018 and 2020. Most of these were homicide cases involving youth between the ages of 15 and 20 years old. Five of these youth homicide cases were reviewed in collaboration with the District of Columbia's Violence Fatality Review Committee (VFRC). One (1) decedent died of natural causes. **See Figure 42.**

The decedents reviewed by the CFRT were all African American/Black males.

The CFRT case reviews provide detailed information gathered from records of the decedents' family's

involvement with human services, education, medical and public safety programs, both public and private. This provides the CFRT with the opportunity to address gaps in services and identify the need for collaboration among agencies. During the 2020 case review year, eight (8) of the CFRT decedents were involved with child welfare and juvenile agencies before the fatal event. Five (5) of the decedents were involved with a behavioral health provider. Records indicate service referrals were unsuccessful in these encounters due to the decedent's disengagement with school, where services were provided. **See Figure 43.**

FIGURE 42
CFRT 2020 Decedent
Manner of Death

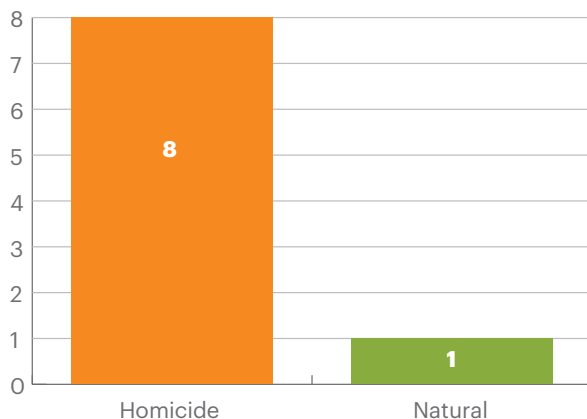
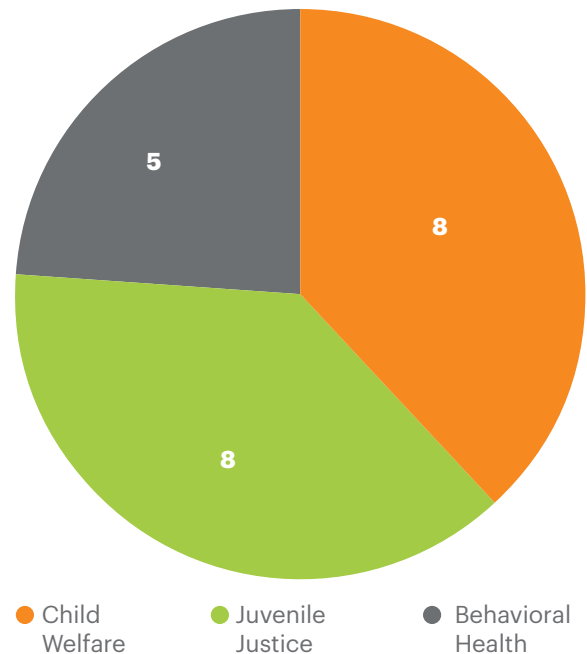


FIGURE 43
CFRT 2020 Decedent
Agency Involvement



CFRT NATURAL DEATH CASE REVIEW

The CFRT reviewed one (1) natural death case.
See Table 5.

This decedent had no previous diagnoses of congenital heart disease, and the death was sudden.

The decedent’s manner of death was natural, and the cause of death was not preventable. However, the death review process revealed the decedent’s family’s involvement with the District of Columbia’s child welfare system and cross-jurisdictional involvement with juvenile justice services. The decedent was also a victim of violence, with previous involvement in a shooting months before the fatal event.

TABLE 5

CFRT Natural Death Case Review

DEMOGRAPHICS
20-year-old male AA/Black Resident of Ward 8
CAUSE OF DEATH
Sudden Cardiac Arrhythmia in the Setting of Hypertrophic Cardiomyopa- thy of Unknown Etiology
CHARACTERISTICS OF LABOR AND DELIVERY
Unknown Congenital Heart Disease



CFRT HOMICIDE CASE REVIEWS

The CFRT independently reviewed three homicide cases during the COVID-19 emergency. Due to a spike in homicides, the CFRT was asked to collaborate with the District Government's Violence Fatality Review Committee (VFRC) for a joint review of five (5) decedents who were involved with juvenile justice services at the time of their death. These Black/African American males' deaths occurred during the first six months of 2020.

Homicide cases reviewed by the CFRT involved youth between the ages of 15 and 18 years old. **See Table 6.**

The case reviews revealed how the decedent's environmental risk factors are also identified as nationally recognized risk factors defined by the National Center for the Review and Prevention of Child Deaths (NCRPCD, 2016). The leading risk factors associated with the CFRT youth homicides are (1) involvement with child

TABLE 6 2018 IMR Statistical Maternal Characteristics of Labor and Delivery

Decedent Demographics/Ward of Residence	Cause of Death	Associate Risk Factors
15-year-old AA/Black Male Ward 8	Gunshot Wound	<ul style="list-style-type: none"> History of Child Welfare Involvement Juvenile Criminal History Poor School Behavior Involved in a fight stemming from a school altercation
16-year-old AA/Black Male Ward 7	Stab Wound	<ul style="list-style-type: none"> No History of Government Involvement Involved in a fight stemming from a school altercation
17-year-old AA/Black Male Ward 8	Gunshot Wound	<ul style="list-style-type: none"> History of Child Welfare Involvement Juvenile Criminal History Previous Sibling Homicide Victim of Violence School Truancy
17-year-old AA/Black Male Ward 7	Gunshot Wound	<ul style="list-style-type: none"> History of Child Welfare Involvement Juvenile Criminal History School Truancy
18-year-old AA/Black Male Ward 8	Gunshot Wound	<ul style="list-style-type: none"> History of Child Welfare Involvement Juvenile Criminal History Unresolved Mental Health Needs School truancy Access to guns Unresolved Special Education Needs
18-year-old AA/Black Male Ward 5	Gunshot Wound	<ul style="list-style-type: none"> History of Child Welfare Involvement Juvenile Criminal History School Truancy Parent/Child Discord Unresolved Special Education Needs
18-year-old AA/Black Male Ward 6	Gunshot Wound	<ul style="list-style-type: none"> History of Child Welfare Involvement Juvenile Criminal History School Truancy Unresolved Mental Health/Substance Abuse Unresolved Special Education Needs
18-year-old Black Male Homeless	Gunshot Wound	<ul style="list-style-type: none"> History of Child Welfare Involvement Juvenile Criminal History School Truancy Unresolved Mental Health/Substance Abuse Unresolved Special Education Needs

welfare, (2) involvement with juvenile justice, and (3) school truancy. Three (3) youths had unresolved mental health diagnoses as there was no service engagement in the school or community setting. Two (2) youths with mental health diagnoses self-disclosed their use of illicit substances, indicating a dual diagnosis of mental illness and substance abuse.

Guns were the leading weapon of choice in youth-related homicide cases reviewed by the CFRT. One (1) decedent was the victim of a stabbing.

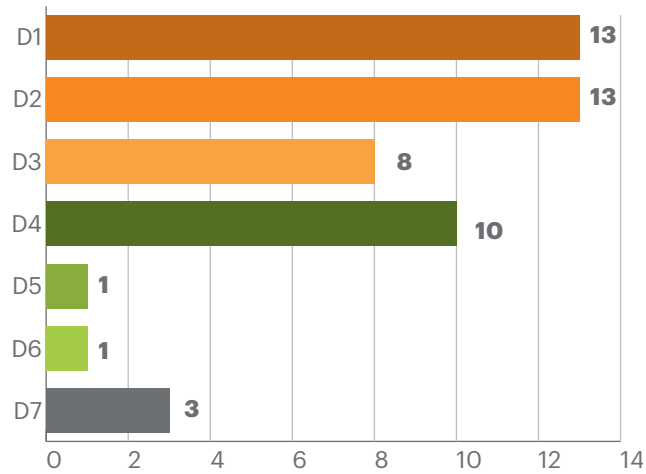
Two (2) decedents were involved in physical altercations that occurred immediately following school. The District of Columbia immediately responded with the implementation of the Safe Passage program – an effort by the Deputy Mayor of Education, Metropolitan Police Department, DC Public Schools, and DC Public Charter Schools that addresses students’ safe travel to and from school.

CHILD WELFARE AND JUVENILE JUSTICE

Seven (7) decedents’ families were involved with the District of Columbia’s child welfare system. Decedents also experienced personal involvement with the juvenile justice system – some cross-jurisdictional. This is an indicator of frequent crises occurring in the home environment.

The decedent’s progression into juvenile justice programs because of criminal activities indicates the need for child welfare and juvenile justice agencies to proactively collaborate and address the needs of this high-risk population of children and youth. Five (5) youths experienced three or more juvenile arrests before and during their involvement with community-based juvenile justice programs. Fostering collaboration throughout the human services care system is essential in preparing discharge plans for youth exiting these programs and returning to their home environment. **See Figure 44.**

FIGURE 44
CFRT Homicide Decedent
History of Arrests





ECONOMIC INSECURITY

Seven (7) of the decedents and their families were participants in the Temporary Assistance to Needy Families (TANF) grant monies, Medicaid, and the Department of Housing and Urban Development (HUD) public housing programs. Youth experiencing economic insecurity are at risk of youth homicide due to the lure of seemingly lucrative illegal drug distribution and subsequent involvement in criminal activities. Low-income youth greatly benefit from working part-time jobs while in school, as they learn how to manage their time, learn skills on the job, and make money to support their endeavors.

SCHOOL TRUANCY

School truancy presents a barrier to academic success for youth receiving special education services. Their disengagement from school, where special education services are mandated by the Individuals with Disabilities Education Act (IDEA) and the student's Individual Education Plan (IEP) is implemented, severs the youth's opportunity for academic success through the public school system. Four (4) decedents identified as truants had unresolved special education needs.

School truancy was identified as an issue for most decedents during their elementary schooling. Recorded as "excessive absences" in school records, truant

behaviors coupled with poor school performance were the causes for the decedent's family's earliest involvement with child welfare services. Five (5) of the decedents had early exposure to child welfare services due to excessive school absences coupled with poor school behavior.

UNRESOLVED MENTAL HEALTH

All the youth were referred for mental health services because of their involvement with the juvenile justice system. The CFRT discussed how youth actively engaged in mental health services while admitted to residential treatment placements. However, upon discharge to their home community, only one (1) decedent engaged in mental health services in their community. This indicates the need to address the stigma of youth participating in readily accessible mental health services in the District of Columbia.

To address the acts of violence that adversely affect the children and youth within the District of Columbia, the CFRT, under the leadership of the Office of the Attorney General and the Court Social Services, committee members developed a Violence Recommendation Subcommittee. Recommendations were proposed and presented to the Violence Fatality Review Committee for adoption. These recommendations are currently pending and will be published for the community at large.



An overhead view of a group of people sitting around a large wooden table in a meeting. Several individuals are using mobile devices like smartphones and tablets. A laptop is open on the table. The image has a warm orange tint on the left and a green tint on the right. The text 'SECTION II' is centered in a white box with an orange background.

SECTION II

COMMITTEE DISCUSSIONS AND RECOMMENDATIONS



CHILD FATALITY REVIEW COMMITTEE MEETING DISCUSSIONS

Before the CFRC's approval to convene confidential case review meetings on the WebEx virtual meeting platform, CFRC members engaged in informative discussions to highlight the work of member agencies. These discussions provided the committee with resources that could be used throughout the human services and public safety cluster agencies.

**"THE CHILD
WHO IS
NOT
EMBRACED
BY THE
VILLAGE
WILL BURN
IT DOWN
TO FEEL ITS
WARMTH"**

African Proverb

The CFRT, through its Recommendations Subcommittee, supported the Child and Family Services Agency's (CFSA) implementation of its' Continuum of Care program. Through the Continuum of Care, young children ages eight to twelve years old who require behavioral health treatment have it in a residential setting that is close to home. This addresses the need for younger children to have access to specialized treatment, an issue the CFRT recognized through case reviews.

Of special interest to the CFRT, the Office of the Attorney General (OAG) provided information on Restorative Justice programs for adjudicated youth entering the District of Columbia's juvenile justice system. There is a correlation between youth involved with the juvenile justice services and their subsequent involvement with other systems, including (child welfare, mental health, victims of violence). These multiple interactions with government systems further indicate the level of trauma youth may have personally experienced. Restorative Justice provides an opportunity for adjudicated youth and their victims to address the conflicts associated with the reasons youth are involved with the juvenile justice program. This program also provides therapeutic services to help diffuse the trauma most adjudicated youth have experienced. Through

the relationships created through this process, the youth involved find a path to redemption.

The CFRT also learned about the Cure the Streets Program, a public safety program implemented through the OAG, currently in Wards 5, 7, and 8. As Violence Reduction and Violence Interrupters, their primary task is to help resolve conflict through mediation and negotiation. Using a public health approach, the goal is to de-escalate violent situations.

The targeted participants have the following characteristics:

- Ages 16–25-year-old
- Recently released from prison
- Recently shot
- Active in a violent street gang
- History of violence
- Known weapon carrier
- Engaged in high-risk street activity

The program also has a psychotherapy component to address the mental health needs of the participants. Cure the Streets staff are trained to relate with at-risk youth and young adults that are involved.

CFRC 2020 ADOPTED RECOMMENDATIONS

The CFRC adopted two recommendations during the 2020 case review year that will (1) ensure the Metropolitan Police Department collaborates with the Child and Family Services Agency when children are present during police investigations, and (2) require service interventions for families participating in the District of Columbia's homeless services program. **See Table 7.**



TABLE 7 CFRC 2020 Adopted Recommendations

AREA OF FOCUS	RECOMMENDATION	RESPONSE
Dual Agency/ Public Safety and Human Services	Recommendation: During investigations in which the Metropolitan Police Department is assessing scenes that involve potential alleged child abuse or neglect, the officers on the scene should contact the CFSA to initiate an investigation before releasing minors to interim caregivers.	Agreed with Modification
Agency Policy And Practice	Recommendation: Social work intervention and wraparound services should be required for families with children under five years residing in the hotel shelter system. This intervention is recommended as a response to the crisis experienced by the parent, which in turn is transferred to the child because of homelessness and the placement in the hotel shelter system.	Agreed

FULL AGENCY RESPONSES TO CFRC RECOMMENDATIONS

► Recommendation for the Metropolitan Police Department and the Child and Family Services Agency

Recommendation: During investigations in which the Metropolitan Police Department is assessing scenes that involve potential alleged child abuse or neglect, the officers on the scene should contact the CFSA to initiate an investigation before releasing minors to interim caregivers.

The Metropolitan Police Department Agrees with this Recommendation with Modification

During investigations where the Metropolitan Police Department is assessing scenes that involve potential alleged child abuse or neglect, the officers on the scene should contact the CFSA to initiate an investigation. The CFSA should decide who would be the best caregiver suited to take possession of minors.

The best practice would be for the Metropolitan Police Department and our partner agencies, including the Child and Family Services Agency (CFSA), to ensure that allegations of child abuse and neglect are investigated thoroughly, professionally, with tact and consideration, and to protect and safeguard any minor.

Currently, an agreement exists between the MPD and the CFSA. Per the agreement, the MPD notifies the CFSA of investigations involving suspected abuse or neglect of minor children. To implement the recommendation with modifications would require commitment from the CFSA. Both agencies would need to discuss to work out the logistics of the recommendation.

To date, MPD members have continued adherence to Metropolitan Police Department General Order 309.06 regarding Child Abuse and Neglect. MPD members continue to partner with the CFSA on these investigations.

The expected outcome would be the best caregiver suited to take possession of minor children would be determined based on the joint efforts of the MPD and the CFSA.

Indicator/milestones: Number of cases where MPD members and the CFSA coordinated on abuse/neglect investigations to determine the appropriate caregiver for a minor child.

The Child and Family Services Agency Agrees with this Recommendation:

This is currently in accordance with our agreement with Youth Division when there is suspected abuse or neglect involved when officers respond on the scene. If the intent is to expand this practice to other Divisions within the MPD, we concur with that recommendation.

Recommendation for the Department of Human Services

Recommendation: Social work intervention and wraparound services should be required for families with children under five years residing in the hotel shelter system. This intervention is recommended as a response to the crisis experienced by the parent, which in turn is transferred to the child because of homelessness and the placement in the hotel shelter system.

The Department of Human Services Agrees with this Recommendation

The DHS agrees that stressors experienced by parents, such as homelessness, can transcend to their minor children. An integrated, multi-disciplinary intervention is often needed to support these families in coping and navigating past these traumatic hardships. The range of social work intervention and wraparound services warranted to support the parents and their children is best accomplished in smaller, intimate settings. To that goal, today, all emergency shelter services are delivered through Short-term Family Housing (STFH) and Apartment-Style shelters. In August 2020, DHS closed the Days Inn, the last hotel used as an overflow shelter capacity for families experiencing homelessness.

At STFH sites, the staffing complement is designed to provide the wraparound services noted in the recommendation. Minimally, program-related staff at each program includes the program director, licensed social worker, case manager supervisor, and case managers (1:15 ratio). Some sites also have additional support staff, including education and employment specialists and/or youth specialists

Should the DHS need to rely on motels for overflow shelter in the future, the Department would use a similar staffing construct to the STFH programs.

Ensuring that families temporarily residing in emergency shelters stay safe - including minor children within these families, is a priority shared by the DHS and each DHS-contracted provider. DHS staff and providers are mandated reporters, making referrals to DC's Child and Family Services Agency (CFSA) for suspected child abuse or neglect. Additionally, all persons assigned by the DHS or its providers to deliver case management services to families residing in emergency shelters are required to receive training on trauma-informed care, domestic violence, motivational interviewing, teaming, child development, and other subject matter proven to best support families' needs. These trainings enable case managers to identify opportunities to support each family's welfare and give them access to needed services.

Regardless of the ages of minor children within the family household, case managers assigned to each family residing in an emergency shelter meet with the family at least twice per week. Time spent with each family includes developing the family's housing plan and connecting the family to services that reinforce the overall well-being of the adults and minor children within the household - including removing barriers to transition to permanent housing, employment, training, and education services (including linkages to the TANF Employment Program), childcare, mental health services, substance abuse, domestic violence, legal and public benefit supports, and primary health care.

In addition to the wraparound services provided by each family's case manager, families residing in emergency shelters receive daily curfew checks to allow visibility into the safe whereabouts of the children.



ACKNOWLEDGMENT

The Office of the Chief Medical Examiner wishes to acknowledge the dedication and unwavering support of the public servants, child advocates, physicians, and residents of the District of Columbia who serve as members of the District of Columbia's Child Fatality Review Committee. Through their act of courage and pursuit of the truth, the members meet monthly to examine the details surrounding a child's life and death. The members' unwavering commitment to improving the lives of all residents of the District of Columbia through this process is admirable.

We would like to thank the members of the Committee for volunteering their time and using their resources to convene during the COVID-19 pandemic. We are grateful for your integrity and service to the residents of the District of Columbia.



THE CHILD FATALITY REVIEW COMMITTEE

2020 ANNUAL REPORT



Office of the Chief Medical Examiner

Fatality Review Division

401 E Street SW

Washington, D.C. 20024

Phone: 202-698-9000 | OCME.DC.gov