



DISTRICT OF COLUMBIA GOVERNMENT  
OFFICE OF THE CHIEF MEDICAL EXAMINER

Child Fatality  
Review Committee  
2016 Annual Report

**DISTRICT OF COLUMBIA  
CHILD FATALITY REVIEW COMMITTEE  
2016 ANNUAL REPORT**

**PRESENTED TO:**

The Honorable Muriel Bowser, Mayor, District of Columbia

The Council of the District of Columbia

The Citizens of the District of Columbia

**OCTOBER 2017**

**DISTRICT OF COLUMBIA  
CHILD FATALITY REVIEW COMMITTEE  
2016 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  
CHIEF MEDICAL EXAMINER, OCME  
CO-CHAIR, CHILD FATALITY REVIEW COMMITTEE

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**OFFICE OF THE CHIEF MEDICAL EXAMINER FATALITY REVIEW UNIT (2016)**

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**DISTRICT OF COLUMBIA  
CHILD FATALITY REVIEW COMMITTEE  
2016 ANNUAL REPORT**

**TABLE OF CONTENTS**

<b>GREETINGS FROM CFRC CO-CHAIRS</b>	<b>5</b>
<b>TEAM COMPOSITION – IMRT AND CFRT</b>	<b>7</b>
<b>INTRODUCTION: CHILD FATALITY REVIEW COMMITTEE</b>	<b>9</b>
<b>EXECUTIVE SUMMARY</b>	<b>10</b>
<b>SECTION I: SUMMARY OF TEAM FINDINGS</b>	<b>17</b>
<b>IMRT DECEDENT DEMOGRAPHICS</b>	<b>18</b>
<b>CFRT DECEDENT DEMOGRAPHICS</b>	<b>32</b>
<b>SECTION II: CHILD WELFARE AND JUVENILE JUSTICE FINDINGS</b>	<b>40</b>
<b>SECTION III: COMMITTEE RECOMMENDATIONS</b>	<b>44</b>
<b>APPENDIX</b>	<b>51</b>
<b>ACKNOWLEDGEMENT</b>	<b>63</b>
<b>REFERENCES</b>	<b>64</b>

## GREETINGS FROM THE CHIEF MEDICAL EXAMINER



During calendar year 2016, the Child Fatality Review Committee (CFRC) and the Fatality Review Unit at the Office of the Chief Medical Examiner (OCME) remained focused on improving the fatality review process. 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 to inform evidence-based programs and policy.

Key activities of the CFRC included outreach, networking, training and education, as well as making improvements to the case review and recommendations process. Further, the OCME was successful in securing a \$100,000 grant from the Office of Victims Services and Justice Grants (OVSJG) to fund these activities and to assist in the process of highlighting trends and recommendations regarding child/infant fatalities in CFRC Annual Reports.

The CFRC is pleased to present the 21<sup>st</sup> Annual Child Fatality Review Report covering statistical data from the 38 child/youth fatalities that were reviewed during calendar year 2016. This report is intended to provide a snap shot into the deaths of children and infants who were residents of the District of Columbia. 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.

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

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



It has been another productive year for the Child Fatality Review Committee in terms of improving the quality of our work, generating influential recommendations to policymakers, and achieving tangible results for the District’s children and infants. While there is still much more that we can do, the Committee is encouraged that by working together we will be able to continue to have a positive impact on improving, and potentially saving, many children’s and infants’ lives in the District.

This year, we have provided further education for our committee members and the community alike. In October 2016, we held a course at the Forensic Laboratory on Sudden Unexpected Infant

Death Investigations for medical, forensic, legal, and social service professionals with a focus on what role each attendee can play. The course had both formal presentations and informal components such as facilitated discussions on best practices to serve the community addressing trauma.

We have accomplished a great deal and are planning to achieve much more before the year’s end. Members are partnering with public and private agencies to plan a Safe Sleep Symposium for residents of Wards 5, 7, and 8; areas which have the highest number of infant fatalities. With the positive feedback the Committee has received thus far, I look forward to our continued collaboration and advocacy on behalf of the District’s children.

Sincerely,

A handwritten signature in blue ink that reads "Cynthia G. Wright". The signature is written in a cursive, flowing style.

Cynthia G. Wright, Esq.  
Assistant U.S. Attorney  
Homicide Section – Special Victim’s Unit  
U. S. Attorney’s Office  
District of Columbia

**DISTRICT OF COLUMBIA  
CHILD FATALITY REVIEW COMMITTEE  
2016 ANNUAL REPORT**

**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 our infants, children and youth we can succeed in reducing 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 2016, 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**

**Department of Health Care Finance**

**Howard University Hospital**

**March of Dimes**

**Office of the Chief Medical Examiner**

**Providence Hospital**

**Trusted Health Plan**

**Unity Health Care**

**US Attorney's Office  
of the District of Columbia**



## **THE CHILD FATALITY REVIEW TEAM (CFRT)**

The CFRT convenes on the third Thursday of each month. In 2016, members representing the following District Government agencies, medical providers and community-based organizations:

**Center for the Study of Social Policy**

**Child and Family Services Agency**

**Children's National Medical Center**

**DC Fire and Emergency Medical Services**

**DC Housing Authority**

**DC Public Schools**

**Department on Behavioral Health**

**Department of Health**

**Department of Health Care Finance**

**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 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**

## **THE CHILD FATALITY REVIEW COMMITTEE.... A CALL FOR ACTION**

The death of an infant, child or youth resident of the District of Columbia initiates a call to action. The District's child fatality review process is the only formally established mechanism within the city government for assessing the circumstances surrounding their deaths and evaluating associated risk factors. This process identifies family and community strengths, as well as improvements needed for our human services, public safety, educational and medical systems to better address the needs of children and families served. The CFRC is a collaborative effort to reduce the number of preventable deaths and improve the quality of life for all residents.

The CFRC reviews the death of District residents from birth through 18 years, and youth older than 18 who were known to child welfare within four (4) years of the fatal event or those known to intellectual and disability services<sup>1</sup> or juvenile justice programs within two (2) years of the fatal event. Committee membership is multidisciplinary, representing public and private child and family servicing agencies and programs. Most importantly, Committee membership includes community members representing the District of Columbia's Wards. All fatality review meetings are confidential. The statute mandates the publishing of an annual report reflecting the work of the Committee during the year of review.

This annual report summarizes data collected from 38 infant, child and youth fatalities that received an in-depth case based review as mandated by law. These cases represent a subset of fatalities that occurred in 2013, 2014, 2015 and 2016. This report is comprised of three sections:

### **Section 1**

Summary of Team Findings - This section provides the reader with data driven from the Infant Mortality Review and the Child Fatality Review team meetings.

### **Section 2**

Child Welfare and Juvenile Justice Findings – This section provides statistics that discuss the Committee's child welfare and juvenile justice case reviews.

### **Section 3**

Committee Recommendations – This section provides the CFRC recommendations submitted to District Government agencies and their responses.

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<sup>1</sup> None of the deaths reviewed by the CFRC in 2016 met the criteria for review due to the decedent's involvement with intellectual and disability services.

## **EXECUTIVE SUMMARY**

The CFRC is a citywide collaborative effort authorized by the Child Fatality Review 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 in the District of Columbia, including those who were known to child welfare or juvenile justice systems. The CFRC may also review the deaths of nonresidents if the death is determined to be accidental or unexpected and occurs within 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.

The CFRC is pleased to present its 21st Annual Report. This report covers data from the 38 infant, children and youth fatality cases reviewed by the Committee in 2016. These cases represent a subset of fatalities that occurred in 2013, 2014, 2015 and 2016. This report does not represent a comprehensive data analysis of all child deaths in the District of Columbia, but represents that subset of cases that received a comprehensive multidisciplinary case review as mandated by law.

### **KEY CHILD FATALITY REVIEW DATA FINDINGS**

#### **DECEDENT DEMOGRAPHICS**

The age of the 38 decedent cases reviewed by the CFRC in 2016 ranged from birth to 20 old. Select demographic information is bulleted below:

- Fifty-five percent (55%, 21 cases) of the decedents were infants (0 to 364 days).
- Seventy-nine percent (79%, 30 cases) of the decedents were Black/African American.
- Fifty percent (50%, 19 cases) of the decedents died of natural causes.

#### **MANNERS OF DEATH**

##### **Natural Deaths**

The CFRC reviewed nineteen (19) natural cases involving infants, children and youth. Fifty-eight percent (58%, 11 cases) of the natural death case reviews involved infant deaths. Among the natural death case reviews, forty-two percent (42%, 8 cases) involved infants who died of causes related to premature birth.

##### **Homicide**

The CFRC reviewed ten (10) fatalities of decedents whose deaths resulted from acts of violence. One (1) case was attributed to fatal child abuse.

### **Accidental and Undetermined Infant Deaths**

The CFRC reviewed two (2) accidental deaths and seven (7) undetermined deaths involving infants. The review of all accidental and undetermined death cases indicates the infant's unsafe sleep environment was the leading risk factor associated with these deaths.

### **CHILD FATALITY REVIEW COMMITTEE COMMUNITY ENGAGEMENT GRANT**

In FY2016, the OCME was awarded a \$100,000 grant from the OVSJG for the CFRC to engage in community outreach, improve its recommendations process and provide training to CFRC members. Trainings focused on trends and themes identified through case reviews and on topics of interest to CFRC members in an effort to further facilitate the CFRC's work. This grant provided funding for an Outreach Program Specialist who was tasked to directly interact with District residents, community leaders, advocates and public agency leaders. This collaboration created the platform to share and address issues identified in the annual report. Training for members on safe sleep practices and on how to develop a more robust findings and recommendations process also took place during the year. As the CFRC benefited greatly from the grant, it is positioned to become a leading voice in the prevention of child deaths. (See Appendix A for more details).

## CHILD FATALITY REVIEW COMMITTEE - TOTAL CASE REVIEWS

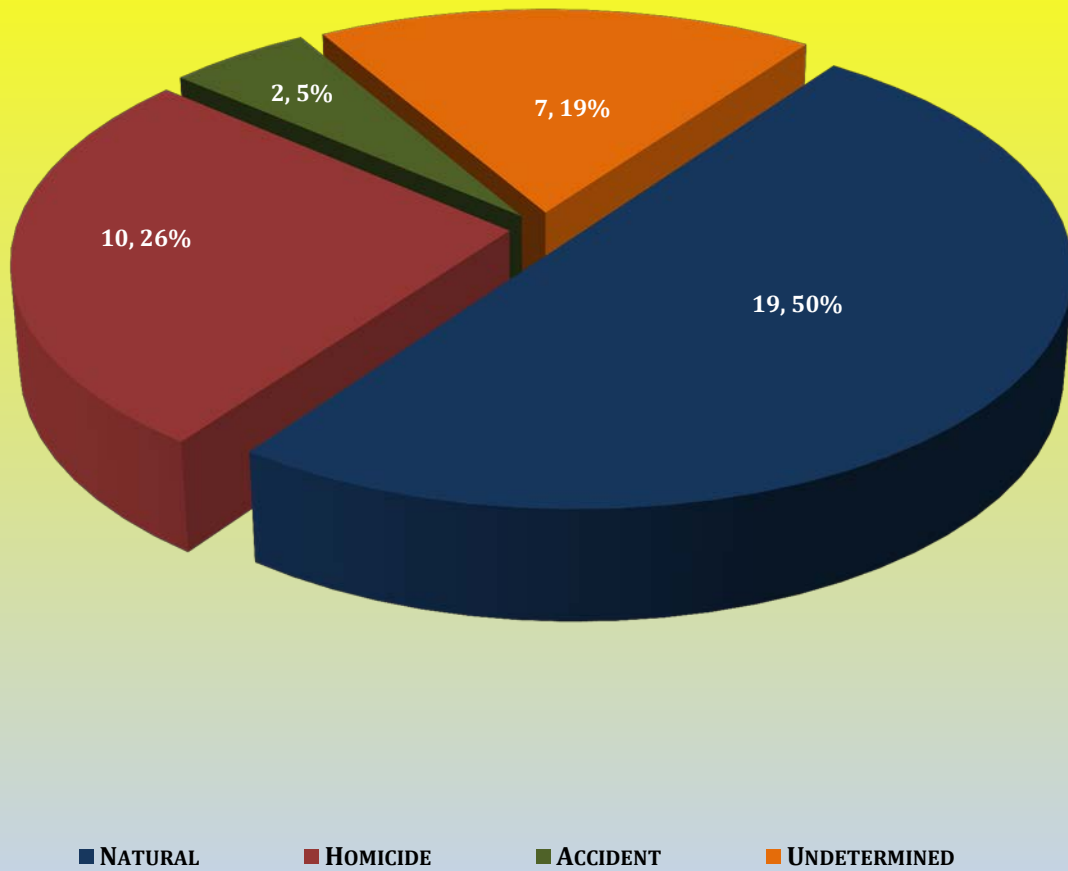
The CFRC is comprised of two teams, the Infant Mortality Review Team (IMRT), and the Child Fatality Review Team (CFRT). Each team convenes monthly to discuss the circumstances surrounding the deaths of infants, children and youth who were residents of the District of Columbia. Due to the vulnerability of this population, each team is charged with evaluating government based systems that provided services to families prior to or at the time of the fatal event. In 2016, the CFRC reviewed 38 cases of infants, children and youth whose deaths occurred in 2013, 2014, 2015 and 2016. The manners of deaths and their definitions are discussed in *Table 1*:

<b>TABLE 1: 2016 MANNERS OF DEATH AS REVIEWED IN CFRC CASES</b>	
<b>CFRC 2016 MANNERS OF DEATH</b>	<b>CFRC ANNUAL REPORT DEFINITION<sup>2</sup></b>
<b>NATURAL</b>	<b>DEATHS CAUSED BY THE NATURAL DISEASE PROCESS AND NOT AN ACCIDENT OR VIOLENCE</b>
<b>HOMICIDE</b>	<b>A DEATH RESULTING FROM THE USE OF PHYSICAL FORCE OR POWER , THREATENED OR ACTUAL, AGAINST ANOTHER PERSON , GROUP[, OR COMMUNITY WHEN EVIDENCE INDICATES THE USE OF FORCE WAS INTENTIONAL</b>
<b>UNDETERMINED</b>	<b>FOLLOWING A THOROUGH MEDICAL AND LEGAL INVESTIGATION, A CONCLUSIVE MANNER OF DEATH IS NOT DETERMINED</b>
<b>ACCIDENT</b>	<b>DEATHS CAUSED UNINTENTIONALLY RATHER THAN BY NATURAL CAUSES, SUICIDE, OR HOMICIDE</b>

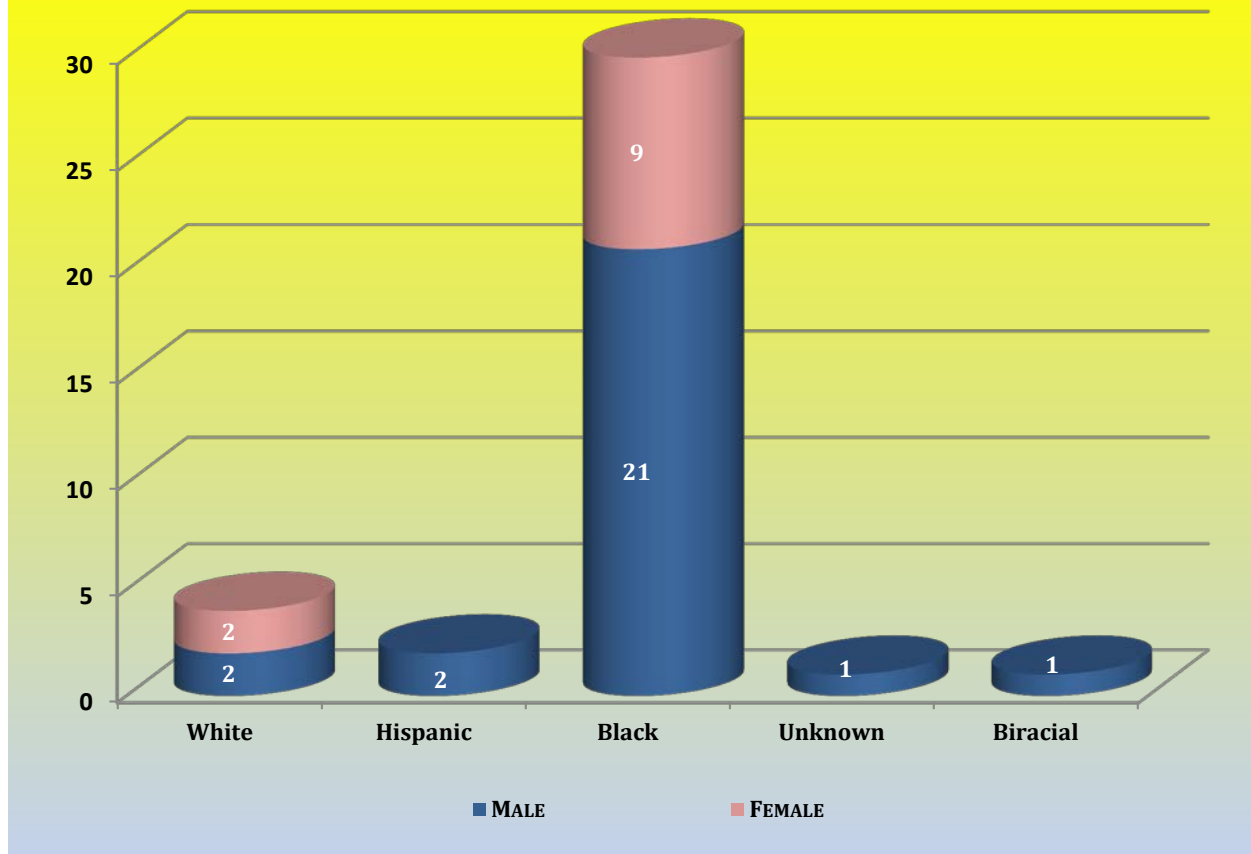
Natural deaths were the leading manners of deaths in cases reviewed by the CFRC in 2016. Fifty percent of the 38 cases were those that involved infants, children and youth who died of natural causes. It is important to note that although the majority of cases reviewed were deaths due to natural causes, this does not suggest that a multitude of these cases could not be prevented. Ten cases reviewed were homicides followed by seven undetermined and two accidents (Figure 1). The majority of homicides were found in youth and young adults ages 13 through 20 years old.

<sup>2</sup> Centers for Disease Control and Prevention definitions for death reporting.

**FIGURE 1: 2016 CFRC CASE REVIEW BY MANNER OF DEATH**

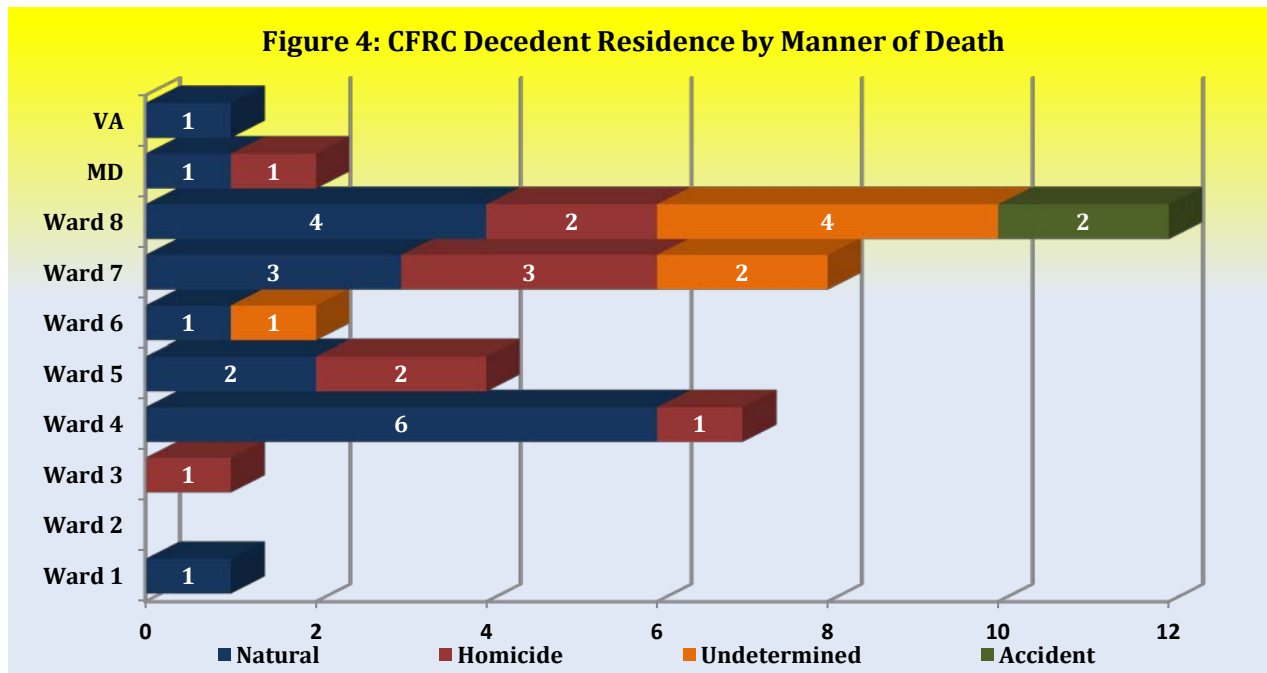
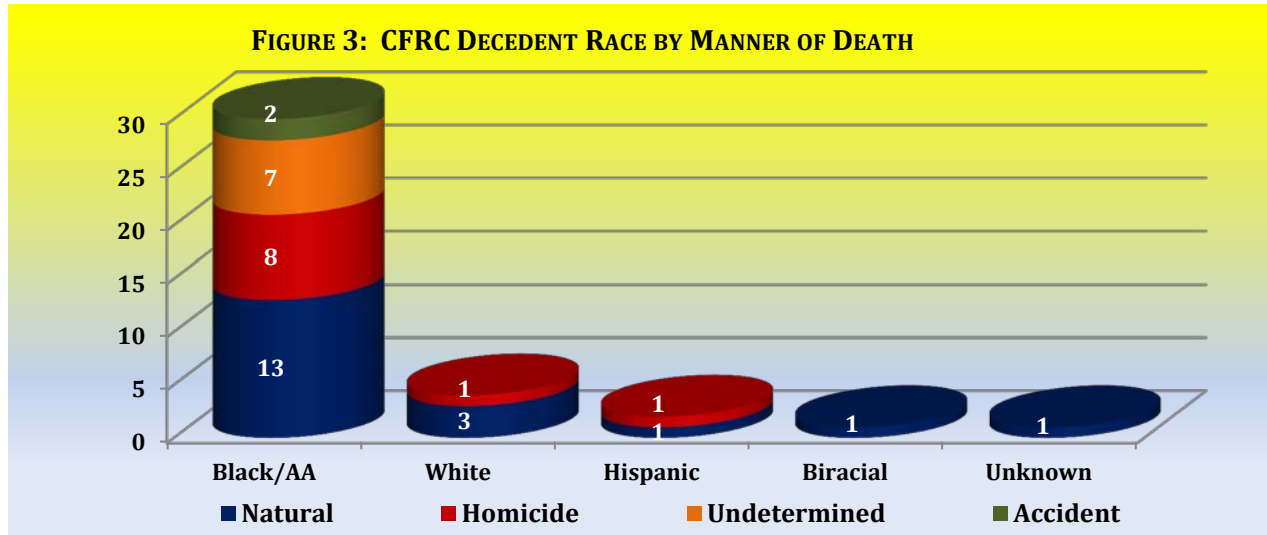


**FIGURE 2: 2016 CFRC DECEDENT RACE AND GENDER**



In 2016, the CFRC reviewed thirty cases (30, 79%) involving Black/African American infant, children and youth. Seventy-one percent (71%) of the cases reviewed involved male decedents. Since its inception, the CFRC has reviewed more cases involving Black/African American males whose deaths encompassed all manners.

Public health researchers agree that Black/African American males face disparities in health that affect their overall quality of life. In 2017, the Department of Health and Human Services, Office of Minority Health reported the death rate for Blacks/African Americans declined by twenty-five percent (25%) as a result of improved access to early intervention (DHHS, 2017). As health disparities still exist, so do opportunities to address barriers to services to improve health equity among Black/African American males.



Health equity is best understood through the lens of social determinants of health. Social determinants takes into consideration where a population, lives, works, and has its' relationships. As the CFRC reviewed a random selection of 38 cases that met the requisite review criteria, the majority of the decedents resided in Ward 8 (12, 32%), followed by Ward 7 (8, 21%), Ward 4 (7, 18%), Ward 5 (4, 11%) and Ward 6 (2, 5%). One decedent each resided in Ward 1 and Ward 3. This is important because Wards 7 and 8 have historically been communities with a lower percentage of college graduates and lower paying employment. Three (3) decedents who were committed wards of the District of Columbia resided in Maryland (2), and Virginia (1) placements at the time of their deaths.



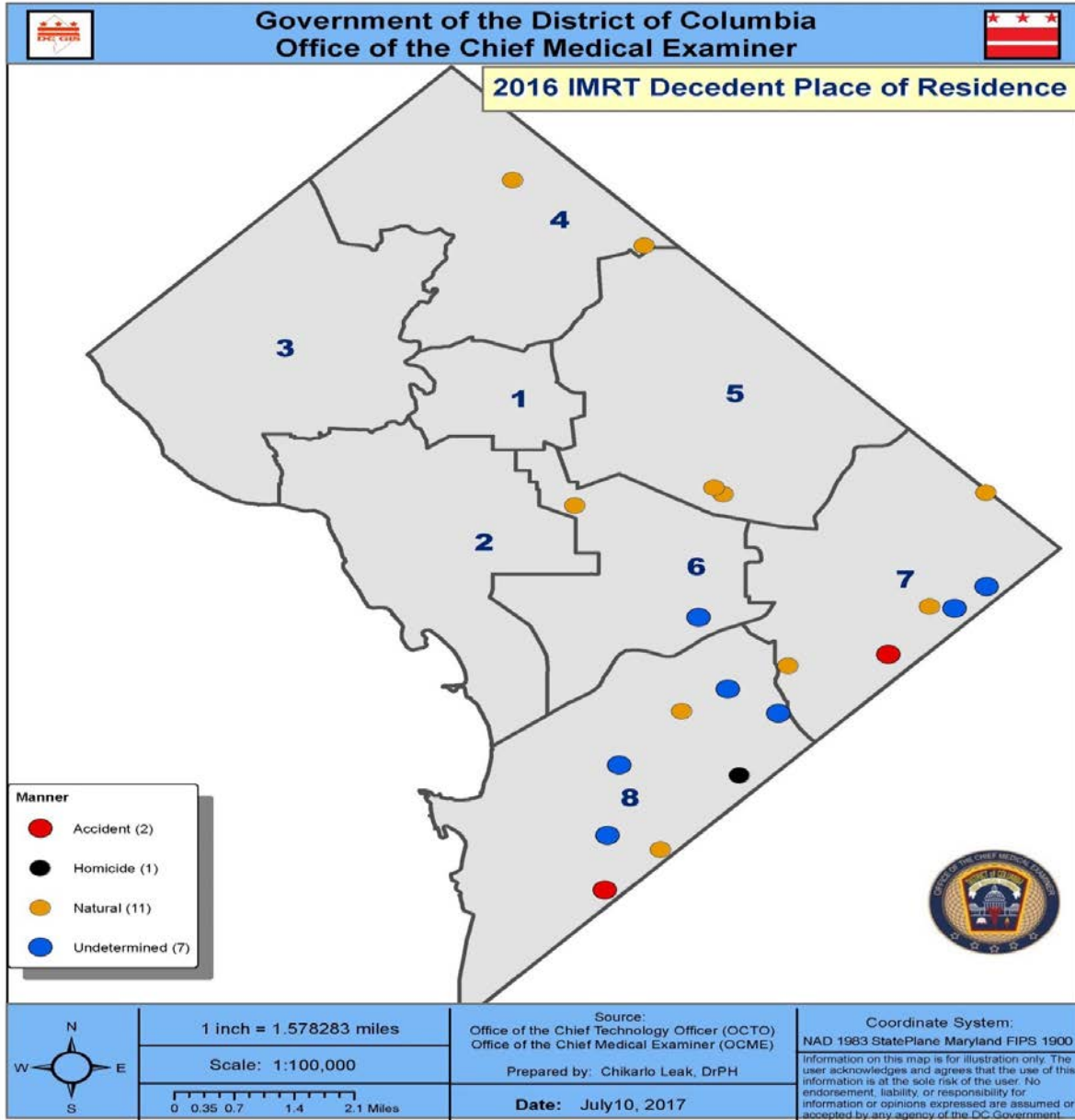
The case review process begins with the staff of the OCME's Fatality Review Division's compilation of decedent case summaries amassed from numerous multidisciplinary records. The summaries speak to the intricate details of each decedent's path from birth to death through their family's access of services from public health, human services, education and public safety cluster agencies. The following section – *Summary of Team Findings* - provides details of pertinent data extracted from those cases reviewed by the IMRT and the CFRT in 2016.

## **SECTION I:**

### **SUMMARY OF TEAM FINDINGS**

# INFANT MORTALITY REVIEW TEAM (IMRT) FINDINGS

In 2016, the IMRT reviewed twenty-one (21) infant mortality cases of deaths that occurred in 2013, 2014 and 2015.<sup>3</sup>



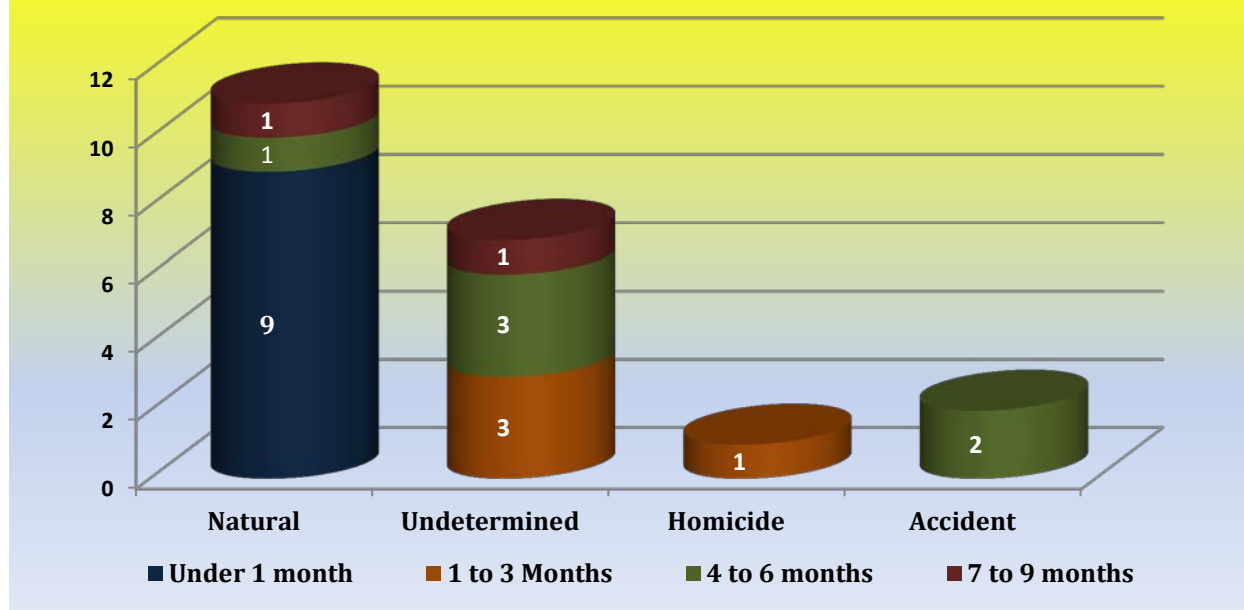
<sup>3</sup> Two of the natural death decedents were twins who resided in the same residence.

Preventing infant mortality is complex, as identifying the underlying medical condition leading to the cause of death is the bottom layer of what are often innumerable issues that may affect maternal health. Without timely intervention, such issues may negatively impact the delivery, birth and health of the infant. It is the IMRTs intent to identify and address those risks that impact maternal health, pregnancies and the lives of infants in the District of Columbia as identified during case review meetings. This begins with the identification of the leading causes of deaths among the cases reviewed by the IMRT in 2016.

<b>TABLE 2: IMRT CASE REVIEWS CAUSES OF DEATH</b>	
<b>CAUSES OF DEATH</b>	<b>NUMBER OF CASES REVIEWED</b>
<b>NATURAL CASES</b>	
<b>COMPLICATIONS OF PREMATURITY</b>	<b>8</b>
<b>CONGENITAL ANOMALIES</b>	<b>1</b>
<b>INFECTION</b>	<b>2</b>
<b>ACCIDENTAL DEATHS</b>	
<b>POSITIONAL ASPHYXIA</b>	<b>2</b>
<b>UNDETERMINED DEATHS</b>	
<b>SUDDEN UNEXPLAINED DEATH IN INFANCY</b>	<b>3</b>
<b>UNDETERMINED – BED SHARING</b>	<b>4</b>
<b>HOMICIDE</b>	
<b>MULTIPLE BLUNT FORCE INJURIES</b>	<b>1</b>

Most of the cases featured infants whose manner of death was natural and the cause of death was due to complications of extreme prematurity (8, 38%). Other natural death causes included infection (2) and congenital anomalies (1). The infant’s sleep environment was a significant risk factor in both accidental and undetermined cases reviewed by the IMRT (9, 43%). The death investigation concluded the infant’s unsafe sleep environment (e.g. bed sharing) may have contributed to the death. The death of one infant was attributed to fatal abuse homicide. This infant suffered multiple blunt force injuries, including skull and rib fractures. All cases reviewed by the IMRT indicated opportunities for intervention by medical professionals, direct services providers and community advocates.

**Figure 5: IMRT Decedent Age and Manner of Death**



Most of these infants died of natural causes (9, 43%) and within the first month of life (11, 52%).

### **PREMATURITY, LOW BIRTH WEIGHT AND INFANT MORTALITY**

The premature birth of infants continues to be one of the leading risk factors associated with infant mortality in the District of Columbia. Over the course of the past few review years, the IMRT has recognized the need to highlight risks associated with prematurity and/or low birth weight of infants born in the District of Columbia. Definitions of these risk factors are as follows:

*Preterm Birth:* 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 (World Health Organization, 2015).

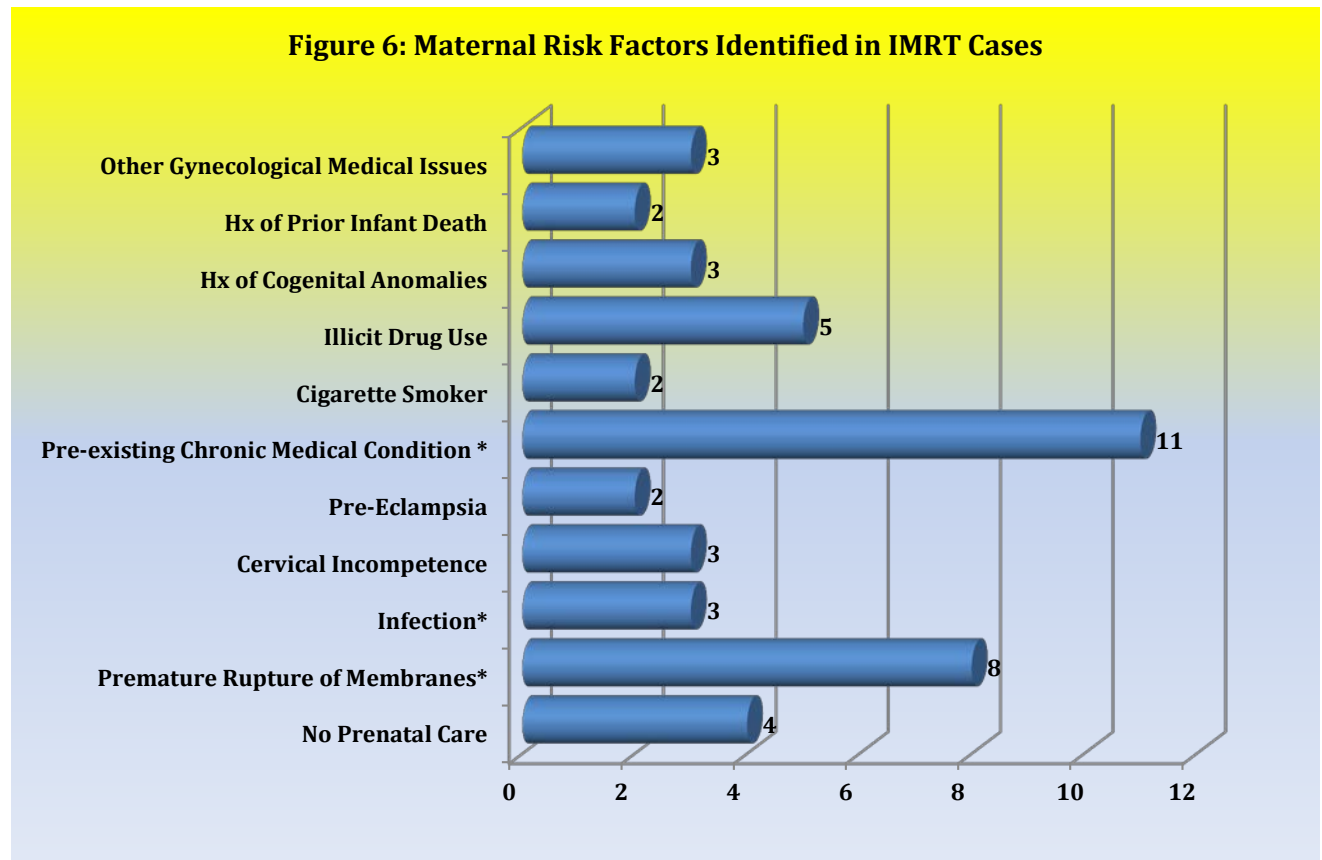
*Low Birth Weight:* This includes infants who are born weighing less than 2500 grams regardless of gestational age. (World Health Organization, 2006)

The risk of death increases in infants who are born less than thirty-two (32) weeks of gestational age, as these infants have not had an opportunity to fully develop. Ten (10, 48%), of the IMRT cases, encompassing all manners of death, involved infants who were born pre-term. The IMRT reviewed thirteen cases (13, 62%) involving infants representing all manners of death who were born with a low birth weight. As there are many different causes of infant mortality, it is equally important to look at contributing factors that make the death more imminent.

## MATERNAL RISK FACTORS

One of the key tenets of the IMRT is to identify the maternal risk factors that affect the health of the mother and fetus during the pregnancy in an effort to reduce the risk of infant mortality. Maternal risk factors are disclosed through the review of the mother's pregnancy/delivery health records and public service records. The IMRT agrees that a comprehensive approach to improve infant outcomes account for the role of women's health before conception, evidence-based clinical and hospital care, and the impact of social and environmental factors in achieving optimal health.

**Figure 6: Maternal Risk Factors Identified in IMRT Cases**

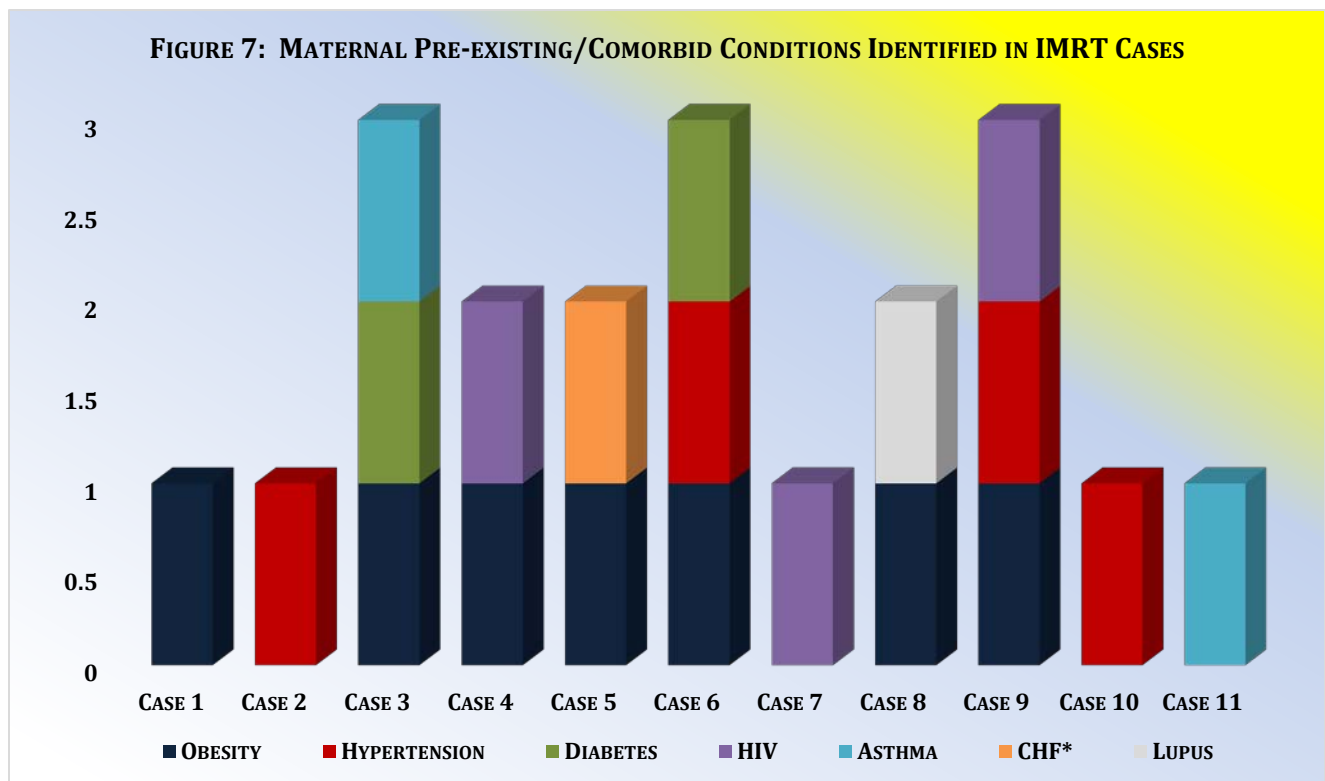


*Pre-existing Medical Conditions*

TABLE 3: PRE-EXISTING MEDICAL CONDITIONS	
PRE-EXISTING MEDICAL CONDITION	NUMBER OF CASES
OBESITY	7
HYPERTENSION	4
HIV	3
DIABETES	2
ASTHMA	2
CONGESTED HEART FAILURE	1
LUPUS	1

Pre-existing medical conditions were observed in the medical records of eleven (11) mothers (one twin gestation) whose infant’s cases met the criteria for review. Conditions noted included diabetes, hypertension, obesity and HIV. Because of innovations in the field of medicine, more women with chronic medical conditions are becoming pregnant. Medical researchers recommend the expectant mother’s clinical care should be provided through a multi-disciplinary team to address the needs of the mother and increase the chances of the infant’s healthy

delivery (Bick, 2014). This model of care is offered in the District.



IMRT case reviews indicated the pre-existing medical conditions often occurred as comorbid conditions – more than one chronic illness identified – which would require specialized pre- and post-birth medical care for both mothers and infants (Figure 7).

<sup>4</sup> CHF – Congestive Heart Failure

### ***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 37<sup>th</sup> 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 six (6, 55%) of the natural death infant cases. PROM was identified as a complication in the birth of two (2) infants who died of undetermined causes.

### ***Prenatal Care***

Inadequate prenatal care has been associated with increased risk of low-birth weight births, premature births, neonatal mortality, infant mortality, and maternal mortality. The receipt of early and consistent prenatal care allows for diagnosis and management of medical conditions that may affect the health of both mother and infant. Screening may be offered to women who are at increased risk for certain genetic disorders.

Of the twenty-one (21) IMRT cases reviewed, four (4, 19%) expecting mothers did not receive prenatal care. The reasons why care was not received was not documented in government or medical records obtained for the case reviews. Developing a mechanism to identify this information through a formal maternal interview process with the mother will be very beneficial.

The American College of Obstetricians and Gynecologists' (ACOG) recommendations for prenatal care are as follows:

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

The IMRT agrees 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 as a considerable 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.

### ***Infection***

Infection during pregnancy places the unborn fetus at risk. Sources of infection include sexually transmitted diseases, chorioamnionitis, and group B streptococcus. An infection of the amniotic fluid and membranes can lead to serious illness and death in newborn infants. Three (3, 14%) of



the IMRT mothers were diagnosed with an infection at the time of delivery which led to the infant's death.

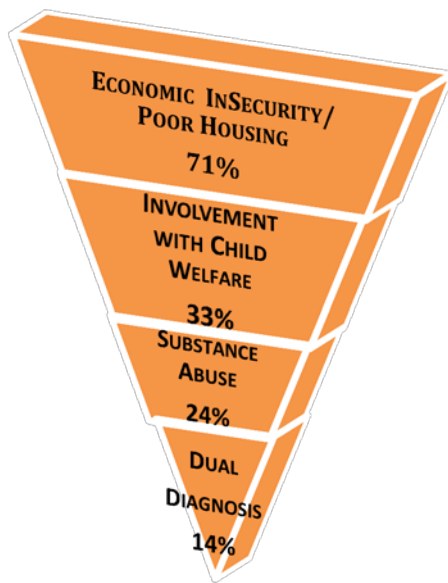
### ***Cervical Insufficiency***

A diagnosis of cervical insufficiency, also known as incompetent cervix, indicates the dilation of the cervix very early during the pregnancy. This condition can cause premature birth, and was indicated in two (2) of the natural death cases and was noted as a birth complication in one (1) of the accidental death cases.

## **SOCIAL ISSUES AFFECTING MATERNAL HEALTH**

During the case review process, members observed how families with a myriad of social issues navigated the District Government's system of care. These issues impact the mother's quality of life, the pregnancy and ultimately the infant's birth and well-being.

**Figure 8: Maternal Socio-Economic Risks**



Economic insecurity - including poor housing conditions - was the leading social issue facing expecting mothers in cases reviewed by the IMRT. Record reviews indicate fifteen (15, 71%) of the mothers met the income threshold to qualify for Temporary Assistance for Needy Families and Medicaid. These families either received housing rental assistance, or were homeless and awaiting permanent housing. Seven (7, 33%) families were involved with child welfare at the time of, or within 4 years of the fatal event<sup>5</sup>. Maternal substance abuse was identified in five (5, 24%) cases, and three (3) of these mothers were dually diagnosed with mental health and illicit substance abuse issues throughout the pregnancy.

## **UNDETERMINED INFANT DEATHS**

The IMRT reviewed seven (7, 33%) cases involving infants whose manner of death was undetermined. In three (3) of these cases, the cause of death was certified as Sudden Unexplained Death in Infancy (SUDI)<sup>6</sup>. Although the decedent's medical history often provided no evidence of chronic illness or congenital anomalies, the common denominator in all of these cases is the decedent's sleep environment and the family's issues with economic insecurity. All of these deaths occurred in economically disadvantaged areas of the District of Columbia.

<sup>5</sup> The CFRC is mandated to conduct fatality reviews of all infants, children and youth known to the District's child welfare system within four (4) years of the fatal event.

<sup>6</sup> The Center for Disease Control categorizes SUID as infant deaths that remain unexplained following a thorough investigation of the death scene, clinical history and an autopsy.

**TABLE 4: IMRT UNDETERMINED CASES**

<b>DECEDENT DEMOGRAPHICS</b>	<b>SLEEP ENVIRONMENT</b>	<b>MEDICAL HISTORY PRIOR TO DEATH</b>	<b>SOCIAL ISSUES</b>
2-month-old Black-AA/Female	Infant placed to sleep on leather sofa with adult	Full Term Infant/low birth weight Perinatal exposure to HIV (AZT Therapy) Intrauterine Growth Retardation	Economic Insecurity Child Welfare History Homelessness
2- month-old/ Black-AA/Male	Infant placed to sleep on stomach on adult bed with both parents	Late pre-term infant Perinatal exposure to HIV (AZT Therapy)	Economic Insecurity
2- month- old/ Black-AA /Male	Infant placed to sleep on adult bed with an adult	Full term infant No prior medical history	Economic Insecurity
4-month-old/ Black-AA/Female	Infant placed to sleep on adult bed with an adult	Pre-term/low birth weight Infant had cold-like symptoms	Economic Insecurity
4-month-old Black-AA/Female	Infant placed to sleep on adult bed with an adult	Full term infant No prior medical history	Child Welfare History Economic Insecurity Previous infant mortality
5-month-old Black-AA/Male	Infant placed to sleep on adult bed with an adult	Full term infant No prior medical history	Economic Insecurity
8-month-old Black-AA/Male	Infant placed to sleep on adult bed with an adult	Full term infant No Prior Medical History	Economic Insecurity

## ACCIDENTAL INFANT DEATHS

Two (2, 10%) of the IMRT decedents died of accidental deaths with the cause of death identified as positional asphyxia.

<b>TABLE 5: IMRT ACCIDENTAL INFANT DEATHS</b>			
<b>DECEDENT DEMOGRAPHICS</b>	<b>SLEEP ENVIRONMENT</b>	<b>MEDICAL HISTORY PRIOR TO DEATH</b>	<b>SOCIAL ISSUES</b>
6-month-old Black-AA/Female	Infant and father slept on sofa	Full Term Infant No Prior Medical Issues	Economic Insecurity
5-month-old/ Black-AA/Female	Infant placed to sleep on sofa while in care of older sibling	Full Term Infant History of Congenital Anomalies Multiple medical Issues	Child Welfare Involvement Economic Insecurity

As observed in these cases, the infants’ sleep environment was a risk factor associated with the accidental deaths reviewed by the IMRT. Placing an infant to sleep on a sofa - particularly with other sleeping individuals - can expose the infant to a dangerous and/or lethal sleeping environment. In these cases, the infants were found wedged between the sofa’s cushions. Records related to the death investigation indicate neither infant regularly used a safe sleep surface (bassinet or crib) when placed to sleep.

The undetermined and accidental death case reviews provide evidence of the parent’s/caretaker’s need to be close to the infant, particularly in the sleep environment. This indicates a need for medical providers and community advocates to place more emphasis on how to safely co-sleep with an infant, particularly for parents with low-economic means.

## IMRT MEETING DISCUSSIONS

During the 2016 IMRT meetings, multidisciplinary participants engaged in discussions involving a diverse representation of District agencies responsible for the care and coordination of services provided to the District’s infants and mothers. Several themes emerged which broadly addressed health and wellness, infrastructure and care coordination, the provision of medical services, safety and substance abuse disorders. Although these discussions did not rise to the level of a formal recommendation, they were vitally important in determining the current status of services and needs within this population. The following information summarizes discussions of the IMRT.

## **Health and Wellness**

The IMRT discussed the concept of developing a public service media and marketing campaign focused on the health and economic benefits of family planning for all age ranges. The program should include information on permanent and reversible contraception methods, as well as a wide range of education on birth spacing and family planning. The information should be accessible and readily available.

Several strategies around family planning were discussed to ensure that women are healthy before pregnancy, that they actively choose to become parents, and that women have optimal health during pregnancy. The IMRT indicated that family planning should be addressed during medical appointments, specifically for women of an advanced maternal age (age 35 and over) with a genetic predisposition for fetal complications. The team stressed the messaging from the medical community should be stronger on how critical the conversation concerning family planning and genetic testing is during prenatal visits.

The IMRT agreed there is a need to provide expedited medical coverage for chronically ill children especially if the family was under extraordinary social and financial stress. The ability to facilitate medical coverage and admission to specialty hospitals for families with social and emotional constraints is vital in ensuring the survivability of medically compromised infants. Advocacy, fluid communication and collaboration between partner agencies are critical to achieve this outcome.

The IMRT reviewed several cases with HIV positive mothers and their involvement in treatment. This precipitated discussion surrounding supportive services that might assist mothers immigrating to the United States who are HIV positive and eligible to receive treatment or supportive services and how they can achieve a successful pregnancy and delivery.

The IMRT was also invested in establishing protocols and guidelines or “best practices” for the discharge of premature infants (at or before 37 weeks gestation) from hospitals to their primary providers and or specialist. The IMRT, through a sub-committee, determined a mechanism did not exist for a “warm hand-off” which included record transfers, medical appointment scheduling and advocacy, or coordinated and integrated treatment plans for preterm infants.

As preterm infants generally require a lengthy birth hospitalization and remain at increased risk for morbidity and mortality, the infant’s discharge from the neonatal intensive care unit (NICU) warrants a change in existing policy. Their discharge may require technological support, compounded by complicated family dynamics, or an irreversible condition that may result in early death. The IMRT discussed developing comprehensive discharge planning guidelines to minimize the risk within this population. The ability to share information and resources between providers would facilitate the coordination of care of premature infants and improve their outcomes.

Obesity is a public health issue that was observed in multiple IMRT case reviews. Throughout the year's reviews, the IMRT recognized the trending impact obesity presented for District residents and highlighted the importance of managing this diagnosis in women of child bearing age. The IMRT discussed the possibility of public health mechanisms tracking obesity in women of child bearing age. Efforts to support women with modifying their lifestyles and managing the stress impacting health and unhealthy choices should be visible. Such interventions might ultimately contribute to more successful pregnancy outcomes.

Post-partum depression and the community's response to grief and bereavement was a point of discussion in most case reviews. This discussion indicated there may not be guidelines and/or established protections for child losses, especially for individuals paid hourly or for temporary employees. The IMRT agreed such traumatic events should meet the criteria for job protection. The IMRT discussed researching the availability of bereavement services offered by the District, and the federal benefits available to those individuals who have experienced traumatic losses of infants, children and youth. Also discussed was the development of a complicated grief protocol which could be implemented when determining what circumstances and who should be covered for protection under these programs. Finally, the IMRT was concerned that mothers who have experienced domestic violence and post-partum depression should receive education and grief services through a health care provider of their choice; at minimum, a referral and risk assessment should be conducted by their doctor.

### **Infrastructure**

The importance of care coordination for mothers and at-risk infants transected every case reviewed during the year with varying levels of severity. As a result, the IMRT agreed the establishment of a family advocacy program could assist families with navigating the support network process including access to bereavement services.

The team discussed the District's current response to homicides, the implementation of the community stabilization process, and how this process could be adapted to generate a city-wide response. There was preliminary discussion regarding a community response system and what resources would be required to implement this work for all manners of death. This led to a discussion around researching the national landscape and identifying federal partners in this area. The IMRT believed it was important to advocate for a grant structure to provide for bereavement and additional support to organizations; especially those serving families experiencing the loss of a child.

Several concerns raised were focused on services and assistance to homeless families. Such assistance included assisting mothers caring for young children and helping them transition from homelessness to permanent housing. Based on the issues faced by the families involved in the cases the IMRT reviewed, there was concern that an increased level of quality case management

services was required. The team agreed families receiving public assistance would benefit from additional support provided through the voluntary home visiting services.

All IMRT participants advocated for increased involvement of fathers in the care of their children at an early stage and incorporating this philosophy in public programming. Fathers should be encouraged to attend well-child and prenatal medical appointments. The father's early involvement in the infant's care, much like early entry into prenatal care, has a positive impact on the health of the mother and the baby.

An ongoing point of discussion referenced families with medically complex infants and the need for Fee-for-Service Medicaid to include the provision of case management services. This will assist a large majority of families in the Medicaid Fee-for-Service program with obtaining critical assistance with identifying appropriate care providers and with managing their health care needs. This is especially true for families caring for medically fragile infants.

### **Safety**

The IMRT expressed the importance of providing parents of infants CPR training at birthing hospitals prior to discharge, and as a component of well-child visits. Developing a training module for parents and families to learn and practice CPR training may be vital for this population.

The infant's unsafe sleep environment continued to be discussed during the IMRT reviews and it was agreed there needed to be consistent education and pediatric follow-up on safe sleep practices. Outreach and intervention should be documented in medical records, and should reach levels similar to those of passenger safety training and laws currently in the United States and as recommended by the American Academy of Pediatrics (AAP). The team discussed the need for the development of a safe sleep initiative with specific inclusion and involvement from birthing hospitals.

The IMRT acknowledged the tireless work of organizations in the District that engage in the vital work of educating caregivers and parents about the ABC's of infant sleep: Alone, on Baby's Back, in a Crib, in a Smoke free environment. Although there are a multitude of agencies and resources, the IMRT agreed to work toward developing a Safe Sleep symposium in the near future.

### **Substance Abuse**

Several of the fatalities reviewed over the course of the year involved mothers who used marijuana, before, during and after their pregnancies. Further study by the medical community on the impact of marijuana in-utero and exposure in infancy is warranted. The IMRT acknowledged there were no substantive studies available in this area, nor was there a strong correlation between marijuana use and infant mortality. However, mothers should receive education regarding the effects of the

infant's exposure to teratogenic drugs. The discussion also generated the idea of a study on marijuana use and prenatal exposure on developmental outcomes, as well as safe sleep outcomes.

The IMRT encouraged a more aggressive approach in formulating solid recommendations addressing the need for specific studies on the impact of prenatal exposure to marijuana use by both parents. The IMRT suggested that more consideration should be given to expanding the role of physicians as guides and teachers, when reporting the neurological impact of marijuana during the reporting of a child welfare referral for further intervention.

The IMRT asserted additional education on mandated reporting should be provided to birthing hospitals specifically regarding positive toxicology cases, with an emphasis on substantiating neglect for cases of the infant's positive toxicology and prenatal exposure to substances.

### **Future Considerations**

The IMRT is working to include interviews with families and caregivers around what motivates them to share the same sleeping surfaces and how this information can be utilized to change sleep practices and behaviors. The IMRT discussed meeting twice a year to review morbidity data and Geo-Spatial Information System (GIS) mapping data to assess risk factors and determine immediate or long-term prevention goals. The IMRT also considered convening quarterly, to review the cases strictly for trends. The idea of meeting with local leaders in order to provide vital information regarding infant deaths and the populations' response to trauma - modeled on the maternal interview process - was also discussed.

Robust discussions occurred on the need to improve inter-agency systems and supports. Improving upon the process of how resources are dispersed throughout the city, and combining public health data, PRAMS (Pregnancy Risk Assessment Monitoring System) data and data obtained through cluster reviews, will greatly assist the IMRT in developing actionable recommendations.

Several points for integration into the case review process were discussed and included applying the ACES-Adverse Childhood Experiences surveys into the case reviews, implementing a quantifying review of sibling deaths and the impact on household functioning, improving data collection by capturing health risk assessment data from managed care organizations, inviting stakeholders to the table and addressing any legal restrictions or mandates. The IMRT recognized the importance of strategic timing when submitting recommendations. The IMRT agreed it would benefit from the participation of an obstetrician in case review meetings to assist in analyzing and interpreting the mother's medical record information.

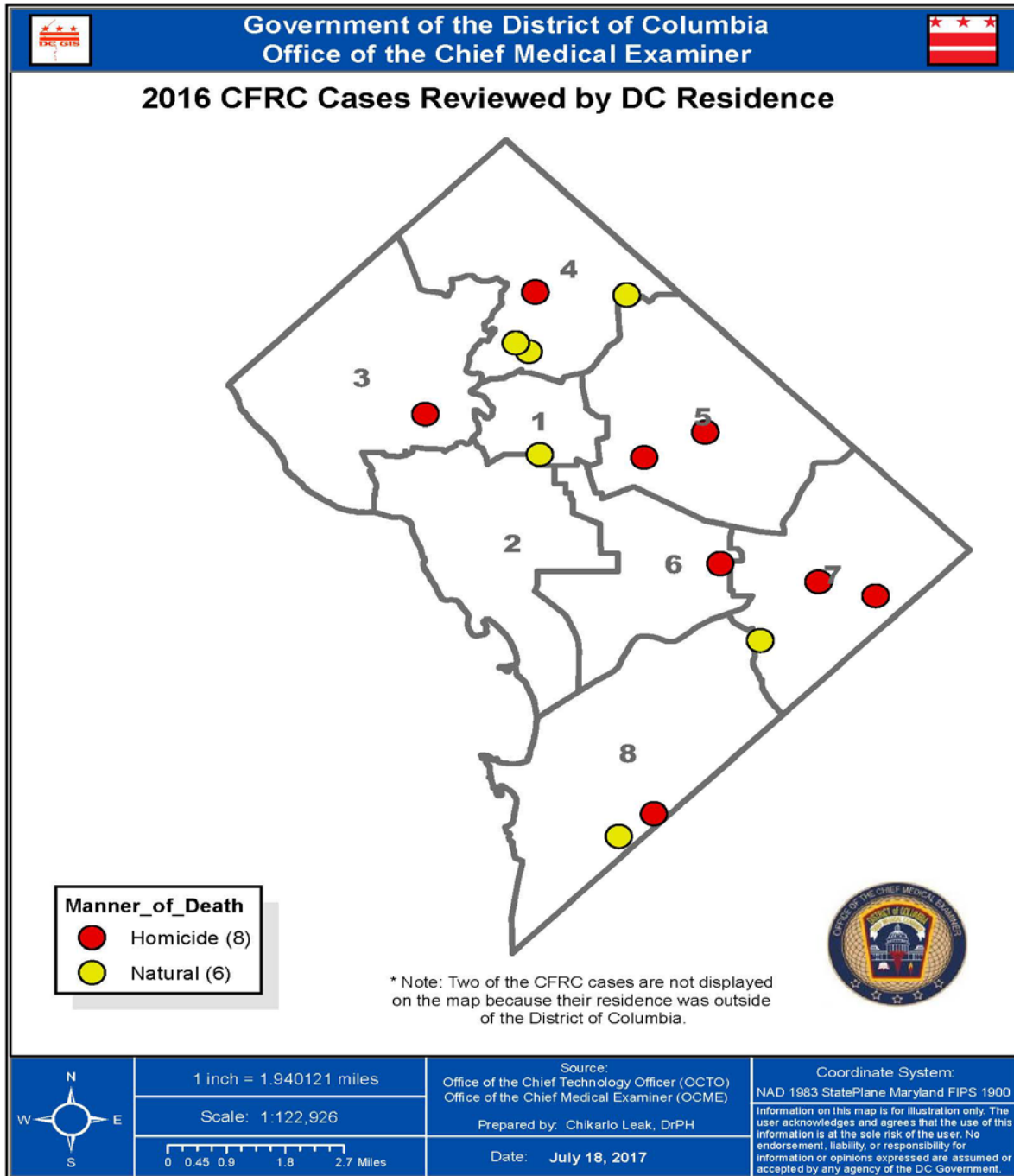
Lastly, the team discussed the importance of implementing the maternal interview process and advocating for support services once the fatal or critical event has concluded. Issues of prenatal care, access and barriers to services could be addressed by the maternal interviewer. This will

contribute to the development of best practices that will provide better outcomes for this population. It was shared during meetings that work was being completed between several agency partners to develop a Maternal Interview Program for the District of Columbia.

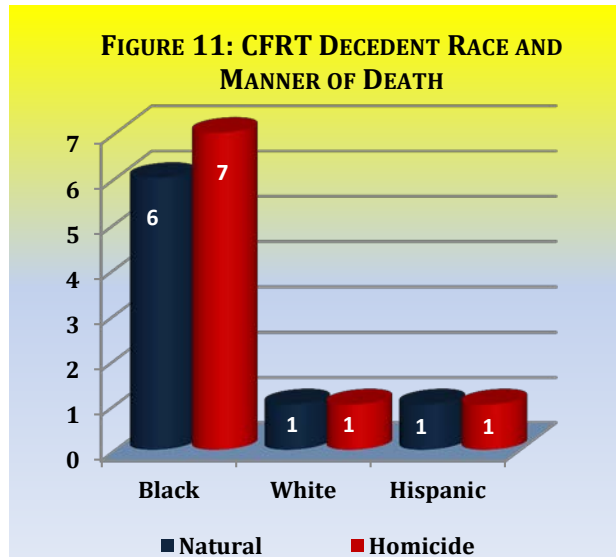
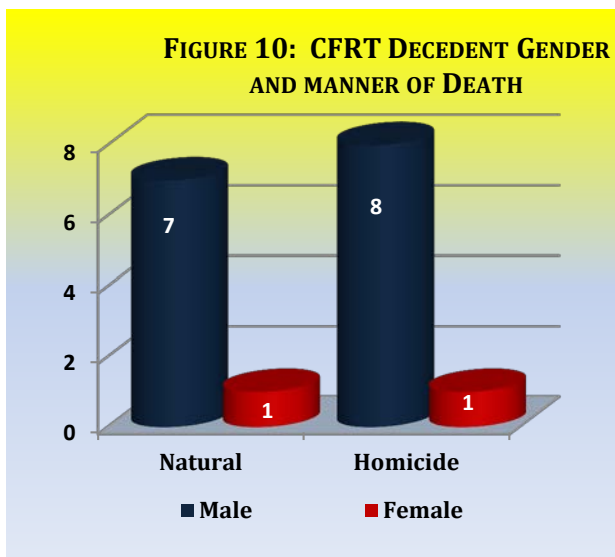
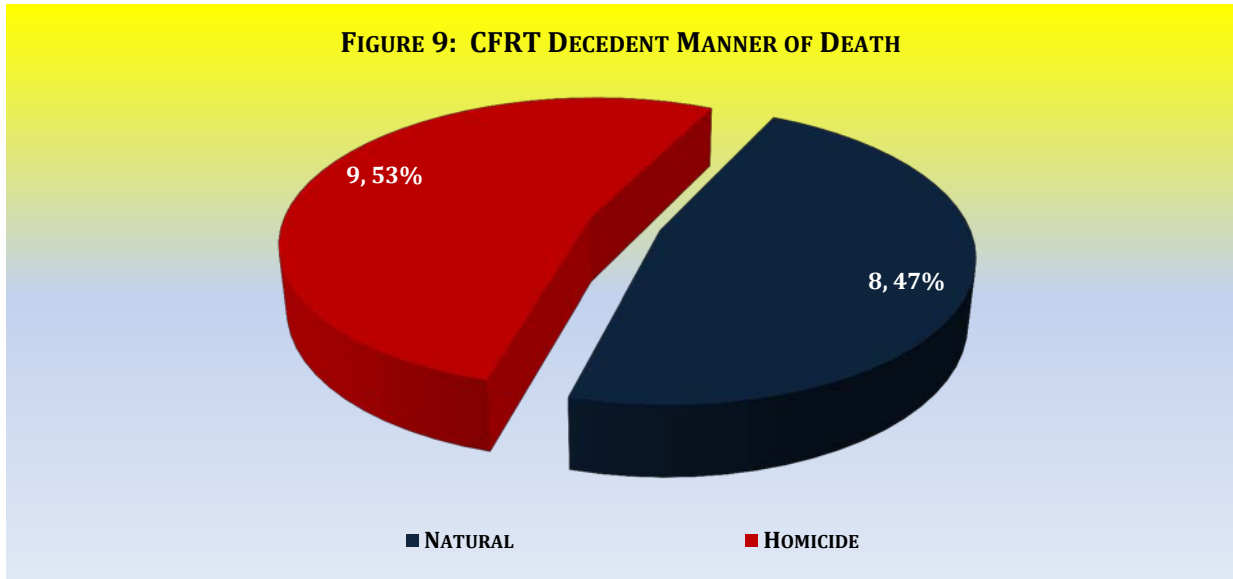


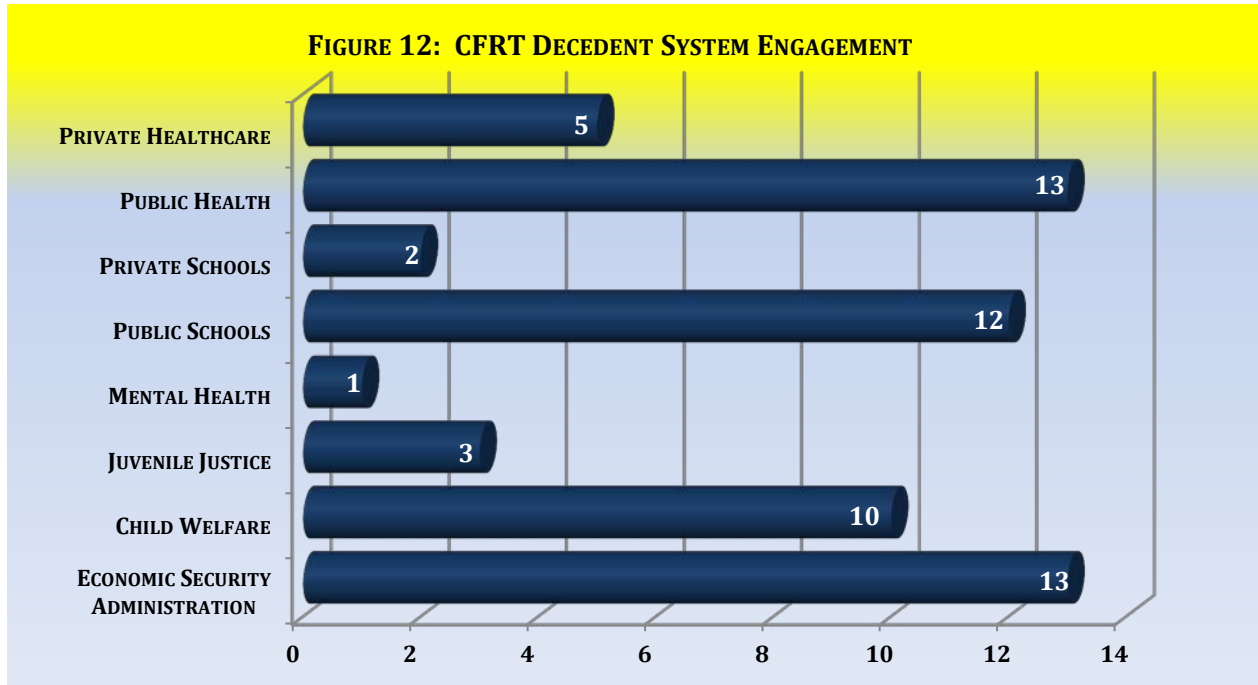
## CHILD FATALITY REVIEW TEAM (CFRT) FINDINGS

In 2016, the CFRT reviewed seventeen (17, 45%) fatalities involving children and youth whose deaths occurred in 2014, 2015 and 2016.



The CFRT reviewed deaths of children and youth who died of natural causes (8, 47%) and homicides (9, 53%). These decedents resided throughout the District of Columbia, and their ages ranged from 1 to 20 years old. Most of these cases involved Black/African American children and youth (76%), and the majority of the decedents were Black/African American males. Due to the decedents' age and involvement with government programs, these cases provided historical information related to the family's social economic history, access to services, and the barriers to service delivery.





CFRT decedents were involved with multiple systems; with seventy-six percent (76%) each involved with the District’s public health and economic security programs as recipients of TANF<sup>7</sup> cash assistance and Medicaid. Seventy-one percent (71%) of the decedents attended public schools, whose case records provided the Committee with details regarding their school attendance, performance and school based services. Fifty-nine percent (59%) of the decedents were known to the District’s child welfare program.

### **CFRT NATURAL DEATH CASE REVIEWS**

The CFRT reviewed eight (8) natural death cases of children and youth between the ages of 1 and 19 years old. Many of these decedents were medically fragile – dependent upon long term medical care due to a pre-existing condition or congenital anomaly. Although these decedents died of natural causes, the case reviews provided the CFRT with information regarding the decedents’ quality of life and associated risks. Case reviews indicated all families needed assistance navigating medical systems as well as government systems of care – indicating the need and opportunity for systems to engage with families caring for medically fragile children.

<sup>7</sup> Temporary Assistance for Needy Families cash assistance program is a federal block grant program.

**TABLE 6: CFRT CASE REVIEWS OF NATURAL DEATHS**

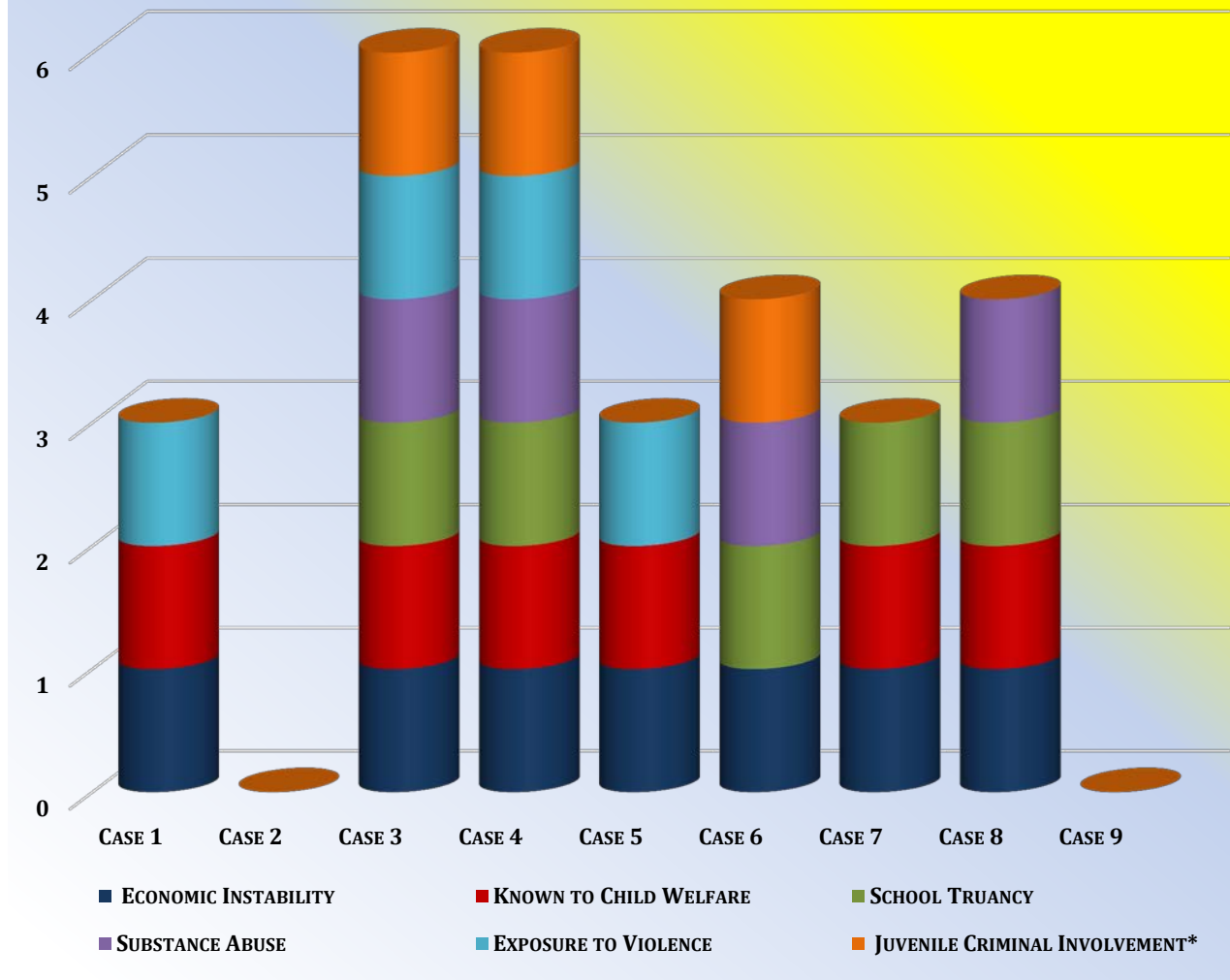
<b>DECEDENT DEMOGRAPHICS</b>	<b>CAUSE OF DEATH</b>	<b>MEDICAL HISTORY</b>
1-year-old Hispanic/Male	Hypercapnia Respiratory Failure due to Viral Respiratory Tract Infection due to Mucopolysaccharidosis Type IV	Medically Fragile
3 – year- old Black-AA/ Male	Cardiac Arrest due to Lymphoma due to Renal Failure	History of Burkitt’s Lymphoma
4-year-old Black-AA/ Male	Cardiopulmonary Arrest due to Severe Hypoxic Ischemic Encephalopathy	Medically Fragile
5- year old Black-AA Female	Active Myocarditis in the setting of Acute Influenza Type B	History of Flu Virus
7-year-old White/Male	Respiratory Failure due to Parainfluenza Pneumonia	Medically Fragile
8-year-old Black-AA/Male	Sudden Cardiac Death due to Severe Hypoxic Ischemic Encephalopathy	No Previous Medical History
17-year-old Black-AA/Female	Acute Confluent Community Acquired Pneumonia and Tracheobronchitis	Pregnant Teen
19-year-old Black-AA/Male	Pulmonary Hemorrhage	Medically Fragile

## CFRT HOMICIDE CASE REVIEWS

The Centers for Disease Control and Prevention indicates injury and violence is the leading cause of death among youth 15 to 24 years old (Prevention, 2016). As the CFRT agrees youth violence homicide is preventable; risks associated with these decedents were discussed during case review meetings and compiled as findings to later support proposed recommendations. Information provided by the Metropolitan Police Department revealed arguments in four cases (4, 44%) as the leading known motive associated with youth homicides reviewed by the CFRT. Gun use was the leading method of homicides in six cases (6, 67%), followed by stabbings in three cases (3, 33%).

<b>TABLE 7 : CFRT HOMICIDE REVIEWS</b>		
<b>DECEDENT DEMOGRAPHICS</b>	<b>CAUSE OF DEATH</b>	<b>MOTIVE</b>
<b>10-year-old White Male</b>	<b>Thermal and Sharp Force Injuries</b>	<b>Home Invasion</b>
<b>13-year-old Black-AA Male</b>	<b>Gunshot Wound of Torso</b>	<b>Accidental Shooting</b>
<b>16-year-old Black-AA/Male</b>	<b>Gunshot Wound</b>	<b>Neighborhood Dispute</b>
<b>17-year-old Hispanic/Male</b>	<b>Multiple Stab Wounds</b>	<b>Unknown</b>
<b>17-year-old Black-AA/Male</b>	<b>Gunshot Wound of the Back</b>	<b>Argument</b>
<b>17-year-old Black-AA/Male</b>	<b>Gunshot Wound of Torso</b>	<b>Argument</b>
<b>18-year-old Black-AA/Female</b>	<b>Multiple Sharp Force Injuries</b>	<b>Argument</b>
<b>19-year-old Black-AA/Male</b>	<b>Gunshot Wound of Abdomen</b>	<b>Robbery</b>
<b>20-year-old Black-AA/Male</b>	<b>Gunshot Wound of Chest</b>	<b>Argument</b>

**FIGURE 13: RISKS ASSOCIATED WITH YOUTH HOMICIDE CASES**



Homicide case reviews indicated the decedents’ family histories of economic instability (7, 78%) and involvement with child welfare (6, 67%) were the leading risk factors experienced among homicide victims. School truancy (5, 56%), decedent substance abuse (4, 44%), and youth involvement with juvenile justice (3, 33%) followed. The CFRC continues to track observations of intra-family/domestic violence (3, 33%) and the need to address this issue within the family home.

The CFRC’s outreach efforts included the collaboration of the OCME Outreach Specialist and the USAO through several community-based meetings. This venture created the environment to exchange information and provide feedback to those individuals most susceptible to youth violence homicides and their families. More information regarding the CFRC’s community outreach efforts can be found in Appendix A.

## CHILD FATALITY REVIEW TEAM DISCUSSIONS

The CFRT’s 2016 meeting discussions addressed observations and risks associated with the decedent, the decedent’s family and government systems engaged with families. As agencies are aware of internal barriers and gaps in service delivery that affect intervention, the CFRT agreed to track recurrent issues as findings. These findings will be used to strengthen the CFRT’s recommendations and prevention activities. The CFRT’s meeting minutes documented the systemic issues members agreed required further research and dialogue.

Table 8: CFRT Committee 2016 Ongoing Discussions		
Point of Discussion	Percentage of Total CFRT Case Reviews	Team Reasoning
Addressing Economic Insecurity and System Navigation	76% of cases reviewed	Economic insecurity is the common denominator observed in cases reviewed by the team. Families need assistance with navigating the system to address economic and health care needs.
Child/Youth Safety Concerns	47% of cases reviewed	Members discussed concerns regarding the decedents family’s multiple contacts with the District’s child welfare system. Also child/youth exposures to acts of violence within the home and their community were areas of concern.
School Attendance and Truancy Documentation	41% of cases reviewed	Multiple school records reviewed detailed issues with tracking school enrollment, the documentation of attendance records and administrative efforts to address truancy.

### **Addressing Economic Insecurity and System Navigation**

Meeting participants shared their support of the DC Cross Connect database spearheaded by the Department of Human Services (DHS) and the Office of the Chief Technology Officer (OCTO). DC Cross Connect provides an integrated view of programs servicing residents and coordinating care using integrated case planning. The CFRT has long proposed the need for a unified communication database, and further suggested that public safety programs- including the Metropolitan Police Department and juvenile justice programs - should be included in the DC Cross Connect system.

### **Child and Youth Safety**

There were several discussions throughout the year regarding multiple unsubstantiated allegations of neglect (primarily lack of supervision and parental substance abuse impacting parenting) involving decedents and their families in the child welfare system. CFSA shared information with the CFRT on its policy that addresses accumulating and escalating reports of chronic neglect that result in unsubstantiated reports. Ongoing conversations about the community papering process<sup>8</sup> continued throughout the year.

As arguments were the motive identified in investigations of several youth homicides, members received informative presentations regarding the restorative justice model utilized within the public-school system. Restorative justice provides youth an opportunity to remedy altercations and prevent acts of violence.

With the implementation of trauma-informed care throughout human services agencies, trauma and its associated social and mental health implications were points of discussion throughout the course of CFRT case reviews. The CFRT received an informative summary of services provided by the William Wendt Center for Grief and Loss, the District of Columbia's leading provider of services focused on assisting individuals and families with traumatic grief. Members agreed to continue to track cases in which families seek grief services yet are waitlisted for lack of resources.

Lastly, the issue of domestic violence treatment was discussed at several meetings. The team believed a spectrum of domestic violence services should be provided to both victims and perpetrators and should not be gender specific. The team will continue to track cases in which domestic violence is an issue but not addressed.

### **School Attendance/ Truancy Documentation**

Fatality review cases involving children and youth identified issues with documenting and tracking school enrollment, attendance, and adherence to the District's protocols developed to address unexcused absences. This was particularly evident during case review meetings involving middle school and high school students. As the student's academic success is paramount, efforts to keep the individual student engaged in school and addressing their academic needs may require a more vigorous approach. To that end, the CFRT recognizes the collaborative efforts of multiple District Government agencies to curb poor school attendance and truancy among the District's youth.

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<sup>8</sup> Child welfare defines community papering as a petition being filed in Family Court that initiates a child abuse or neglect case when an emergency removal by the child welfare agency has not occurred. In some community papering situations, court intervention is requested even though the child remains in the home with the parent or parents.



**SECTION II:**

**CHILD WELFARE**

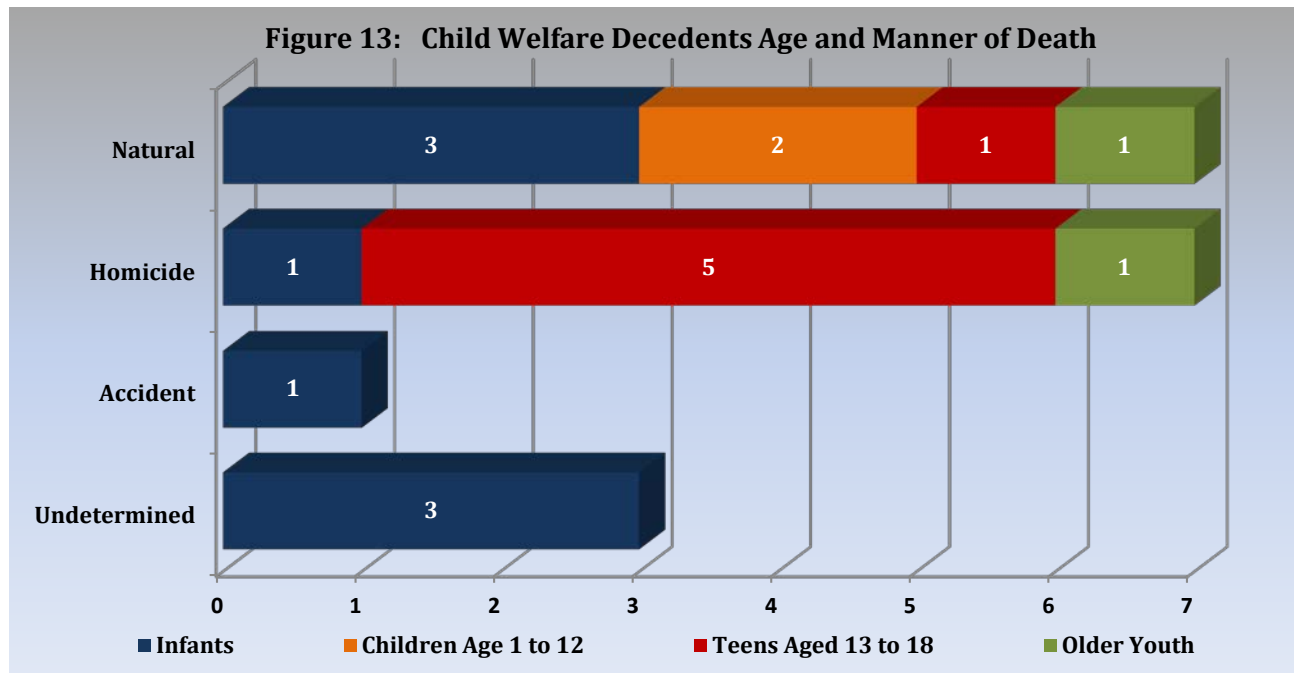
**AND**

**JUVENILE JUSTICE DECEDENTS**

## CFRC DECEDENTS KNOWN TO CHILD WELFARE

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 interact with multiple publicly funded providers (e.g. mental health, education, or community resources). Documentation related to this system of care provided the Committee with the opportunity to learn how systems collaborate 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 experiences (CDC-Kaiser ACE Study, 2016). Such adverse experiences – which may include child maltreatment, exposure to violence, substance /alcohol exposure and abuse, and poor educational outcomes – may have lasting negative effects on the overall health and social outcomes of children and youth. As the ACE study concluded, the key to improving outcomes for this vulnerable population is to prevent their exposure to adverse childhood experiences.

During the 2016 review year, the CFRC reviewed eighteen (18) cases (47% of the total cases reviewed) involving infants, children and youth who were known to the District’s child welfare agency within four years of the fatal event. Two of these youth, Black/African American males ages 16 and 19, were co-involved with juvenile justice services. Thirty-eight percent (8, 38%) of all cases reviewed by the IMRT were known to child welfare services, as fifty-nine percent (10, 59%) of all cases reviewed by the CFRT.



Most decedents involved with child welfare were infants (8, 44%) and youth between the ages of 13 and 19 years old (6, 33%). As all decedents known to child welfare were participants in the Temporary Assistance to Needy Families (TANF) Program, and recipients of Medicaid, economic insecurity was the leading risk factor observed in child welfare associated fatality reviews (18, 47%). Most of these decedents (6, 33%) experienced interactions with child welfare because of multiple allegations of neglect and/or abuse reported to child protection services. Documentation of these interactions provided evidence of layers of adverse experiences that created a crisis within the family, requiring crisis intervention services and advocacy.

### **Family Trauma**

Sixty-one percent (61%, 11) of the decedents and their parents involved with child welfare services experienced trauma (e.g. grief and/or loss, multiple placements). Records of one (1) decedent indicate their interaction with mental health services. Records reviewed indicate decedents often discussed their loss with direct service providers, however failed to participate in services to address their loss with public mental health providers. Seven (7) of these decedents died of homicide, and four (4) died of natural causes.

### **School Truancy**

Twenty-eight percent (28%, 5) of the decedents were truant from school during their involvement with child welfare. Three (3) of these decedents were identified as having special education needs. Reports of unexcused school absences were the primary focus of their interaction with child welfare. Records reviewed indicate these decedents disengaged and failed to return to school. Four (4) decedents died of homicide and one (1) died of natural causes.

### **Intra-family Violence and Domestic Violence**

Thirty-three percent (33%, 6) of the decedents were exposed/involved in ongoing arguments with other members of the household. These same decedents were exposed to domestic violence between parents at a young age. The effects of the exposure to violence within the home and subsequent reports to child welfare services led to some decedents experiencing multiple placements, separation of families and their exhibition of violent behavior in the community. In four (4) of these cases, intra-family and/or domestic violence in the home was the focus of child welfare services initial involvement with the family. Five (5) of these decedents died of homicide and (1) died of natural causes.

## DECEDENTS KNOWN TO JUVENILE JUSTICE

Table 7: CFRC Juvenile Justice Decedents		
DECEDENT DEMOGRAPHICS	CAUSE OF DEATH/MOTIVE	IDENTIFIED RISKS
16-year-old Black AA/Male	Gunshot Wound/ Neighborhood Dispute	Economic Insecurity Family Involvement with Child Welfare Exposure and Victim of Intra-Family Violence School Truancy Unresolved Trauma Limited Family/Community Support
19-year-old Black AA/Male	Gunshot Wound/ Robbery	Family Involvement with Child Welfare Exposure and Victim of Intra-Family Violence School Truancy Unresolved Trauma Decedent Substance Abuse Limited Family/Community Support
20-year-old Black AA/Male	Gunshot Wound/ Argument	School Truancy Decedent Substance Abuse Limited Family/Community Support

Three (3) cases reviewed by the CFRT were Black/African American male youth who were involved with the District of Columbia’s juvenile justice system. All three youth were involved with both Court Social Services (probation) and were eventually committed to the Department of Youth Rehabilitative Services. Each youth experienced a myriad of social issues that affected their discharge from juvenile justice services. Due to the decedent’s years of involvement with District Government programs, case reviews provided the team members with pertinent information - including the decedent’s early adverse childhood experiences.

School truancy and limited family/community support were leading risks associated with these decedents, followed by unresolved trauma and decedent substance abuse. Two (2) decedents were co-involved with child welfare services due to intra-family and domestic violence.

**SECTION III:**  
**COMMITTEE RECOMMENDATIONS**

## **CHILD FATALITY REVIEW COMMITTEE RECOMMENDATIONS**

The following are recommendations developed by the CFRC to address the need for improvements in systems and/or program initiatives that will positively affect the most vulnerable infants, children and youth in the District of Columbia. As each team concludes the fatality review, members and participants collectively formulate findings – case observations that may require further discussion – and proposed recommendations. The proposed findings and recommendations are then submitted to the CFRC Recommendations Subcommittee for discussion and formal adoption.

These three (3) recommendations were generated following the review of these 38 cases and adopted by the CFRC. These recommendations address the need for training the District's investigative partners, addressing maternal risk factors associated with infant mortality and full funding for DC Cross Connect.

### **RECOMMENDATION #1: OFFICE OF THE CHIEF MEDICAL EXAMINER AND THE METROPOLITAN POLICE DEPARTMENT**

The Office of the Chief Medical Examiner (OCME) in collaboration with the Metropolitan Police Department (MPD) will convene doll reenactment training for its investigative partners to inform the circumstances related to the death. The joint facilitated reenactment education program will include the District's public safety agencies, the US Attorney's Office (USAO), and the Office of the Attorney General (OAG).

### **AGENCY'S RESPONSE: YES, WITH PLANS FOR IMPLEMENTATION**

The OCME will take the lead in implementing this recommendation. Doll reenactments should be completed on all sudden and unexpected infant deaths, particularly when safe sleep is in question and/or a contributing factor. The OCME will work with MPD to develop the proper training and education for doll reenactments. The OCME will work to identify grant funding opportunities to support the procurement of reenactment dolls to provide to the appropriate MPD units. In fiscal year 2017, the OCME hosted an interdisciplinary meeting on Sudden Unexpected Infant Death investigations. MPD representatives were represented in addition to multiple other disciplines that contribute to the death investigation process. Expected outcomes include declining infant death investigations taking place that do not have doll reenactments conducted.

### **RECOMMENDATION #2: THE DEPARTMENT OF HEALTH AND THE DEPARTMENT ON HEALTH CARE FINANCE**

The District of Columbia government's outreach initiatives to address infant mortality should include discussions of the health risks associated with obesity, advanced maternal age and infant

safe sleep environments. Information and education on these health risks related to infant mortality should be made available to the citizenry, maternal health practitioners and advocates. This information should also be included in the Department of Health's Behavioral Risk Factor Surveillance System.

**AGENCY RESPONSE: YES WITH MODIFICATIONS**

The District of Columbia government's education strategies to address infant mortality should include information about preconception health and pregnancy planning, ways to achieve healthy pregnancies, and how to ensure optimal infant health. Information and education on health risks related to infant mortality should be made available to the citizenry, maternal and primary care health practitioners, and advocates. (Note: The Behavioral Risk Factor Surveillance System (BRFSS) is a telephone survey administered by DOH. The survey collects information from District adults regarding their health-related risk behaviors, chronic health conditions, and use of preventive services. BRFSS is not exclusive to perinatal women, nor does it have the capacity to report survey results for pregnant or postpartum women. DOH has begun implementation of the Pregnancy Risk Assessment Monitoring System (PRAMS). PRAMS will allow us to obtain survey data on maternal attitudes and experiences before, during, and shortly after pregnancy, including assessing risks like obesity and advanced maternal age.)

The DC Department of Health's (DOH) approach to infant mortality reduction and improving perinatal health outcomes reflects core public health principles, including the use of a life course perspective, addressing social determinants of health, and implementation of systems level interventions. DOH uses the best available data to apply local context to evidence-based approaches in order to best meet the needs of communities. Efforts focus on the leading causes of infant deaths in the District, which include congenital disorders, maternal health complications and prematurity related deaths. The Department of Health (DOH) currently implements the following strategies to promote awareness about healthy pregnancies and infant care:

- Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) - promotes healthy eating through nutrition assessments and counseling, and provides healthy foods tailored to the specific needs of pregnant women and their babies.
- Maternal, Infant and Early Childhood Home Visit (MIECHV) Program- evidence-based home visiting that gives pregnant women and families, particularly those considered at-risk, necessary resources and skills to raise children who are physically, socially, and emotionally healthy and ready to learn.
- Healthy Start- provides comprehensive case management (psychosocial risk assessments with linkages, education and navigation) for women and their families into Healthy Start at various stages of pregnancy, including pre-conception, inter-conception, and post-conception.

- Safe Sleep and Fetal Alcohol Spectrum Disorder (FASD) Program-Safe sleep and FASD education for all District residents in community based settings. Program participants receive free Pack-‘N-Plays for DC residents to provide safe sleep environments for infants. DOH provides trainings to maternal and child health partners and community-based organizations.
- One Key Question®- promotes reproductive life planning to prevent unintended pregnancies and to promote healthier pregnancies among women who desire them. OKQ asks, “Would you like to become pregnant in the next year?” If the woman answers no then she receives education and counseling about contraception. If she answers yes, then she receives education and counseling regarding healthy pregnancy (including folic acid supplementation). In the instance of an affirmative response, if a woman is obese, she may be counseled on the associated risks and receive guidance on achieving a healthy weight.

DOH works collaboratively with the medical community to serve the residents of the District, which includes promoting evidence-based prenatal and parenting education. DOH partners with community health centers to implement perinatal programs (WIC, MIECHV and DCHS) to ensure women and infants can have a full range of health and social services within their primary medical home. DOH also works with physicians and payers through the Department of Health Care Finance’s Perinatal Collaborative.

The Department of Health Care Finance (DHCF) Division of Quality and Health Outcomes (DQHO) hosts the Perinatal Quality Improvement (QI) Collaborative, a quarterly meeting of the MCO quality leaders, representatives from DOH, March of Dimes, providers, practitioners and community stakeholders to discuss progress on the performance improvement projects (PIP) required in the Medicaid MCO contracts. The Perinatal QI Collaborative focuses on one of two CMS-required PIPs that the District designed to improve the perinatal and birth outcomes of Medicaid beneficiaries enrolled in an MCO. The QI Collaborative engages participants in continuous quality improvement activities by: developing a system intervention (the OB Assessment/Authorization form); discussing barriers and identifying opportunities for improvement; and collaborating with community stakeholders and sister agencies to assist in the integration and coordination of services district-wide to improve maternal health & birth outcomes. Through the Perinatal QI Collaborative, the MCOs work to improve on the following outcomes for moms and babies: birth weight, bringing babies to full term, HIV testing during pregnancy, miscarriage/fetal loss, unknown birth outcomes, infant deaths, and other adverse outcomes.

In 2009, the QI Collaborative first implemented the OB Assessment/Authorization form as a system-wide intervention that all MCOs would use to receive timely notification of a member’s pregnancy, historical pregnancy information; identifying social determinants of health; and programmatic referrals which allow them to initiate case/care management and care coordination



services early to ensure a healthy pregnancy and delivery. Among the data currently transmitted on the OB form are maternal age, BMI, and risk factors associated with a need for nutritional services. The QI Collaborative continues to work with providers to refine the process of timely transmitting the OB form to the MCOs. Starting in 2017, DHCF will receive CMS enhanced federal matching funds to implement an electronic Perinatal Registry, which will be able to track MCO Medicaid members' pregnancies; identified social determinants of health which can impact maternal and birth outcomes; streamline the flow of information between providers and the MCOs so as to initiate prenatal care and care coordination services as early as possible.

The Perinatal QI Collaborative will devote its July 2017 meeting to safe sleep, as this was a topic of interest to the Infant Mortality Review Committee, on which DHCF and the MCOs are represented. The QI collaborative heard presentations from DOH as well as local service providers on the Safe Sleep program as well as a representative from the Baby Box University. The presentations included ways to get available resources like free Pack n' Plays, safe sleep education, and maternal mental health services to Medicaid members. All MCOs currently provide care coordination for pregnant women and promote access to these services today.

One Key Question has been integrated into Healthy Start and School Based Health Centers, with plans to expand to other clinical sites, WIC and home visiting programs. When done in non-clinical settings, program staff works to link women with an annual well woman visit so they may receive comprehensive primary and preventive care, including reproductive life planning and chronic disease management.

Also, DOH has been working with CFSA to ensure alignment of our respective safe sleep efforts.

**RECOMMENDATION #3: DEPARTMENT OF HUMAN SERVICES, OFFICE OF THE CHIEF TECHNOLOGY OFFICER**

Through its mandate to improve outcomes for the District's vulnerable children, youth and families, the Child Fatality Review Committee agrees the District of Columbia should allocate funding for the implementation and utilization of DC Cross Connect throughout the human services and public safety cluster agencies. As a unified, fully integrated multidisciplinary master data management system, DC Cross Connect will encourage the ongoing coordination of care amongst the District's direct service staff, and allow for a more holistic approach to addressing the complex needs of this special population.

## **RESPONSE: YES WITH MODIFICATIONS**

While a unified data management system is a tool that can support a coordinated service delivery model, it is not what drives the change needed. The focus needs to be on the practice, not the IT system.

Through DC Cross Connect, the District began to use a ‘teaming’ model of care management to integrate DHS, CFSA and DBH services, to promote continued family participation in goals and improve family outcomes. Expanding the capacity of front-line staff to: (1) identify when a teaming approach is needed; (2) convene a team to deliver a coordinated, unified set of services, and (3) document the progress is the focus and should be the recommendation. Note that this project is managed through a joint-governance approach between DHS, CFSA and DBH. DHS is responding since the recommendation came from the Committee to DHS.

All families benefit from a coordinated service delivery model, in which agency providers and families partner to achieve goals included in a collaboratively-created plan. This is especially true for families with behavioral health conditions or/and who are at risk of, or are experiencing, homelessness. As such, DHS partnered with CFSA and DBH to pilot an integrated care approach called DC Cross Connect. After a year’s worth of experience and data collected through this pilot, DHS, CFSA and DBH decided to broadly incorporate this integrated service model into existing systems to better serve more families. Expanding the DC Cross Connect model from a pilot to a standard of practice includes training the agencies’ direct service staff and community service providers on the teaming approach to care management. Training will begin in mid-August. To support these efforts immediately, the three agencies are developing ways to share information about clients in as real-time as possible, and will eventually leverage a unified, fully integrated multidisciplinary master data management system available through the DC Access System (DCAS). In the short term, the teaming method will leverage existing systems. Cross Connect staff will monitor ongoing touch points between DHS, CFSA and DBH and regularly brief agency leadership through existing governance structures to review the impact, successes and challenges.

Milestones include the following:

- Execute data sharing agreement between DHS, CFSA and DBH authorizing routine share client-level data exchange and how case managers and agency entry points should use the data.
- 100% of DHS and CFSA entry point staff and case managers trained on ‘teaming’ approach ---specifically how to integrate the multiple agency and community-based resources available to clients, when they use them and how to increase their use of them (if needed). DBH currently uses a mixed-team method, thus this agency’s care management practices will be bolstered by CFSA and DBH’s trainings.
- Establish a mechanism for monitoring deployment of the approach, tracking families identified for “teaming”, frequency, outcomes, additional training needs etc.



## **APPENDIX**

## **APPENDIX A**

### **CHILD FATALITY REVIEW COMMITTEE STATUS OF GRANT FUNDING**

In FY2016, the OCME was awarded a \$100,000 grant from the Office of Victims Services and Justice Grants (OVSJG) for the CFRC to engage in community outreach, improve its recommendations process and provide training to CFRC members on trends and themes identified through case reviews or on topics of interest to the Committee in an effort to further facilitate the Committee's work. This project further enhanced the Committee's efforts to improve outcomes of the District's most vulnerable residents and is a strategic tenant within the Committee's spectrum of advocacy activities. The OCME hired an Outreach Program Specialist, who brought with him a wealth of knowledge of the juvenile justice system and the practice of Restorative Justice Programs. The Outreach Program Specialist was tasked to directly interact with District residents, community leaders and advocates and other public agency leaders to share and address the issues identified and discussed in previous CFRC Annual Reports and on trends the Committee believed to be vitally important.

The Outreach Program Specialist developed a communication strategy and partnered with the Malcolm X Opportunity Center, the US Attorney's Office and the FBI to share information on youth violence at some of the local DC Schools. The Outreach Program Specialist partnered with other public agency partners such as the Mayor's Office of Community Relations (MOCR), Safer Stronger Outreach Team and the Deputy Mayor for Health and Human Services (DMHHS) who welcomed and included him in their outreach activities, unit meetings and worked to identify other ways of partnering.

One of the Outreach Program Specialists other critical tasks was to identify national speakers to present to the CFRC on identified risk factors of the population of decedents reviewed by the Committee. Training was provided to CFRC members in late July 2016 on Sudden Infant Death Syndrome (SIDS) and Sleep Related deaths and was presented by Dr. Rachel Moon from the University Of Virginia School Of Medicine's Children's National Medical Center. Training was also provided to CFRC members on the creation of a hospital based infant safe sleep education and awareness program by Dr. Michael Goodstein, Director, York County Cribs for Kids Program at York Hospital in Pennsylvania. Both Dr. Moon and Dr. Goodstein are revered as experts in the field and their presentation furthered the Committee's findings and supported discussion on the need for the District to further safe sleep education and possibly establish a Safe Sleep Campaign.

The Committee also embarked on 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. Theresa Covington, Director, National Center for Fatality Review and

Prevention presented to the CFRC in July 2016 and to the IMRT in November 2016 on the process for developing actionable recommendations and findings. Part of the discussion included how the teams could obtain better traction on their findings and further their role in the recommendations process, specifically, how the teams could work to improve inter-agency systems, supporting families and collaborating with each other on data sharing initiatives and resource distribution. Director Covington shared the idea that fatality review teams should consider developing recommendations with a similar process taken by the National Transportation Safety Board (NTSB) where 82% of their recommendations are adopted. She shared that risk factors should be discussed in all meetings and that recommendations should be developed to address areas that teams can most effectively impact; those that are most prevalent and modifiable. It was recommended the teams come together at least twice per year to review findings and rank order the most common risk factors and determine which ones are immediate goals, and which are long term goals.

Director Covington shared that recommendations are a good final step for system modifications and prevention measures and that it was critical to determine which ones are considered as best practices for inclusion in the final recommendations. Good recommendations are those similar to SMART (specific, measurable, achievable, results-focused and time-bound) goals. They should be specific and strongly worded. They should identify who is responsible for implementation, the target population, and a timeline for implementing the recommendations. Recommendations can assist with monitoring effectiveness and good recommendations are those that can be implemented. Did we meet the needs of families before, during and after the death? Are there gaps in service delivery and what can we do to fix them?

Additional discussion focused on the notification process to agencies which are impacted by recommendations and that recommendations should relate directly to the findings identified in each case. Director Covington suggested ways to achieve this even further by considering the establishment of Community Action Teams which can bring more individuals to the table and identify more risk factors and findings from a community perspective. Organizing and grouping cases by type and by risk factor and bringing new subject matter experts into the process based on trends to further support the development of targeted recommendations. She recommended continuing to track discussions and team ideas that may not lead to official recommendations, in meeting minutes, and to later reflect upon and possibly use the information to support the development of new recommendations.

The CFRC benefited greatly from the grant resources provided and it is hoped that with continued funding, the Committee will be recognized as a leading voice in the prevention of child deaths.

## **APPENDIX B- CFRC LEGISLATION**

### **§ 4-1371.01. Short title.**

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

(Oct. 3, 2001, D.C. Law 14-28, § 4601, 48 DCR 6981.)

### **§ 4-1371.02. Definitions.**

For the purposes of this subchapter, the term:

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

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

(Oct. 3, 2001, D.C. Law 14-28, § 4602, 48 DCR 6981.)

### **§ 4-1371.03. Establishment and purpose.**

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

(b) The Committee shall:

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

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

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

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

- (5) Recommend components for prevention and education programs; and
- (6) Recommend training to improve the investigation of child deaths. (Oct. 3, 2001, D.C. Law 14-28, § 4603, 48 DCR 6981.)

**§ 4-1371.04. Composition of the Child Fatality Review Committee.**

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

- (1) Department of Human Services;
- (2) Department of Health;
- (3) Office of the Chief Medical Examiner;
- (4) Child and Family Services Agency;
- (5) Metropolitan Police Department;
- (6) Fire and Emergency Medical Services Department;
- (7) D.C. Public Schools;
- (8) Department of Housing and Community Development; and
- (9) Office of the Attorney General.

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

- (1) Superior Court of the District of Columbia;
- (2) Office of the United States Attorney for the District of Columbia;
- (3) District of Columbia hospitals where children are born or treated;
- (4) College or university schools of social work; and
- (5) Mayor's Committee on Child Abuse and Neglect.

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

(d) Governmental appointees shall serve at the will of the Mayor, or of the federal or judicial body designating their availability for appointment. Community representatives shall serve for 3-year terms.



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

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

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

(Oct. 3, 2001, D.C. Law 14-28, § 4604, 48 DCR 6981; Mar. 13, 2004, D.C. Law 15-105, § 36, 51 DCR 881; April 13, 2005, D.C. Law 15-354, § 85(c), 52 DCR 2638.)

#### **§ 4-1371.05. Criteria for case review.**

(a) The Committee shall be responsible for reviewing the deaths of children who were residents of the District of Columbia and of such children who, or whose families, at the time of death:

(1) Or at any point during the 2 years prior to the child's death, were known to the juvenile justice or mental retardation or developmental disabilities systems of the District of Columbia; and

(2) Or at any point during the 4 years prior to the child's death, were known to the child welfare system of the District of Columbia.

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

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

(1) Multidisciplinary review of individual fatalities;

(2) Multidisciplinary review of clusters of fatalities identified by special category or characteristic;

(3) Statistical reviews of fatalities; or

(4) Any combination of such approaches.

(d) The Committee shall establish 2 review teams to conduct its review of child fatalities. The Infant Mortality Review Team shall review the deaths of children under the age of one year and the Child Fatality Review Team shall review the deaths of children over the age of one year. Each team may include designated public officials with responsibilities for child and juvenile welfare from each of the agencies and entities listed in § 4-1371.04.

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

(1) Those children known to the juvenile justice system;

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

(Oct. 3, 2001, D.C. Law 14-28, § 4605, 48 DCR 6981; April 12, 2005, D.C. Law 15-341, § 4, 52 DCR 2315.)

#### **§ 4-1371.06. Access to information.**

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

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

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

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

(4) Information made confidential by §§ 4-1302.03, 4-1303.06, 7-219, 7-1203.02, 7-1305.12, 16-2331, 16-2332, 16-2333, 16-2335, and 31-3426.

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

(c) Notwithstanding subsection (a)(1) of this section, information and records concerning a current law enforcement investigation may be withheld, at the discretion of the investigating authority, if disclosure of the information would compromise a criminal investigation.

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

(1) The investigation is concluded;

(2) The investigating authority determines that providing the information will no longer compromise the investigation; or

(3) The information or records are provided to the Committee.

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

(Oct. 3, 2001, D.C. Law 14-28, § 4606, 48 DCR 6981.)

#### **§ 4-1371.07. Subpoena power.**

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

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

(1) By a special process server, at least 18 years of age, designated by the Committee from among the staff of the Committee or any of the offices or organizations represented on the Committee; provided, that the special process server is not directly involved in the investigation; or

(2) By a special process server, at least 18 years of age, engaged by the Committee.

(c) If, after a reasonable attempt, personal service on a witness or witness' agent cannot be obtained, a special process server identified in subsection (b) of this section may serve a subpoena by registered or certified mail not less than 8 business days before the date the witness must appear or the documents must be produced.

(d) If a witness who has been personally summoned neglects or refuses to obey the subpoena issued pursuant to subsection (a) of this section, the Committee may report that fact to the Superior Court of the District of Columbia and the court may compel

obedience to the subpoena to the same extent as witnesses may be compelled to obey the subpoenas of the court.

(Oct. 3, 2001, D.C. Law 14-28, § 4607, 48 DCR 6981.)

#### **§ 4-1371.08. Confidentiality of proceedings.**

(a) Proceedings of the Committee shall be closed to the public and shall not be subject to § 1-207.42, when the Committee is discussing cases of individual child deaths or where the identity of any person, other than a person who has consented to be identified, can be ascertained.

Persons other than Committee members who attend any Committee meeting which, pursuant to this section, is not open to the public, shall not disclose what occurred at the meeting to anyone who was not in attendance, except insofar as disclosure is necessary for that person to comply with a request for information from the Committee. Committee members who attend meetings not open to the public shall not disclose what occurred with anyone who was not in attendance (except other Committee members), except insofar as disclosure is necessary to carry out the duties of the Committee. Any party who discloses information pursuant to this subsection shall take all reasonable steps to ensure that the information disclosed, and the person to whom the information is disclosed, are as limited as possible.

(b) Members of the Committee, persons attending a Committee meeting, and persons who present information to the Committee may not be required to disclose, in any administrative, civil, or criminal proceeding, information presented at or opinions formed as a result of a Committee meeting, except that nothing in this subsection may be construed as preventing a person from providing information to another review committee specifically authorized to obtain such information in its investigation of a child death, the disclosure of information obtained independently of the Committee, or the disclosure of information which is public information.

(c) Information identifying a deceased child, a member of the child's immediate family, the guardian or caretaker of the child, or an alleged or suspected perpetrator of abuse or neglect upon the child, may not be disclosed publicly.

(d) Information identifying District of Columbia government employees or private health-care providers, social service agencies, and educational, housing, and child-care providers may not be disclosed publicly.

(e) Information and records which are the subject of this section may be disclosed upon a determination made in accordance with rules and procedures established by the Mayor.

(Oct. 3, 2001, D.C. Law 14-28, § 4608, 48 DCR 6981.)

#### **§ 4-1371.09. Confidentiality of information.**

(a) All information and records generated by the Committee, including statistical compilations and reports, and all information and records acquired by, and in the possession of, the Committee are confidential.

(b) Except as permitted by this section, information and records of the Committee shall not be disclosed voluntarily, pursuant to a subpoena, in response to a request for discovery in any adjudicative proceeding, or in response to a request made under subchapter II of Chapter 5 of Title 2, nor shall it be introduced into evidence in any administrative, civil, or criminal proceeding.

(c) Committee information and records may be disclosed only as necessary to carry out the Committee's duties and purposes. The information and records may be disclosed by the Committee to another child fatality review committee if the other committee is governed by confidentiality provisions which afford the same or greater protections as those provided in this subchapter.

(d) Information and records presented to a Committee team during a child fatality review shall not be immune from subpoena or discovery, or prohibited from being introduced into evidence, solely because the information and records were presented to a team during a child death review, if the information and records have been obtained through other sources.

(e) Statistical compilations and reports of the Committee that contain information that would reveal the identity of any person, other than a person who has consented to be identified, are not public records or information, and are subject to the prohibitions contained in subsection (a) of this section.

(f) The Committee shall compile an Annual Report of Findings and Recommendations which shall be made available to the Mayor, the Council, and the public, and shall be presented to the Council at a public hearing.

(g) Findings and recommendations on child fatalities defined in § 4-1371.05(e) shall be available to the public on request.

(h) At the direction of the Mayor and for good cause, special findings and recommendations pertaining to other specific child fatalities may be disclosed to the public.

(i) Nothing shall be disclosed in any report of findings and recommendations that would likely endanger the life, safety, or physical or emotional well-being of a child, or the life or safety of any other person, or which may compromise the integrity of a Mayor's investigation, a civil or criminal investigation, or a judicial proceeding.

(j) If the Mayor or the Committee denies access to specific information based on this section, the requesting entity may seek disclosure of the information through the Superior Court of the District of Columbia. The name or any other information identifying the person or entity who referred the child to the Department of Human Services or the Metropolitan Police Department shall not be released to the public.

(k) The Mayor shall promulgate rules implementing the provisions of §§ 4-1371.07 and 4-1371.08. The rules shall require that a subordinate agency director to whom a recommendation is directed by the Committee shall respond in writing within 30 days of the issuance of the report containing the recommendations.

(l) The policy recommendations to a particular agency authorized by this section shall be incorporated into the annual performance plans and reports required by subchapter XIV-A of Chapter 6 of Title 1.

(Oct. 3, 2001, D.C. Law 14-28, § 4609, 48 DCR 6981.)

#### **§ 4-1371.10. Immunity from liability for providing information to Committee.**

Any health-care provider or any other person or institution providing information to the Committee pursuant to this subchapter shall have immunity from liability, administrative, civil, or criminal, that might otherwise be incurred or imposed with respect to the disclosure of the information.

(Oct. 3, 2001, D.C. Law 14-28, § 4610, 48 DCR 6981.)

#### **§ 4-1371.11. Unlawful disclosure of information; penalties.**

Whoever discloses, receives, makes use of, or knowingly permits the use of information concerning a deceased child or other person in violation of this subchapter shall be subject to a fine of not more than \$1,000. Violations of this subchapter shall be prosecuted by the Corporation Counsel or his or her designee in the name of the District of Columbia. Subject to the availability of an appropriation for this purpose, any fines collected pursuant to this section shall be used by the Committee to fund its activities.

(Oct. 3, 2001, D.C. Law 14-28, § 4611, 48 DCR 6981.)

#### **§ 4-1371.12. Persons required to make reports; procedure.**

(a) Notwithstanding, but in addition to, the provisions of any law, including § 14-307 and Chapter 12 of Title 7, any person or official specified in subsection (b) of this section who has knowledge of the death of a child who died in the District of Columbia, or a ward of the District of Columbia who died outside the District of Columbia, shall as soon as practicable but in any event within 5 business days report the death or cause to have a report of the death made to the Registrar of Vital Records.

(b) Persons required to report child deaths pursuant to subsection (a) of this section shall include every physician, psychologist, medical examiner, dentist, chiropractor, qualified mental retardation professional, registered nurse, licensed practical nurse, person involved in the care and treatment of patients, health professional licensed pursuant to Chapter 12 of Title 3, law-enforcement officer, school official, teacher, social service worker, day care worker, mental health professional, funeral director, undertaker, and embalmer. The Mayor shall issue rules and procedures governing the nature and contents of such reports.

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

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

(e) Nothing in this section shall affect other reporting requirements under District law. (Oct. 3, 2001, D.C. Law 14-28, § 4612, 48 DCR 6981.)

**§ 4-1371.13. Immunity from liability for making reports.**

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

(Oct. 3, 2001, D.C. Law 14-28, § 4613, 48 DCR 6981.)

**§ 4-1371.14. Failure to make a report.**

Any person required to make a report under § 4-1371.12 who willfully fails to make the report shall be fined not more than \$100 or imprisoned for not more than 30 days, or both. Violations of § 4-1371.12 shall be prosecuted by the Corporation Counsel of the District of Columbia, or his or her agent, in the name of the District of Columbia.

(Oct. 3, 2001, D.C. Law 14-28, § 4614, 48 DCR 6981.)

# 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 extended to the community volunteers who continue to serve the citizens of the District throughout every aspect of the child fatality review process.

REFERENCE



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