

Government Of the
District of Columbia

Office of the
Chief Medical Examiner

**CHILD FATALITY REVIEW COMMITTEE
2014 ANNUAL REPORT**

GOVERNMENT OF THE DISTRICT OF COLUMBIA
MURIEL BOWSER, MAYOR

**DISTRICT OF COLUMBIA
CHILD FATALITY REVIEW COMMITTEE**

2014 ANNUAL REPORT

MISSION:

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

PRESENTED TO:

The Honorable Muriel Bowser, Mayor, District of Columbia

The Council of the District of Columbia

DECEMBER 2015

DISTRICT OF COLUMBIA CHILD FATALITY REVIEW COMMITTEE

DEDICATION

This Annual Report is dedicated to the memory of the infants, children and youth of the District of Columbia who lost their lives due to medical problems, senseless acts of violence, accidents and suicide. It is our vision that as we learn lessons from circumstances surrounding the deaths of these children, we can succeed in positively affecting the future of our infants, children and youth by reducing the number of preventable deaths and promoting quality of life for all residents.

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GREETINGS FROM THE CHIEF MEDICAL EXAMINER



Over the last year the Child Fatality Review Committee (CFRC) and the Fatality Review Unit at the Office of the Chief Medical Examiner remained focused on improving the Fatality Review Process. We hired a new Fatality Review Manager to lead this process. In addition to the new staff leadership the Committee appointed a new Co-Chair.

During the assessment for improvement of the process we also identified the need to amend the governing statute. Recently approved by the Mayor and the Council of the District of Columbia, the following five agencies that provide critical services to the case population were added to the Committee: Department of Behavioral Health, Department of Health Care Finance, Department of Youth Rehabilitation Services, DC Housing Authority, and the Office of the State Superintendent of Education. The amendment also contained a technical adjustment to reflect the proper title of what is now the “Office of the Attorney General” and removed a non-stakeholder representative from the Committee. These legislative amendments were made in efforts to ensure that the relevant District agency service providers were properly represented for a more informed case 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. The Child Fatality Review Committee is committed to developing systemic recommendations that can be used to inform evidence-based programs and policy.

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

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

Yours in Truth and Service,

Roger A. Mitchell, Jr.

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



This year, the Committee unanimously voted for Ms. Cynthia G. Wright, Esq. to co-chair the CFRC. Ms. Wright has been a member of the CFRC since 2012. As an Assistant U.S. Attorney since 1991 in the Homicide Special Victim's Unit specializing in prosecuting cases involving the death of children, Ms. Wright has prosecuted hundreds of cases, including numerous child homicides, violent street gangs, domestic violence, child sexual abuse cases, child pornography, and sex trafficking cases. According to Ms. Wright, "Our City is fortunate to have two active teams under the Child Fatality Review Committee, (CFRT and the IMRT) whose members are dedicated professionals from a variety of different disciplines who have contact with children."

Ms. Wright prosecuted one of the first sex trafficking cases in the United States presented to a jury - *United States v. Carlos Curtis*, who received a life sentence in jail for trafficking children as young as twelve years old. She received the Department of Justice Director's Award for her work in the *Curtis* case and has earned sixteen Special Achievement Awards while at the U.S. Attorney's Office. Ms. Wright is Chair of the D.C. Court of Appeals Unauthorized Practice of Law Committee. She is the President of the William B. Bryant Inn of Court and serves on the Executive Board of Directors for the Council for Court Excellence.

Since her tenure on the CFRC, Ms. Wright noted that the members of the Committee have forged strong bonds from meeting face-to-face. In her words, "Members of the Committee use their synergy to resolve issues involving not only cases where a child death has occurred, but also to actively connect in current cases to share resources, prevent injuries to living children, and seek justice for those who otherwise would not have a voice. Overall, our network strengthens the support to all families and children in the District. I am privileged to work with such a great group of individuals who genuinely care about children and who constantly strive for a better tomorrow. They are an inspiring team!"

THE INFANT MORTALITY REVIEW TEAM (IMRT)

Committee members and participants of the IMRT convene on the 1st Tuesday of each month. In 2014, members and meeting participants represented the following District Government agencies, medical providers, and community based organizations:

The American College of Obstetricians and Gynecologists
Amerihealth DC
A DC Midwife
March of Dimes
Children's National Medical Center
Child and Family Services Agency
Department of Health
Office of the Chief Medical Examiner
Providence Hospital
Unity Health Care

THE CHILD FATALITY REVIEW TEAM (CFRT)

The CFRT convenes on the 3rd Thursday of each month. In 2014, 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
Department on Behavioral Health
Department of Health Care Finance
DC Public Schools
DC Fire and Emergency Medical Services
Department of Health
Howard University School of Social Work
Metropolitan Police Department
Mayor's Committee on Child Abuse and Neglect
Office of the Attorney General
Office of the Chief Medical Examiner
Office of the US Attorney for the District of Columbia
Office of the State Superintendent for Education
Residents of the District of Columbia
Superior Court of the District of Columbia
Superior Court of the District of Columbia Court Social Services Division

WHEN A CHILD DIES...THE WORK OF THE CFRC

The District's child fatality review process is the only formally established mechanism within the city government for tracking infant, children and youth fatalities, assessing the circumstances surrounding their deaths and evaluating associated risk factors. This process assists in identifying family and community strengths, as well as deficiencies and improvements needed for service delivery systems to better address the needs of children and families served. The process provides a wealth of information used to enhance services and systems in an effort to reduce the number of preventable deaths and improve the quality of children and youth's lives.

The Child Fatality Review Committee (CFRC or Committee) is divided into two teams; the Infant Mortality Review Team (IMRT) reviews the deaths of District infants from birth through 12 months. The Child Fatality Review Team (CFRT) reviews the death of District children ages 1 through 18 years, and youth between the ages of 18 and 25 years who were known to child welfare and/or juvenile justice programs. In accordance with DC Official Code §4-1371.04, Committee membership is multidisciplinary, representing public and private child and family servicing agencies and programs. Most important, Committee membership includes community members representing the District of Columbia's Wards. All fatality review meetings are confidential. This annual report summarizes data collected from 52 infant, child and youth fatalities reviewed by the Committee during calendar year 2014. The statute mandates the publishing of an annual report reflecting the work of the Committee during the year of review.

When an infant, child or youth dies in the District of Columbia, the Committee is notified through several established sources. Upon notification, the Committee staff obtains copies of the decedent's birth and death certificates, copies of records from the medical examiner, police, hospitals and other applicable child and family-serving agencies. Records are reviewed, and the Committee's staff composes a summary developed for presentation during the monthly case review meetings.

In 2014, the IMRT and the CFRT convened for a total of 25 meetings. During these meetings, each team discussed the intricate details surrounding the events leading to the fatality. Members also received information pertaining to the decedent's social, educational, and medical history – providing a story depicting their life while residing in the District of Columbia. The information shared during the course of these meetings provides an opportunity for our city's decision makers to learn what works in the realm of human services and public safety. The goal is not to place blame. Members discuss how our city can improve the overall outcomes for our most vulnerable infants, children and youth through the evaluation of programs and services. This year, the Committee members also agreed to challenge themselves by addressing prevention from a systems perspective. Members focused on social determinants that act as barriers to services, and developed recommendations with the intention to improve how systems collaborate and mitigate these barriers to prevent the fatalities of infant, children and youth -the District's most vulnerable populations.

EXECUTIVE SUMMARY

The District of Columbia Child Fatality Review Committee (CFRC) is pleased to present its 19th Annual Report. This Report covers data from 52 infant, child and youth fatality cases reviewed by the CFRC in 2014.

The CFRC is a citywide collaborative effort authorized by the Child Fatality Review Committee Establishment Act of 2001 (see Appendix B: DC Code, § 4-1371.01 *et. seq.*). This committee was established for the purpose of conducting retrospective reviews of the circumstances contributing to the deaths of infants, children and youth who were residents of the District of Columbia, or were known to the child welfare or juvenile justice systems of the District. The primary goals of the District's child death review process are to: 1) identify risk reduction, prevention and system improvement factors, 2) recommend strategies to reduce the number of preventable child deaths, and (3) improve the quality of life of District residents.

KEY CHILD FATALITY REVIEW DATA FINDINGS

DECEDENT DEMOGRAPHICS

In 2014, the CFRC reviewed 52 cases involving decedents whose ages ranged from birth to 23 years old. Select demographic information is bulleted below:

- ◆ Sixty percent (60%, 31 cases) of the decedents were infants.
- ◆ Eighty-one percent (81%, 42 cases) of the decedents were African American.
- ◆ Sixty- seven percent (67%, 35 cases) of the decedents were males.

Child fatalities significantly impact the eastern wards of the District of Columbia. The majority of cases reviewed by the IMRT were of infants who resided in Ward 8 (9, 28%), Ward 7 (7, 22%), and Ward 5 (7, 22%). The majority of cases reviewed by the CFRT were of children and youth who resided in Wards 8 (6, 30%), and Ward 5 (5, 25%).

MANNERS OF DEATH

Natural Deaths

In 2014, the CFRC reviewed twenty-six (26) natural death cases involving infants, children and youth. Twenty-three (23, 88%) of these were infants. Sixteen (16) infants died of causes related to premature birth.

Homicide and Suicide

The CFRC reviewed sixteen (16) fatalities of infants, children and youth whose deaths resulted from acts of violence. One (1) case involved the suicide of one (1) youth. Five (5) of these cases involved the fatal abuse of two (2) infants and (3) three children.

Accidental Deaths

The CFRC reviewed three (3) accidental deaths involving children and youth. The circumstances leading to these accidental deaths were hyperthermia, an accidental neck compression, and a motor vehicle collision.

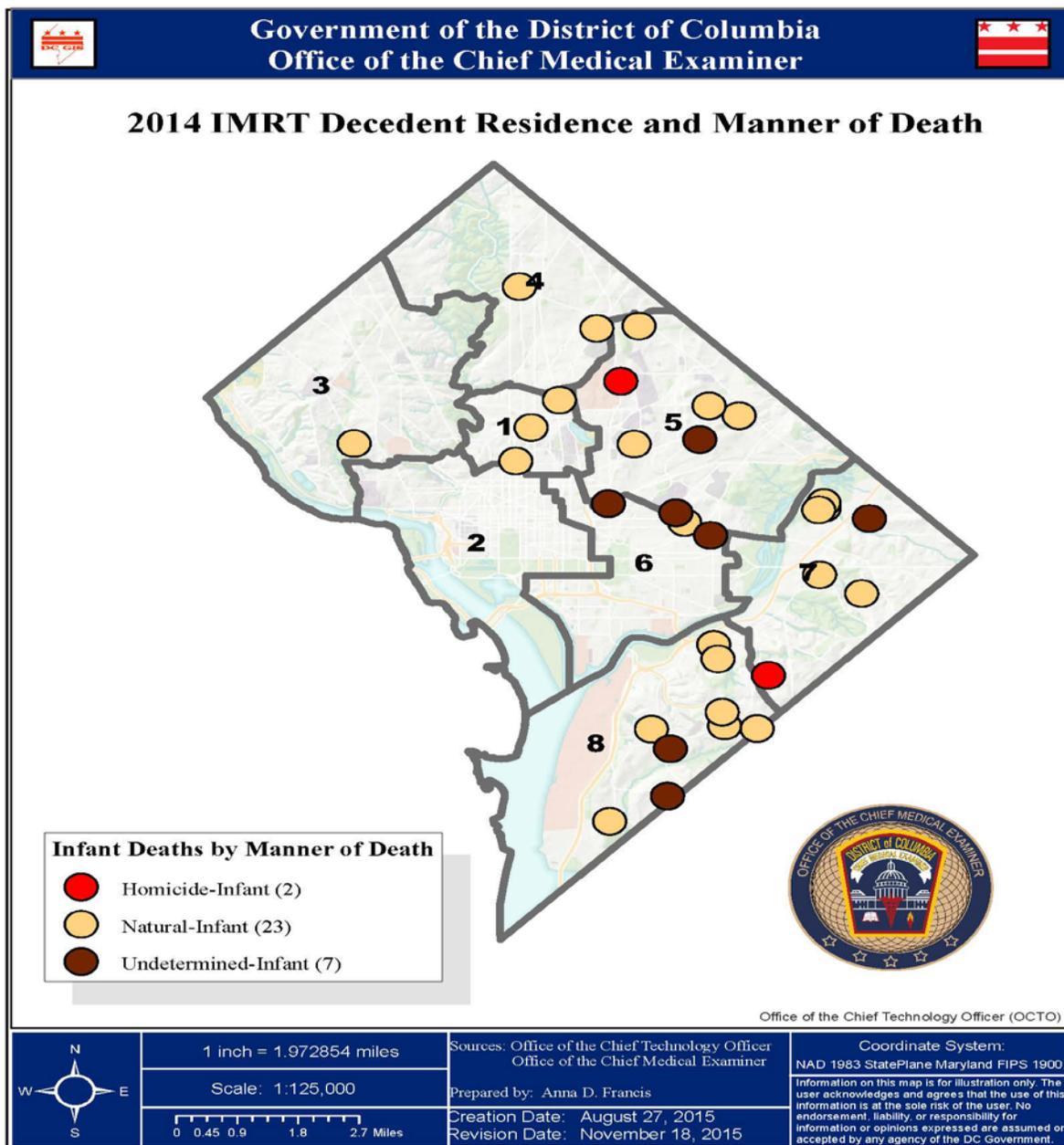
Undetermined Deaths

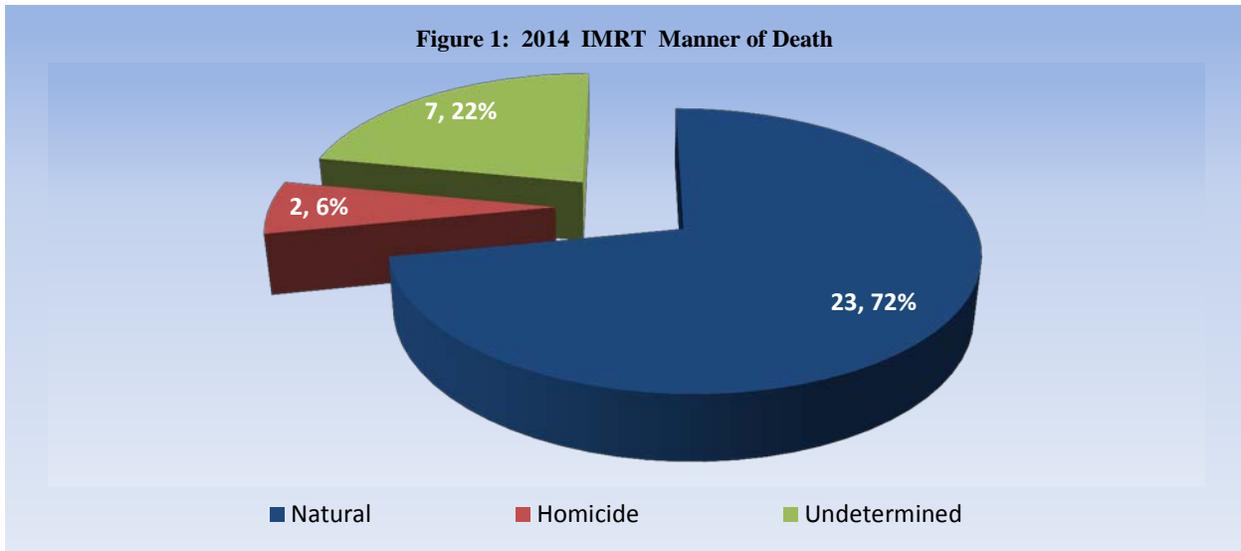
The CFRC reviewed seven (7) infant and child fatalities in which the manner of death was classified as undetermined. In six (6) of these cases, Sudden Unexpected Infant Death (SUID) associated with an unsafe sleep environment was the cause of death.

SECTION I:
SUMMARY OF TEAM FINDINGS

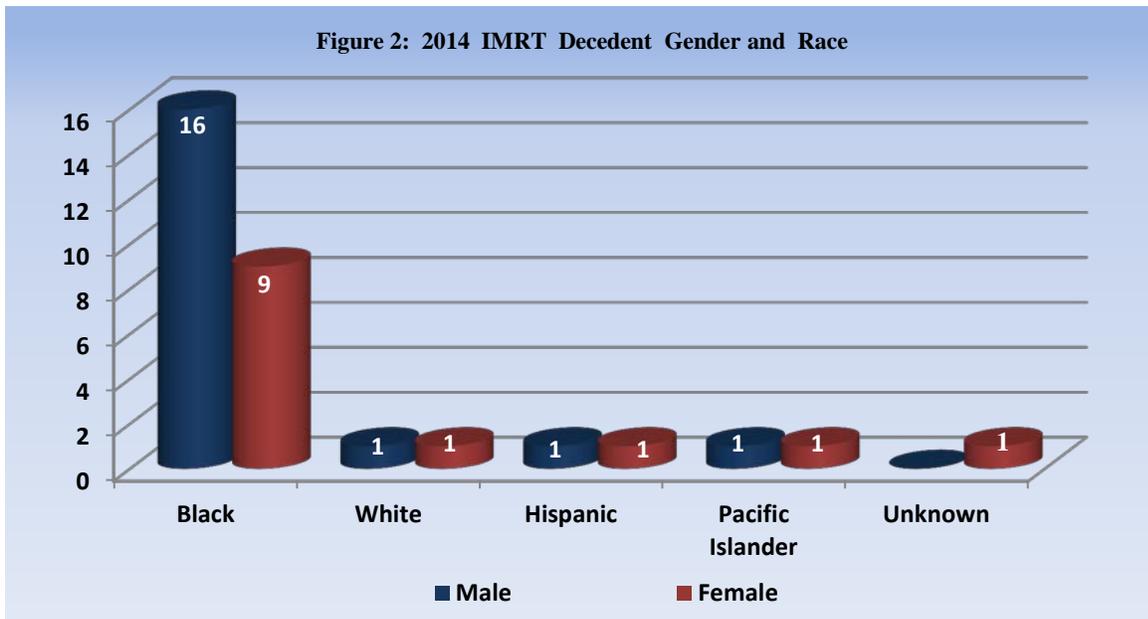
INFANT MORTALITY REVIEW TEAM FINDINGS

In 2014, the IMRT reviewed thirty-two (32) infant mortality cases of deaths that occurred in 2012, 2013, and 2014. As depicted in the map below, infant mortality significantly affects the eastern wards of the District of Columbia. The majority of cases reviewed (72%) were of infants who resided in Ward 8 (9, 28%), Ward 7 (7, 22%), and Ward 5 (7, 22%).

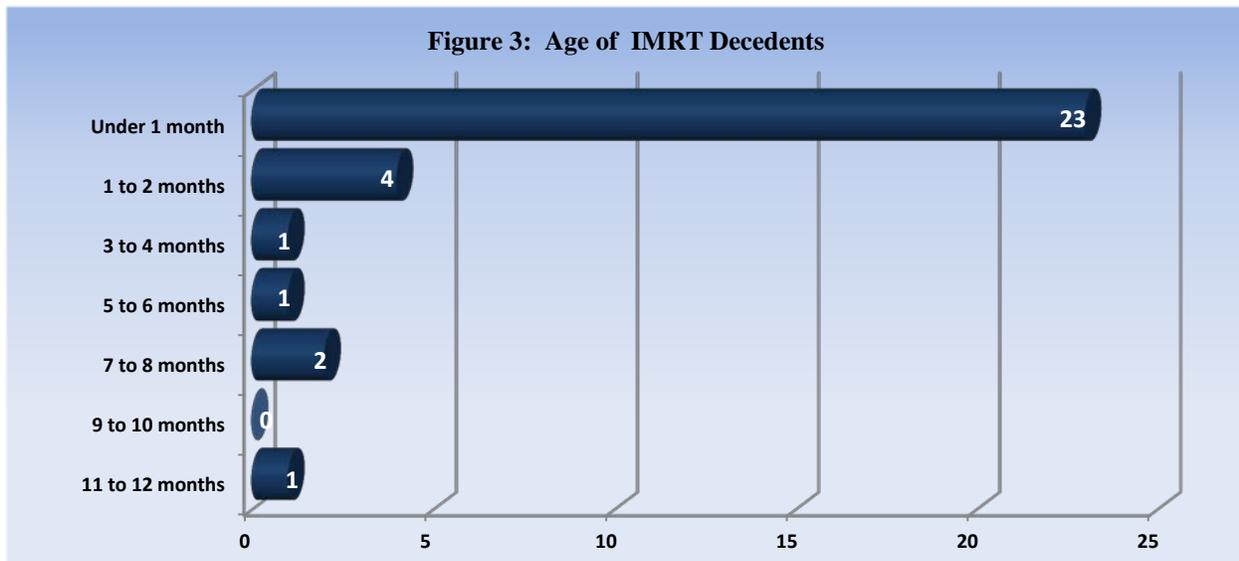




As indicated in *Figure 1*, seventy-two percent (23, 72%) of the cases reviewed by the IMRT were natural deaths, followed by deaths that were deemed undetermined (7, 22%), and two (2) infant homicides. In the cases with a natural manner of death, sixteen (16) of the cases indicated the infant's death was due to premature birth. Records indicate seventeen (17, 74%) of the natural death decedents were recipients of Medicaid. Five families (5, 22%) participated in private health insurance programs, while one (1) parent had no health insurance.



Racial demographics are obtained and verified as indicated on the death certificate. As illustrated in *Figure 2*, the majority of decedents reviewed by the IMRT were Black/African American males and females (25, 78%). The race of one female decedent was not identified in records provided to the IMRT. *Figure 3* depicts the decedent's ages ranged from under 1 month to 12 months. Twenty-three (23, 72%) of the IMRT decedents were under 1 month of age.



Prematurity and Infant Mortality

The American Academy of Pediatrics defines a preterm birth as any delivery, regardless of birth weight that occurs before thirty-seven (37) completed weeks of gestation from the first day of the last menstrual period. Infant mortality increases in infants born less than thirty-two (32) weeks of gestational age, as these infants have not had an opportunity to fully develop.

Twenty-three (23) of the IMRT infants died within the first month of life. Thirteen (13) infants were born within 17 to 24 weeks gestation, and weighed less than 1000 grams at birth. Seven (7) infants were born within 24 to 36 weeks gestation and weighed between 1001 to 3500 grams at birth. Three (3) infants were born full term. In eight (8, 35%) of the infant mortality cases reviewed by the IMRT medical records indicated the infant was nonviable at the time of birth.

The IMRT reviewed sixteen (16) cases in which the cause of death was associated with the premature birth of the infant. The following are the maternal and infant risk factors associated with these deaths:

Prenatal Care

With the focus on the timeliness of the initial prenatal visit and subsequent routine visits, ten (10, 63%) expecting mothers whose infants were born premature received adequate prenatal care as recommended by the American College of Obstetricians and Gynecologists (ACOG). Below are the recommendations:

- ✚ First and second trimester, (between the 1st and 28th week of gestation) the mother can expect to have monthly visits with the health care provider.
- ✚ Third trimester, the mother can expect to visit their health care provider every two weeks. After the 36th week of gestation, the mother can expect to see the health care provider every week until the infant's birth.

The IMRT agrees that the mother's participation in regularly scheduled prenatal care visits is crucial to the infant's development and the health of the mother. All expecting mothers, particularly those whose

pregnancy is deemed high risk, teenagers, women 35 years or older, and women with medical conditions such as diabetes, high blood pressure and HIV can benefit from prenatal care.

Premature Rupture of Membranes (PROM)

Premature rupture of membranes (PROM) occurs when the amniotic sack that surrounds the infant during the pregnancy ruptures prior to the 37th completed week of gestation. PROM was the cause of the infant's premature birth in six (6, 38%) of the premature infant cases reviewed by the IMRT.

Infection

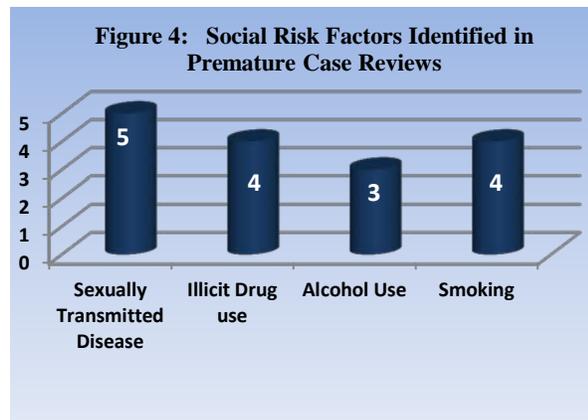
Chorioamnionitis is a bacterial infection of the membranes that surrounds the infant and the amniotic fluid. Eight (8, 50%) of the premature births were due to chorioamnionitis infection detected at the time of delivery. Chorioamnionitis can lead to serious illness and death in newborns.

Cervical Incompetence

Cervical incompetence is a medical condition in which the expectant mother's cervix begins to dilate (widen) and efface (thin) before the pregnancy has reached term. Cervical incompetence was recognized as a risk factor in seven (7, 44%) of the premature infant cases. Risks of cervical incompetence include premature birth and fetal death. (Mayo Foundation for Medical Education and Research, 2014).

Obesity

Maternal obesity is a risk factor addressed in the medical records reviewed in seven (7, 44%) of the premature infant cases. Several studies report a negative impact of excessive maternal weight on the outcome of a pregnancy. In its *Committee Opinion* issued in January 2013, ACOG reported obesity has negative consequences for both the mother and the fetus, as obese mothers are at risk of pregnancy related complications including gestational diabetes mellitus and pre-eclampsia. Complications for infants include premature birth, and still birth (ACOG, 2013).



Social Risk Factors in Premature Cases

Medical records reviewed provided additional information related to the mother's social risk factors associated with premature births. As illustrated in *Figure 4*, sexually transmitted disease was a risk factor in five (5, 31%) of the premature birth cases reviewed, followed by illicit drug use and smoking identified in four (4, 25%) cases, and alcohol use identified in three (3, 19%) cases reviewed by the IMRT.

Other Natural Infant Deaths

The IMRT reviewed seven (7, 22%) infant mortality cases in which prematurity was not the cause of death. In these cases, Congenital Anomalies was the leading cause of death as illustrated in *Table 1*. Congenital Anomalies are medical conditions that are present at the time of, or before the infant's birth. Congenital anomalies are also the cause of chronic illnesses and disease in infants, and can lead to death. Of cases reviewed, only one (1) mother did not have regularly scheduled prenatal visits.

TABLE 1: OTHER CAUSES OF INFANT DEATHS	
MEDICAL CONDITION	NUMBER OF INFANT DEATHS
Congenital Anomalies	3
Spontaneous Abortion	1
Placental Abruption	1
Congenital Heart Disease	1
Brain Injury	1
TOTAL	7

Undetermined Infant Deaths

The undetermined death of infants was the second leading cause of death among infant cases reviewed by the IMRT. Although a thorough forensic death investigation and examination was conducted immediately following the infant's death, a definitive cause of death could not be determined in seven (7, 22%) infant mortality cases in which the cause of death could not be determined through the medical legal investigation and autopsy. In six (6) of these cases, the undetermined death was attributed to Sudden Unexpected Death in Infancy (SUID) associated with unsafe sleeping conditions.

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

- ✚ Infants placed to sleep on adult mattresses
- ✚ Infants placed to sleep on excessive soft bedding
- ✚ Infants placed to sleep on air mattresses
- ✚ Infants placed in cluttered cribs or bassinets
- ✚ Infants placed to sleep with adults and/or children

Although the above unsafe sleep conditions were observed in IMRT cases, this is not a complete list of risks associated with SUID deaths. Nationally, education surrounding safe sleep practices is provided through the Centers for Disease Control, the National Institute of Child Health and Human Development, and the American Pediatric Association, to name a few organizations invested in the prevention of infant

mortality. In the District of Columbia, both public and private agencies, including CFRC member agencies, are collaborating to continue to improve upon programs that currently address prevention efforts to curb the incidence of SUID related fatalities.

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

TABLE 2: IMRT UNDETERMINED INFANT DEATHS		
DECEDENT DEMOGRAPHICS	ISSUES ASSOCIATION WITH SUDDEN UNEXPLAINED INFANT DEATH	MEDICAL HISTORY PRIOR TO DEATH
8- month-old/ Black-AA/Female	Placed to sleep in prone sleep position in crib with excessive bedding	Full Term Infant No Prior Medical Issues
2- month- old/ Black-AA/Female	Placed to sleep in supine sleep position in adult bed with parents and siblings	Premature birth No Prior Medical Issues
2- month- old/ Black-AA/Male	Placed to sleep in supine sleep position in adult bed with parent and sibling	Full Term Infant No Prior Medical Issues
1- month- old/ Black-AA /Female	Placed to sleep in supine sleep position in adult bed with parent	Premature birth No Prior Medical Issues
6- month- old/ Black-AA/Male	Placed to sleep in prone position on pillow in adult bed with parent	Premature birth No Prior Medical Issues
3- month-old/ Black-AA/Male	Placed to sleep in an adult bed with parents and siblings. Family had no crib in the home	Premature birth Diagnosed Congenital Anomaly
6- month- old/ Black-AA/Female	Placed on Boppy© Pillow to sleep in adult bed	Full Term Infant No Prior Medical Issues

Four (4, 57%) of the undetermined decedents were born premature, however only one infant was receiving ongoing medical care for a congenital anomaly. Three (3, 43%) were born full term (beyond 37 weeks gestation). In all but one (1) of the undermined cases reviewed by the IMRT, the infant’s unsafe sleep environment was cited as a condition related to the death.

IMRT Infant Homicide

The IMRT reviewed two cases of infanticide during the 2014 review period. *Table 3* provides information pertaining to these fatalities.

TABLE 3: INFANT FATAL ABUSE CASE REVIEW			
DECEDENT DEMOGRAPHICS	CAUSE OF DEATH	PERPETRATOR	SIGNIFICANT MEDICAL/ SOCIAL HISTORY
1-day-old / Samoan/ Male	Asphyxia due to Smothering	Mother	Unwanted Pregnancy
1-month-old/ Black-African American/Male	Promethazine Intoxication	Mother	Maternal Substance Abuse

In preparation of the IMRT's review of infant homicides, records pertaining to the infant's birth, as well as documents surrounding the police investigation, and prosecution of the convicted perpetrator of the homicide were provided to Committee staff. The perpetrators of both homicides pled guilty to manslaughter and each received a sentence of four years in prison. One perpetrator will have to complete 5 years of supervised release following their release from prison, and may face deportation from the United States.

CHILD FATALITY REVIEW TEAM FINDINGS

In 2014, the CFRT reviewed 20 fatalities involving children and youth in which the death occurred in 2012, 2013 and 2014. As depicted in the CFRT map, the majority of the cases reviewed were of decedents who resided in Wards 8 (6, 30%), and Ward 5 (5, 25%). One decedent, a committed ward of the District of Columbia, resided in Prince Georges County, Maryland at the time of the fatal event.

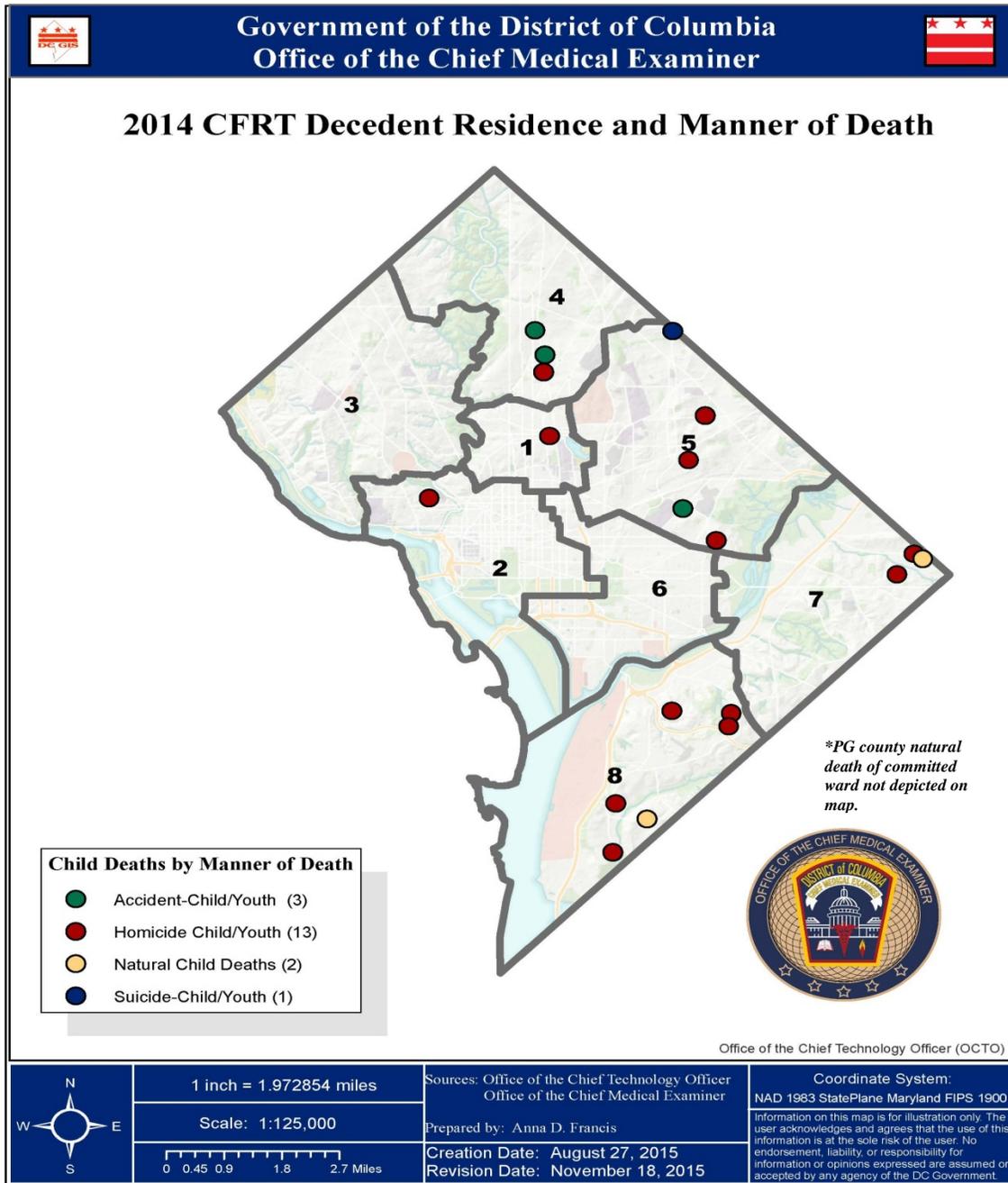
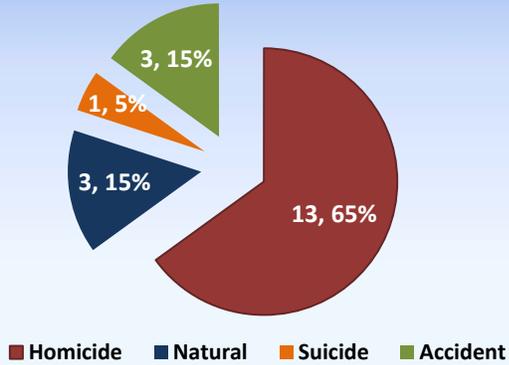


Figure 5: 2014 CFRT Case Manner of Deaths



The majority of cases reviewed by the CFRT were youth homicide cases (13, 65%). The team reviewed three (3, 15%) cases of natural and accidental deaths respectively, and one (1) case involving a teen suicide.

As detailed in Figures 6 and 7, Black/AA male children and youth were the leading subjects of cases reviewed by the CFRT in 2014 (16, 80%). Eleven (11, 55%) of the cases reviewed by the team involved Black/African American children and youth who were victims of homicides (11, 55%).

Figure 6: Decedent Race and Manner of Death

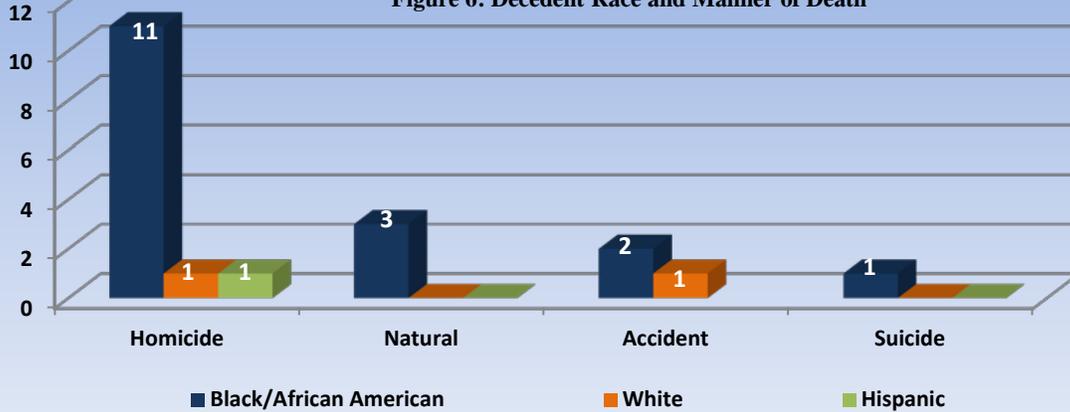
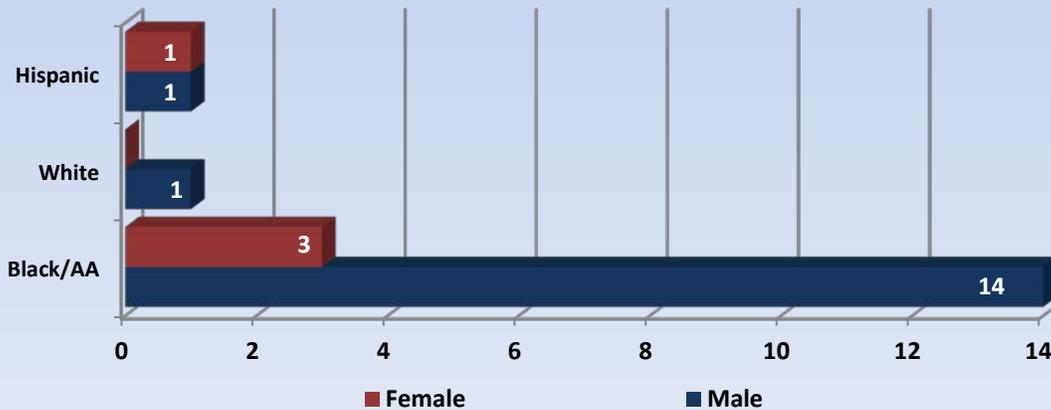


Figure 7: CFRT Decedent Gender and Race



CFRT HOMICIDE CASE REVIEWS

Since the inception of the District’s Child Fatality Review Committee, child and youth homicides have been the leading category of cases reviewed by the CFRT. The Committee categorizes homicide case reviews in the following manner:

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

The review of youth homicide cases provided insight into the issue of domestic violence among families in the District of Columbia. Records reviewed indicated four (4) of the decedents were exposed to domestic violence within the family home. Two (2) of the decedents were involved in a teen relationship where domestic violence was a lethality factor. Three (3) of the decedents were parents. *Table 4* provides the demographic and causes of deaths associated with the CFRT youth homicide case reviews, as well as nationally recognized risk factors associated with youth homicide death reviews.

DECEDENT DEMOGRAPHIC	CAUSE OF DEATH	ASSOCIATE RISK FACTORS
16-year-old/ Black – AA/ Male	Gunshot Wound of Chest	<ul style="list-style-type: none"> • High Crime Community • 3rd Child Fatality in Family • History of Involvement with Child Welfare
18-year-old/Black – AA/ Male	Multiple Gunshot Wounds	<ul style="list-style-type: none"> • Family History of Domestic Violence • School Truancy • History of Involvement with Child Welfare • History of Involvement with Juvenile Justice
19-year-old/Black- AA/ Female	Gunshot Wound of Abdomen	<ul style="list-style-type: none"> • History of Family and Teen Domestic Violence • School Truancy • History of Involvement with Child Welfare • History of Involvement with Juvenile Justice
19-year-old/Black – AA/ Male	Gunshot Wound of Back	<ul style="list-style-type: none"> • History of Teen Domestic Violence • Teen Substance Abuse • History of Involvement with Juvenile Justice
21-year-old/Black – AA/ Male	Blunt Injuries of Head and Neck	<ul style="list-style-type: none"> • Family History of Domestic Violence • History of Involvement with Child Welfare
17-year-old/Black- AA/ Male	Gunshot Wound of Head	<ul style="list-style-type: none"> • History of Involvement with Child Welfare
21-year-old/ Black-AA/ Male	Gunshot Wound of Chest	<ul style="list-style-type: none"> • History School Truancy • History of Involvement with Juvenile Justice
23-year-old/Black- AA/Male	Multiple Gunshot Wounds	<ul style="list-style-type: none"> • High Crime Community • History of Involvement with Child Welfare

TABLE 4: CFRC YOUTH HOMICIDE DECEDENTS DEMOGRAPHICS, CAUSES OF DEATH AND RISK FACTORS (CONTINUED)

DECEDENT DEMOGRAPHIC	CAUSE OF DEATH	ASSOCIATE RISK FACTORS
18-year-old/ Hispanic/Male	Gunshot Wound of Torso	<ul style="list-style-type: none"> • Truancy • Physical Safety Issues • Family History of Domestic Violence • History of Involvement with Child Welfare • History of involvement with Juvenile Justice
22-year-old/ Black-AA/ Male	Complications of Gunshot Wounds of the Head	<ul style="list-style-type: none"> • H.S. Drop Out • Unaddressed Grief • History of Involvement with Child Welfare • History of Involvement with Juvenile Justice

Table 5 depicts the motives for the homicide cases reviewed by the CFRT in 2014, as provided by the Metropolitan Police Department.

TABLE 5 : YOUTH HOMICIDES	
MOTIVES	NUMBER OF CASES
Motive Unknown	4
Fatal Child Abuse	3
Argument/Domestic Violence	2
Justified by Citizen	1
Justified by Law Enforcement	1
Accidental	1
Retaliation	1
Total	13

Fatal child abuse (3, 23%) is the leading known motive associated with child/youth homicide case reviews conducted by team in 2014. Homicides associated with arguments/domestic violence (2, 15%) were the second leading known motive. Two (2) homicides were deemed justifiable either by citizen or law enforcement. One (1) homicide was categorized as accidental and another was the result of retaliation. The motives for four (4) of these homicides are unknown.

TABLE 6: HOMICIDE METHODS	
METHODS OF HOMICIDE	NUMBER OF CASES
Gunshot Wounds	9
Blunt Force	2
Fatal Ingestion	2

Gun violence is the leading risk factor associated with youth homicides (9, 69%). Youth ages 15 years and older represented the leading number of victims of homicides (10, 77%).

TABLE 7: CFRT FATAL ABUSE HOMICIDE VICTIMS		
DECEDENT DEMOGRAPHICS	CAUSE OF DEATH	SIGNIFICANT SOCIAL HISTORY
1-year-old/Black-AA/ Female	Complications Following Ingestion of Battery	Involvement with child welfare and inexperienced teen parent
4-year-old/ Black- AA/Male	Multiple Blunt Force Injuries	Involvement with child welfare and family history of domestic violence
1-year-old/White/Male	Complications Following Ingestion of Exogenous Substance	No involvement with government programs

In preparation of the CFRT’s review of fatal abuse homicides, records pertaining to the decedent’s involvement with government programs, as well as documents surrounding the police investigation, and prosecution of the convicted perpetrator of the homicide are provided to Committee staff. Although the manner of death was determined to be homicide, the criminal investigation of the circumstances surrounding the death did not result in the arrest and prosecution of a perpetrator in two cases. In one case, the perpetrator pled guilty and was sentenced to 20 years in prison.

NATURAL DEATHS IN CHILDREN

As shown in *Table 8*, the CFRT reviewed three (3) cases involving the natural deaths of children. All of the natural death cases reviewed involved Black/African American males.

TABLE 8: CFRT CASE REVIEWS OF NATURAL DEATHS

DECEDENT DEMOGRAPHICS	CAUSE OF DEATH	MEDICAL HISTORY
15-year-old Black-AA/ Male	Left Ventricle Failure due to Aortic Valve Insufficiency	History of Global Developmental Delays
11-year-old Black-AA/ Male	Gram Positive Bacteremia Associated with Multi-Organ Septic Embolization of Unknown Etiology	No significant medical history
9-year-old Black-AA/ Male	Complications of Anomalous Origin of Left Main Coronary	No significant medical history

ACCIDENTAL DEATHS

The CFRT reviewed three (3) cases of Accidental Deaths. Two (2) of the victims were Black/African American males, and one (1) victim was a Hispanic female.

TABLE 9: CFRT ACCIDENTAL DEATH CASE REVIEWS

DECEDENT DEMOGRAPHIC	CAUSE OF DEATH	SPECIAL CIRCUMSTANCES
8-year-old Black-AA Male	Hyperthermia	Unsupervised child with Special Needs trapped in overheated automobile
16-year-old Black-AA Male	Subdural Hematoma due to Motor Vehicle Accident	Teen driver - speeding was a factor in motor vehicle accident
9-year-old Hispanic Female	Consequences of Neck Compression	Child playing with scarf

Suicide

The CFRT reviewed one (1) case of the suicide of a Black/African American female.

TABLE 10: CFRT SUICIDE DEATH CASE REVIEW

DECEDENT DEMOGRAPHIC	CAUSE OF DEATH	SPECIAL CIRCUMSTANCES
18-year-old Black-AA Female	Acute Combined Toxic Effects of Opiates and Ethanol	Unaddressed issues of Grief and Loss

SECTION 2:
**COMMITTEE DISCUSSIONS
AND RECOMMENDATIONS**

CHILD FATALITY REVIEW COMMITTEE DISCUSSIONS

During the full Committee meetings, members identified systemic issues and risk factors associated with infant, child, or youth fatalities. As in previous years, data demonstrate a District wide issue with deaths of infants due to unsafe sleep environments (13% of cases reviewed), and the deaths of children and youth due to gun violence (17% of cases reviewed). These trends continue to concern Committee members and require ongoing attention and planning by District officials and community at large. In most cases, members agreed that many of the risk factors associated with these fatalities, if alleviated, could prevent the death. *Table 10* details the Committee’s discussions related to the cases reviewed 2014.

Table 10: Child Fatality Review Committee Prevention Focused Recommendations		
Team	Area of Focus/ Percentage of Case Reviews	Committee Reasoning
Infant Mortality Review	Implementation of Maternal Interviews/ 100% of IMRT cases	With the inclusion of maternal interviews in the fatality review process, Committee members will gain a better understanding of the circumstances surrounding the infant’s death, as well as the family’s access utilization and barriers to services.
	Review of nonviable births/ 27% of IMRT cases	In an effort to reduce infant mortality, the IMRT will review cases where the infant was determined to be non-viable at birth yet resuscitated by the medical team. This research will provide information that can be used to improve outcomes for infants and their families.
Child Fatality Review	Improvements in educational and vocational opportunities for government agencies servicing at-risk youth/ 100% of youth violence homicide cases	Many older youth who succumb to homicide were truant and failed to re-engage with education or vocational programs during/following involvement with government programs. Providing education and vocational opportunities to older youth is essential to improve their outcomes as adults.

The IMRT agreed to work with the Office of the Chief Medical Examiner to develop and implement the maternal interview process. The American College of Obstetricians and Gynecologist (ACOG) through the National Fetal and Infant Mortality Review Program considers the maternal interview to be an integral piece in vanquishing infant mortality (ACOG, National FIMR Program, 2015). Through the maternal interview process, committee members will learn how mothers utilized public health care services. It is also the expectation that the maternal interviews will provide insight into access and barriers to services. This vital yet often missing information will ultimately improve the team’s recommendations for systemic improvements.

The review of non-viable births is a more recent task the IMRT has chosen to undertake. In its efforts to improve outcomes for infants and their families, the IMRT will charge a subcommittee of medical experts and community based providers to review the circumstances leading to the death of infants who were medically deemed non-viable at birth, yet resuscitated. In 2014, the IMRT reviewed eight (8) cases where the infant was deemed non-viable. These infants were born within 17 to 24 weeks gestation and weighed less than 1000 grams at birth. The IMRT agreed it is important to conduct a study and discuss the findings as these infant fatalities impact the District of Columbia’s overall infant mortality rate.

During the review of youth violence related homicides, the team discussed the youths' failure to complete school and/or educational/vocational programs prior to exiting commitment from public child welfare, or juvenile justice programs. The lack of engagement in education and vocational programs negatively impacted the youths' opportunity to obtain employment. Records reviewed indicated at least three of the youth homicide victims were known to be parents of young children. The need for youth to have a stable income and the lure of participating in criminal activities to increase financial stability is a real issue facing the District's youth.

CFRC Recommendations

The following are recommendations developed by the Child Fatality Review Committee to address the need for improvements in systems and/or program initiatives to improve outcomes for children and families in the District of Columbia.

Recommendation #1: Child and Family Services Agency

In the event of a child death under the investigation of the Child and Family Services Agency, the Child and Family Services Agency shall not close its investigation until the Office of the Chief Medical Examiner has communicated the "cause and manner of death" or provided the Child and Family Services Agency with a completed autopsy report. In such cases where the cause and manner of death is pending or the cause of death is undetermined or homicide, the Child and Family Services Agency should communicate with the Office of the Chief Medical Examiner and the Metropolitan Police Department to evaluate the safety and risk to children remaining in the home prior to closing the Child Protective Services investigation.

Agency Response: No, with alternative plan of action

The Child and Family Services Agency (CFSA) proposes the following alternative resolution for situations where the OCME has not identified a manner of death for a child who has surviving minor siblings and where there are no other reasons (identifiable safety factors) justifying the opening of an ongoing case:

1. Prior to closing the investigation, CFSA will notify the detective handling the investigation (if any) of its intent to close the case and ask a call be made to the CFSA hotline in the event that MPD learns of information suggesting that the child died of abuse or neglect, or that any surviving minor children might be in danger.
2. Prior to closing the investigation, the CPS supervisor will notify CFSA's Quality Assurance Program Manager or designee that a fatality investigation is being closed without an identified manner of death, and request that communication be maintained on the matter between QA and OCME. The Quality Assurance unit will follow up at least monthly until the finding is returned.
3. CPS will clearly document its final safety and risk assessment in FACES.net and will include a written narrative explaining why it has assessed that the investigation can be closed.

If the investigation is closed but a case is opened on the family, the responsibility for following up with OCME will rest with the ongoing worker. CPS will communicate this responsibility to the ongoing worker and supervisor during the case transfer staffing.

Recommendation # 2: Child and Family Services Agency

In cases involving the care and custody of medically fragile children, the Child and Family Services Agency should implement integrated case planning to include the social worker and the medical teams to ensure the child's needs are met. Also early intervention, including community papering should be implemented when necessary.

Agency Response: Yes, with Modifications

In Home Services utilizes the Consultation and Information Sharing Framework, specifically the R.E.D. Team Framework, to actively engage the assigned Social Worker and all other partners on cases. More specifically, in cases that involve medically fragile children the medical team is engaged and participates in RED team meetings along with the family and other key supports that the family has. This collaboration helps to ensure that everyone on the team has the needed information to be able to support the family. In addition to this teaming process, In Home also utilizes a combination of assessments to accurately determine the strengths and needs of the family. These assessments include the Caregiver Strengths and Barriers Assessment and the CAFAS/PECFAS. Together these tools provide a clear and precise view of the family and provide a guide for the work to head in. Furthermore, there are several early intervention strategies and tools at our disposal to help ensure the success and the safety of the child and family. One such program is the Homebuilders program which provides intensive family preservation services for up to 6 weeks. The goal of this program is to help stabilize the family and prevent the need to remove the child from the home. We also can utilize Community Papering, where CFSA brings a case to court and asks for legal oversight and connect the family to behavioral health services for depression or other mental health diagnosis when warranted. The purpose of this is to encourage a family to engage in services and to help prevent harm to the child. If a family is not able to follow a case plan that is being monitored by the courts, the child can be removed from the home for their safety.

In April, 2015, training began for all casework and CFSA medical staff on the CAFAS/PECFAS and Caregiver Strength and Barriers tools. Sessions are being offered to train all case-carrying ongoing workers outside of CPS by July 1, 2015. Lastly, CFSA is actively identifying all medically fragile children and youth engaged with child welfare through cross reference of internal and external data and Social Worker identification based on criteria provided by CFSA's Health Services Administration. Identification of these children/youth will allow a proactive approach for assessment and intervention to ensure medical needs are appropriately addressed and sustained. The Agency's Office of Well-Being is also developing a guide for social workers to assist them in identifying medical concern for children in their caseload and when they should seek support from the health staff.

Recommendation #3: Child and Family Services Agency

The Child and Family Services Agency (CFSA) should monitor cases referred to the Healthy Families Thriving Communities Collaborative organizations for 30 days prior to closing the case to ensure that the family is stable, whether or not the collaborative agency's services were utilized by the family. CFSA should document the efforts of the Collaborative organizations during this 30 day monitoring period.

Agency Response: No, with alternative plan of action

A family can only be referred to the Collaborative if the final risk assessment rating for the family is determined to be low or moderate. Family Declined Services indicates that the family was offered services for ongoing supports in the community, however the family chose not to participate. CFSA cannot force a family to participate with collaborative services. Additionally, a family's choice not to participate in services in these situations is not grounds for amending the risk assessment, for opening a case, or for a new referral for abuse or neglect. The recommendation to hold a case open for 30 days would require a CPS social worker to provide ongoing case management services for a low to moderate risk assessment. This is counter to CPS Investigation and Family Assessment practice.

The agency is partnering with the Healthy Family Thriving Communities Collaborative (HFTC) Agencies to receive data on family compliance, level of participation and the impact of the services on the family. If there is a new concern or chronicity of a current concern, which rises to the level of child abuse or neglect, the HFTC staff is aware to contact the Hotline to refer the family for CPS intervention. In those instances where the risk level is high or intensive CPS refers the family to In Home Services for service coordination and case management services. Partnership with the HFTC case is likely in these instances. CPS and In Home Services can request community papering when the families refusal of services compromises the safety of the child in the home.

Recommendation #4 – Department of Health Care Finance and the Department on Human Services

The Department of Health Care Finance and the Department of Human Services should ensure that case management is offered to all families receiving Medicaid. The goal is to ensure that participants receive guidance and assistance with obtaining timely health care services that promote healthy outcomes– such as transportation to and from appointments, notification of EPSDT related appointments, and services available for infants and children with special needs.

Joint Agency Response – Yes, with modification

All Medicaid beneficiaries in managed care organizations (MCOs) receive care coordination and case management services upon assessment. About 90% of children covered by Medicaid are enrolled in MCOs (including most children in households receiving Temporary Assistance for Needy Families (TANF). Children in families enrolled in Fee for Service (FFS) Medicaid fall into five groups (1) disabled children living at home; (2) CFSA children; (3) DYRS children; (4) children in long-term care placements; and (5) adopted/permanent placed children). For children in categories (2)-(5) there is an identifiable entity responsible to helping to ensure that those children receive the services and care that they need; therefore DHCF and DHS recommend that, unless the facts of the case indicate otherwise, the focus of this recommendation be limited to those children who are enrolled in FFS and are living at home, the vast majority of which are disabled, and therefore represent the most vulnerable and whose families are in need of additional support. DHCF and DHS also recommend that the term “case management” be changed to “additional support”, as case management is one approach to providing additional support, but is not the only effective approach. Finally, please note that based on the “beneficiary population” indication of “infants”, this agency response is limited to that population.

Building a robust support system for FFS Medicaid beneficiaries is a priority for the Department of Health Care Finance, which is planning a multi-faceted approach, including:

- (1) Systematic identification and quarterly outreach to families whose claims data shows they have not completed recommended or required EPSDT services, including dental services, well-child visits, and lead screens. Outreach would take the form of tailored postcard reminders, phone calls, and scheduling assistance as needed.
- (2) For eligible families, coordinate with DOH home visiting programs that provide home-based case management and care coordination support for families with infants and toddlers.
- (3) Update the DHCF FFS Handbook.
- (4) Create a FFS fact sheet that is family friendly that DHS, medical and community-based service providers can offer to FFS beneficiaries that explains in plain language the basics of how to maximize their FFS benefits and where to go or who to call to get questions answered and additional help connecting to services.

The agencies will develop a strategic plan for outreach to FFS children enrolled in the Medicaid Program with more focused outreach to families with children enrolled in FFS Medicaid so that they can access EPSDT services. DHCF's goal is to have a FFS fact sheet to share with DHS by January 2016.

Recommendation #5 – Deputy Mayor for Health and Human Services in Collaboration with the Deputy Mayor for Education

The Deputy Mayor for Education in collaboration with the Deputy Mayor for Health and Human Services should review current regulations for General Educational Development (GED) programs utilized by the District of Columbia's youth serving agencies (such as OSSE, CFSA, and DYRS) and develop criteria based upon best practices to address the needs of older youth with Individual Education Plans (IEP) who wish to obtain the GED credential.

Joint Agency Response – No, with explanation and alternative recommendation

First, it is important to note that the existing GED regulations only speak to test administration and not GED instruction requirements. Next, GED instruction is offered in many different settings including publicly funded LEA and CBO based programs, as well as programs that receive no public funding at all. OSSE's authority to regulate or impose specific requirements on these different programs varies widely, with very limited to no authority for those programs receiving no public funds. Those LEA based GED programs that receive federal IDEA funding are monitored for IDEA compliance to ensure that eligible students with IEPs receive the services needed.

Currently, CBOs that receive adult education funding from OSSE are required to conduct a Learning Disability (LD) screening assessment for all residents served. This LD screening is used to identify who may need additional assessment to determine special needs. Additionally, OSSE has also made available a more robust learning needs inventory to our CBOs that can be used for those residents whose LD screening indicated they need additional assessment. These two tools were developed by national experts and together produce a set of recommendations for specific instructional accommodations that the CBO can implement.

Additionally, to better identify and serve adult students with special needs, OSSE has been working with the District's Department of Disability Services to contract with external educational psychologists,

speech pathologists, and other professionals to allow adult education programs (including both CBO and LEA based GED programs) to refer students for comprehensive educational learning disability assessments. These, assessments will not only identify specific instructional accommodations, but will also identify needed testing accommodations (such as GED or industry certification assessments) as well as workplace accommodations. Furthermore, OSSE has also contracted with an expert vendor to provide professional development to our adult education CBOs around better serving adult students with special needs.

Lastly, OSSE has recently launched the DC ReEngagement Center (REC) which is focused on reconnecting youth (up thru age 24) who have dropped out back to “best-fit educational options”. As part of this process, the REC staff checks the students’ academic history, including whether the student had an IEP, and they administer the same LD screening that OSSE’s adult education CBOs. They then use this information to make a referral to a program that has the right set of academic and non-academic services, which includes their capacity to serve students with special needs.

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Acknowledgement

We wish to acknowledge the dedication and unwavering support of the public servants, private agency/program representatives and community volunteers who serve as members of the District of Columbia'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 your time, giving of your 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.



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