


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

2019





DISTRICT OF COLUMBIA **CHILD FATALITY REVIEW COMMITTEE** **2019 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

March 2021

Mission

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



CHILD FATALITY REVIEW COMMITTEE MEETING CO-CHAIRS

Roger A. Mitchell, Jr., MD FASCP

Chief Medical Examiner, OCME
Co-Chair, Child Fatality Review Committee

Cynthia G. Wright, Esq.

Assistant US Attorney
Homicide Special Victims Unit, USAO
Co-Chair, Child Fatality Review Committee

Succeeded by

Kristinza Gieze, MD

Deputy Medical Examiner, OCME
Co-Chair, Child Fatality Review Committee

Erica McClaskey, MD, MS, FAAFP

Family Health Bureau Chief, DC Health
Co-Chair, Child Fatality Review Committee

OFFICE OF THE CHIEF MEDICAL EXAMINER FATALITY REVIEW UNIT

Jenna Beebe-Aryee, MSW

Fatality Review Program Manager

Tracie T. Martin, MSW

Senior Fatality Review Program Specialist

Jacqueline Corbin-Armstrong, MSW, MSM

Fatality Review Program Specialist

Toya Byrd

Staff Assistant

Table of Contents

Greetings from The Chief Medical Examiner
8

Greetings from CFRC Co-Chairs
9

Committee Composition and Membership
11

Introduction: The DC Child Fatality Review Committee
13

Executive Summary
14

Section 1: Summary of Team Findings
18

Infant Mortality Review Team Findings
32

Child Fatality Review Team Findings
48

Section 2: Committee Recommendations and Agency Responses
60

Acknowledgments
66





Greetings from the Chief Medical Examiner

In 2014, I became the newly appointed Chief Medical Examiner of the District of Columbia. I was also appointed to Co-Chair the Child Fatality Review Committee (CFRC) with Assistant US Attorney Cynthia G. Wright. We worked together to make significant improvements in the fatality review process. I have used the findings and recommendations developed from the CFRC to facilitate an outreach component for the Office of the Chief Medical Examiner. Whether in my official capacity as a speaker at town hall meetings, university symposiums, or memorial services, the data derived from the work of this committee on the sensitive subjects of infant mortality or violence in our communities has helped us address those challenging barriers to healthy outcomes for all District residents. Discussions with our community leaders and subject matter experts led to the growth of the Fatality Review Division of the OCME. We now have the Violence Fatality Review Committee (VFRC), the Opioid Fatality Review Board (OFRB) and the Maternal Mortality Review Committee (MMRC). I am proud that the growth of the Fatality Review Unit will foster systemic improvements that will benefit those we serve.

In 2019, the CFRC selected two new co-chairs - Dr. Erica McClaskey, Family Health and Bureau Chief of DC Health, and Dr. Kristinza Giese, Deputy Medical Examiner at the OCME. I will continue to work in my capacity as a member of the CFRC under our new leadership. Together, we present the 24th Child Fatality Review Annual Report to Mayor Bowser and the residents of the District of Columbia.

In Truth and Service,

A handwritten signature in black ink, appearing to read "Roger A. Mitchell, Jr.", written over a light blue silhouette of a group of children sitting on a bench.

Roger A. Mitchell, Jr.
Chief Medical Examiner



Kristinza W. Giese, Md
Deputy Medical Examiner



Erica McClaskey, MD, MS, FAAFP

Family Health Bureau Chief
Co-Chair, Child Fatality
Review Committee

Greetings from the CFRC Co-Chairs

As the newly appointed Co-chairs of the District of Columbia's Child Fatality Review Committee, we express our gratitude for being elected to represent a body of multifaceted individuals. The task of addressing systemic barriers that impede healthy outcomes for the infants, children and youth of the District of Columbia is difficult; however, we welcome the challenge. Through our collective experience in family health and pathology, we recognize the importance of utilizing public health policies and practices to prevent the deaths of children.

This unprecedented time in our history presents an inimitable opportunity to focus on the social determinants of health - experiences that adversely affect the health and safety of our children and families throughout their lifetime. Through the CFRC's discussions on the effects of marijuana during pregnancy or improving care coordination for children with chronic health needs involved in child welfare, the necessary conversations are taking place. Individually, we recognize the disparities in health and public safety that specifically affect our communities - including, but not limited to, infant mortality and youth violence. Through the leadership of our predecessors Dr. Roger Mitchell (OCME) and Cynthia G. Wright, JD (USAO), the CFRC has risen to be the voice of the voiceless. We are honored to carry the torch to continue this path toward progress.

We present the 24th Child Fatality Review Committee Annual Report and hope that it will help to lead discussions throughout our social spectrum on how we can improve systems to prevent the deaths of children. We thank and appreciate the CFRC members, participants and OCME staff for their hard work and commitment to the children and families of the District of Columbia.

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 conditions, senseless acts of violence, accidents, and suicide. It is our vision that – as we learn lessons from circumstances surrounding the deaths of our infants and children – 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 1st Tuesday of each month. In 2019, members and meeting participants represented the following District Government agencies, medical providers, and community-based organizations:

- A DC Midwife
- AmeriHealth Caritas DC
- Center for the Study of Social Policy
- Child and Family Services Agency
- Children’s National Hospital
- DC Health
- DC Housing Authority
- Department of Behavioral Health
- Department of Health Care Finance
- Department of Human Services
- Evermore
- George Washington University Hospital
- Health Services for Children with Special Needs
- Howard University Hospital
- March of Dimes
- MedStar, Washington Hospital Center
- Metropolitan Police Department
- National Institutes of Health – Children’s Health and Human Development
- Office of the Attorney General
- Office of the Chief Medical Examiner
- Residents of the District of Columbia
- Thrive By Five DC
- Trusted Health Plan
- United States Attorney’s Office for the District of Columbia

THE CHILD FATALITY REVIEW TEAM (CFRT)

The CFRT convenes on the 3rd Thursday of each month. In 2019, members and meeting participants represented the following District Government Agencies, medical providers, and community-based organizations:

AmeriHealth Caritas
Center for the Study of Social Policy
Child and Family Services Agency
Children’s National Hospital
DC Fire and Emergency Medical Services
DC Health
DC Housing Authority
DC Public Schools
Department of Behavioral Health
Department of Health Care Finance
Department of Human Services
Department of Youth Rehabilitative Services
Health Services for Children with Special Needs
Howard University School of Social Work
Howard University Hospital
Metropolitan Police Department
Office of the Attorney General
Office of the Chief Medical Examiner
Office of the State Superintendent of 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
The United States Attorney’s Office for the District of Columbia

THE DISTRICT OF COLUMBIA’S CALL TO ACTION

The death of a District of Columbia infant, child or youth initiates a call to action for District government public safety and human services agencies. The process identifies family and community strengths and deficiencies as well as recommends improvements needed to better serve the community. The process provides a wealth of information used to enhance services and systems to reduce the number of preventable deaths and improve the quality of life.

The District of Columbia’s Child Fatality Review Committee (CFRC) provides our community with the unique opportunity to address the critical needs of our most vulnerable residents: infants, children, and youth through the retrospective death review process. The CFRC is divided into two teams: The Infant Mortality Review Team (IMRT) and the Child Fatality Review Team (CFRT). The IMRT reviews the deaths of District infants from birth through 12 months. The (CFRT) reviews the deaths of District children ages 1 through 18 and youth older than 18 who were involved with the District’s child welfare services within four (4) years of their death, or juvenile justice programs within two (2) years of their death. Membership is multidisciplinary and inclusive of public and private child servicing agencies, medical providers, academia, legal professionals, and child advocates. Most importantly, residents representing neighborhoods throughout the District have a seat at the table to ensure those most impacted have a voice in the discussions and recommendations.

When an infant, child or youth dies in the District of Columbia, the CFRC is notified through several established sources. Upon notification, the staff obtains copies of the decedent’s birth and death certificates, copies of records from the medical examiner, other public agencies, and hospitals. A comprehensive summary is developed for presentation to the CFRC during monthly confidential fatality review meetings.

This report is comprised of two sections:

Section 1

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

Section 2

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

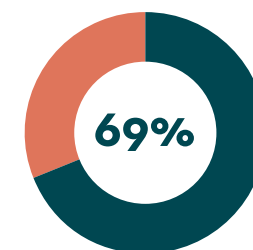
EXECUTIVE SUMMARY

The District of Columbia's Child Fatality Review Committee (CFRC) is pleased to present its 24th Annual Report. The CFRC 2019 Annual Report covers data from the 51 cases reviewed by the Committee in 2019. These cases represent infant, children and youth deaths that occurred in 2015, 2016, 2017 and 2018.

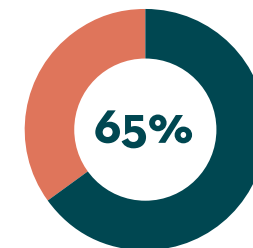
The CFRC is a citywide collaborative effort authorized by the Child Fatality Committee Establishment Act of 2001 (see Appendix A: DC Official Code, §4-1371.01 et. seq). This committee was established to conduct retrospective reviews of the circumstances contributing to the deaths of infants, children and youth who were residents of the District of Columbia or were known to the child welfare or juvenile justice systems. The primary goals of the child death review process are to: 1) identify risk reduction, prevention, and system improvement factors, and 2) recommend strategies to reduce the number of preventable child deaths and/or improve the quality of life of our residents. The CFRC also considers adverse environmental factors – relevant in cases involving premature births, youth homicides and the sudden unexpected death of an infant.

» Child Fatality Review Committee Key Data Findings

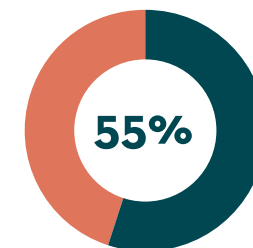
The ages of the 51 decedent cases reviewed by the CFRC in 2019 ranged from birth to 19 years of age. Of those decedents:



Sixty-nine percent (69%, 35 cases) of the decedents were infants.



Sixty-five percent (65%, 33 cases) of the decedents were Black.

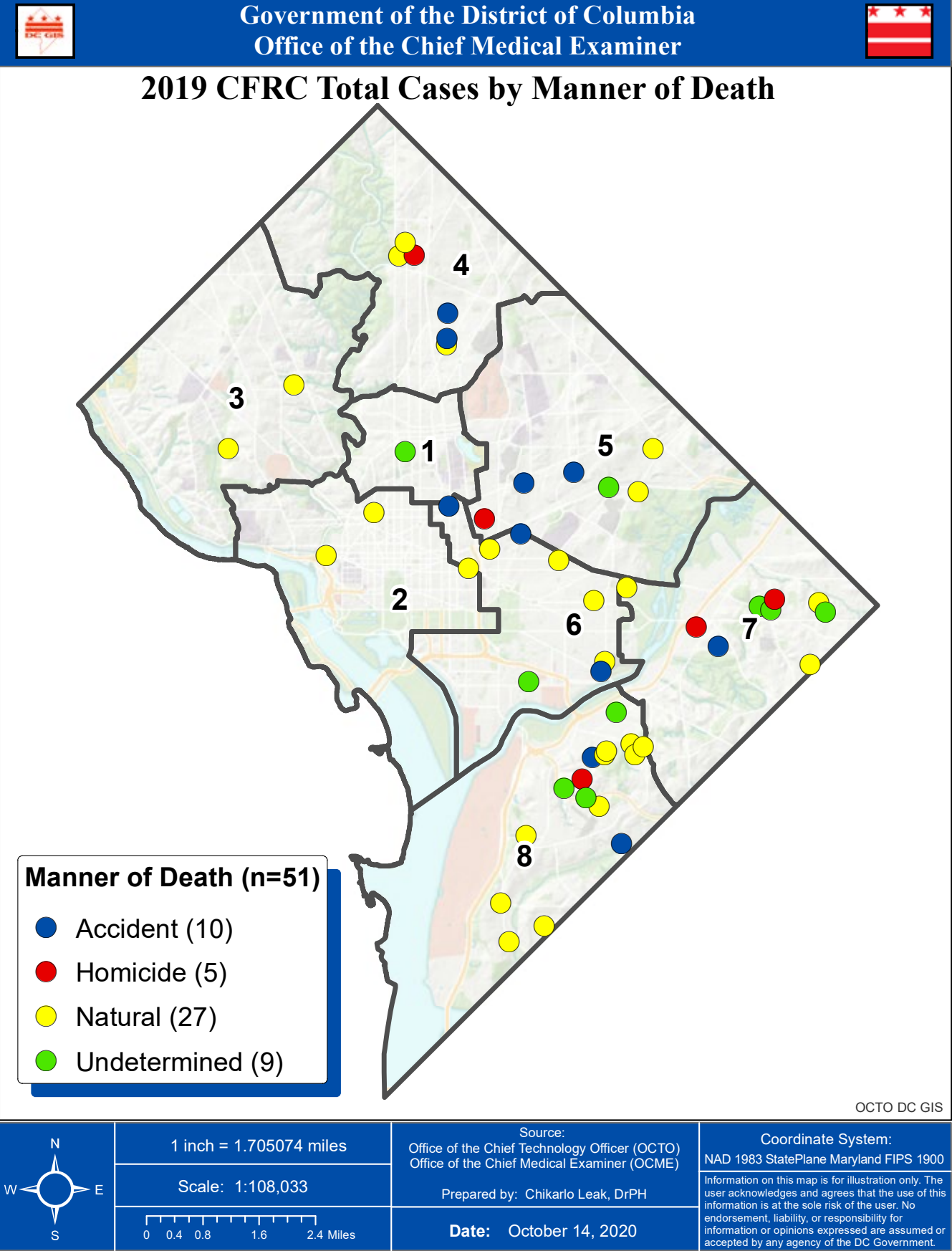


Fifty-five percent (55%, 28 cases) of the decedents died from natural causes.

TABLE 1: MANNER OF DEATH

Table 1: Manner of Death	
MANNER OF DEATH	CFRC ANNUAL REPORT DEFINITION
Natural Death Case Reviews	Deaths caused by the natural disease process and not by accident or violence
Homicide Case Reviews	The deliberate and unlawful killing of a person by another person
Undetermined Case Reviews	Following a thorough medical and legal investigation, a conclusive manner of death is not determined.
Accidental Death Case Reviews	Deaths caused unintentionally rather than by natural causes, suicide, or murder
Suicide Case Reviews	Deaths caused by self-inflicted behavior with the intent to die

- » Twenty-eight (28) cases involved infants, children, and youths whose deaths were classified as natural causes.
- » Five (5) cases involved youths whose deaths were classified as homicide.
- » Nine (9) cases involved infants, children, and youths whose deaths were classified as accidents.
- » Nine (9) cases involved infants whose deaths were classified as undetermined.





Summary of Team Findings

INFANT MORTALITY REVIEW TEAM STATISTICAL CASE REVIEWS

The Child Fatality Review Committee (CFRC) Infant Mortality Review Team (IMRT) reviewed 14 cases applicable for review of infants who died of natural causes in calendar year 2017 during their gestational age consistent with third trimester and onwards. These infants lived up to a matter of minutes, hours, and days, none of whom lived longer than 24 days, and none who were involved with District Social Service agencies at the time of the fatality. The following is a summary of statistics obtained from the review of these cases utilizing information gathered from the DC Health (DOH) Vital Statistics – Certificate of Live Birth, Certificate of Death, and medical records (when available).

Of the 14 decedents included in this review, 36% (N=5) were male and 64% (N=9) were female. Approximately 29% (N=4) of decedents were Black residents of Ward 8. Eighty-six percent of the decedents were Singleton pregnancies with 14% being one of a set of Twins. 85% of decedents lived between 2-24 days with an average of 10 days lived. About 25% of decedents lived for less than one day.

All births occurred later than 27 weeks with an average gestational age of 36 weeks. At a gestational age of 36 weeks, the average birth weight nationally ranges from 2,117 to 3,594 grams (Duryea et al., 2014). A minority of decedents fell into the Low Birth Weight category with 43% (N=6) of decedents weighing 2,500 grams or less. Of the low birth weight decedents, none weighed less than 1,000 grams and there were no decedents in the Extremely Low Birth Weight category. The average weight of all decedents was 2,549 grams.

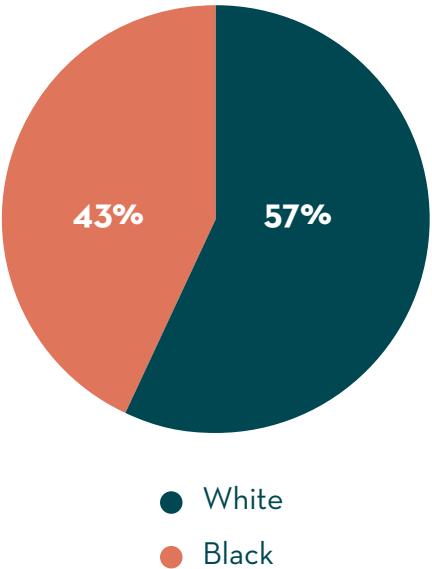
The most common immediate causes of death among these decedents were disorders of newborns related to cardio-respiratory-pulmonary conditions. Other common causes of death included septic shock and hypoplastic left heart syndrome.

71% (N=10) of the decedents, were delivered by Cesarean section, while 29% (N=4) were born via spontaneous vaginal delivery. 36% (N=5) had an Apgar score of one or two at one (1) minute.

Additionally, 29% of decedents had an Apgar score of one at five (5) minutes; only one of the decedents' scores at five minutes was not recorded.

The average age of all mothers in this statistical review was 30 years old. 50% (N=7) of the mothers were White, while 43% (N=6) were Black. Approximately 86% (N=12) of mothers obtained at least a GED or graduated high school, with 64% (N=9) combined completing some college, a Bachelor's, Master's Degree, Doctoral or Professional Degree.

FIGURE 1: 2017 IMRT STATISTICAL MATERNAL RACE



About 50% of mothers were not married or were in a registered domestic partnership at the time the child was conceived, at the time of birth, or at any time between conception and giving birth. Except for one mother, all mothers received prenatal care and 64% (N=9) of mothers attended ten or more scheduled prenatal care visits. 36% (N=5) of mothers were enrolled in DC Medicaid.

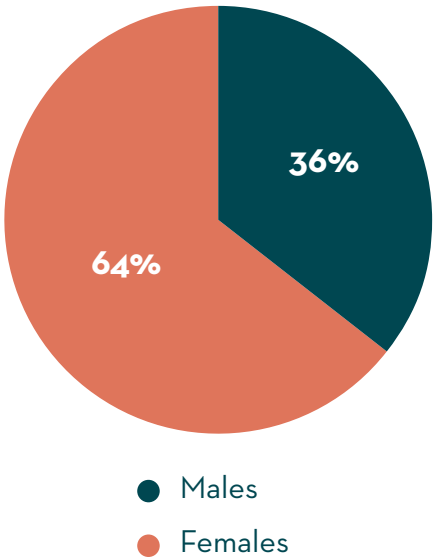
The average maternal height was five feet four inches with an average pre-pregnancy weight of 185 pounds. Approximately 50% (N=7) of mothers did not have any previous live births. The number of previous live births ranged from 0-4. About 43% of mothers had 1 or 2 previous live births. The number of other living children ranged from 0-4 and 50% (N=7) of mothers did not have any other living children. Approximately 50% (N=7) of mothers reported experiencing no previously induced losses or ectopic pregnancies. The number of previous pregnancy losses of such mothers ranged from 0-5.

The greatest number of pregnancy risk factors listed on the certificate of live birth was obesity and "other previous poor pregnancy outcomes." Other risk factors included previous Cesarean delivery. Of the 13 responses recorded, 85% (N=11) of mothers did not have any infections present or treated during this pregnancy, and there was only one diagnosis of Chlamydia.

Of the 13 responses recorded, in 69% (N=9) of the cases, the identity of the father was known but 67% (N=6) of fathers did not have their paternity acknowledged at birth. In addition, 69% (N=9) had their ages recorded on the certificate of live birth. Of these, the average age of fathers was 33 years old with 11% (N=1) of fathers being Black and 11% (N=1) of fathers being Latino.

» Decedent Information

FIGURE 2: IMRT 2017 STATISTICAL GENDER



Of the 14 decedents reviewed, 36% (N=5) were male and 64% (N=9) were female.

FIGURE 3: 2017 IMRT STATISTICAL DECEDENT RACE

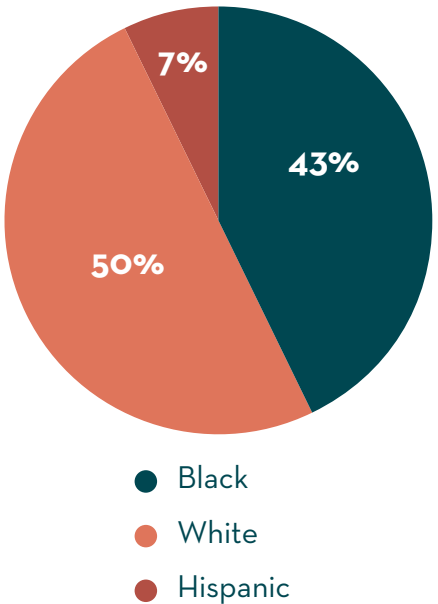
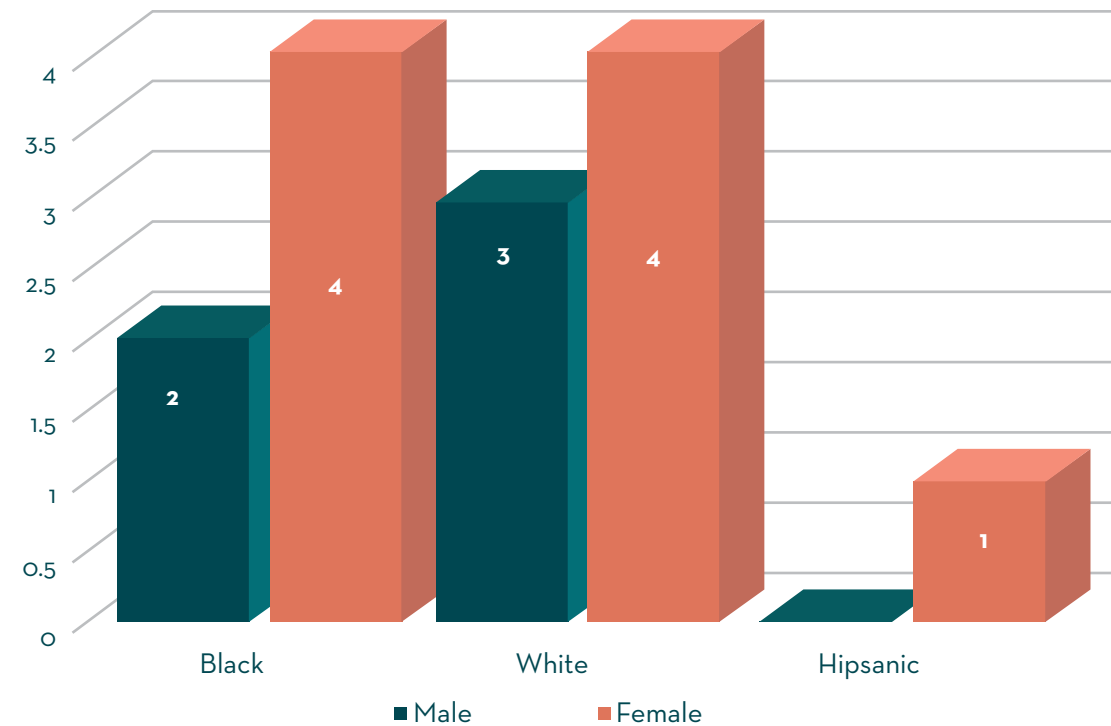
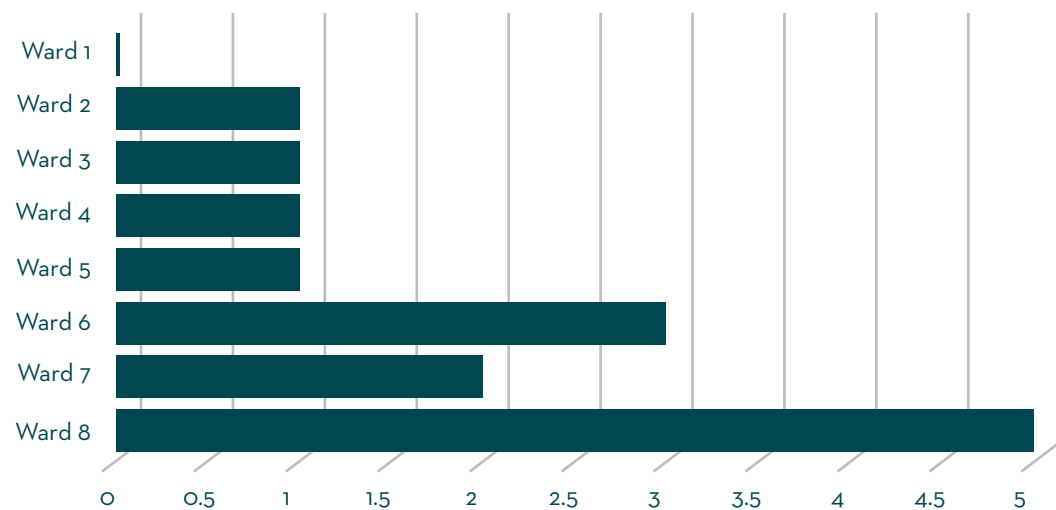


FIGURE 4: 2017 IMRT STATISITCAL DECEDENT GENDER AND RACE



Most of the decedents were White, accounting for 50% of all decedents. The number of female decedents exceeded the number of male decedents in all racial groups. There were as many Female White decedents as Female Black decedents.

FIGURE 5: 2017 IMRT STATISTICAL DECEDENT WARD OF RESIDENCE.



Wards 6 and 8 comprised the highest number of decedent deaths, which accounted for 21% (N=3) and 36% (N=5) respectively of the decedents reviewed in this statistical review.

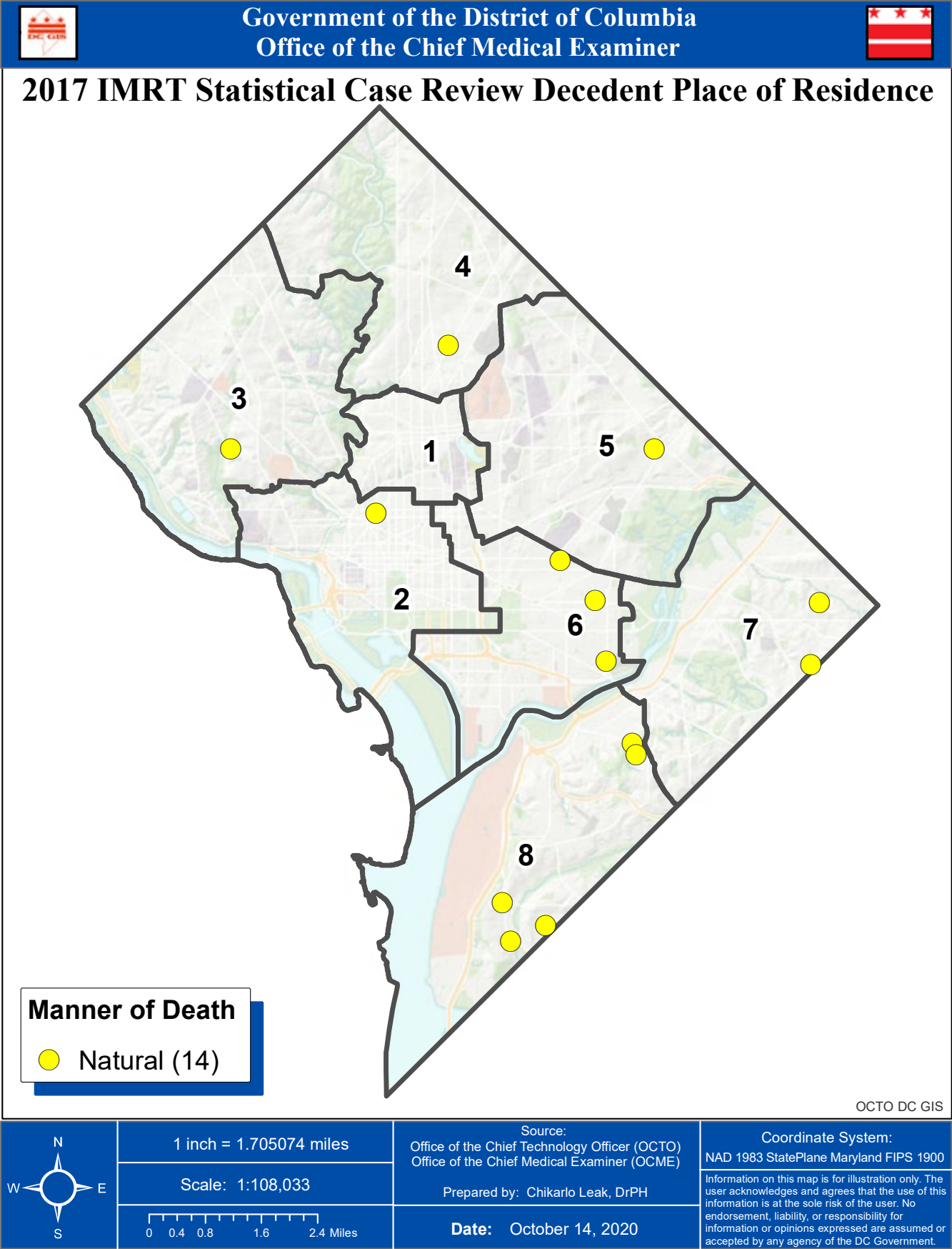
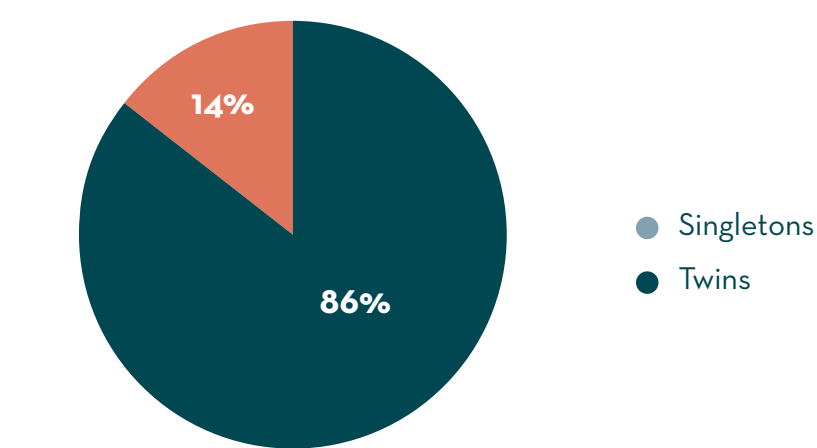
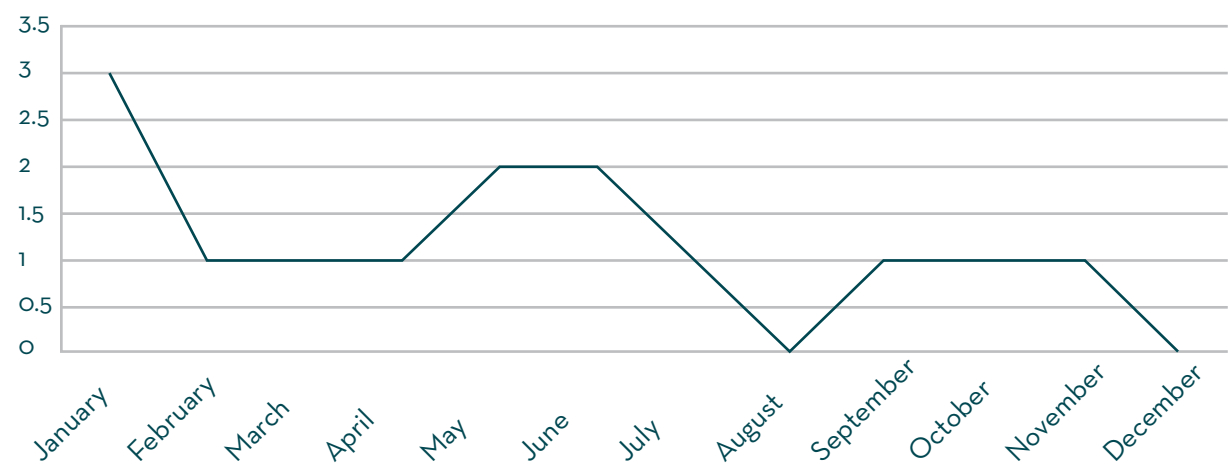


FIGURE 6: 2017 IMR DECEDENT BIRTH PLURALITIES¹



86% (N=12) of decedents were born as a singleton pregnancy and 14% (N=2) were born as a twin pregnancy. Of note, there were no sets of twins who died simultaneously.

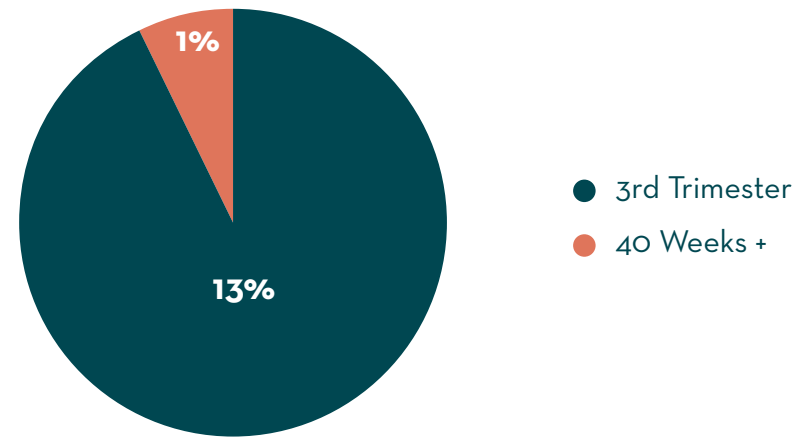
FIGURE 7: DEATH BY FREQUENCY



The highest number of decedents were born and died in the month of January, which records three (3) decedents or 21% of the total number of decedents born in this sampled.

¹ The number of babies resulting from a single pregnancy

FIGURE 8: 2017 IMRT STATISTICAL DECEDENT GESTATIONAL AGE AT BIRTH



The largest number of decedents, 79% (N=11) lived between two to twenty-four days with an average number of ten (10) days lived. Approximately 14% (N=2) of decedents lived between one to seven hours with an average of four (4) hours lived. One (N=1, 7%) decedent lived for 58 minutes.

All births occurred in the third trimester or later. Most births, 93% (N=13) occurred during the third trimester with an average gestational age of 36 weeks. Approximately 7% of births (N=1) occurred after 40 weeks.

TABLE 2: 2017 IMR DECEDENT DETAILS - THIRD TRIMESTER GESTATIONAL AGE AT BIRTH

Weeks of Gestation at Birth	Frequency	Percent
27 weeks	1	7%
32 weeks	2	14%
35 weeks	1	7%
36 weeks	1	7%
37 weeks	4	29%
38 weeks	1	7%
39 weeks	2	14%
40 weeks	1	7%
41 weeks	1	7%

Twenty-nine percent (29%) of third trimester births occurred at 37 weeks gestation. The second highest number of third trimester births occurred at 32 weeks and 39 weeks gestation, accounting for a combined 28% (14% each) of births.

FIGURE 9: 2017 IMRT STATISTICAL DECEDENT WEIGHT

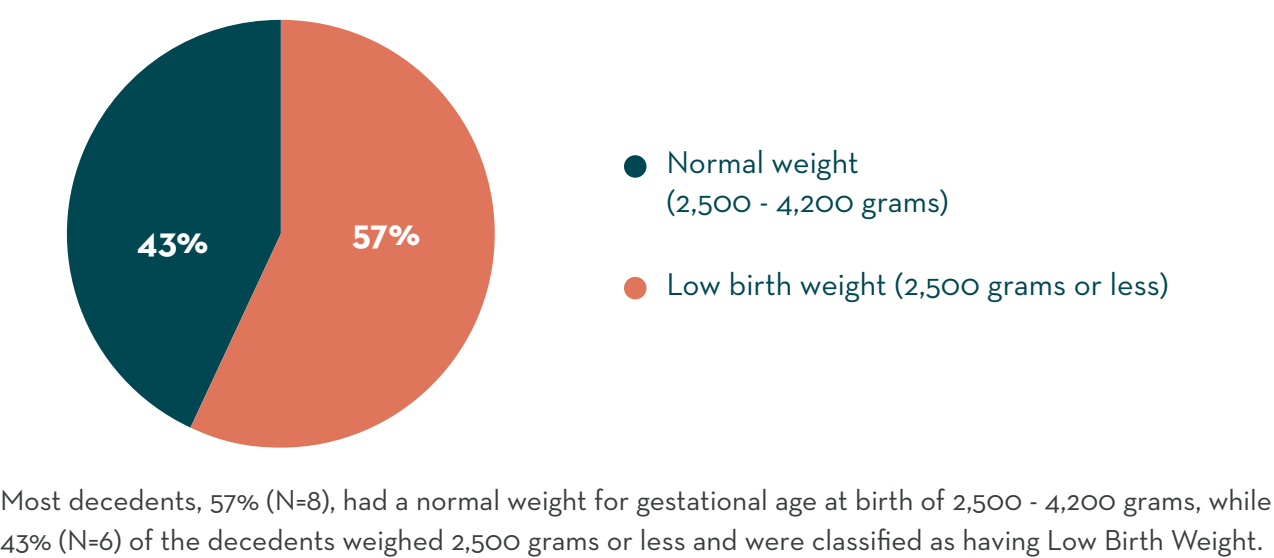
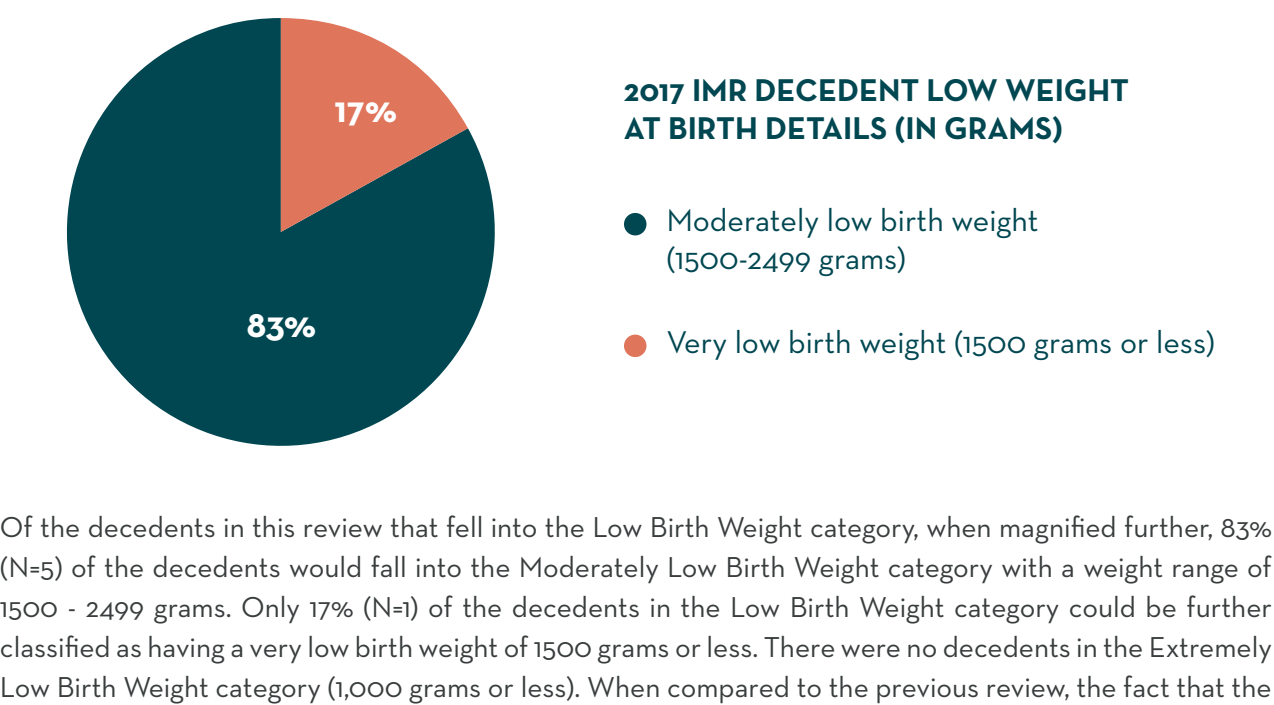


FIGURE 10: 2017 IMRT STATISTICAL DECEDENT LOW WEIGHT AT BIRTH DETAILS



birth weights are higher on average is consistent with the decedents' older gestational age. However, this is unexpected when compared to city-wide trends in previous years, where more decedents would be characterized by low birth weight or extremely low birth weight.

TABLE 3: 2017 IMRT BIRTH WEIGHT BY GESTATIONAL AGE AT DEATH

Birth Weight Category	Gestational Age
Above average (over 4,200 grams)	0 decedents
Normal (btw 2,500 - 4,200 grams)	32 - 41 weeks (average 38 weeks)
Moderately low (1,500 - 2,499 grams)	32 - 37 weeks (average 35 weeks)
Very low (1,500 grams or less)	27 weeks
Extremely low (less than 1,000 grams)	0 decedents

There were no decedents who were born in the above average birth weight category (over 4,200 grams). Those born with a normal birth weight (2,500 - 4,200 grams) in the third trimester had a gestational age range of 32-41 weeks and an average gestation of 38 weeks. There were 5 decedents born with a moderately low birth weight (1,500 - 2,499 grams), who had a gestational age range of 32-37 weeks and an average gestation of 35 weeks. There was only one decedent born in the very low birth weight category (1,500 grams or less) with a gestational age of 27 weeks and a weight of 1025 grams. There were no decedents born with an extremely low birth weight (less than 1,000 grams) in this sample.

All the decedents in this statistical review, N=14, died in a District of Columbia hospital.

The most frequent causes of death by theme for these decedents born in the third trimester were attributed to cardio-respiratory-pulmonary conditions. Other common causes of death included septic shock and hypoplastic left heart syndrome.

The average Apgar score for these decedents was 4 at one (1) minute with the lowest score being 0 and highest score 9. Only one decedent did not have a score recorded at 5 minutes. The average Apgar score at five (5) minutes was 5, with the lowest score being 0 and the highest score 9. The Apgar score is an expression of the infant's physiological condition at one point in time, which includes subjective components. Of note, the Apgar score alone cannot be evidence or a consequence of asphyxia; moreover, it does not predict individual neonatal mortality or neurologic outcomes, and should not be used alone for that purpose. There are numerous factors that can influence the Apgar score, including maternal sedation or anesthesia, congenital malformations, gestational age, trauma, and inter-observer variability.

Additionally, as seen in this dataset, when a newborn has an Apgar score of 5 or less at 5 minutes, umbilical artery blood gas from a clamped section of the umbilical cord should be obtained and the placenta submitted for pathologic examination (ACOG opinion, 2015).

There were 14 cases in the third trimester with special characteristics noted. Characteristics of Labor and Delivery revealed that 79% (N=11) of mothers received an epidural or spinal anesthesia during labor. Fourteen percent (N=2) were administered steroids for fetal lung maturation and 36% (N=5) of mothers were induced. Seven percent (N=1) of mothers experienced augmented labor, moderate to heavy meconium staining of amniotic fluid, or an emergency cesarean section.

Seventy-nine percent (N=11) of the decedents had congenital abnormalities. Of the cases where congenital anomalies were noted, all decedents were 27 weeks gestation or greater. Such congenital anomalies included cardiac anomalies (hypoplastic left heart), and congenital diaphragmatic hernia.

Twenty-one percent (N=3) of mothers in this category did not have any pregnancy risk factors noted. Thirty-six percent (N=5) were obese, 21% (N=3) had a previous cesarean delivery, 14% (N=2) were of advanced maternal age, and 29% (N=4) had experienced other previous poor pregnancy outcomes. Twenty-nine percent (N=4) of mothers gave birth via vaginal delivery.

Seventy-one percent (N=10) of decedent cases had abnormal conditions of the newborn indicated on the certificate of live birth. Such conditions included 57% (N=8) of decedents requiring admission to the NICU with an additional 14% (N=2) requiring assisted ventilation and 7% (N=1) requiring antibiotics to be administered for suspected neonatal sepsis.

Seventy-one percent (N=10) of mothers did not experience any other poor previous pregnancy outcomes that include spontaneous or induced

losses or ectopic pregnancy. Seven percent (N=1) percent of mothers experienced one prior loss, two mothers (14%) experienced two prior losses, and one mother (7%) experienced four prior losses.

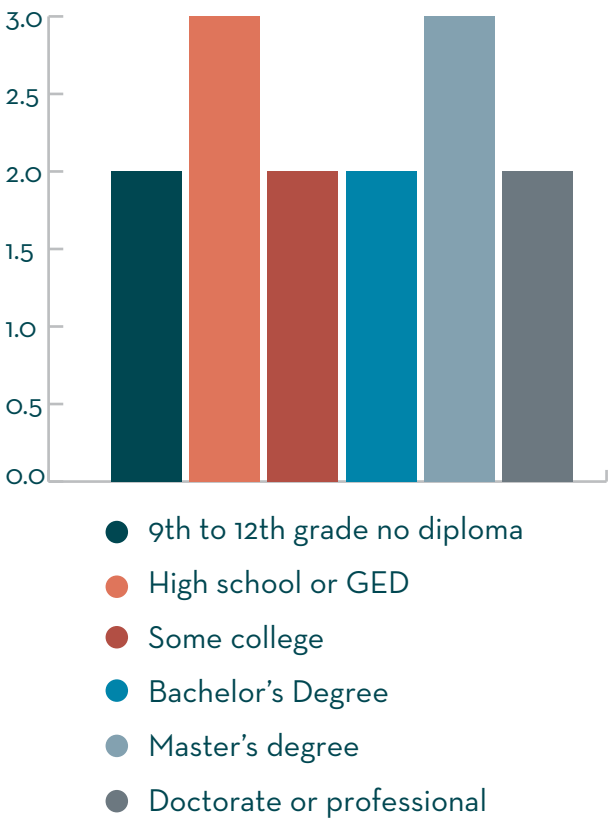
Seventy-one percent (N=10) of mothers giving birth in the third trimester had attended at least ten prenatal visits and so were receiving regularly scheduled prenatal care. The average age of the mothers who gave birth during the third trimester was 30 years old, the youngest mother being 20 years old and oldest mother being 38 years old.



» Maternal Information

There were 14 decedents included in this statistical review and 14 mothers counted in the maternal information section. Forty-three percent (N=6) of mother’s were Black and 57% (N=8) were White.

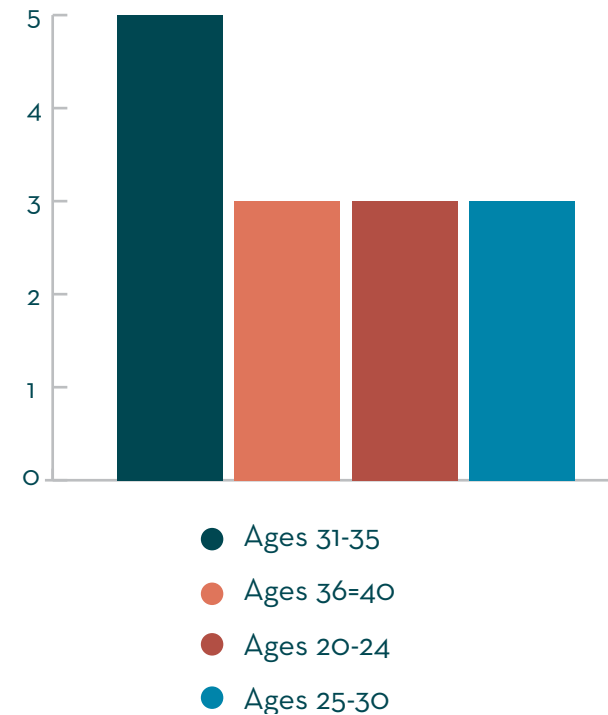
FIGURE 11: 2017 IMRT STATISTICAL MATERNAL EDUCATION STATUS



Fourteen percent (N=2) of mothers attended school during their ninth to twelfth grade years but did not obtain a diploma. Twenty-one percent (N=3) had attained a high school diploma but did not further their education. An additional 14% (N=2) of mothers had attained some college credits. There were no mothers who had less than an eighth-grade

education or an associate degree. Fourteen percent (N=2) of mothers had obtained their bachelor's degree, 21% (N=3) of mothers obtained their master's degree and 14% (N=2) obtained a doctoral or professional degree. Overall, 86% of the mothers had completed high school education.

FIGURE 12: 2017 IMRT MATERNAL AGE



Thirty-eight percent (N=5) of mothers were between 31-35 years of age at the time of the decedents birth an additional 23% (N=3) were between 36-40 years. This shows that in this sample, advanced maternal age could be one of the factors contributing to high rates of infant mortality in the District. The youngest mother was 20 years old while the oldest mother is 38 years old. The average age of all mothers in this statistical review was 30 years old.

Fifty percent (N=7) of mothers were not married or in a registered domestic partnership at the time the child was conceived, at the time of birth, or at any time between conception and giving birth, while 29% (N=7) of mothers were married.

DC Medicaid insured 50% (N=7) of mothers in this statistical review. Thirty-six percent (N=5) had private insurance. One mother was uninsured and the health insurance status of one mother was unknown.

During the review of documented pre-pregnancy statistics from the Certificate of Live Birth, the shortest mother in this statistical review was 5 feet tall and the tallest mother was 5 feet 9 inches tall. The average height of all mothers was 5 feet 5 inches.

The lowest pre-pregnancy weight among all mothers was 100 pounds and the highest weight was 517 pounds with an average pre-pregnancy weight of all mothers of 185 pounds. The average maternal weight gain was 29 pounds. The American College of Obstetrics and Gynecology supports the Institute of Medicine’s Guidelines that recommend weight gain in pregnancy (ACOG opinion, 2012).

In brief:

- Under-weight women (BMI under 18.5) should gain 28-40 pounds.
- Normal weight women (BMI, 18.5-24.9) should aim for 25-35.
- Overweight women (BMI, 25-29.9) should aim for 15-25.
- Obese women (BMI, 30 or more) should gain only 11-20.

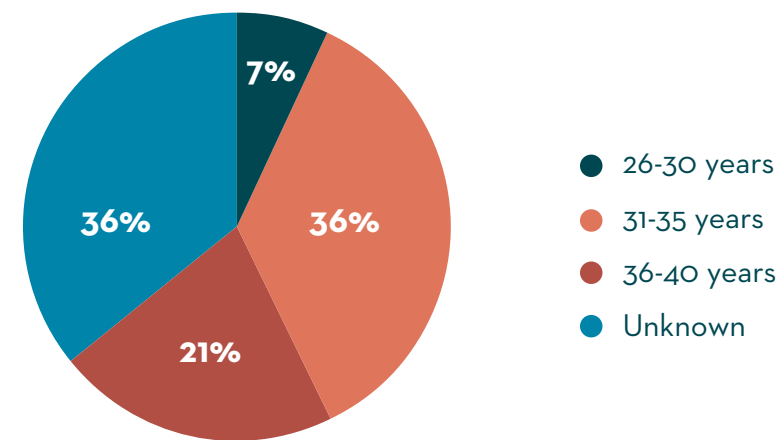
Fifty percent of mothers (N=7) did not have any previous live births or other living children. Twenty-eight percent (N=4) of mothers had given birth to one (1) child previously. Fourteen percent (N=2) of mothers had given birth to two (2) children previously and 7% (N=1) of mothers had given birth to four (4) children previously.

» Paternal Information

There were 14 fathers included in this statistical review.

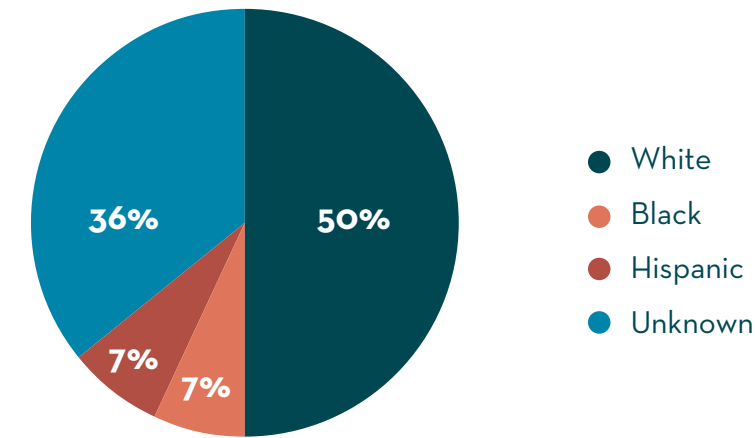
Sixty-four percent (N=9) of fathers were identified and their information was recorded on the birth certificates. Further, Paternity Acknowledgements were signed at the hospital at the time of the decedents’ birth in 14% (N=2) of cases reviewed. Paternity Acknowledgements were not signed at the hospital at the time of the decedents’ birth in 36% (N=5) of cases.

FIGURE 13: 2017 IMRT STATISTICAL PATERNAL AGE



Approximately 36% (N=5) of the fathers were between 31-35 years years and 21% (N=3) were 36-40 years old. One (N=1) father (7%) was between 26-30 years old. There was no information recorded for five fathers. Of the fathers whose ages were recorded, the average age was 33 years. The youngest father was 26 years old and the oldest father was 38 years old.

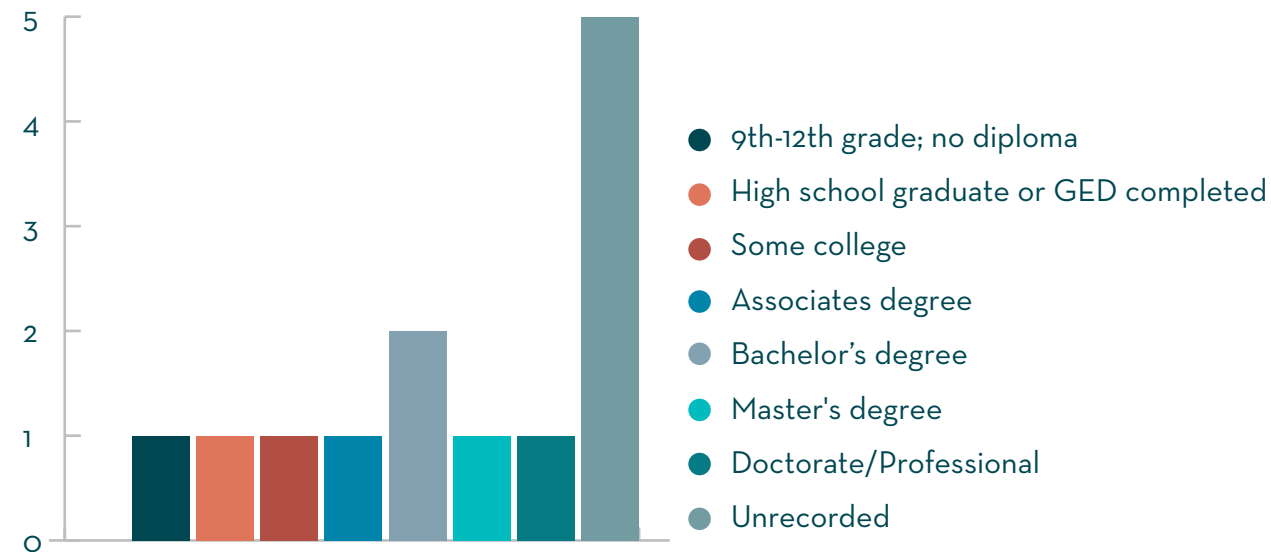
FIGURE 14: 2017 IMRT STATISTICAL REVIEW PATERNAL RACE



Half, 50% (N=7) of fathers were White, 7% (N=1) were Black, and 7% (N=1) were Hispanic. There was no paternal race information listed on the certificate of live birth for 36% (N=5) of fathers.

There was an almost evenly distributed range in paternal educational attainment. Twenty-two percent (N=2) of fathers obtained a Bachelor’s degree while 11% each (N=1) of fathers completed high school without a diploma; graduated high school or obtained a GED; had some college; obtained an Associate’s degree; obtained a Master’s degree; obtained a Doctorate or Professional degree or did not have their educational status recorded.

FIGURE 15: 2017 IMRT STATISTICAL REVIEW PATERNAL EDUCATION



INFANT MORTALITY REVIEW TEAM FULL CASE REVIEW FINDINGS

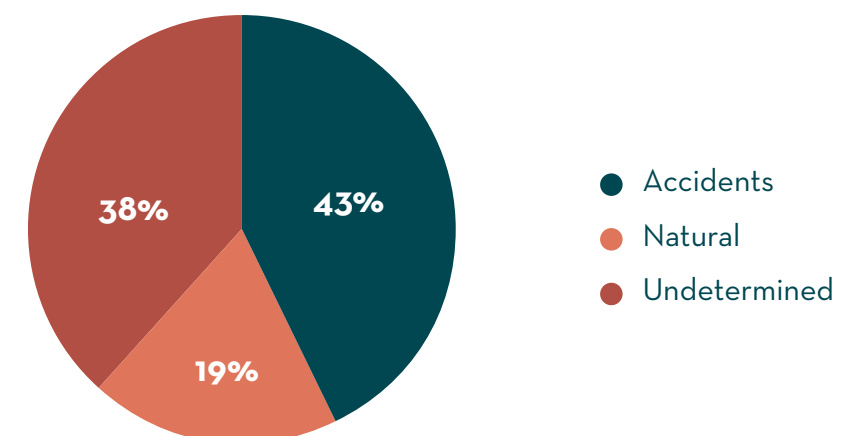
In 2019, the Infant Mortality Review Team (IMRT) continued to draw upon the expertise of the diverse subject matter specialists who volunteered their time monthly to insure the most vulnerable citizens received a thorough examination of the circumstance contributing to their untimely deaths.

During the 2019 Calendar year, the Infant Mortality Review Team completed comprehensive case reviews of 21 Infants who died in the District of Columbia. Full case reviews were completed when the decedent lived more than 30 days and the decedent family was involved or received services from one or more District social services agencies to include: Child and Family Services Agency, the Department of Behavioral Health, the Department of Human Services, and the Department of Health Care Finance. The comprehensive reviews in 2019 covered all the 21 fatalities in the 2017 calendar year.

The investigation of the 21 cases that received a full comprehensive review revealed many commonalities among the fatalities, and the in-depth discussion centered on the following overarching themes: Unsafe Sleep fatalities and the education and resources provided to parents; Marijuana and substance use to include tobacco as a risk factor in infant deaths; the utilization of Health Information Platforms to promote data sharing and linkages to critical resources, and the Negligence of caregivers (personal responsibility) in the death of an infant.

The IMRT also reviewed the impact of District Agencies who were responsible for providing resources to families and the responsibility those agencies had when a client, who was known to have received services, suffered a fatality. The IMRT discussed findings and developed recommendations that involved the following agencies: The Department of Human Services, the Child and Family Services Agency, the Department of Health Care Finance, and the District of Columbia Health Department.

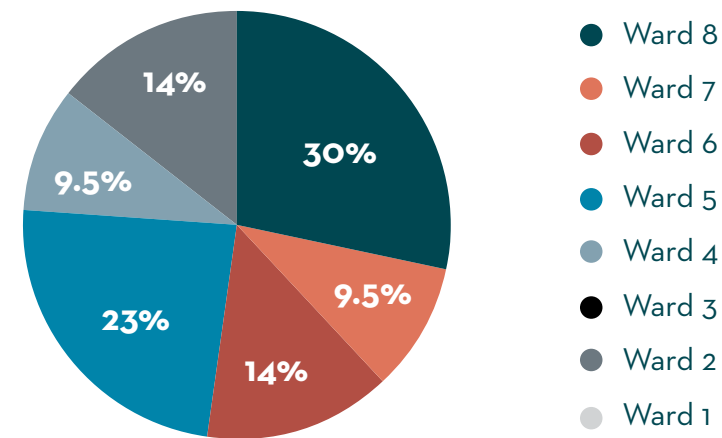
FIGURE 16: IMRT 2019 MANNER OF DEATH



In the review of infant fatalities in 2019, 9 cases were classified as Undetermined Cause of Death and 8 were classified as Accidental Cause of Death. Of these 17 cases, 8 reviews revealed some form of substance use. Of those fatalities classified as Accident or Undetermined, 82% (N=14) had a contributory cause of Unsafe Sleep Environment.

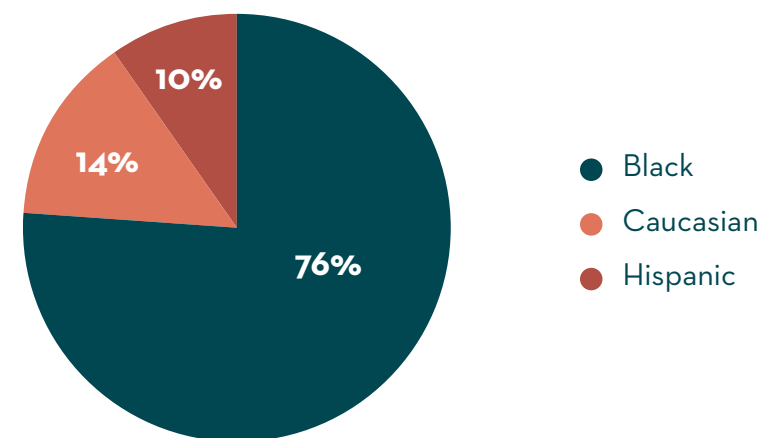
Most fatalities occurred in Ward 8 (N=6) and Ward 5 (N=5). There were 11 fatalities reviewed of decedents who resided in these wards and 90% had an Unsafe Sleep component associated with the death.

FIGURE 17: IMRT 2019 CASE REVIEW DECEDENT WARD OF FATALITY

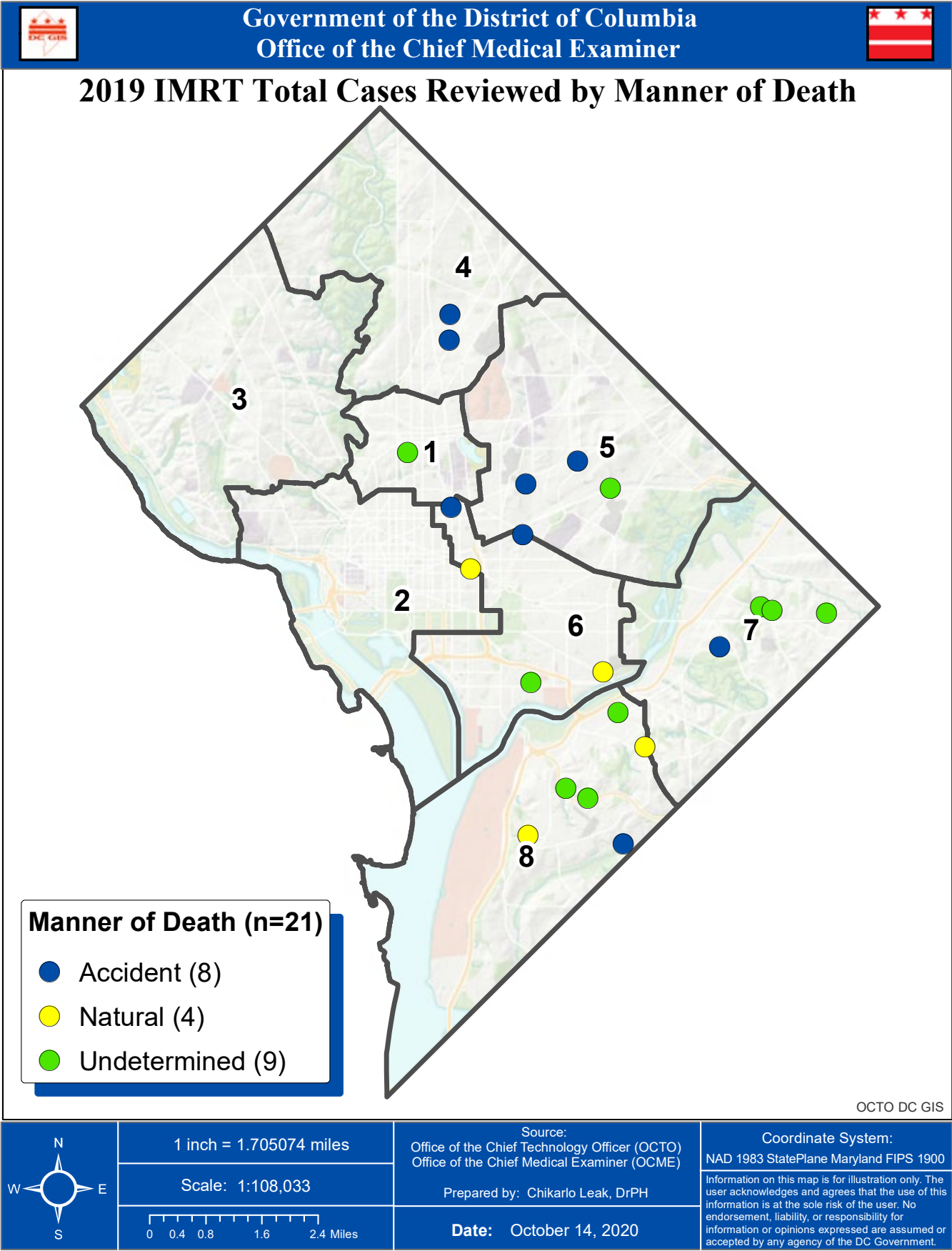


Of the 21 IMRT cases reviewed, the majority of the decedents (76%) were Black.

FIGURE 18: IMRT 2019 DECEDENT RACE



According to the 2014-2018 American Community Survey Data, (16.5%) of the population residing in Ward 8, zip code 20032 reported a household income less than 10,000 dollars. In 2014-2018, 29.8% of people were in poverty. An estimated 38.6% of children under the age of 18 were below the poverty level, compared with 21.2% of people 65 years old and over. An estimated 26.7% of people 18 - 64 years were below the



poverty level. In Ward 8, for people reporting one race alone, 8.6% were White, and 87.8% were Black or African American.

In Ward 5, the American Community Survey of 2014-2018 revealed that 14.3% of people were in poverty. An estimated 10.7% of children under 18 were below the poverty level, compared with 16.2% of people 65 years old and over. An estimated 14.8% of people of 18 to 64 years were below the poverty level. In Ward 5, for people reporting one race alone, 27.2% were

White, while 61.4% were Black or African American.

The average age of the decedents' mothers reviewed in 2019 was 27 years old and the youngest was 21 years old. The average age of decedents' fathers reviewed in 2019 was 30 years old, and the youngest age was 19 years old. On the Certificate of Live Birth, 90% (N=19) of mothers indicated their marital status was single and 10% (N=2) indicated their status was married.

» Infant Mortality Review Team Meeting - Trends and Observations

The IMRT observed the impact of the family's social determinants of health on the poor outcomes experienced by families. The following is a compilation of the discussions and observations made during the 2019 IMRT meetings.

SAFE SLEEP FATALITIES, SAFE SLEEP EDUCATION

The IMRT devoted a considerable amount of time to the discussion of Unsafe Sleep Fatalities in the District of Columbia. Ten of the eleven scheduled meetings comprised reviews where the incidence of parents placing infants in unsafe sleep environments was a contributory factor in this fatal outcome. During the reviews, the IMRT participants provided feedback to member agencies regarding safe sleep criteria and practices in accordance with the American Academy of Pediatrics. The IMRT discussed the prevalent behaviors displayed by caregivers in making safe sleep decisions. The IMRT participated in robust dialogues regarding educational resources and safe sleep equipment provided to district residents and their commitment to improving the caregivers' understanding and implementation of safe sleep practices.

The American Academy of Pediatrics, Safe Sleep practices recommends placing an infant on their back for all sleep times – naps and at night. It is

recommended to use a firm sleep surface, such as a safety-approved mattress and crib, keeping soft bedding such as blankets, pillows, bumper pads, and soft toys out of the infant's sleep area. Caregivers are encouraged to share their room, not their bed.

A. Care-Giver Unsafe Sleep Environment Decisions

One of the fatalities reviewed involved the care provided by a live-in childcare provider. The decedent was sleeping on the caregiver's chest, on a couch. The IMRT engaged in a robust discussion around caregivers, especially hired live-in childcare providers. When obtaining a qualified CPR certified, criminally cleared, caretaker or childcare provider, the IMRT further discussed the importance of the credential review and vetting process, since parents trust agencies when procuring care takers for children. Overall best practices are paramount when choosing live-in childcare services.

In the case reviewed, the live-in childcare provider was hired through an online agency. The IMRT participants commented that online agencies at

the time were not completing comprehensive State and FBI criminal background checks (fingerprints). Moreover, there were loopholes in the regulatory process regarding the mandate for federal background checks. There was no provision that required all live-in childcare providers to have CPR and Safe Sleep training prior to their employment. The IMRT discussed the need for a larger policy of messaging around safe sleep to include childcare providers and the mandate to be trained on safe sleep practices. Currently, there is no standard for safe sleep and CPR training for agencies that provide linkages to a prospective caregiver. Neither is there a universal mandate for these agencies to provide safe sleep training.

The IMRT discussed the benefit of developing a set of questions that would be a useful tool for parents who are utilizing childcare facilitating agencies when locating a secondary provider. This set of questions could be used to assist in determining whether individuals are qualified to fill the role of infant caregiver, and to provide the services being contracted.

Another of the fatalities reviewed involved a two-week old decedent who shared an adult bed with her twin brother and mother; this family had experienced a prior sleep-related fatality. The decedent's mother did not follow the recommended safe sleep messaging and training she received during her prenatal and antenatal appointments. As the first fatality for this family was classified as a

SIDS death, there was no Child and Family Services Agency involvement and no mechanism to identify the family as being more at risk or vulnerable to another sleep related fatality.

Another case reviewed a decedent sharing a Pack and Play® with the other infant siblings (multiple gestation births). The level of safe sleep education received was noted as a concern, as the infants were sleeping on their backs in an AAP approved sleep resource, but they were not alone, compromising the decedent's sleep environment. It was noted that not all IMRT participants attending the meeting realized it was unsafe to put more than one infant in a crib or Pack and Play® at the same time. This opportunity was utilized as a "teachable moment," for providers and resource agencies.

The IMRT agreed there was a need to address common misconceptions regarding infant sleep patterns, and appropriate safe sleep environments with District residents.

1. Stomach sleeping inhibits an infant's ability to rouse, promoting a deeper sleep. Stomach sleeping is contrary to the AAP Safe Sleep Guidelines.
2. The IMRT identified exposure to various substances and agents (illicit drugs and alcohol) which may lead to hyper-somnolence in caregivers as a factor contributing to Unsafe Sleep Environment fatalities.



3. The investigation of decedent environments revealed that many contained too many items including, pillows, blankets, and other infant children and adults, making it an unsafe sleep environment.
4. It was also recognized that mothers might receive mixed messages in the hospital concerning safe sleep environments, as well as resistance to changing their behaviors, which may have not resulted in a fatality in previous child-rearing activities.
5. Parents admitting to being tired and using marijuana; this substance combined with fatigue, was identified as a concern, impacting the caregiver's state of sleep and arousal.
6. A special concern was noted for secondary caregivers, who had not received the same safe sleep training as the primary caregiver. In not receiving the appropriate training, they were ill equipped in providing the same level of care as the primary caregiver, when preparing the decedent for sleep.
7. In one fatality, the medical provider for the decedent identified SIDS as a risk factor for this family in the medical records, but no documentation was noted reflecting re-education or training provided to the decedent's family.

It was noted, the IMRT process captures more specific data than the Death Certificate or the Autopsy Report. The team reflected that safe sleep behaviors could be targeted, mirroring car seat education and training, for use in medical facilities discharging infants to their home. In relation to the above-mentioned fatalities, The IMRT inquired if the Department of Health Care Finance (DHCF) could access and see the details of safe sleep education and concern identified by the medical provider in the Health Information system (CRISP),

currently employed in the District. This discussion was generated during the review of a fatality where the decedent's medical provider indicated the infant was at risk for SIDS, given the caregiver's stated behaviors of bed-sharing with the infant in an adult bed. The IMRT discussed ways in which the medical provider could use referrals to harness the resources in the District to include the MCO care managers. The IMRT participants were unable to develop agreed upon recommendations, but indicated the findings warranted further discussion to provide District families with critical information and support concerning the decisions made regarding safe sleep environments for infants.

The MCOs use different methods to capture repetitive and critical issues; one is the Nurse triage process, which is used as a check and balance system. In this system, the nurse can reiterate the critical information, create a notation in the medical record, and then send an alert to the Health Information system, such as for safe sleep.

When safe sleep practices are not followed, the IMRT observed poor outcomes. In one case reviewed, the decedent's mother indicated she wanted the decedent to feel as if she was sleeping with her; she placed an unapproved pillow and blanket in the AAP approved sleep environment. Although comforting, bed-sharing with infants increases the likelihood of asphyxia.

The IMRT indicated that speaking with mothers and fathers via the maternal interview process would shed light on cases with many unanswered questions as to why they felt sleeping with their infant was safe, contrary to current information they received on infant safe-sleep. IMRT noted that caregivers required written directions on safe sleep detailing the "ABCs" of safe sleep (alone, on the back, in a crib, in a smoke-free environment). The participants noted that caregivers require more than verbal information regarding safe sleep protocols at discharge, and that prior parenting behaviors

cannot always be implemented with a vulnerable pre-term infant. The review of these types of cases revealed that Safe Sleep protocols were not always being discussed at prenatal appointments.

It was noted that the distribution of Safe Sleep education has been provided by DC Department of Health (DC Health) for 18 years in the District of Columbia. The IMRT also discussed that Safe Sleep education materials should include consideration of the educational and comprehension level of caregivers.

Providing safe sleep training, counseling and education requires extensive training of the educators to embrace the safe sleep information and impart that knowledge to the community. During the review of cases, the medico-legal investigator present indicated that most caregivers report what a safe sleep environment looks like but did not think a fatality would happen in their situation. An IMRT participant indicated that it is not enough to know what a safe sleep environment is but is equally important for individuals to know why it is critical. There is a gap in explaining "the why" to families and it begins with the providers of safe sleep information.

In an effort to further advocacy and preventive health measures, IMRT Co-Chair, along with other IMRT participants, met with the DC Hospital Association (DCHA) on October 17, 2019 to discuss the pre-term discharge protocols the IMRT developed to address the warm hand-off of fragile infants to medical and service providers, insuring the continuity of care and services. This discussion included

discharge policy for medically fragile infants and the uniformity of practices and safe sleep training among the birthing hospitals. The information was well received, and the IMRT continues to nurture the collegial relationship to foster improvements in systems which provide services and resources to families and infants. The Office of the Chief Medical Examiner, DC Health and the Department of Healthcare Finance continue to meet with the Hospital Association on topics of public health that affect infant mortality in hopes of addressing future recommendations.

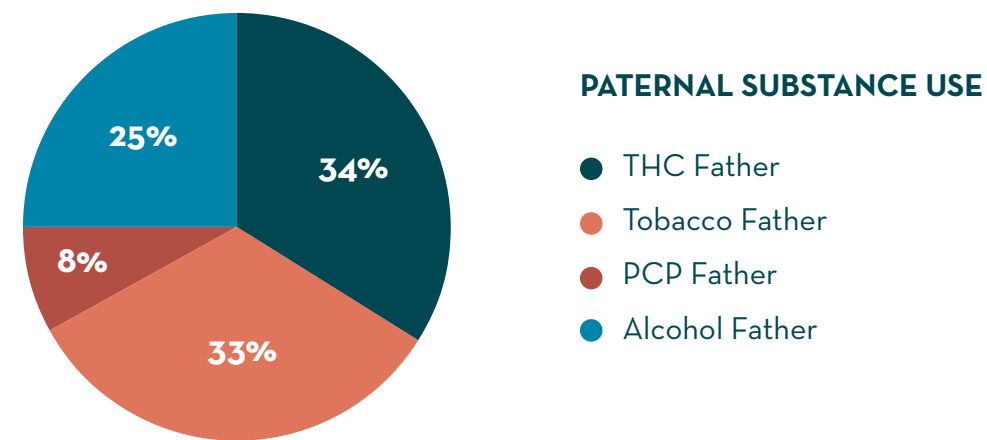
B. Substance Use as a Contributory Cause

Infants exposed to an Unsafe Sleep Environment, to include bed-sharing with adults while impaired, was a wide concern. The IMRT found it was important to educate the community on accurate infant safe sleep practices to include the impact of substances that diminish one's ability to rouse from a deep sleep, and the potential asphyxia component and risks associated with pre-term births.

The IMRT discussed the implication of caregiver's smoking on infants' birth weight and respiratory development, whether tobacco or marijuana, and a need for coordinated public service messaging, especially with the advent of vaping products. Forty-eight percent (48%, N=10) of the fatalities reviewed revealed some substance use by the primary caretaker to include: tobacco, marijuana, alcohol, PCP or K2; THC use was observed in five of the fatalities with an Unsafe Sleep component, and eight mothers reported using tobacco during their pregnancy and after delivery.

During the IMRT meetings of infant fatalities, the role of fathers in the outcomes was analyzed as an area for targeted interventions. Although information on the decedents' fathers was not always available, the IMRT was able to obtain some pertinent data, to include substance use and age. The average age of the decedents' fathers was 30 years old in the cases reviewed; with the oldest being 41 years old. Four fathers used tobacco, four used marijuana, three used alcohol and one used PCP, while three of the fathers were poly-substance users.

FIGURE 19: PATERNAL SUBSTANCE USE



C. Substance Use and Negligence

The IMRT indicated there was a need for a robust conversation around parental negligence in safe sleep deaths and also observed this could be an opportunity for health systems to have interactions and impact on the care and resources provided to caregivers during routine health visits. The IMRT observed that it is important to educate anyone in the home that using tobacco or marijuana may contribute to increased risk factors, leading to poor outcomes for infants.



» Marijuana (Cannabis) Work group and Team Findings

The IMRT led a marijuana workgroup that met several times to discuss best practices and current research on the use of marijuana and any observable impact in fatalities, especially unsafe sleep. Although the work group met separately from the regular scheduled fatality reviews, all the team members provided vital information and insight. The following are the discussion points from those members:

1. As with all drugs/medications, the risks and benefits during pregnancy need to be assessed for the individual mother. That does not prevent recommendations regarding purely recreational marijuana during pregnancy or recommending trying other non-drug solutions first for symptoms when it is believed there could be some risks.
2. It will take a long time to determine the impact of marijuana during pregnancy or breastfeeding. Behavior, learning and executive function problems (which can have a big impact on school readiness and success) may not be apparent until the age of five years. Continued success in school and adult outcomes for unsuccessful students, and those diagnosed with Attention Deficit/Hyper-Activity Disorder (as examples, may put young adults at higher risk for car accidents, risky sexual behavior and drug use). Moreover, susceptibility for addictions will not be apparent for many more years, therefore making the IMRT cautious about making sweeping assumptions in view of the lack of data.
3. Although marijuana has been in use for a long time, data indicates that the marijuana used today may be more potent than previous variants. The collection of this data is known because there are more mothers that are only using cannabis (rather than poly drug abuse), thus providing valuable data, now that marijuana use is being studied.

- a. The article “Risk of pre-term and early term birth by maternal drug use” in the Journal of Perinatology (2019) 39:286-294 found an increased rate of 11.6% of pre-term births.
- b. Two presentations at the Society for Maternal-Fetal Medicine 2019 Annual Pregnancy Meeting are pertinent:
 - 1. Bailey studied 531 mothers from Colorado, Tennessee, and Virginia. The mothers studied, confirmed with a positive urine drug screen at delivery, matched for background and other perinatal exposures with an equal number of control infants with mothers with a negative drug screen. All birth outcomes examined were significantly worse for infants exposed to cannabis than for unexposed infants, after race, parity, socioeconomic status and in utero exposure to tobacco, alcohol, benzodiazepines, and opioids were controlled for (p<.05). Cannabis-exposed newborns were 82% more likely than unexposed newborns to be of low birth weight, 79% more likely to be born before term, and 43% more likely to be admitted to the NICU. This is among the first relatively large and well-designed studies to show that birth outcomes are linked to cannabis exposure (as an independent factor) in pregnancy.²
 - 2. Metz looked at 2392 women who delivered at the University of Colorado, of whom 1165 delivered before legalization of marijuana, and 1227 delivered after legalization of marijuana. Pregnant women were significantly more likely to use cannabis after legalization than before (OR 1.8), and after adjustment for factors such as ethnicity and other drug use, fetal growth restriction was more common after legalization (OR 1.9), as was spontaneous pre-term birth (OR 1.5). There were no differences in the use of alcohol, tobacco, illegal drugs, or opioids. This was an observational study, so further research is needed before causation can be confirmed.
- a. Smoking marijuana around an infant might lead to poor parent decision-making and could contribute to sleep related deaths.
- b. Marijuana use impacts caregivers’ coping mechanisms, and the decriminalization of marijuana in the District of Columbia might impact the perception of marijuana usage as being accepted and appropriate in all circumstances.
- c. The IMRT reflected there was no consistent policy regarding universal toxicology screening at some hospitals during a live birth until an infant had a wet diaper. The need for universal toxicology screening was discussed to avoid profiling a family.
- d. The IMRT observed there was no written directive from DC Health concerning the impact on infants when mothers use marijuana. DC Health indicated guidelines from the American Academy of Pediatrics (AAP) is required before the District makes providers responsible for advising mothers on marijuana use.

² Newborn Health Harmed by Cannabis Exposure - Medscape - Feb 19, 2019. Society for Maternal-Fetal Medicine (SMFM) 2019 Annual Pregnancy Meeting: Abstracts 75 and 341. Presented on February 15 and February 13, 2019.

- e. One of the IMRT’s participating hospital members was identified as a hospital that conducts universal drug testing. The Infant Mortality Review Team indicated all drug testing should include the components of CBD or THC. The Infant Mortality Review Team was interested in the AAP policy on marijuana use and impact on care giving for an infant.
- f. It was recommended the marijuana workgroup review the information and research on breast-feeding mothers who smoked marijuana, to address the idea of no breast feeding while smoking marijuana, given the movement to full legalization of marijuana use.
- g. The IMRT also discussed when a pregnant woman should avoid using marijuana, in alignment with the available literature. It was observed that substance use is a common denominator in fatalities where unsafe sleep is a cause. The IMRT discussed a reflection of a caregiver’s decision-making skills and, more broadly, how we can help caregivers in their decisions concerning other health choices, including participation in WIC and prenatal care.

The IMRT determined it was vital for DC Health, the Department of Health Care Finance (DHCF) and Medicaid participating Managed Care Organizations (MCO) to develop a plan on messaging marijuana health to parents and pregnant women.

A. BMI-Obesity and Overweight

The Infant Mortality Review Team began tracking Maternal Adult Body Mass Index (BMI) in 2017. Obesity has been linked to poor pregnancy outcomes³ and was observed in the death of the infants reviewed, especially those in compromised safe sleep environments. These deaths were often with an adult or child on the same sleep surface contributing to the asphyxia of the decedent. Maternal obesity was reported in four fatalities where an infant and an adult were sharing the same sleep surface, resulting in a rollover, or wedging; six caregivers (other than mothers) were overweight in fatalities where bed-sharing was observed.

The Center for Disease Control (CDC) classifies adult weight and BMI categories as:

Adult weight	BMI	Category Description
124 lbs. or less	BMI is less than 18.5	Underweight
125 lbs.to 168 lbs.	BMI is 18.5 to < 25	Healthy Weight
169 lbs. to 202 lbs.	BMI is 26.0 to < 30	Overweight
203 lbs. or more	BMI is 30.0 or higher	Obese

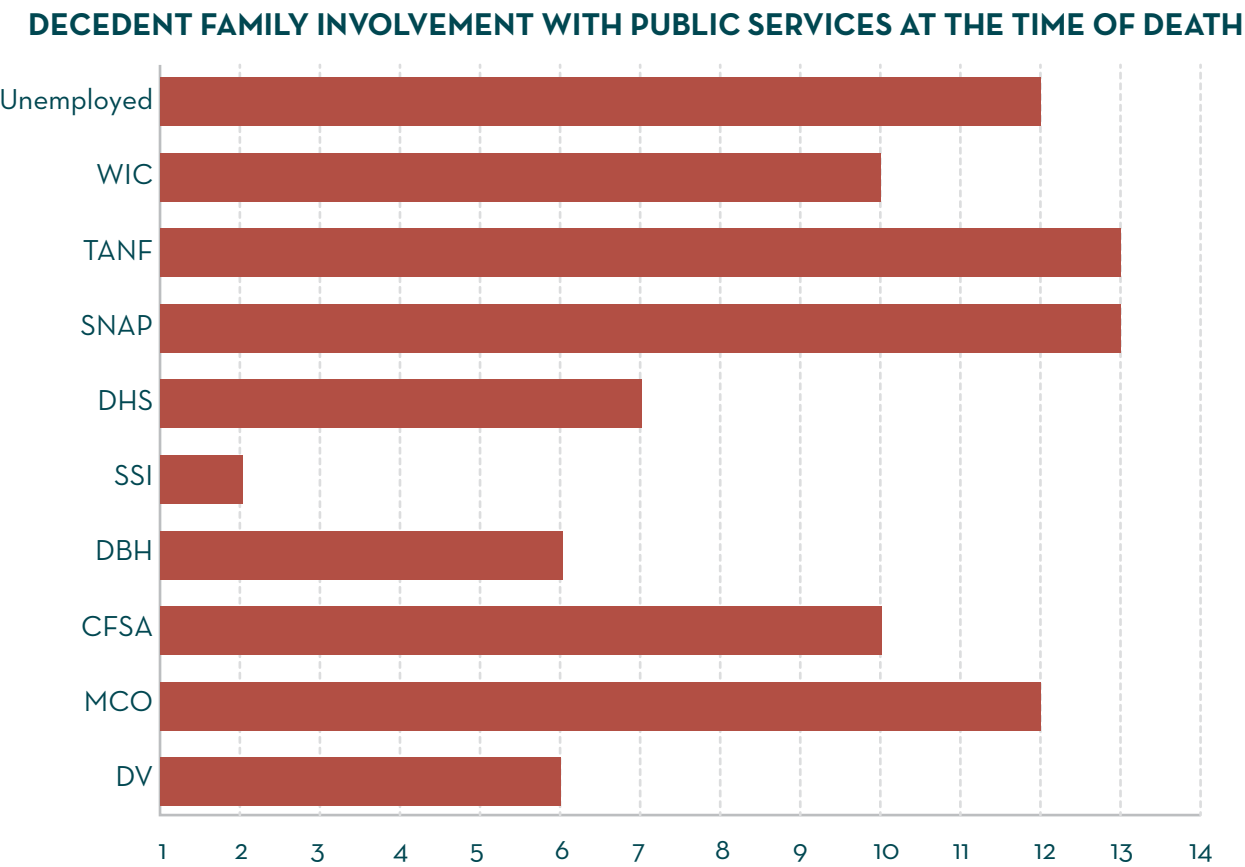
<https://www.cdc.gov/obesity/adult/defining.html>

³ <https://www.ncbi.nlm.nih.gov/pubmed/23757084>

» Social Determinants of Health

During the review of infant fatalities, involvement and engagement with public health, human services, public safety, and child welfare services was noted as a commonality. IMRT discussed the social determinants of health in relation to who the decedents’ families were and if they had to navigate any barriers in accessing medical and mental health services. The conditions in the places where people live, learn, work, and play affect a wide range of health risks and outcomes. These conditions are known as social determinants of health (SDOH).

FIGURE 20: PARTICIPATION IN PUBLIC SERVICES



The IMRT recognized several themes in the review of infant fatalities receiving public services from the District of Columbia:

1. Medical Treatment and access to training and resources

The American Community Survey revealed that in Ward 8, among the civilian non-institutionalized population in 2014-2018, 95.7% had health insurance coverage, and government coverage was assessed at 60.6%, respectively. The percentage of children under the age of 19 with no health insurance coverage was 1.3%. The District of Columbia has worked to ensure that anyone who is eligible for health insurance is afforded the opportunity to apply and receive health insurance.

In Ward 5, among the civilian non-institutionalized population in 2014-2018, 94.7% had health insurance coverage, and government coverage was assessed at 32.2%, respectively. The percentage of children under the age of 19 with no health insurance coverage was 10.2%.

The IMRT encountered several circumstances where decedents’ families did not appear to have access to or understand the process of accessing their medical resources. The Infant Mortality Review Team hypothesized that missed medical follow-up care by the decedents’ caregivers might highlight social and individual gaps in understanding resources and expectations. The IMRT identified the following observations and areas for consideration:

a. Engaging non-primary caregivers and the provision of resources and training

Outreach to fathers was identified as a need. One case involved a decedent’s father who was providing care when the decedent’s mother was hospitalized. The father was not trained on safe sleep recommendations or basic infant care to include feeding, or his access to Medicaid health insurance. Case management was not provided for-fee-for service Medicaid participants. The IMRT observed that case management would have provided follow-up to this decedent. The IMRT indicated that this family would have received outreach services and/or a telephone call if they were enrolled in a Managed Care Organization. This family also utilized medical services in another adjoining jurisdiction. The IMRT discussed the importance of developing messaging for private institutions around the need to standardize follow-up processes for all caregivers, not just mothers. The IMRT observed that the decedent’s father needed an advocate at the hospital, preferably in pediatrics, that could have addressed the decedent’s needs.

b. Uniformity in administering standard newborn test and follow-up

During the review of two cases, the IMRT encountered fatalities where the newborns’ metabolic screen was inconclusive or abnormal, but no follow-up or retest was recorded in the medical records reviewed. The IMRT drafted and sent correspondence to the providers of record. This action was pursued to notify the providers of the findings and to elicit responses as to how the deficiencies might be addressed if they existed.

The IMRT engaged DC Health in this process which requires providers to contact families who have an inconclusive or abnormal metabolic screen, as follow-up is a mandatory component of metabolic screening. The IMRT received a presentation from the DC Health regarding the planned intent of metabolic screens and follow-up as well as the gaps in service when the system fails. The IMRT noted that conducting mandatory newborn screens is not effective if follow-up is not provided when indicated. Follow-up screening

is mandatory for abnormal or inconclusive results. The IMRT discussed the importance of hospital-specific policies and procedures for completing newborn metabolic screenings and discharge planning, specifically ensuring all screening tests procedures follow clinical guidelines; all birthing facilities implement workflows to improve rates of screening, identification of abnormal results and follow-up procedures; and all newborns have a primary care appointment prior to hospital discharge

c. Decedents lost to follow-up care and the use of the Health Information Systems to address critical events

The IMRT discussed the importance of engaging with families with medically fragile infants and those requiring regular pediatric well-child visits. The IMRT discussed the possibility of insurance providers being able to observe, and see gaps in services, within the Chesapeake Regional Information System for our Patients (CRISP), the District’s health information exchange, when an infant is lost to follow-up care. Medicaid Managed Care Organizations (MCO) can detect if a customer is “lost to care,” through CRISP and build in outreach requirements as part of their MCO contract with DHCF. All four MCOs in the District have a tracking system and care coordination teams, utilizing telephone calls and outreach methods to contact those with due and overdue primary care visits. The CRISP DC health information exchange (HIE) has recently been selected as the District’s Designated HIE and is now accessible to more than 9,300 providers, who have the ability to receive in real-time a common platform used in the District of Columbia that can be utilized, sending information back to the receiver (internal system). While CRISP can develop new care alerts, those have not yet been built. All MCOs can access information through CRISP.

The IMRT noted that they heard that physician visits and follow-up notes are not always seen in the CRISP system. The IMRT discussed the concept of instituting an alert system within CRISP to ensure that risks for a beneficiary are identified for the Medicaid MCO and elevated to a care coordination function. Some examples of clinical system alerts to target referrals would include SIDS, breastfeeding, safe sleep education, etc. The IMRT pointed out that MCOs may have processes in place to address this issue; however, there is no system-wide mechanism throughout all MCOs to address a beneficiary’s failure to follow-up on primary care visits or medical treatments. It was discussed that presently the response would not take place in “real-time” and may take up to three months before an MCO receives a claim from the medical provider. The discussion illuminated that there are “levels” of care coordination at the provider and MCO levels. The IMRT noted that facilitating excellence in care, transportation services and monitoring appointment cancellations is critical from a medical/insurance provider perspective.

The IMRT noted that medical or nursing notes to the providers can be utilized as another set of eyes on the infant. The findings and discussions undertaken by the IMRT underscore the critical importance of collaboration and communication in working to create a comprehensive, safe environment for our families and children.

2. Housing Insecurity

The mission of the D.C. Department of Human Services is to empower every District resident to reach their full potential by providing meaningful connections to work opportunities, economic assistance, and supportive services. Many of the cases reviewed received support from the Department of Human Services; this included: Temporary Cash Assistance for Needy Families (TANF), Medical Assistance,

Supplemental Nutrition Assistance Program (SNAP) (formerly Food Stamps), Child Care Subsidy, Burial Assistance, Family Assistance and Homeless and Homeless Prevention services.

The IMRT reviewed two fatalities which occurred in a District contracted homeless shelter or hotel shelter. The IMRT recognized the crisis of housing insecurity experienced by the parent, can be transferred to the child, and the stressors which precipitated the housing insecurity, can impact the families’ functioning and decision-making capabilities. The IMRT discussed the importance of protocols for the shelters, especially conducting an assessment or checklist when completing the nightly room checks to monitor the appropriateness of the sleep environment for families with children.

The Department of Human Services CFRC member provided a comprehensive presentation to both the IMRT and CFRC during the 2019 meeting cycle to inform the participants regarding the current practices, oversight practices and resources provided to families that utilize District programs, experiencing housing insecurity. Inter-agency teaming and collaboration has been implemented to support families and children, to include mandatory case management services.

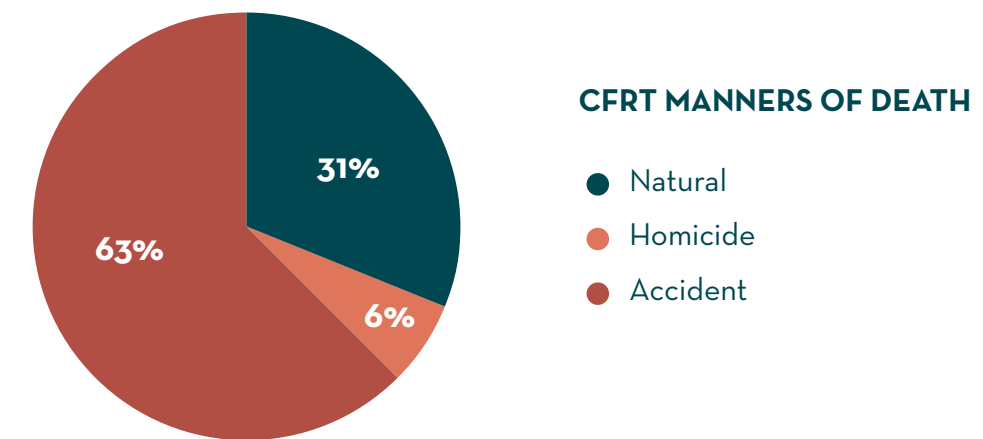
As shown in Figure 23, many families participate in public services provided by the Department of Human Services. To help address the needs of families involved with multiple agencies, the Department of Human Services (DHS) created data sharing agreements with hospitals and District agencies in 2018, which expire in 2022. The Department of Human Services indicated it would be more efficacious if more District agencies could become a part of the agreement, enabling a robust, coordinated system of addressing family and individual needs.



CFRT MEETING FINDINGS AND DISCUSSION

In 2019, the CFRT reviewed sixteen (16) fatalities involving children and youth in which deaths occurred in 2015, 2016, 2017 and 2018.

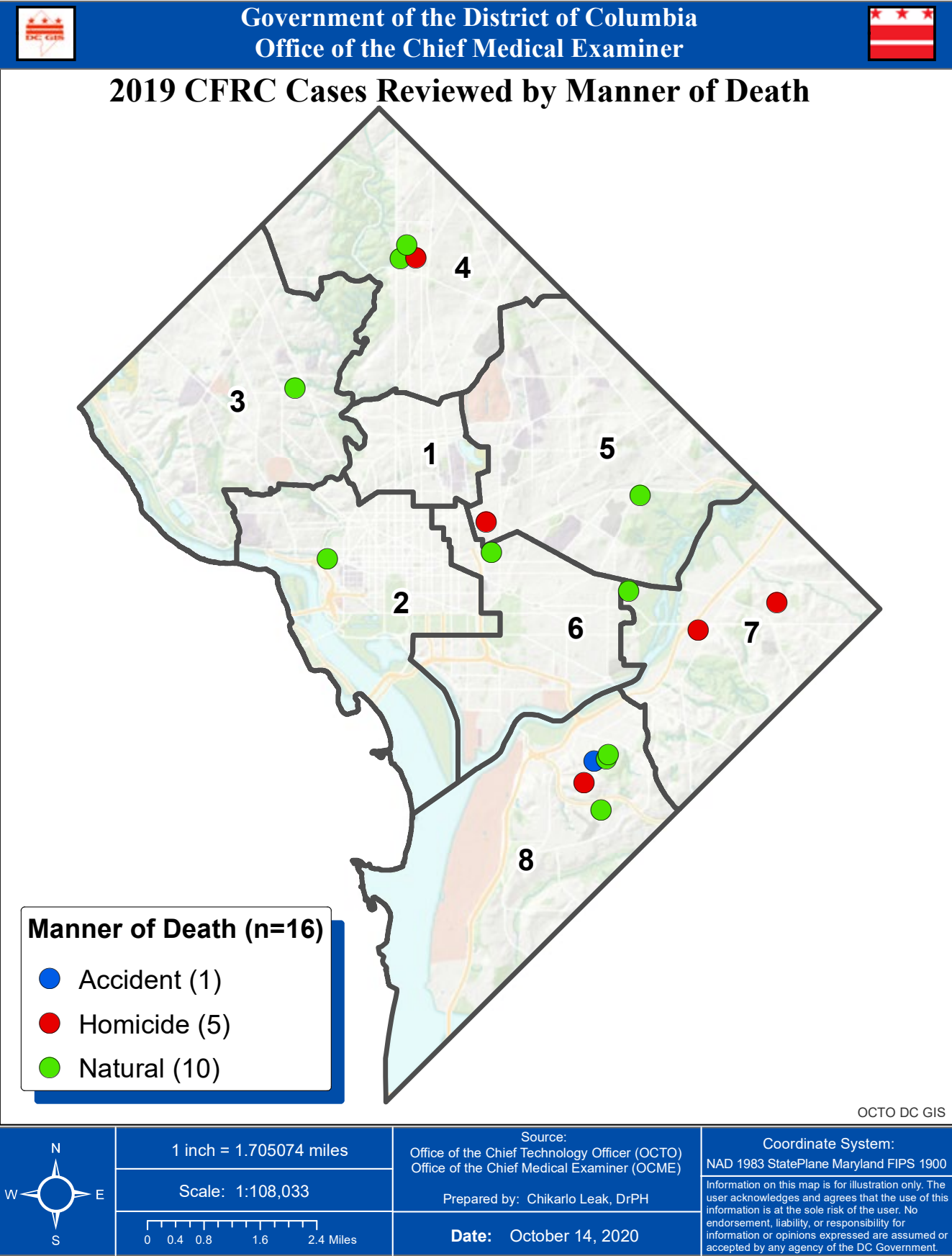
FIGURE 21: CFRT CASES MANNER OF DEATH



As detailed in Figure 25, child fatalities due to natural causes (63%, N=10) were the leading cases reviewed by the team, followed by the homicides of children and youth. One of the homicide cases involved the fatal abuse of one child who was 2 years old. The remaining case involved the accidental drowning of a 3-year-old child.

Figure 26 indicates most cases reviewed by the CFRT in 2019 involved Black children (68%, N=11). Hispanic children and youth accounted for three of the cases, followed by one white child and one child who was from Kuwait.





» CFRT Homicide Case Reviews

The CFRT reviewed five (5) homicides, of which one (1) was attributed to fatal child abuse.

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

Table 4: CFRC Homicide Decedent Demographics - Causes of Death and Risks		
DECEDENT DEMOGRAPHICS/ WARD OF RESIDENCE	CAUSE OF DEATH	ASSOCIATED RISK FACTORS
2-year-old/Black-AA/Male Ward 8	Blunt Force Trauma	Caretaker Substance Abuse Family Child Welfare Involvement Family History of Economic Instability
16-year-old/Black-AA/ Female Ward 6	Gunshot Wound	Decedent Substance Abuse School Truancy History of Involvement with Child Welfare Family History of Economic Instability Gun Play
17- year-old/Black-AA/ Male Ward 8	Gunshot Wounds	School Truancy History of Involvement with Child Welfare History of Involvement with Juvenile Justice Decedent substance abuse Family History of Economic Instability Family History of Intra-Family Violence
19-year-old/Black-AA/ Male Ward 8	Gunshot Wounds	School Truancy History of Involvement with Child Welfare History of Involvement with Juvenile Justice Decedent Substance Abuse Family History of Economic Instability
16-year-old/Hispanic Male Ward 4	Gunshot Wound	Neighborhood Gang Activity

As shown in Table 4, youth homicide cases reviewed by the CFRT involved decedents between the ages of 2 and 19 years old. The case reviews revealed how the decedent's environmental risk factors are similar to the nationally recognized risk factors identified by the National Center for the Review and Prevention of Child Deaths (NCFRP, 2016).

Children and youth experiencing economic instability are at risk. Truant youth, and those with frequent child welfare or juvenile justice contacts, are at greater risk. This indicates an opportunity for child welfare and juvenile justice agencies to proactively collaborate and address the needs of this high-risk population of children and youth. Exposure to and early drug use are contributory risks. Record reviews also indicated 3 of the 4 youth homicide victims were actively using marijuana. This provides an opportunity for further research on the implications of marijuana use among children and youth, available treatment options for this population within the District of Columbia, and securing youth engagement in such programs.

As the perpetrator remains unknown in the one (1) fatal abuse case, the case discussion encouraged the vigilant observation and engagement with caretakers and parents of toddlers attending childcare facilities. This engagement with caretakers and parents can occur during the drop-off and pick-up times within daycare facilities. Such a high level of engagement with parents and caretakers will provide child care center staff with an opportunity to learn about the family's support system and create an environment in which parents and caretakers will openly discuss their needs to ensure the overall wellbeing of the child. Marijuana use was also a contributory risk factor observed in this one (1) fatal abuse case reviewed by the CFRT.

The homicide case review findings included the need to teach children and youth to have healthy relationships, particularly amongst teenagers engaging in intimate partner relationships. As discussed during case review meetings, this is an issue that is addressed through the DCSC Court Supervision Services, the agency that provides probation services for non-adjudicated youth. Members from the Office of the Attorney General, DCSC Court Supervision Services and the Department of Youth Rehabilitation Services engaged in an information exchange with members and participants of the CFRT in 2019. All three agencies are diligently working to address the youth engagement in criminal activity and those environmental and mental health issues that lead to recidivism among youth involved in the District's juvenile justice programs. Members also agreed there is a need to further discuss the continuum of care for committed youth who require inpatient mental health treatment that will also address their individual educational needs. A subcommittee, led by CFSA member and Principal Deputy Robert Matthews, will convene in 2020 to develop a recommendation for this system improvement.





» Agency Spotlight - Office of the Attorney General

Death by gun violence in Washington, DC is one of the most serious public safety and public health concerns we are facing. We know that gun violence thrives in economically disadvantaged communities - where poverty, joblessness, lack of stable housing, and food insecurity are rampant. Gun violence attacks unstable homes, when poverty, mental health illness and substance abuse are present, families and children are at risk. The trauma inflicted upon our young people by gun violence cannot be underestimated - our city's young people are affected by this crisis - as perpetrators and victims. This communal loss has devastating long term, generational effects. City agencies, non-profit partners and our communities must be united in our mission to find the cure to this deadly disease.

In 2019, CFRC reviewed four cases involving youth where the death was the result of homicide with a firearm. Unfortunately, this sad truth does not tell the whole picture of how violence - particularly gun violence - touches the lives of many young people who live in the District of Columbia. The Office of the Attorney General (OAG) prosecutes youth who are arrested in our city. OAG attorneys regularly engage with youth arrested for carrying guns, committing robberies with guns, shooting others with guns, and even killing with guns. We have learned that youth carry guns for a variety of reasons - for personal safety, peer pressure, to seek acclaim amongst peers, or because guns are "cool" and make a young person feel important. We have also learned that youth have easy access to guns. Illegal firearms are passed around friend groups or are "rented" and "sold" throughout our communities.

When youth are arrested in Washington DC, OAG is charged with the responsibility of addressing the dual goals of public safety and the care and rehabilitative needs of youth who touch the

juvenile justice system. To further these goals, we try to identify the rehabilitative needs of a youth upon first touch with the justice system - we make an effort to discern why the youth is involved in the criminal conduct in the first place, and then we take steps to address the underlying reasons in an effort to support the youth so that the conduct isn't repeated. Often this is achieved through comprehensive diversion programs including ACE Diversion, that provide mentoring, academic and mental health support for system involved youth, or our Restorative Justice Program that brings perpetrators and victims together to discuss the harm that occurred and figure out ways for both parties to move past the incident in a structured, supportive conversation moderated by trained facilitators. We are using Restorative Justice to reach youth charged with gun offenses in hopes that these facilitated conversations, along with Cognitive Behavioral Therapy, will help them make better decisions. Through a more typical prosecutorial process, we also work with the Court Social Services Division and the Department of Youth Rehabilitative Services to find the best placement, programming and supports for youth in the justice system. The thing we know most, is that the less a youth penetrates the justice system, the better the outcome for the youth.

To that end, OAG is committed to exploring and implementing innovative, data driven solutions to reduce the incidents of gun violence amongst the children of our city. We must work together to find a solution to stop this public safety and public health crisis.

Elizabeth A. Wieser

DEPUTY ATTORNEY GENERAL FOR THE
PUBLIC SAFETY DIVISION

OFFICE OF THE ATTORNEY GENERAL FOR
THE DISTRICT OF COLUMBIA

» CFRT Natural Deaths Case Reviews

As shown in Table 5, the CFRT reviewed ten (10) cases involving the natural deaths of children. Six (6) of the natural death cases involved Black/African American females, two (2) Hispanic females and one (1) white male. One (1) case involved a male of Kuwaiti decent. These decedents were medically fragile and required more frequent medical management of chronic conditions. The causes of deaths were identified as follows:

TABLE 5; CFRT 2019 CAUSES OF NATURAL DEATHS

Table 5: CFRT 2019 Causes of Natural Deaths	
CAUSE OF DEATH	TOTAL NUMBER OF DEATHS
Cerebral Injury	3
Cancer	2
Complications of Prematurity	1
Diabetes	1
Infection	1
Congenital Anomaly	1
Respiratory Distress Syndrome	1

Medical malfeasance was not observed in the fatality reviews of these natural death cases. Case reviews revealed the intricate needs of chronically ill children participating in the District’s Medicaid program, and the importance of care coordination. As observed in the natural death case reviews, parents and caretakers need assistance with navigating the spectrum of services available as participants in managed care organizations.

» CFRT Accidental Death Case Review

TABLE 6; CFRT ACCIDENTAL CASE REVIEW

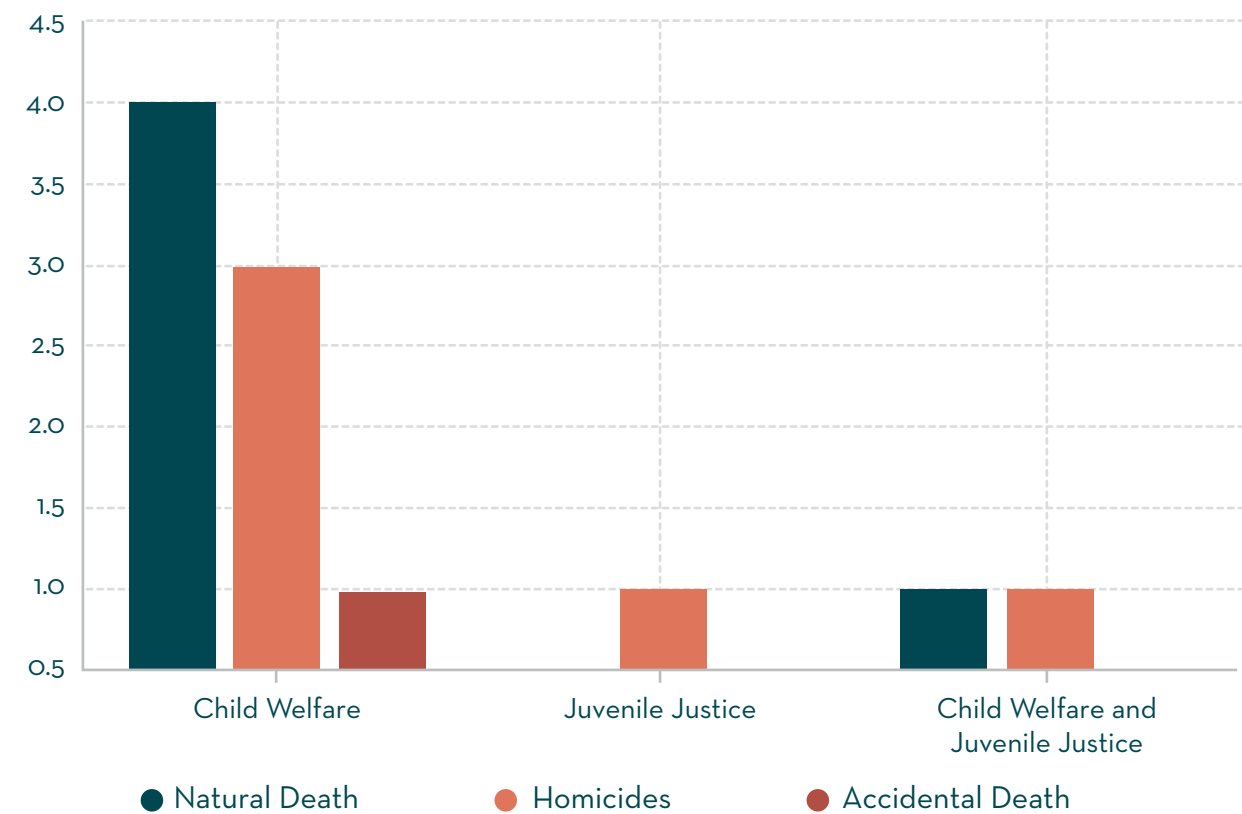
Table 6: CFRT Accidental Death Case Review		
DECEDENT DEMOGRAPHICS	CAUSE OF DEATH	Associated Risks
3-year-old/Black-AA/Male Ward 8	Drowning	Unsupervised Child Global Developmental Delays

Most recently, the CFRT has reviewed cases involving medically fragile children, many with global developmental delays. Review findings included the need to address the caretakers’ systemic barriers that may increase stress and impede successful outcomes for this special population of children. Successful outcomes for medically fragile children include their regular participation in medically necessary treatment, participation in recommended home health care programs, and successful engagement in academics.



The CFRT is mandated by statute to conduct retrospective fatality reviews of children and youth involved with the District of Columbia’s child welfare and juvenile justice programs. The complexity of these cases provides an opportunity to observe and discuss the adverse childhood experiences of those children and youth involved with these systems. Of the CFRT decedents (N=16), ten (N=10) died due to natural deaths, five (N=5) due to homicides, and one from accidental death (N=1). Recurring topics discussed involved medically fragile children, children and youth with special education needs, and substance use among youth. Most of the cases reviewed by the CFRT were children and youth who were involved⁴ with the District of Columbia’s child welfare program (N=11). Five (5) were children with chronic illnesses.

FIGURE 22: CFRT SPECIAL POPULATION KEY FINDINGS



Four (4) natural death child welfare decedents and one (1) accidental death decedent required assistance with daily medication management. Two (2) of these decedents had in-home nursing care. Eight (8) of the child welfare and juvenile justice decedents had documented Individual Education

⁴ CFRC Statute mandates the review of child welfare decedents whose deaths occurred within 5 years of their involvement with child welfare, 2 years for decedents involved with juvenile justice and 2 years for decedents involved with the Department on Developmental Services. None of the cases reviewed during the 2019 review year included decedents who were involved with the Department on Developmental Services.

Plans with learning disabilities that were diagnosed in their early childhood school environment. Two (2) decedents had dual involvement with both child welfare and juvenile justice programs. Both were youth whose complicated cases required the broad involvement of community-based organizations and government agencies. Compromised family networks, unaddressed mental health issues and school disengagement significantly impacted the academic achievement of these youth.

Three (3) of the homicide decedents had child welfare involvement within five(5) years of the fatal event. Two (2) were victims of gun violence and one (1) was a victim of fatal abuse. The circumstances surrounding these deaths indicated the prevalence of domestic violence and its associated trauma that was unaddressed.

The CFRT discussion of these special populations will continue during the 2020 review year. This includes improving user navigation of the Medicaid system of care since the child welfare and juvenile justice decedents were participants in the DC Medicaid program. Care coordination of medical, social, and educational services for children and youth with overlapping involvement with child welfare and juvenile justice programs requires systemic collaboration.





Recommendations

The CFRC adopted two recommendations for dissemination to District Government Agencies. The recommendations address (1) the collaboration of the Metropolitan Police Department and the Child and Family Services agency that will increase protective actions for children present during police investigations and (2) ensuring social work intervention as a required response for families with young children residing in the District of Columbia's shelters.

RECOMMENDATION FOR THE METROPOLITAN POLICE DEPARTMENT (MPD) AND THE CHILD AND FAMILY SERVICES AGENCY (CFSA): During investigations in which the Metropolitan Police Department is assessing scenes that involve potential alleged child abuse or neglect, the officers on the scene should contact CFSA to initiate an investigation before releasing minors to interim caregivers.

Agency Response:

The Metropolitan Police Department agrees with this recommendation with modifications. During investigations in which the Metropolitan Police Department is assessing scenes that involve potential alleged child abuse or neglect, the officers on the scene should contact CFSA to initiate an investigation. CFSA should make the decision as to who would be best caregiver suited to take possession of minors.

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

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

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

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

Indicator and measurable outcomes will include the number of cases where MPD members and CFSA coordinated on abuse/neglect investigation to determine the appropriate caregiver for the minor child. This will be conducted on a monthly basis.

The Child and Family Services Agency agrees with this recommendation as it is currently in accordance with our agreement with Youth Division when there is suspected abuse or neglect involved when officers are responding on the scene. If the intent is to expand this practice to other Divisions within MPD we concur with that recommendation.

RECOMMENDATION FOR THE DEPARTMENT OF HUMAN SERVICES (DHS):

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

Agency Response:

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

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

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

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

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

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





In Memoriam

The CFRC expresses our deepest sympathy for the loss of **Ms. Claudia Booker.**

Ms. Booker was a trailblazer and steadfast advocate for positive health outcomes for the families of the District of Columbia.

As a member of the CFRC since 2008, Ms. Booker's passion and presence will be greatly missed.



Acknowledgments

We express our sincere appreciation for the members and participants of the DC Child Fatality Review Committee.

Your continuous advocacy on behalf of the District of Columbia's endeavors to improve outcomes for our most vulnerable residents. Thank you for your service.



Government of the District of Columbia
Office of the Chief Medical Examiner

FATALITY REVIEW DIVISION

📍 401 E. STREET SW 6TH FLOOR
WASHINGTON, D.C. 20024

☎ (202) 698-9000

