Washington City Paper

How the District's Children Die

Stories of a city failing its most vulnerable wards.

By Jason Cherkis
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Every year between 130 and 160 children and youth die in the District—by murder, by suicide, by infection, by falls, by a fire that broke out from a candle being used to heat a house, by neglect. We didn't know them in life—how they were born premature, how they had a beef with a kid in the neighborhood that escalated, how they fell through the cracks on the city's watch.

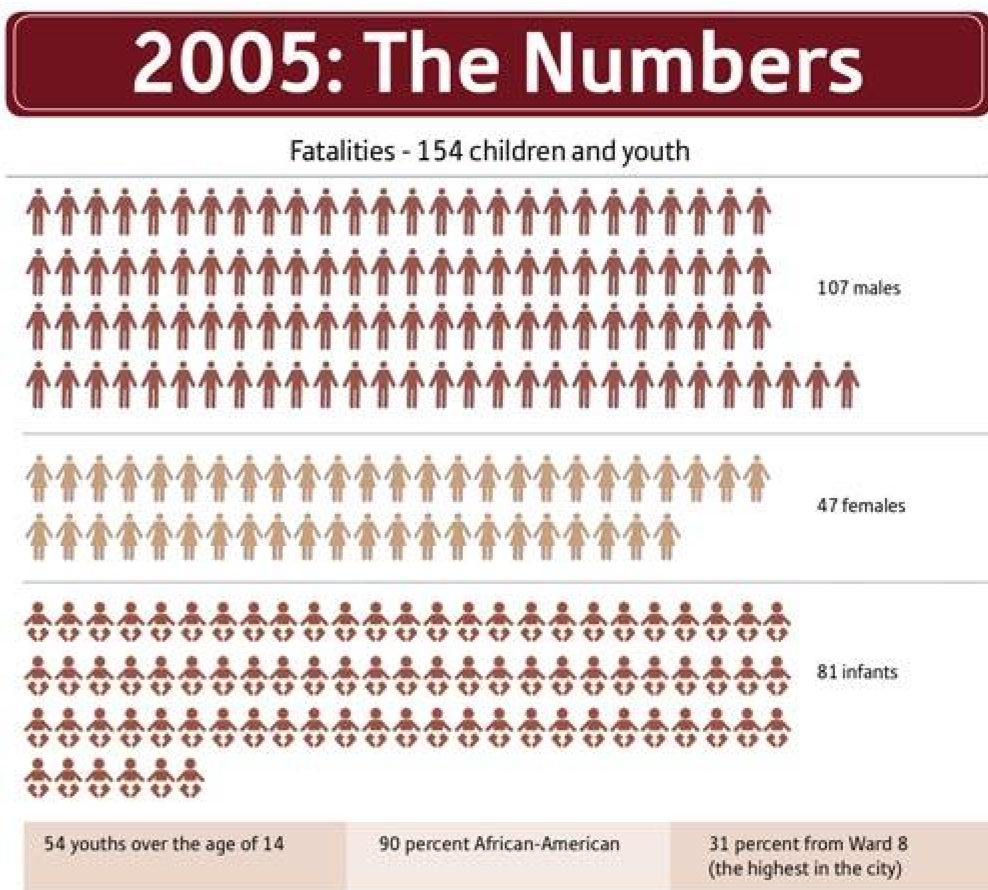
For each one, someone kept a record of their death. A doctor recorded the respiratory disorder on a chart. A cop started a murder investigation. A social worker kept a file.

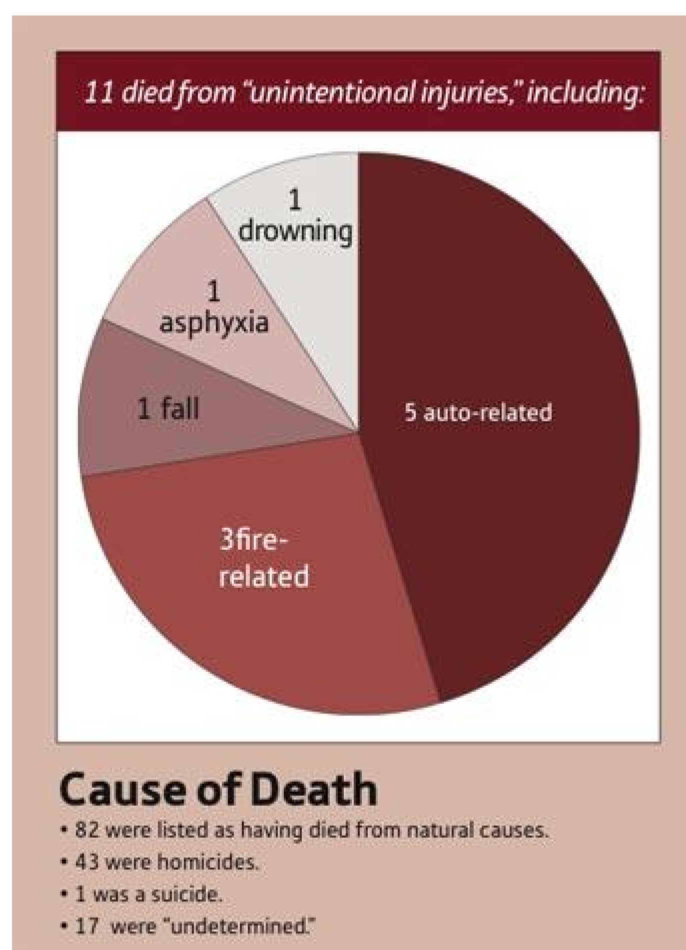
The District government puts it all together: compiling statistics, taking medical histories, interviewing mothers, studying social-worker files. And each year the Child Fatality Review Committee issues a public report—the one from 2007 is the most recent available—on its obit work. Much of it is statistics.

The committee tabulates and catalogs the deaths by age, gender, race, ward, cause, and so on. The demographics rarely shock; most of the dead are African-American males from the poorest wards, and many died under the monitoring of a social worker. Of the youth who died from homicides in 2006, 56 percent had been known to the Child and Family Services Agency (CFSA).

Hundreds of dead kids get analyzed in the report. Only a handful become case studies written by the committee for the public record. There are no names. Their identities have been obscured. The neighborhoods where they lived and died are omitted. We do get to know the details of their final days. The stories are essentially and essential autopsies of how a city can fail its most vulnerable wards.

Committee authors start with the circumstances of death. They then chronicle the chain of social workers, probation officers, mental-health counselors, and others who were charged with their care. Many of the narratives end with a jolt: Somebody was paid to protect these kids, sometimes from their parents, sometimes from themselves.





Juvenile Justice Histories

- 29 of the 154 fatalities were known to the juvenile justice system.
- 100 percent were African-American.
- 97 percent were males.
- 80 percent had had multiple arrests. 62 percent had active cases at the time of their deaths.
- 12 youth were under law enforcement supervision or in a District facility.
- In six of the active cases, the youth were AWOL from the system.
- 79 percent had known histories of drug use or involvement.
- 2 had received high school diplomas; 11 had dropped out; 13 were in school. 13 were also known to CFSA.

Case Study No. 1: Natural Death of a Young Child

"One winter evening, a 6-year-old female child, FT, was brought to a local pediatric hospital in critical condition by ambulance and accompanied by a relative. Medical records indicated that there were no signs of trauma or injury; her brain was swollen, but there was no bleeding present. On the day after hospitalization, FT coded and had to be resuscitated. A brain study was performed which indicated that there was no brain activity….

The grandmother reported that FT had eight teeth pulled at a local university several weeks prior, but she appeared fine. She reported no history of falls, fights, accidents or known illnesses. She stated that FT played outside and was very active, playing with the other grandchildren who were at her home.

The maternal grandmother further reported that at approximately 7:00 pm on the day prior to FT's hospitalization, she woke up complaining that her stomach and legs were hurting. She offered her something to eat, but she refused; she gave her some ginger ale to soothe her stomach and a half dropper of children's liquid Tylenol.

The child also complained of her ear hurting so she placed toilet tissue in [her] ear in the absence of cotton ball[s]. The grandmother indicated that FT's head felt warm so she assumed she had the flu. Her symptoms continued and she was given another dose of Tylenol with ginger ale. The next day, FT did not get out of bed.

She slept and sporadically watched television. She ate a little soup and drank a little ginger ale. She was given more Tylenol and she went back to sleep. FT became weaker and began complaining of pain in her legs and was unable to walk unassisted. The grandmother rubbed her legs with an ointment to soothe the pain. On the day of her hospitalization, FT began talking incoherently and laughing and crying inappropriately. It was at this point, that the grandmother realized she could no longer treat the child and sought medical attention.

Based on a review of the child's dental records, she was taken to a clinic in early January, escorted by her school teacher, who had acquired consent from her mother for a special dental program that provides dental services to needy children. During this one visit, FT had eight teeth extracted, which were described as 'rotten.'

Prophylactic antibiotics were not given [to FT] prior to the procedure. Additionally, antibiotics were not given

following the procedure and were not prescribed as part of the discharge instructions. In addition to the extractions, FT received several fillings and was given Fluoride treatment.

The discharge instructions which were provided to the teacher included: stay home for 24 hours; use Chloroseptic mouth wash as needed; use Advil 200 mg for fever and or pain, and see physician in 72 hours. Based on a review of school records, FT returned to the school with [her] teacher. The school nurse noted as part of Progress Notes the following: 'Gauze packing applied to tooth extraction sites with noted decrease in amount of bleeding.' The nurse's notes also documented that the mother picked FT up from school and that she 'gave her instructions to follow to relieve further bleeding from her gums and to contact the doctor immediately if the bleeding continued or increased.'

The mother did not speak to the dentist or clinic staff and it was unclear during the case review meeting whether she fully understood the importance of follow-up with the pediatric physician or the significance of symptoms of fever and lethargy that ensued over a two-week period.

Cause/manner of death: Acute Bacterial Meningitis/Natural"

Case Study No. 2: Abuse Death

"At approximately 8:37 am a 911 call was made for a report of an unconscious child. Upon arrival of the emergency response team, the victim was immediately noticed lying face down with his hands tied behind his back. The caller reported that the child was discovered face down in a tub full of water with his hands and feet bound.

The victim was pulled from the tub and CPR was attempted although medics advised that there were no signs of life. The body was wet and clammy; with rigor mortis noted in the lower legs; and the lower [jaw] was rigid. The body was noted to have abrasions on the left side of the face and to the left side of the back. There were also old scars noted on the left and right lower leg.

Death was apparent and the victim was pronounced dead on the scene. During the investigation, a relative admitted to killing the child and based on the evidence was arrested and charged with the murder."

Case Study No. 3: Accidental Infant Death

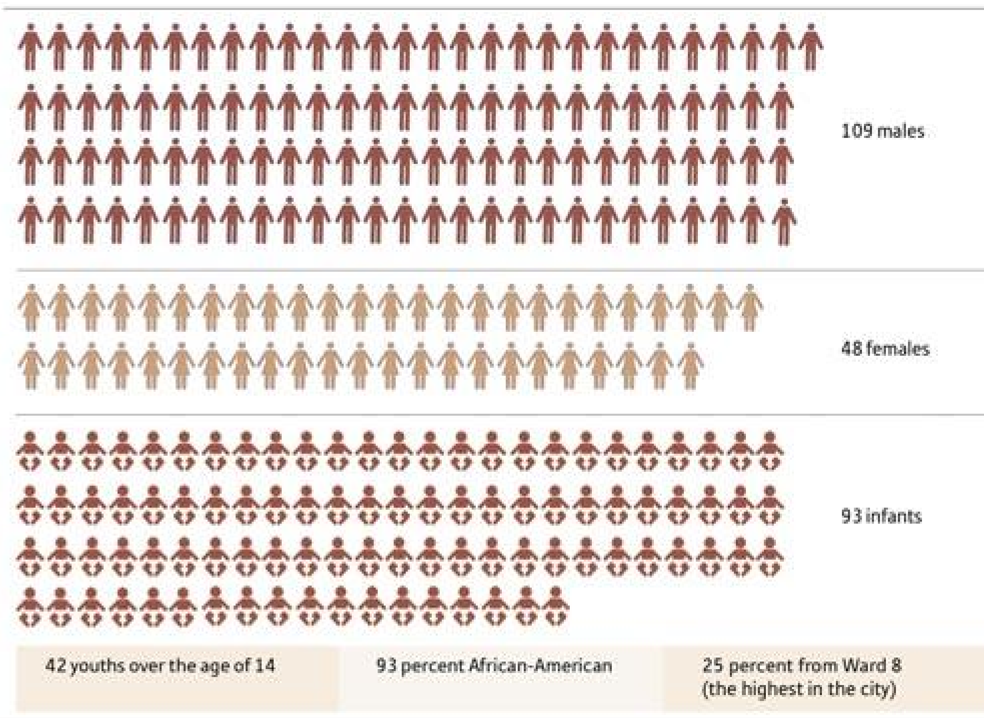
"At 2:30 a.m., the Office of Unified Communications Center received a 911 call concerning a fire at a residence where the mother, an infant and other family members resided. The Fire Department responded to the scene and fire fighters entered the apartment and discovered the infant lying in the crib in the rear bedroom. The infant was transported to the nearest hospital where she was noted to have no signs of life and severely charred.

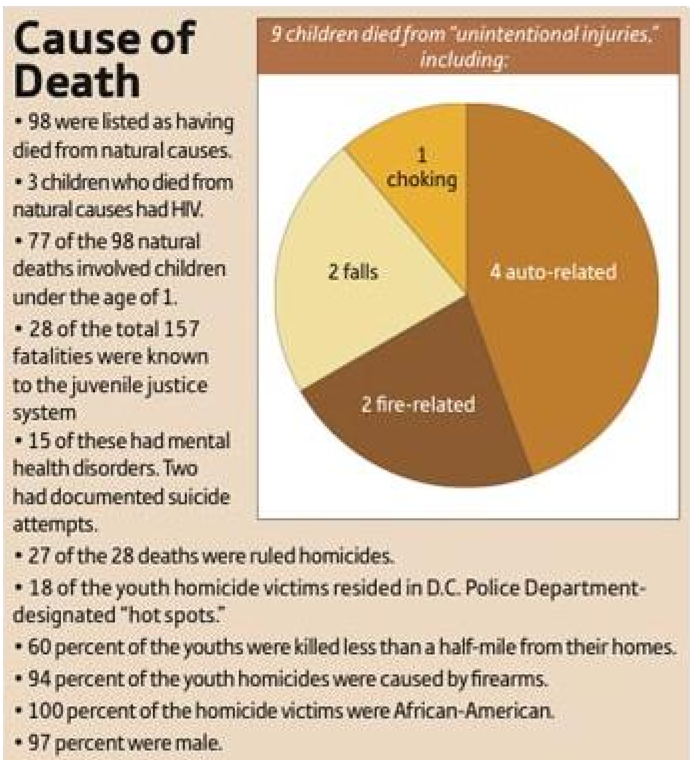
She was pronounced dead at 2:50 a.m.

The mother reported that she and the father of the infant had gone out for the evening leaving the infant and other children in the care of an adult relative. Prior to leaving the mother reported that she checked on the infant who was sleeping in her crib; and she lit a candle which was in a candle holder that was attached to the wall in the child's room.

According to the mother she was using candles because the electricity had been turned off in the apartment two weeks prior to the fatal incident due to lack of payment. During the review it was revealed that the mother had applied and been approved for energy assistance however the electric company was unaware of the approval.

The cause of the fire was the candle which ignited combustible items in the room causing extensive damage to the walls and ceilings where the child was sleeping."





The committee found:

- **More than 50 percent of the 2006 child welfare youth over 13 years old had histories of drug use, 31 percent were diagnosed with mental health and behavioral disorders, and 29 percent had chronic health problems.**
- **One 15-year-old disabled child had never attended school.**
- **16 of the 32 school-age children were enrolled in special education or alternative programs.**
- **30 percent of the youths were homicide victims.**
- **75 percent of the families were referred to the child welfare system multiple times. "The number of reports ranged from one to 49, with an average of four reports per family," the committee wrote.**
- **At the time of death, 25 percent of the child welfare fatalities had families with active cases.**
- **75 percent of the families were referred to the child welfare system multiple times. "The number of reports ranged from one to 49, with an average of four reports per family," the committee wrote.**

Case Study No. 1: A Homicide

"On 3/1/06, MPD responded to a report of a shooting in the rear of a residential area in the SE quadrant of the city. Upon arrival on the scene, officers located the body of an unidentified Black male suffering from an apparent gunshot wound to the head. FEMSD responded to the scene and found no signs of life….

Based on information from the investigation, the victim was shot while standing on the street with several other youth….The motive for the death was retaliation and was related to a previous robbery. There were witnesses to the fatal crime, and a 20 year old, Black male suspect was identified. Records indicate that the victim and perpetrator were acquaintances and resided in the same neighborhood. Additionally, both the suspect and the victim were known to the District's juvenile justice systems….

At the time of the death, the victim was in abscondence from the juvenile justice system and was also known to the District's mental health, substance abuse treatment and public assistance programs….The victim was academically two grades behind grade level and had a history of truancy with the DC public school system. Records indicate that he aspired to be a basketball player and he reported that his greatest challenge was 'the world.'"

Case Study No. 2: A Natural Death

"A 13 year old youth, with a medical history of cerebral palsy and mental retardation, was found by a relative in his NE home, along with his mother in an unconscious state on the floor.

The youth was transported by emergency medical services to a local hospital. It was determined that he was suffering from pneumonia, dehydration and malnutrition. Based on the investigation, it was also determined that the mother had died from a drug overdose at least one day prior, leaving the youth without any means of care or support."

The report states the cause of death: Lung Collapse due to Pneumonia, Sepsis, renal failure/natural.

Case Study No. 3: HIV/AIDS Natural Death

"As an African American teenage male born HIV positive, JB longed to be reunified with his mother and infant sibling. JB was known to the District's child welfare system since the age of 10, as he was left alone while his mother was shoplifting. A total of six neglect allegations were reported between 1998 and 2003.

As a result, JB experienced multiple living arrangements between foster care placements, and relatives. JB worried frantically about his mother, who was homeless, and a substance abuser. He absconded from placements on numerous occasions in order to search for his mother, and exhibited unpredictable behaviors, such as excessive crying and biting.

Child welfare services had difficulty arranging both medical and mental health services for JB, who at the age of 12, refused to participate in services offered. A relative became his legal guardian, however he continued to refuse medical treatment.

JB also experienced school failure; and school officials reported that [when] he did attend he was 'ill, and sick looking.' Concerned about other kids knowing about his illness, he completely withdrew from school in 2005, and was reportedly uncooperative with the home schooling program.

In the summer of 2006, JB presented to a local emergency room with a five-day history of coughing, chest pains and chills. He coded, and medical interventions were futile.

Although child welfare services were being provided to the family at the time of his death, records indicate that services for JB terminated in 2003, without specific reasoning. The review confirmed that JB's medical needs were not properly addressed, and multi-disciplinary planning was not implemented for JB and his caretakers, which should have included community-based resources for teens living with HIV/AIDS."

Case Studies No. 4 and No. 5: Double Homicide In Benning Heights

"[On] a brisk morning in the SE quadrant of the District, MPD 6th District officers were called to the scene of an apparent shooting of two young African-American males. Victim #1 was suffering from a gunshot wound to the right side of the chest and Victim #2 was suffering from a gunshot would to the head….both were pronounced dead on the afternoon of the day of the shooting….

Victim #1 was over 18 years of age and at the time of his death was not a District resident. He was known to the juvenile justice system and his case had terminated approximately 1 year prior to his death….As a result of this involvement with the juvenile justice system, he had received a range of services within the District. His mentor had reported that 'he was a strong individual with endless possibilities.'

Victim #2 was known to the District's child welfare and juvenile justice systems at the time of his death. As a three-year old, he witnessed the violent death of his father. Later, he would experience the grief of losing three younger siblings to premature birth; he also witnessed the fatal stabbing of an uncle.

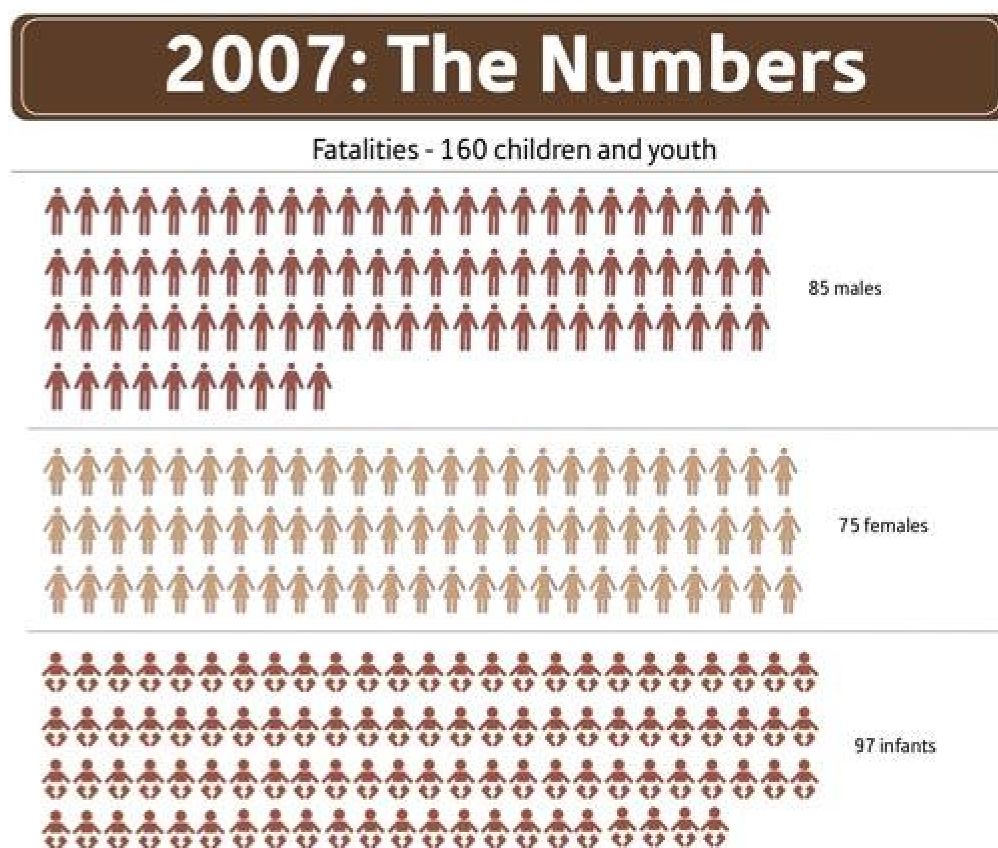
In 2001, due to his poor behavior as a 5th grade student, school officials referred him to the Persons in Need of Supervision Program (PINS) through the DC Superior Court and he began a series of inpatient psychiatric hospital

stays.

Records indicated that his mother was emotionally and physically unstable, which created an unstable home environment. At the age of 12, Victim #2 admitted to watching his mother abuse drugs. He also admitted that he used marijuana and PCP. At the age of 13, he began to commit criminal acts, which led to his commitment to the District's juvenile justice system.

After having escaped from residential treatment at the age of 14, he was involved in a physical altercation and received serious injuries that required hospitalization. He again returned to the custody of the juvenile justice system, and was subsequently returned to his home. His mother reported to government officials that she knew 'he had a gun.' He continued to participate in criminal activities that led to further juvenile arrests and remained committed to the juvenile justice system until his death at the age of 16.

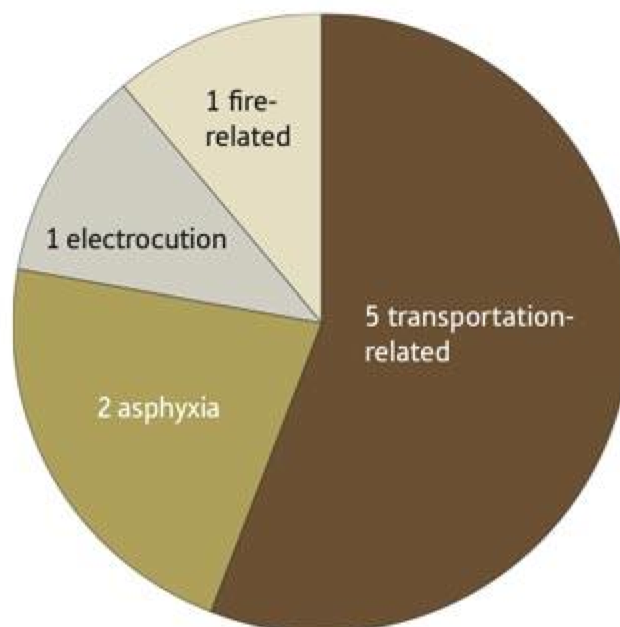
The Committee's review of Victim #2 found that he had been referred for numerous community-based and government services however there were several systemic concerns associated with the services provided. Records indicated that providers and government agencies did not share information regarding the services provided, and providers were not evaluated for their effectiveness. Victim #2 never gained the ability to appropriately cope with the loss of significant persons in his life, and continued to abuse drugs….he never maintained regular school attendance….The committee was able to associate Victim #2 to the death of two other [reviewed] 2006 homicides."



Cause of Death:

- **103 were listed as having died from natural causes.**
- **86 natural deaths involved children under 1 year old.**
- **3 children had HIV/AIDS.**
- **10 deaths were "undetermined."**
- **38 children died from violent acts.**
- **36 of these deaths were ruled homicides.**
- **32 of these deaths were the result of youth violence.**
- **Ninety-seven percent of these were caused by firearms.**
- **100 percent of these decedents were known to the District's public-assistance program; 38 percent were receiving services.**
- **50 percent had a diagnosed mental illness and received public mental health services.**
- **53 percent were known to the District's juvenile justice system.**
- **34 percent reported dealing with issues of grief and loss.**
- **38 percent were known to the District's child-welfare system.**
- **21 of the 160 fatalities were youth known to the juvenile justice system within the two years prior to their deaths.**

- **1 was a suicide.**



Case Study No. 1: Abuse Death

“At approximately 2:00 PM, DC medics responded to a report of a toddler ‘having breathing difficulty.’ CPR was performed on the scene and in route to the hospital. Once at the hospital life saving measures continued but failed; the child was pronounced dead at 3:35 PM. Investigation revealed the child had been in the care of the mother’s paramour, who eventually admitted to ‘accidentally killing the child.’

Cause/Manner of death: Blunt Impact Trauma of Torso with Lacerations of Liver, Spleen, Pancreas, Kidneys and Right Adrenal Gland/Homicide.”

Case Study No. 2: A Suicide

“DC Medics arrived on the scene and found a teenage victim lying on the floor, unconscious and unresponsive, suffering from a gunshot wound to the head. Resuscitation efforts were initiated on the scene and continued in route to a local hospital. Life saving measures continued in the hospital emergency room; however, efforts failed and the victim was pronounced dead approximately one hour after arrival.

Based on the investigation, the events leading to the death involved a domestic dispute between the victim and his significant other. As the argument began to escalate, the victim began making suicide threats.

Based on family members interceding, the argument subsided several times and would then resume shortly afterwards. After approximately an hour, a relative reported hearing a loud noise and then the victim’s paramour scream repeatedly, ‘he shot himself.’

The investigation revealed the decedent had threatened to take his life numerous times prior to the fatal incident. It was also revealed that friends were aware that the decedent had a gun and on at least one other occasion had placed the gun to his head and threatened to [shoot] himself.

The victim had an extensive history with the mental health system but was non-complaint with his treatment and medication during recent years. Based on the autopsy, the victim had experienced significant losses as evident by several tattoos observed during the examination. His toxicology screen at autopsy was positive for methamphetamines.”