

# Child Fatalities, 2013

**Statistics, Analyses, and Recommendations**



**D.C. Child and Family Services Agency**

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## Overview

The 10th Annual Child Fatalities Report describes the trends, findings, and practice recommendations from reviews of deaths children known to the Child and Family Services Agency (CFSA) within four years of their death.<sup>1</sup> A known child or known fatality is one where the family had contact with CFSA within four years of the fatality. All fatalities occurred in the District of Columbia during 2013, and were known to the Child Fatality Review unit of CFSA's Quality Assurance division (hereafter QA) as of February 1, 2014.<sup>2</sup>

An important trend is the steady decline over the past five consecutive years of fatalities of children known to CFSA. Although this decline coincides with decreasing caseloads for CFSA, the decline in the number of deaths of known children (as defined above) is still more rapid than the decline in number of children CFSA actually served. Deaths of known children declined 48 percent between 2009 and 2012 while the foster care population declined 36 percent during the same time period. There was also a 24 percent drop in the number of families served in their homes.<sup>3</sup> At the same time, the number of investigations increased every year between 2009 and 2012, increasing the number of families with recent child welfare involvement at least at the investigation or family assessment stage.<sup>4</sup>

Among the observations from the 2013 reviews are the following:

- Deaths connected to unsafe sleeping arrangements appear to be occurring among older mothers.
- Abuse homicides involving children known to CFSA, as well as those with no prior history, disproportionately affect the very young (two years old and under).
- Gunshot homicide remains the principal cause of death for known youth 17 and older.
- Parental substance abuse continues to play a role in child fatalities. Four of the 2013 fatalities had a known or potential link to parental substance abuse.

Currently, the number of deaths in 2013 follows the decreasing trend in 2012 but also marks the lowest number of deaths in the last 10 years (Table 1).

<b>Table 1: Ten-Year Trend in Deaths of Known Children and Youth</b>											
Year:	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	
Deaths of Known Children	59	53	59	44	68	50	33	26	25	24	
Non-Abuse Homicide	21	15	16	14	21	19	9	11	3	9	
Abuse Homicides	4	2	0	0	8	4	4	0	1	2	

Tables 2 through 5 highlight some of the characteristics of the 24 fatalities that occurred in 2013.

<sup>1</sup> CFSA follows the guidelines that govern the citywide Child Fatality Review process, which can be found in DC Official Code §4-1371.05 (a) (2).

<sup>2</sup> The number of fatalities for 2013 may not be complete due to notification of some fatalities months after a child's death. CFSA is committed to making the information in this report available as early as possible so that the findings and conclusions may lead to prompt action where necessary.

<sup>3</sup> Source: Management Report CMT 232, run March 15, 2009 and March 15, 2013.

<sup>4</sup> Source: Management Report INV 054 run March 15, 2014.

Table 2: Manner of Death		
<i>Out of 24 deaths, more than 1/3 were homicides.</i>		
Natural	5	(21%)
Homicide	9	(38%)
Abuse Homicide	2	(8%)
Accident	2	(8%)
Suicide	0	(0%)
Undetermined	2	(8%)
Pending	4	(17%)
Total	24	

Table 3: Child Welfare Case Status		
<i>CFSA had current involvement with six families at the time of the fatality.</i>		
Closed case	10	(42%)
Active case	2	(8%)
Closed investigation, no case	8	(33%)
Active investigation <sup>5</sup>	4	(17%)
Total	24	

Table 4: Age of Decedents		
<i>One third of the decedents were younger than age 2, and a quarter were over age 17.</i>		
<24 months	8	(33%)
2-6 years	4	(17%)
7-12 years	3	(13%)
13-16 years	3	(13%)
17+ years	6	(25%)
Total	24	

Table 5: Gender of Decedents		
<i>The decedent was male in two thirds of the fatalities.</i>		
Males	16	(67%)
Females	8	(33%)
Total	24	

## Significance of Pending Reports

The Office of the Chief Medical Examiner (OCME) determines the cause and manner of death for child fatalities in the District of Columbia. Table 2 above lists the causes for 18 of the 24 children included in this report at the time of this writing. Two fatalities have been officially declared “undetermined.” Four fatalities remain pending. In this report, we provide all findings according to the available data.

## Continuing Trends

The following trends have been noted in previous years and continue to be evident in 2013:

- **More than 90 percent of the children who died in 2013 were African American, which is consistent with the population CFSA serves.**

Over 95 percent of children in the District’s foster care population are African American.<sup>6</sup> Twenty-two (92 percent) of the children who died were African Americans. Two (8 percent) were identified as Hispanic.

<sup>5</sup> This number includes one family that had both an open case and an open investigation at the time of the fatality.

<sup>6</sup> As of Dec. 31, 2013, the percentage was 96.6%. Source: FACES.net management report PLC 156.

- A quarter of the fatalities occurred on open cases or active investigations.**  
Table 3 above indicates that CFSA had active involvement with six families at the time of the child's death. Of these, three were active investigations and two were active cases, including one family that had both an active investigation and an active case. None of these fatalities was due to abuse: two were accidental, one was natural, and one was a non-abuse homicide. The other two remain pending as of this writing.
- Abuse homicides continue to be rare.**  
Fatalities that occur at the hands of a parent, legal guardian, or other caregiver are considered to be abuse homicides. Of the 24 known child fatalities in 2013, two (8 percent) children died from abuse.
- The youngest continue to be most vulnerable.**  
As shown in Table 4, eight (33 percent) of these 24 children were younger than age 2. There was no other age group with this number of child deaths.
- Males continue to be overrepresented.**  
As indicated in Table 5, 16 (67 percent) were males.
- Inappropriate sleeping or bed sharing was associated with a significant number of infant deaths.**  
In 2011, no child known to CFSA died while bedsharing or in an unsafe sleeping arrangement. There were four such deaths (16percent) in 2012, and five (21 percent) in 2013. One of these deaths was attributed to Sudden Unexplained Infant Death but associated with unsafe sleeping conditions. The Medical Examiner could not determine the manner of death. The cause and manner of death of the four remaining infants are pending the results of an autopsy. In addition, one of the fatalities of families with no prior contact with CFSA involved bed sharing.

## Background and Methodology

The fatality review process is a vehicle to assist CFSA in improving case practice, correcting deficiencies, strengthening child protective performance, and identifying systemic factors that require citywide attention - all with the goal of reducing preventable child deaths. The report also informs the public of CFSA's efforts to ensure the safety of children in the District's care. Unless otherwise noted, fatality data presented here represent information known as of February 1, 2014.

The District has a two-tiered process for reviewing child fatalities.

At the macro level, the citywide Child Fatality Review Committee (CFRC) identifies broad systemic issues that influence child fatalities. Under the auspices of the

### Focus of the Internal Child Fatality Review

- Did CFSA take every action and make every reasonable effort to ensure the safety of the child and other children in the household?
- Does this child fatality reveal any practice, training, or policy issues that we need to resolve? Are there other systemic issues such as supervision, staffing, access to records etc.?
- Knowing what we know now, what would we do differently?
- What interagency issues should we present to the Citywide Child Fatality Review Committee?
- Did parental or familial behavior factors contribute to the fatality?

Office of the Chief Medical Examiner (OCME), CFRC is a multidisciplinary review team comprised of representatives from public and private agencies working in education, health and mental health, human services, jurisprudence, law enforcement, public safety, and from the community. OCME also issues annual reports of citywide statistics and recommendations regarding child fatalities, as well as fatalities involving domestic violence.

At the micro level, District child-serving agencies conduct internal reviews of deaths of children known to them. CFSA's internal Child Fatality Review process includes employees from several programs and functions and representatives from the Center for the Study of Social Policy (CSSP), and the community.

## **Overview of CFSA's Child Fatality Review Process**

As noted earlier, CFSA internally reviews all deaths of children whose families have had contact with CFSA within the current year or previous 4 years. The term "contact" includes a referral to the CPS hotline that has been screened in for investigation or family assessment<sup>7</sup>, or a foster care or in-home services case monitored by CFSA or a contracted partner agency. It does not include referrals that were screened out at the hotline, families who had an open case only for the purpose of payment of an adoption or guardianship subsidy, or cases open with a Collaborative but not with CFSA or a contracted partner.

### **Immediate First-Level Review**

CFSA's QA unit convenes a Child Fatality Critical Event Meeting within 24 hours of receiving notice of a recent child fatality.<sup>9</sup> Meeting participants include representatives from relevant CFSA program areas. The meeting focuses on the immediate needs of the family and particularly any surviving children while still exploring circumstances surrounding the child's death. Meeting participants assess the level of risk, if any, to other children in the home and recommend immediate next steps for the investigative social workers or other personnel, as appropriate.

As of November 2013, this immediate first level review has been enhanced to include the RED<sup>8</sup> team format. The meetings are now known as Critical Event RED teams and have incorporated the RED team format to include genograms, safety and risk statements, strengths and protective factors, complicating factors, and gray areas.

### **CPS Investigation of Fatalities**

If there is reason to believe that a child fatality was the result of abuse or neglect, the circumstances around the death may be investigated by the Child Protective Services (CPS) administration. In many cases, the investigation is closed before the autopsy report is completed and CPS makes no findings regarding abuse or neglect. Frequently the role of the investigative

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<sup>7</sup> In September 2011, CFSA implemented the Differential Response model which allows the Agency to respond to Hotline reports with a family assessment (versus a formal CPS investigation) for families with low-to-moderate risk of child abuse and neglect. Services are voluntary for these families. Fatalities of these children count as "known children" and may be included in future counts and reviewed.

<sup>8</sup> The RED (review, evaluate, and direct) teams are composed of individuals representing various administrations within the Agency, depending on the case being reviewed. For example, RED team members may be staffed from CFSA's Child Protective Services (CPS) administration, the In-Home and Permanency administrations, mental health and kinship services, and/or CFSA's contracted community partners, the Healthy Families/Thriving Communities Collaboratives. Each RED team has a unique focus depending on the program area but the framework is the same for all teams.

social worker is to offer services to the family and to ensure that any surviving children in the home have their needs met.

### **Monthly Second-Level Review**

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QA prepares a written report for the monthly internal Child Fatality Review meetings. These reviews include a multidisciplinary panel of representatives from CFSA (e.g., training, health services, program operations, policy, and legal) alongside external stakeholders (citywide CFRC, CSSP, and the community). CFSA's CFRT strives to review the fatality within 45 days of the Agency receiving notification of the child's death.

Each report is based on a comprehensive review of information about the decedent and his or her family. Sources of information include the CFSA investigative or case record; the Automated Client Eligibility Determination System (ACEDS) of the DC Department of Human Services; interviews with current and past social workers, when possible; and information available from OCME, the Metropolitan Police Department (MPD), and media coverage.

The Internal Child Fatality Review process includes an examination of the child and family's involvement with the child welfare system, identification of issues surrounding the involvement and the death, and recommendations for immediate actions. Recommendations also include long-term strategies for improving case practice, enhancing child protection, and minimizing preventable deaths.

On a quarterly basis, QA reviews the recommendations and findings from the reports and internal review meetings. The information is subsequently incorporated into the Quarterly Trend Analysis Report. Issues that require more immediate attention are elevated to the deputy director of Office of Planning, Policy, and Program Support.

### **Investigations of Families without Prior Agency Involvement**

CPS is sometimes notified by law enforcement or medical personnel of child fatalities in families which do not meet the criteria of known children, i.e. the family either did not have prior history with CFSA or where the history was beyond four years. While we do not include these fatalities in our annual statistics or in the charts in this report, we have included information from three of those fatalities in the discussions below as they provide additional information on risks facing District children.

### **Notification of Child Fatalities**

Immediate notification of a child fatality generally comes to CFSA through one of two sources: law enforcement officers or CFSA employees. One or both parties will notify the CPS Hotline of any fatality involving a child or former child client. This prompts CPS to check the safety of other children in the home and to assist the family in addressing immediate needs, if any.

CFSA also learns about some District child fatalities through media sources and notifications from the OCME. These notices may be well after the deaths and involve children or families who were involved with CFSA in the past.

Of the 24 fatalities discussed in this report, the QA received 23 notifications from the CFSA Hotline and one from OCME. Of the 23 reports to the Hotline, three were made by CFSA staff who learned of the fatality through news reports, and six from information in Homicide Watch ([www.homicidewatch.org](http://www.homicidewatch.org)). The remaining reports originated from MPD and a hospital nurse or

social worker. The number of known death notifications that CFSA has received from the OCME have followed the decreased trend of the past two years.

## Sources of Information

To prepare this report, QA relies first on a database of basic information about fatalities of children who had contact with CFSA, such as date and cause of death (if determined), circumstances surrounding the death, and pertinent demographics. In addition, QA reviews its own reports based on the 24 fatalities in 2013 of children known to CFSA during the past five years (i.e., current year and past four years).

QA reviewed the autopsy reports to determine cause and manner of death and reconciled statistical data on fatalities. In addition to analyzing all information gathered from OCME, CFRC, MPD, and CFSA, QA gathered information from interviews and direct contact with social workers, service providers, attorneys, administrators, and others who had past involvement with the child or family.

For homicides, MPD and local news media, in combination with information from the CFRC, provided CFRU with the time and location of death.

## Fatalities of Children Who Had Contact with CFSA

A total of 24 of the District children who died in 2013 or their immediate families had contact with CFSA within the four years before they died. As noted in Table 1, these numbers reflect a continuous decrease from 2008, which represented the highest number of overall child deaths in the District and of those known to CFSA in the 10 years since CFSA has been preparing these reports.

## Overall Findings

The following are major findings related to the 2013 deaths of the 24 District children who had contact with CFSA at any time since 2009.

### **As in previous years, more than half of the children who died in 2013 were males.**

Following a continuous trend, a disproportionately high number of the children and youth who died were males. Males account for 67 percent of the fatalities for the 10-year period. The ratio of male to female in 2013 was 2:1. The prevalence of males in this distribution is due largely to the number of young adult males who are victims of gunshot homicide; a quarter of all child fatalities in 2013 were male victims of non-abuse homicide age 17 or above.

**Table 6: Gender of Child Decedents Known to CFSA, 2004-2013**

Year:	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
Male	63%	72%	71%	59%	66%	72%	58%	73%	58%	67%
Female	37%	28%	29%	41%	34%	28%	42%	27%	42%	33%



**A quarter of the decedents known to CFSA are youth age 17 and older.<sup>9</sup>**

Older youth continue to account for a large percentage of known fatalities. Only in 2012 was the percentage of fatalities of known children over the age of 17 below 25 percent.

Year:	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>	<b>2013</b>
0-2 years	34%	45%	41%	43%	38%	44%	11%	35%	46%	33%
2-6 years	5%	2%	3%	11%	10%	4%	9%	8%	8%	17%
7-12 years	14%	6%	8%	7%	9%	8%	0	0	4%	13%
13-16 years	19%	17%	15%	11%	12%	10%	24%	8%	29%	12%
17 years and up	29%	30%	32%	30%	31%	34%	33%	50%	13%	25%

**Six families were actively involved with CFSA at the time of the death.**

In 2013, six of the 24 fatalities (25 percent) were children with families actively involved with CFSA. The ages of these children ranged from five months to 15 years. Three were active cases and three were active investigations.

**Continuing a trend, few children known to CFSA died from accidental deaths.**

In 2013, the deaths of two known children were accidental.

**In 2013, more than a quarter of the children known to CFSA who died were victims of non-abuse homicide.**

In 2013, nine (38 percent) of the fatalities of children known to CFSA were victims of non-abuse homicide (i.e., killed by someone other than a parent or guardian). This is by far the most prevalent cause of death for known fatalities in 2013. Non-abuse homicide statistics in previous years included 21 children (31 percent) in 2008 and 9 children (27 percent) in 2010 (Table 8 below). This continues to be the leading manner of death for male children and youth. In 2013, six of these children were 17 years of age or older, two were 16 years old, and one was 4 years old. All but one was male. Six of these homicides involved gunfire and one involved stabbing with a knife. One died from blunt impact injuries of head and neck with no weapon identified. The 4-year-old died in a fire that was intentionally set by a relative.

Suspects have been charged in two of the homicides. Four are listed in the unsolved homicides web page of the MPD. CFSA has no information on the status of the remaining three.

As a percentage of total known fatalities over the past eight years, homicides were at the lowest level in 2012. The percentage increased in 2013 despite the fact that the decreasing trend from 2011 continues.

**Abuse Homicides**

There were two abuse homicides in 2013 of children or families previously known to CFSA.

A mother left her 4-year-old son in the care of her boyfriend. The boyfriend disciplined the child by punching him repeatedly in his stomach, fracturing his rib and lacerating his liver. The boyfriend was found guilty and sentenced to 20 years in prison. CFSA substantiated failure to protect regarding the mother, who had prior knowledge of the boyfriend's rough treatment of the child.

<sup>9</sup> As CFSA works with youth up to the age of 21, the count can include infants and youth up through age 25.

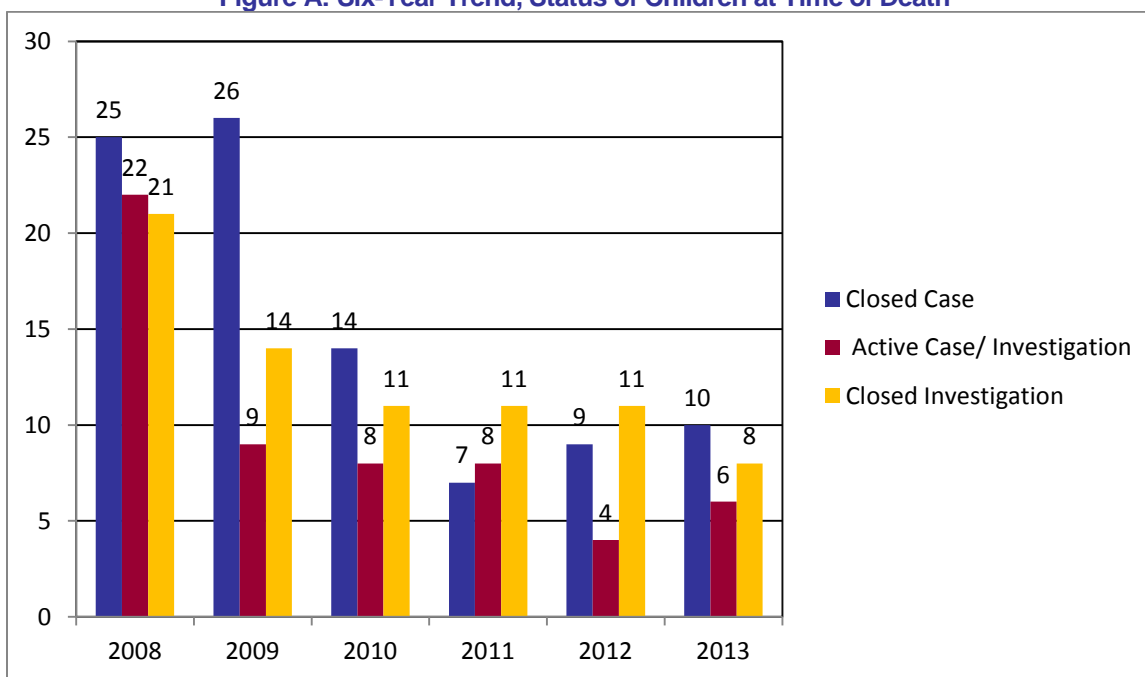
A mother found her one-month-old son, who had been sleeping in bed with her, lying on his back and unconscious. She called 911, and paramedics performed CPR and transported the infant to a hospital where he died. The autopsy report revealed the cause of death as promethazine intoxication. Promethazine is a neuroleptic medication with strong sedative effects. CFSA substantiated abuse, and the mother later pled guilty to voluntary manslaughter.

There were two other children whose cause of death in 2013 was determined to be abuse homicide but neither family was previously known to CFSA. Both involved mothers who had only recently immigrated to the United States. One mother had been in the country for five days and the other for less than one year. Both mothers had support systems but no one was aware of the pregnancies. Both mothers tried unsuccessfully to hide the birth and death of the infants. An eight-month-old child unknown to CFSA was found to have both old and new fractures when taken to the hospital for labored breathing and died shortly after going into cardiac arrest. No cause or manner of death has yet been determined.

In the last year for which data are available (FY2012), the District's rate of child fatality caused by maltreatment was 1.83 deaths per 100,000 children, below the national average of 2.2 maltreatment deaths per 100,000 children.<sup>10</sup> Nationally, the rates have been rising since 2010.<sup>11</sup>

## CFSA Involvement

Figure A: Six-Year Trend, Status of Children at Time of Death



<sup>10</sup> U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau, p. 56. (2013). *Child Maltreatment 2012*. Available from <http://www.acf.hhs.gov/programs/cb/research-data-technology/statistics-research/child-maltreatment>.

<sup>11</sup> *Ibid*, p. 51.

Of the six children who died while involved with CFSA, three had active cases, and three were part of an investigation. As noted earlier, the age ranges of these fatalities were 1 month to 15 years. This is in contrast to 2012 when all the fatalities that took place while CFSA was involved were infants.

## Analyses of Specific Categories of Child Decedents

This section takes a closer look at specific circumstances in terms of age, medical condition, or cause of death (when known) as related to the 24 known children who died in 2013. Table 8 provides a snapshot of the information on these children.

<b>Table 8: Manner of Death and Demographics for 24 Children Who Died in 2013 and Whose Family Had Contact with CFSA at any Point in the Preceding 4 Years</b>								
<i>Manner of death:</i>	<i>Natural Cause</i>	<i>Non-abuse Homicide</i>	<i>Abuse Homicide</i>	<i>Accident</i>	<i>Suicide</i>	<i>Undetermined</i>	<i>Pending</i>	<i>Total</i>
<b>Age</b>								
<24 months	3	0	1	0	0	2	2	8
2-6 years	1	1	1	0	0	0	1	4
7-12 years	0	0	0	2	0	0	1	3
13-16 years	1	2	0	0	0	0	0	3
17+ years	0	6	0	0	0	0	0	6
<b>Gender</b>								
Male	4	8	2	1	0	0	2	17
Female	0	1	0	1	0	1	4	7
<b>Status with CFSA at the Time of Death</b>								
Closed case	3	6	0	0	0	0	1	10
Active case	1	0	0	0	0	0	1	2
Closed investigation, no case opened	0	3	1	0	0	1	3	8
Active investigation	0	0	1	2	0	0	1	4
<b>Placement Status</b>								
Not applicable: case closed/ investigation	2	9	2	2	0	1	5	21
In home	0	0	0	0	0	0	1	1
Out-of-home placement	2	0	0	0	0	0	0	2
<b>Total</b>	4 (17%)	9 (38%)	2 (8%)	2 (8%)	0	1 (4%)	6 (25%)	24

### **Age 17 and above**

As noted, there were six (25 percent) deaths in 2013 of youths age 17 and above whose family had contact with CFSA within the four years preceding their death. All were the victims of non-abuse homicide. CFSA was not involved with any of the families at the time of the fatalities.

Although this number of homicides is low compared to previous years, some of the same characteristics and risk factors are noted in previous reports. The following information helps to identify common factors that appear to place District young people at risk:

- The majority of these youth had minimal involvement with their birth fathers and few, if any, had positive male role models.

- All six families were investigated for abuse and neglect multiple times; one had as many as 32 referrals.
- All six youth were alleged to have been neglected and two of them had the allegations substantiated more than one time.
- The mothers of three of the youth were 17 years or younger at the birth of their first child, and two mothers were age 21 or younger at the birth of the decedent
- The fathers of three youths and three mothers had foster care history.
- Three homicide victims had a history of truancy or educational neglect.
- Four mothers had a substance abuse history.
- All six families required public assistance due to financial instability during CFSA's involvement with the families.

Only one of these youth had a criminal history, and only one had spent time in foster care.

### **Infant Fatalities**

Of the eight fatalities of children under age 2, the OCME has attributed one to Sudden Unexplained Death of Infant associated with an unsafe sleeping environment and bedsharing and one as undetermined. The death of one infant was determined to be an abuse homicide and is described above. Three died of natural causes, and the cause and manner of death of two are still pending. The deaths of five of these infants involved co-sleeping/inappropriate sleeping arrangements.

Families of three infants had closed cases with CFSA at the time of death, and families of three others had closed investigations. One family had an active investigation and one family had both an active investigation and an active case at the time of the fatality. The fathers were involved in six of the cases.

Fatality review reports indicated the following information for these eight infants:

- There were four males and four females.
- Two mothers (25 percent) were younger than age 18 at the time of their first pregnancy.
- Six mothers and four fathers had a known history of using substances, including alcohol, marijuana, cocaine, phencyclidine (PCP), and prescription drugs.
- Two infants were exposed to PCP or marijuana in utero.
- Two mothers had a criminal history.
- Six families had at least one prior substantiated investigation, including one infant who was adjudicated to have been neglected resulting from a positive toxicology at birth.
- Two mothers had been in foster care as children or youth.

While none of these factors is confirmed to have contributed directly to the child's death, the information is included to indicate the types of stressors and complications experienced by parents of young children associated with CFSA.

Of the total of nine fatalities where the families had no prior contact with CFSA, five were in this age group. One of these fatalities involved bed sharing, two were abuse homicides, the fourth fatality was determined to be natural, and the fifth fatality is pending the results of an autopsy.

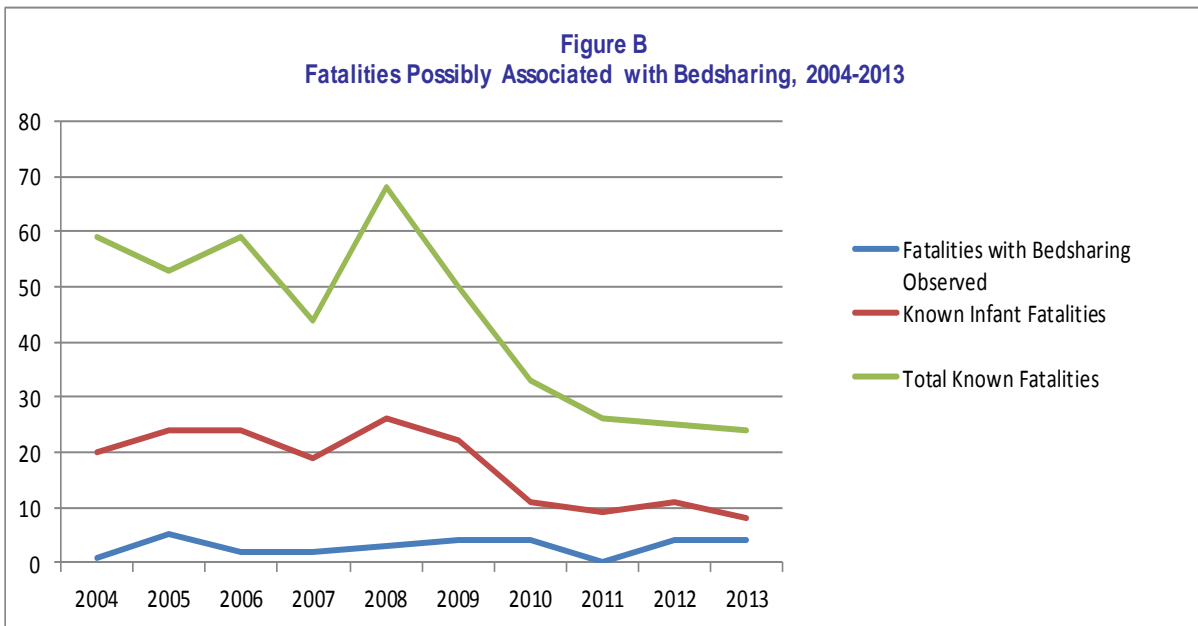
It is noteworthy that the District of Columbia has seen improvements in the child mortality rate in recent years. In 2010, the rate was at a historic low of 8 per 1000 live births, down from 9.9 per

1000 just a year earlier.<sup>12</sup> The city's infant mortality rate is still higher than the national average of 6.14 per 1,000 live births.

**Fatalities Involving Questions about Sleeping Arrangements**

The National Institute of Child Health and Human Development (NICHD), in conjunction with other child and infant health organizations, encourages the creation of safe sleep environments for infants to reduce the risk of sleep-related child fatalities such as Sudden Infant Death Syndrome or SIDS. The Institute encourages parents of young children to keep their sleep areas clear of pillows, blankets, and toys, to have children sleep on their backs, and not to sleep on an adult bed or couch with or without an adult.<sup>13</sup> Although bedsharing is not considered child abuse or neglect in the District, CFSA staff routinely address sleeping arrangements with parents of young children, provide recommendations on safe sleeping arrangements, and assists with the provision of cribs, bassinets and other equipment to keep children safe.

The number of fatalities where bedsharing was observed has remained largely stable over the last ten years, even though the number of fatalities of infants (under 24 months), as well as those of all known children, have fluctuated significantly, as Figure B below shows:



There were five fatalities where the circumstances included bed-sharing or other inappropriate sleeping arrangements and/or a breastfeeding pillow. In these cases the sleeping arrangement has not necessarily been identified as a factor contributing to the child's death.

A few things stand out in looking at the details of these families. The average age of the mother of the child was 33 years, and the average age at which they had their first child was 23 years. The mothers, then, were older, experienced parents, who nevertheless exposed their children to

<sup>12</sup>DC Department of Health, *2010 Infant mortality Rate for the District of Columbia*. [http://newsroom.dc.gov/show.aspx?agency=doh&section=2&release=23327&year=2012&file=file.aspx%2frelease%2f23327%2f2010%2520Infant%2520Mortality%2520FINAL%2520\(05%252014%25202012\\_MAPS\\_edited\)%2520.pdf](http://newsroom.dc.gov/show.aspx?agency=doh&section=2&release=23327&year=2012&file=file.aspx%2frelease%2f23327%2f2010%2520Infant%2520Mortality%2520FINAL%2520(05%252014%25202012_MAPS_edited)%2520.pdf) This is the most recent information available at the time of this writing.

<sup>13</sup> National Institute of Child Health and Human Development, *Safe Sleep Campaign*. Accessed at <http://www.nichd.nih.gov/sts/about/environment/pages/look.aspx>

potentially unsafe sleep practices. In addition, four of the five children lived in two-parent homes. The fifth child was in the care of a single mother with support from two adult relatives. Four of the mothers had substance abuse history; one each used PCP, cocaine, marijuana, and prescription drugs. One father was known to use marijuana socially.

CFSA is aware of one other fatality from 2013, involving a family without prior child welfare history, where a 7-week old child died in bed with her parents.

### **Fatalities Associated with Parental Substance Abuse**

Four of the fatalities of young children involved some level of substance abuse by the parent or parents. In two of these, the children were born suffering from severe medical problems which might have been linked to the mother's use of drugs during pregnancy. One child weighed one pound at birth and survived less than an hour. The other died at five months after several surgeries and hospitalizations. In both cases, the mother tested positive for drugs at the time of delivery and had previous CPS involvement due to substance abuse. Medical personnel were unwilling to establish a causal link between the mother's substance use and the child's medical conditions or to state that the mother's substance use affected the children's health or viability.

### **Accidental Deaths**

The deaths of two children known to CFSA were listed as accidental. The first was a 9-year-old girl found in a closet with a scarf around her neck. There was no indication of depression or history of prior attempts at self-harm. OCME determined that it was an accidental death rather than a suicide attempt.

The second was a 7-year-old male diagnosed on the autism spectrum. This child died of hyperthermia after wandering away from his home and becoming locked in an abandoned car.

### **Medically Fragile Children, Youth, and Young Adults**

Some children and youth involved with the child welfare system have serious, chronic medical conditions. Medical fragility makes these youngsters vulnerable to abuse and neglect, and CFSA intervention generally focuses on ensuring they are safe and receiving appropriate medical care consistently.

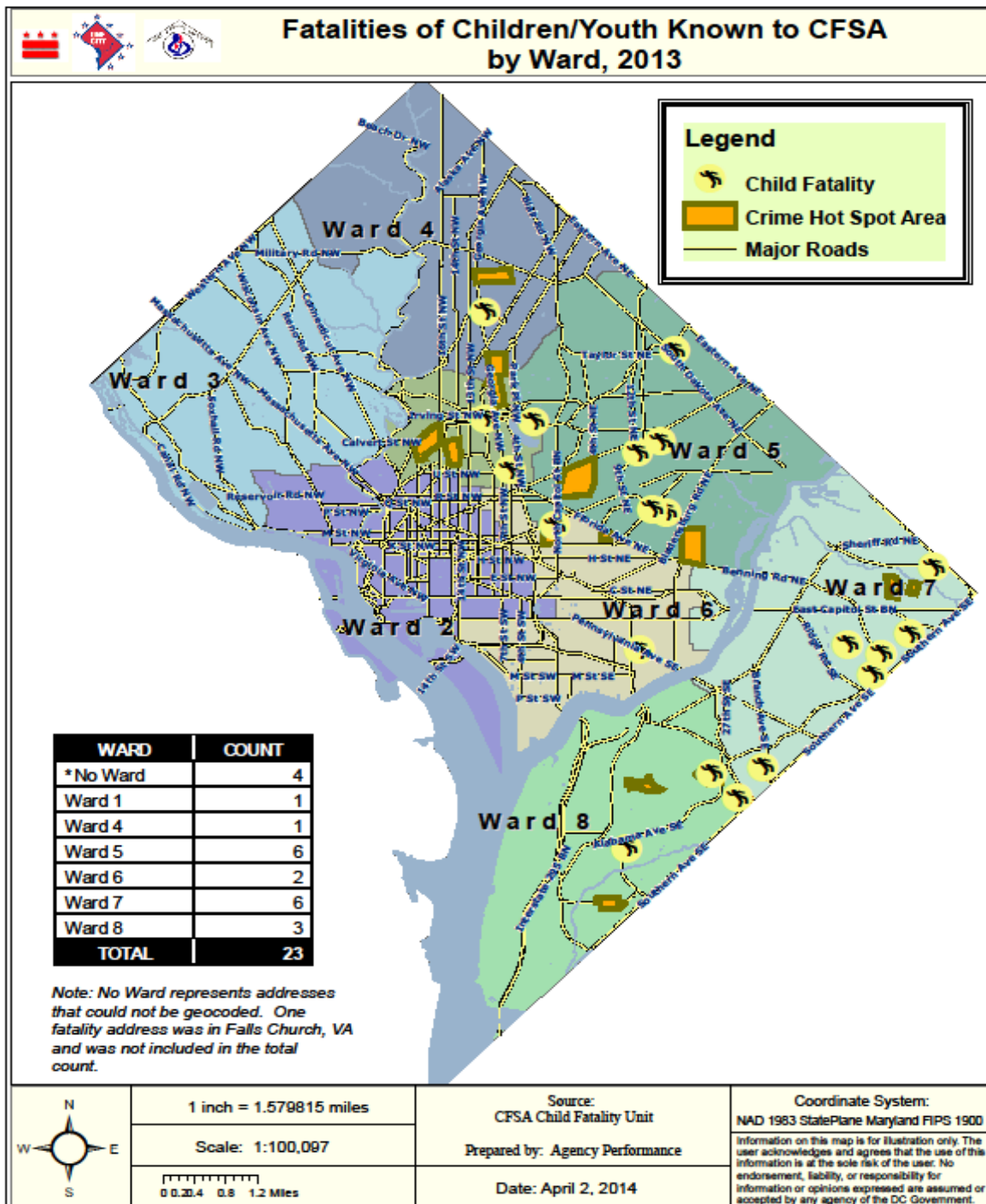
In 2013, six children died from chronic medical conditions. Two were in out-of-home placement, one of which was kinship care, and the other was in a residential medical care center. The remaining four children resided at home with their birthparents. The children ranged in age from 1 month to 15 years and included five males and one female.

### **Child Fatalities without CFSA Involvement**

In 2013 the CFSA Hotline received notification of nine child fatalities whose families had had no prior contact with CFSA. Two of these children, born in unusual circumstances died on the day they were born. OCME has determined the manner of death of one of these fatalities as Homicide caused by asphyxia from smothering, four are Natural, and the remaining four are still Pending.

## **Geographic Location of Fatalities**

The map which follows (Figure C) shows the locations of the fatalities for 2013.



## Recommendations and Actions

*The recommendations selected for inclusion are those that fit under categories of improving case practice correcting deficiencies, strengthening child protective performance and identifying systematic factors that require Citywide attention.*

### From the CFSA Internal Child Fatality Review

#### *Second Level Review under Strengthening Practice*

- (1) During one of the second-level reviews, there were concerns regarding CFSA's ability to offer services to families whose cases were closed at the time of the child fatality. The following recommendation was made to address this deficiency and to strengthen practice outcome.

Recommendation 1: Ensure that CFSA has a formal mechanism set up for internal funds and provide staff access to this fund for clothing and funeral expenses.

Status: Procedure D of CFSA's [Child Fatality Review](#) policy (available on-line) details the steps to access internal and external resources available for families to support funeral arrangements and associated expenses. [Administrative Issuance number CFSA-12-10](#) (available on-line) also details the process for social workers to request and access gift cards and vouchers.

- (2) Another concern raised during the review was that although the family accepted Wendt Center services for grief counseling, the Center had no homicide support group in the family's local center.

Recommendation 2: Encourage the Wendt Center to expand its homicide survivors' services to high crime areas (Southeast) to accommodate these and other families.

Status: The Wendt Center has a location in Southeast where services can be accessed and also maintains a 24-hour help line. At this writing CFSA's Health Services Administration is engaged in discussions with the Wendt Center about access to their crime victim services in high crime areas. In addition, discussions are taking place with regard to collaborations with community-based organizations in traditionally under-served parts of the city to provide information on available services and how they can be accessed.

- (3) During the review there were concerns that CFSA's request to Maryland for a courtesy safety check was not implemented.

Recommendation 3: Though CFSA consistently conducts safety checks for other jurisdictions, the following two recommendations were nonetheless set forth:

- CPS and Family Assessment workers could benefit from clarification and training on conducting courtesy home assessments across jurisdictions.
- CFRU will follow up on the specifics of the recently updated Border Agreement with Maryland.



Status: The District of Columbia and the State of Maryland (MD), entered into a border agreement on February 7, 2013. This agreement will serve as a mechanism to expedite the interstate movement of children across the borders of the District and MD for the purpose of kinship and foster care placements:

“The usual and mandatory submission of an Interstate Compact on the Placement of Children (ICPC) packet and required receiving-State ICPC approval prior to a child’s placement is no longer required when, in appropriately applicable and valid ‘Border Agreement’ cases, a child is temporarily placed from one jurisdiction to another when the child is being placed with a receiving State-licensed Child Placement Agency or Residential Child Care program. When the ‘Border Agreement’ procedure is followed, the ICPC’s protections and obligations are met and remain active until the child is returned to the sending State or permanency is otherwise appropriately achieved in keeping with the ICPC Article V.

When CFSA or MD’s Department of Human Resources requires a safety check on a child in the other state, a request will be made to the local Child Protective Services (CPS) office for a safety check by the local office. If the local office is unable to accommodate the request, the requesting agency may enter the other state to complete the safety check. In that case, the requesting agency will inform the local CPS office by the next business day that a safety check was completed in that jurisdiction. Only dually-licensed social workers will be permitted to complete safety checks in the other jurisdiction.”

- (4) During a discussion about the services the youth who had an in-home case could have benefited (i.e. GED, job/vocational training), and whether or not she could have received these services from the Office of Youth Empowerment (OYE) program.

Recommendation 4: CFSA’s Office of Planning, Policy, and Program Support should clarify the policy to ascertain if non-committed youth can be referred for OYE services.

Status: The Older Youth Services Policy which outlines the services provided through OYE is only applicable for youth in foster care. The criteria for services outlined in the policy state that OYE does not provide services for youth who are not committed to CFSA. The policy was finalized in May, 2014.

## **Recommendations from the Citywide Child Fatality Review Committee**

Recommendation #1: “The Child and Family Services Agency should ensure qualitative measures are practiced prior to reaching case closure. This includes ensuring accountability in the documentation of case records both internal and contracted social workers, and supervision of services rendered to families through case closure.”

CFSA accepted the recommendation with the following modification:

“The Child and Family Services Agency ensures qualitative measures are practiced prior to reaching case closure. A detailed protocol is evolving within the current updating of the In- and Out-of-Home Procedural Operations Manual (POM). Part of updating the POM is a written outline of steps that social workers and their clinical supervisors must follow to ensure that the Agency’s stated qualitative measures are practiced prior to reaching case closure. This outline emphasizes accountability in the documentation of case records and supervision of services rendered to families for purposes of achieving case closure.

“The RED Team process is also being implemented (detailed in the Best Practices section below) for all ongoing cases and will occur at critical points throughout the life of the case. This process will serve to ensure that qualitative measures are practiced throughout the life of the case, ensuring greater accountability throughout CFSA and the private agencies involvement with the family, as well as greater oversight of services rendered through case closure.”

Recommendation #2: “The Child and Family Services Agency should consider a program to support children with complex needs as they move out of foster care and return to the home of their parents. The agency could consider a program based upon the model of the Center of the Vulnerable Child in Oakland, California, that provides clinical and social services to this special population of children from birth to 18 years of age.”

CFSA rejected this recommendation but offered the following:

“It is the opinion of CFSA that children and youth with complex needs, such as the decedent, would be better served if improved communication between existing providers was strengthened, rather than involving an extra agency, which may potentially duplicate services already being provided. As part of its ongoing CQI activities (such as KidStat, Grand Rounds, and Quality Services Review), CFSA reminds and encourages both internal staff and the agencies with whom we partner to communicate regularly with other professionals involved with their families and to make well-informed team decisions regarding case planning and services.

“If the District determines that such a program is needed, it should be made available to all District residents for preventive services, not just to those exiting foster care to reunification. The number of children exiting foster care to reunification with severe medical challenges issues is very small. It is believed to be less than five children in the past year.”

Recommendation #3: “The Child and Family Services Agency should develop and implement a protocol to address issues related to poor living conditions found in publicly funded housing (e.g. mold, poor air quality) that may present health risk to the home’s residents. The Child and Family Services agency should provide all agencies with a review of the Mandated Reporter Law for child abuse and neglect to ensure that employees and their contractors are aware and adhere to this statute to ensure the safety of children residing in publicly funded housing programs.”

CFSA rejected this recommendation but offered the following:

“Currently, the CFSA front line staff undergoes extensive initial training provided via CFSA Child Welfare Training Academy. In this training curriculum, social workers learn how to assess for unhealthy living conditions (aka deplorable conditions) that could affect the health and well-being of a child. Social workers are trained to overall assess routinely the home environment. If not deemed safe, and if the family is living in public housing, for example, than those hazardous conditions are elevated to the appropriate entity who will address them within DC Government (e.g. DCRA, DCHA, DOE, and/or DOH). Of note, this specific family where the fatality occurred was not known to CFSA at the time of the fatality... At the time the family’s case closed [with CFSA], their housing conditions were safe for all family members.

“Regarding the recommendation that the Mandated Reporter Law for child abuse and neglect be reviewed for all agencies, as previously noted, CFSA’s website provides the necessary information for all District government agencies to ensure their staff and contractors are provided with essential information on the Mandated Reporter Law, including who is considered a mandated reporter and

access to the online training. As deemed necessary, however, CFSA could provide classroom training for identified entities.”