Child Fatalities:

Statistics, Observations, and Recommendations

2019

Contents

I. Introduction

The 15th annual *Child Fatality Review (CFR) Report*[1] presents data and practice recommendations based on the internal child fatality reviews conducted by the Child and Family Services Agency (CFSA) during calendar year (CY) 2019. Although CFSA reviews fatalities from prior calendar years as part of its internal continuous quality improvement (CQI) efforts, the present report focuses on fatalities that occurred during CY 2019.[2] Fatality reviews include only those children whose families were known to CFSA within five years of the child's death.[3]

Cases Reviewed

Over the course of CY 2019, the CFSA CFR Unit examined demographic information, as well as child welfare histories and receipt of services documented for 13 families with fatalities of children aged 2 months to 20 years old. The CFR Unit presented the results of each review to members of CFSA's monthly Internal Child Fatality Review (ICFR) committee meeting. Committee members include the CFR Unit and manager, CFSA administrative leadership,[4] and representatives from CFSA's contracted private agencies, the Healthy Families/Thriving Communities Collaboratives, the Office of General Counsel, the District's Office of the Chief Medical Examiner, and the Center for the Study of Social Policy.

In line with CFSA's CQI efforts, and based on the CY 2019 reviews, the ICFR committee members made practice recommendations to potentially help reduce future child fatalities. CFSA's director approved the recommendations, which are included in this report along with programmatic responses to the recommendations. In addition, ICFR committee members will review the yearly data trends presented in this current Annual CFR Report to inform and guide recommendations for the 2020 report.

Case Review Methodology

The fatality review process is one of CFSA's strategies for examining and strengthening child protective performance. It provides the Agency with specific information that helps to address areas in need of improvement and to identify any systemic factors that require citywide attention—all with the goal of reducing preventable child deaths.

When examining a child fatality, the CFR Unit looks at the cause and manner of the child's death. Historically, CFSA received partial data on cause and manner from the Office of the Chief Medical Examiner (OCME). However, in 2015, CFSA established a memorandum of understanding with the District's Department of Health (DOH), which is responsible for vital statistics. As a result, the CFR Unit now contacts DOH on a quarterly basis with a list of child fatalities for which the official cause and manner of death has not yet been confirmed. The process ensures that data on cause and manner of death is directly provided to the CFR Unit.

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[1] DC Official Code §4-1371.05 (a) (2)

[2] Overall, the ICFR Committee reviewed 33 fatalities during CY 2019; however, only thirteen fatalities (39 percent) occurred during CY 2019. Of the remaining reviews, ten fatalities (30 percent) occurred during CY 2018; another seven fatalities (21 percent) were from CY 2017. The CFR Unit reviewed two fatalities (6 percent) from CY 2015 and one fatality (3 percent) from CY 2016.

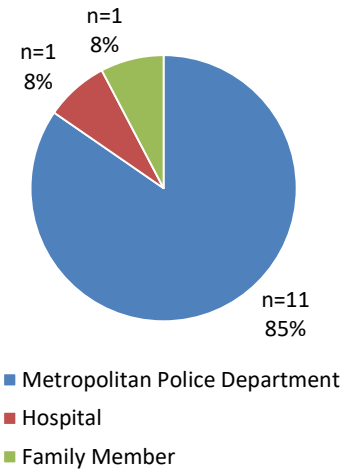
[3] In 2019, CFSA reviewed one fatality that occurred three months outside of the five-year time span. Had CFSA not reviewed this fatality, the total number of reviews would have been 32. However, for the purpose of data integrity, CFR leadership agreed to maintain the total number of reviews as 33 for the final report.

[4] A full list of administrations and program areas is available in Appendix A.

"Cause of death" is defined by the "what," i.e., the specific disease, injury or poison that led to the child's death. "Manner of death" is defined by the "how," i.e., the circumstances that caused the death. There are five manners of death (natural, accidental, suicide, homicide, and undetermined).[5] The CFR Unit's first focus is on whether the child's fatality occurred as the result of maltreatment by a parent, legal guardian, or person responsible for the child's care. When CFSA or OCME deems a parent or caregiver as directly responsible for the death of the child, this manner of death is considered an abuse or neglect homicide. Non-abuse homicide applies only to persons who are not in a caregiving capacity, e.g., an acquaintance, visitor, or a person in the community unknown to the child or family. Based on the available data for cause and manner of death (as of the writing of the CY 2019 Annual CFR Report), CFSA confirmed three abuse or neglect homicides for CY 2019.

The CFR Unit received notification of all CY 2019 fatalities from the District's 24-hour Child Abuse and Neglect Hotline. The Hotline itself receives notification from a variety of sources. For example, of the 13 child fatalities that occurred during CY 2019, the Hotline received notification of 11 child fatalities (85 percent) from the District's Metropolitan Police Department (MPD). There was also one (8 percent) individual report to the Hotline from a decedent's family member and there was an additional report (8 percent) from a local hospital reporter. All Hotline reports included a critical event report.[6]

Figure A: Hotline Reporting Sources - CY2019 Fatalities



The CFR Unit also looks at child and family involvement with CFSA at the time of the fatality. Thirty-one percent (n=4) of families from the CY 2019 fatality reviews were involved with CFSA at the time of the child's death. CFSA's Permanency Administration (foster care) managed all four cases.

In preparation for the 2019 Annual CFR Report, the CFR Unit consulted with members of the ICFR committee to refine a "reviewer survey" that would capture notable trends related to the families and their service needs. For example, data in this year's report includes families' involvement with other DC government agencies within the five-year review period, as well as decedents' diagnoses and service history. By examining service needs more closely, CFSA creates an opportunity for uncovering and addressing gaps in practice standards and service delivery.

[5] Source: https://ocme.dc.gov/sites/default/files/dc/sites/ocme/2017%20OCME%20Annual%20Reportupdated.pdf
[6] Per CFSA policy, "critical events" are events and/or incidents that threaten or compromise the well-being of a child or youth. Critical events require CFSA's immediate response and action.

II. Demographics and Findings

The CFR Unit gathers demographic information related to cause and manner of death, distribution of fatalities by ward, child residency at the time of the fatality, race and ethnicity breakdown, and case status (i.e., whether or not a case was open at the time of the fatality, including investigations, in-home and foster cases, and family assessment[8] referrals). The CFR Unit also gathers data on infant fatalities related to bed sharing or unsafe sleeping practices. Table 1 depicts the overall demographics for the 13 child fatalities that occurred during CY 2019.

Regarding gender, nine of the children (69 percent) were male; four were female (31 percent). Of the four infants under one year of age, three were male and one was female. For children between the ages of 1 and 5 years, two were male and three were female. The one child who was between the ages of 6 and 12 years was male. One youth between the ages of 13 and 17 years was male. Of the two young adults, both were male.

Table 1: Demographics According to Manner of Death

	Natural Causes	*Non-Abuse Homicide*	*Abuse or Neglect Homicide*	*Accident*	*Suicide*	*Undetermined*[7]	*Unknown*	*Total*
Age								
<1 year	0	0	1	3	0	0	0	4
1 – 5 years	2	0	2	0	0	1	0	5
6 – 12 years	0	1	0	0	0	0	0	1
13 – 17 years	0	1	0	0	0	0	0	1
18+ years	1	1	0	0	0	0	0	2
Total	**3**	**3**	**3**	**3**	**0**	**1**	**0**	**13**
Gender								
Male	2	3	0	3	0	1	0	9
Female	1	0	3	0	0	0	0	4
Total	**3**	**3**	**3**	**3**	**0**	**1**	**0**	**13**

Cause and Manner of Death

As noted earlier, CFSA partnered with the District's Department of Health (DOH) to increase the timely and accurate data on the cause and manner of death. Timely receipt of cause and manner is important to the ICFR committee's ability to tie risk factors to possible prevention strategies. An official cause and manner of death was available for 92 percent (n=12) of the CY 2019 fatalities reviewed by the ICFR

[7] OCME defines a manner of death as "undetermined" when autopsy findings are indecisive, i.e., there is insufficient or inconclusive information to assign a specific manner. An undetermined death may also have an "unknown" manner, or an undetermined cause of death with a known manner, or a determined cause of death and an unknown manner. Note: Sudden Unexpected Deaths in Infancy (SUID) carry an "undetermined" manner of death.
Source: https://ocme.dc.gov/sites/default/files/dc/sites/ocme/2017%20OCME%20Annual%20Reportupdated.pdf

[8] Family assessments are part of the Differential Response approach used by child welfare agencies to separate out severe allegations that require a traditional investigation from reports where a child's safety is not immediately threatened. The family assessment process specifically looks at strengths and needs and then provides help outside the child welfare system. Effective April 1, 2019, the strengths of CFSA's family assessment process was merged into the CPS investigation process, returning Entry Services to a one-track system with all accepted reports of child abuse and neglect undergoing a CPS investigation.

committee. Of the 12 fatalities where cause and manner are known, manner of death for 23 percent (n=3) was due to natural causes. Manner of death was 23 percent (n=3) each for accidental deaths and non-abuse homicides. **Cause of death was abuse or neglect by a caregiver for three CY 2019 fatalities (23 percent), compared to zero in CY 2018.** All three fatalities involved decedents under the age of 3. For two of the three fatalities, the cause of death was abuse due to blunt force trauma. For the one neglect homicide, the cause of death was ingestion of the drug fentanyl.

Twenty-three percent of the CY 2019 fatalities were due to natural causes. Of the three fatalities where the manner of death was due to natural causes, 66 percent (n=2) were male and 33 percent (n=1) was female. Two of the children (66 percent) were between the ages of 1 and 5 years, while the third natural cause death was of a young adult over the age of 18 years.

Non-abuse homicides accounted for 23 percent of CY 2019 fatalities. As stated earlier in the report, non-abuse homicides include any homicide not committed by a parent or caregiver. In CY 2019, all three non-abuse homicides were male victims between the ages of 11 and 20 years old. The cause for each of the homicides was gunshot wounds. Each of the homicides occurred in the community. Outside of the 11-year-old victim, the other two males had history with the juvenile justice system. At the time of the reviews, police were able to solve only the homicide of the 11-year-old youth. His alleged murderer was arrested and in jail awaiting trial at the time of the fatality review. No arrests were made in the other two homicides. The remaining non-abuse homicide victims included a 16-year-old male and a 20-year-old male. Each of the young males lived in Ward 8.

All three accidental deaths were infant fatalities. Complicating factors for all three infant fatalities included unsafe sleeping arrangements. Gender for all three of the 2019 accidental deaths were males.

Distribution by Ward

Table 2 provides the distribution of children under age 18 living in the District's eight wards in CY 2016 and 2018.[9] In 2018, the majority of the District's children lived in Wards 4, 7 and 8 (53 percent). In comparison to the CY 2016 data[10] presented in the 2018 Annual CFR Report, the overall population of

Table 2: Number and Percentages of Children under Age 18 by Ward, 2016 and 2018

	2016		*2018*		*Population Change*	
	n	***%***	***n***	***%***	***n***	***%***
Ward 1	10,444	9%	10,908	9%	464	4%
Ward 2	4,387	4%	4,790	4%	403	9%
Ward 3	12,902	11%	13,879	11%	977	8%
Ward 4	17,233	15%	18,713	15%	1,480	9%
Ward 5	15,470	13%	15,027	12%	-443	-3%
Ward 6	11,547	10%	13,448	11%	1,901	16%
Ward 7	17,963	16%	19,757	16%	1,794	10%
Ward 8	24,765	22%	25,215	22%	450	2%
Total	114,711	100%	121,737	100%	7,026	6%

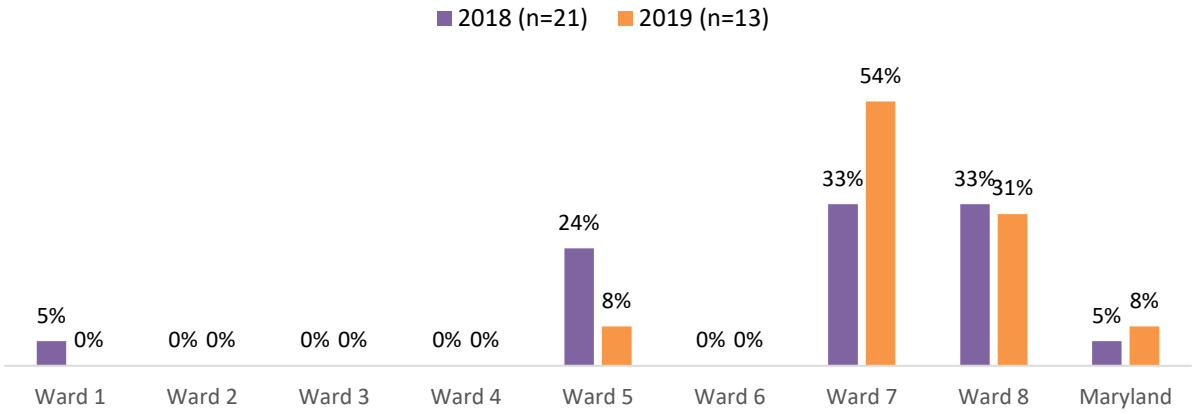
[9] The most recent data available; source: Kids Count Data Center, 2019

[10] The 2016 data were the most recent data available at the time of the 2018 Annual CFR Report.

children under age 18 in the District has increased by 6 percent (n=7,026) with the largest increases shown for Ward 6 (16 percent, n=1,901), Ward 7 (10 percent, n=1,794) and Ward 4 (9 percent, n=1,480).

The Ward data distribution does not correspond with the distribution of the 13 fatalities that occurred during CY 2019 (Figure B) where the highest percentage (54 percent, n=7) of fatalities occurred in Ward 8, followed by Ward 7 (31 percent, n=4). One child resided in Ward 5 (8 percent) and one child resided in the state of Maryland (8 percent). No reviews included fatalities from Wards 1, 2, 3, 4 or 6. Data from 2018 were similar for the 21 CY 2018 child fatalities reviewed: 33 percent (n=7 of 21) of the child decedents resided in Ward 8 and another 33 percent (n=7 of 21) from Ward 7. In contrast to 2019, there were a significant number of fatalities (24 percent, n=5) from Ward 5 in 2018. One child resided in Ward 1 while another child resided in Maryland. There were no fatalities reviewed for Wards 2, 3, 4, and 6.

Figure B. Actual Child Fatalities by Ward Location - CY 2018 & CY 2019



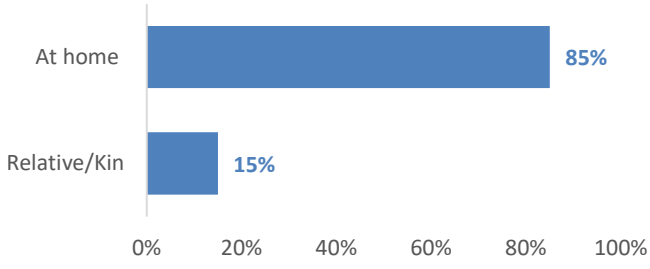
Race and Ethnicity

African Americans account for all child fatalities reviewed. Although African Americans accounted for 55 percent of the District's population under the age of 18 as of CY 2018,[11] African American children disproportionately accounted for 100 percent (n=13) of the CY 2019 fatalities. Similarly, African Americans accounted for 100 percent (21 of 21) of child fatalities in CY 2018.

Child Residency at the Time of the Fatality

Most children were living at home at the time of the fatality. Of the 13 child fatalities that occurred during CY 2019, 85 percent (n=11) of the children were living at home with their family at the time of the fatality (Figure C). Two children (15 percent) were living with relatives.

Figure C. Child Residency at Time of Fatality (n=13)

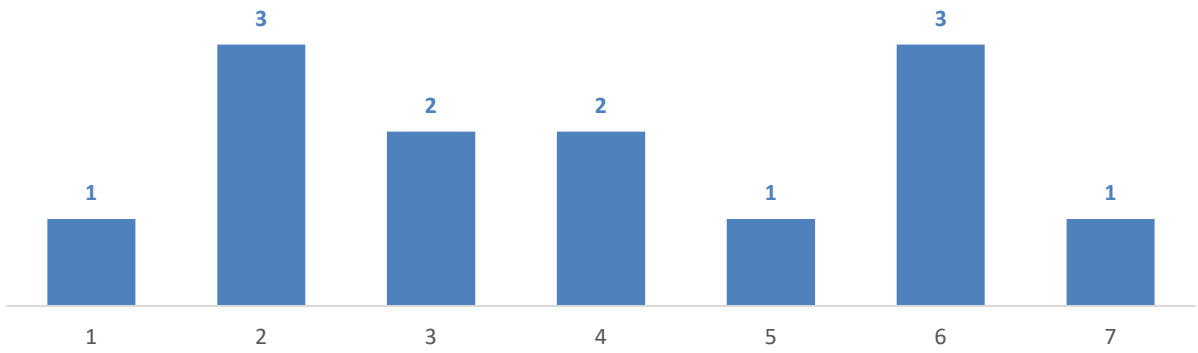


[11] U.S. Census Bureau, American Community Survey, *2014-2018 ACS 5-Year Data Profile: 2018*, https://www.census.gov/acs/www/data/data-tables-and-tools/data-profiles/2018/.

Siblings

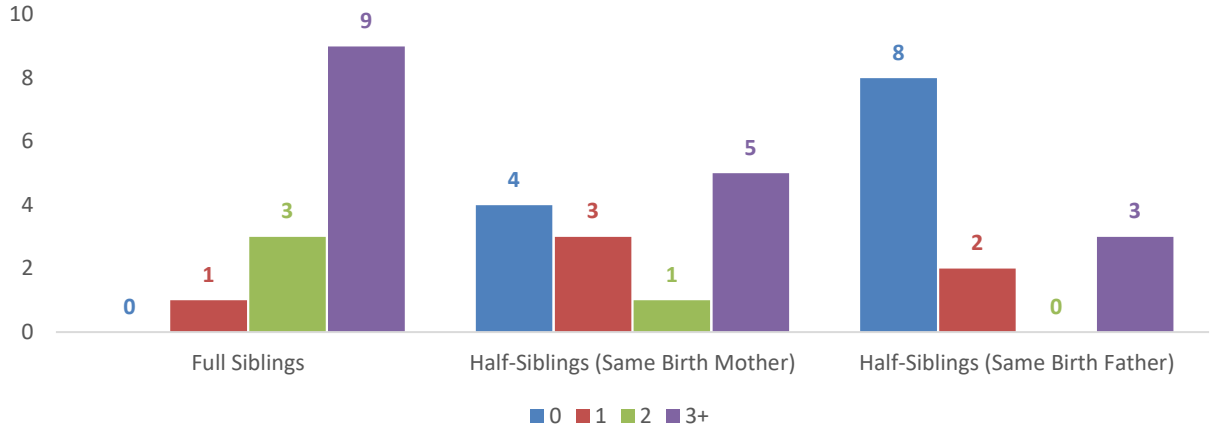
Approximately 70 percent of decedents had three or more siblings (Figure D). Three decedents (23 percent) had two siblings. One decedent (8 percent) had one sibling. None of the decedents were an only child.

Figure D. Count of Decedent Siblings (n=13)



Full siblings and half-siblings:[12] Full and half sibling counts are presented in Figure E. Seven of the decedents (54 percent) did not have any full siblings. Three decedents (23 percent) had one full sibling and an additional three decedents (23 percent) had two full siblings. **Approximately 92 percent of the decedents had at least one half-sibling (n=12)**. Sixty-nine percent of the decedents (n=9) shared siblings from the same mother but different fathers. Five decedents (38 percent) were known to share siblings from the same father. Only one decedent (8 percent) did not have any known half-siblings.

Figure E. Count of Decedents' Known Full and Half-Siblings (n=13)



[12] A "full sibling" is a sibling who has the same birth parents (birth mother and birth father) as the decedent. A "half-sibling" is a sibling who shares only one birth parent (birth mother or birth father) with the decedent.

Sibling Removals

As the result of the fatality, 31 percent of families (n=4) experienced a removal from the household where the fatality occurred. A total of eight children were removed: three were formally removed by Child Protective Services (CPS) and five were informally placed with relatives (Table 3). Of these four families, there was one family that experienced both a formal removal and an informal placement of the decedent's siblings. The manner of death was abuse homicide for the family's three-year-old decedent (cause being a fentanyl overdose). The Agency formally removed an 11-month-old sibling to foster care while the three other siblings (ages 7 to 16) were informally placed with their respective birth fathers.

Table 3: Sibling Removals after Fatality

# of Siblings Formally Removed	***# of Families***	***Total Siblings Removed***
One sibling*	1	1
Two siblings	1	2
# of Siblings Informally Placed	***# of Families***	***Total Siblings Placed***
One sibling	2	2
Three siblings*	1	3
Total	4	8

*One family had both a formal removal (one sibling) and informal placement (three siblings).

For the second of the four families, manner of death was also determined to be an abuse homicide. The cause was blunt force trauma to the head. The decedent's six-year-old brother was informally placed with a paternal aunt.

The third family had a younger sibling who was informally placed with the biological father. The manner of cause for the decedent was also an abuse homicide with the cause being blunt force trauma to the abdomen.

Lastly, for the fourth family, CFSA formally removed a three-year-old and a one-year-old to foster care. Their sibling decedent's cause of death was determined to be a blunt force injury to the head, but the manner was undetermined. The medical examiner noted that the blunt force could have been caused by a fall but there was no additional evidence to confirm maltreatment. At the time of the fatality, the decedent was visiting with his father and his father's girlfriend. The three-year-old and one-year-old siblings were also in the home. The decedent was alone with the three-year-old when the father discovered the decedent as unresponsive. As a result of CFSA's investigation, the Agency substantiated the father for lack of supervision, and substantiated his girlfriend for suspicious death of a child and imminent danger of another child in the home being abused.

Case Status

The majority of families (69 percent, n=9) did not have an open case with CFSA at the time of the child fatality (Table 4). For the remaining 31 percent (n=4), all four families had an open case with the Permanency Administration (foster care).

Of the four families with open foster care cases, there were a total of 17 siblings for the four decedents. The manner of death for the

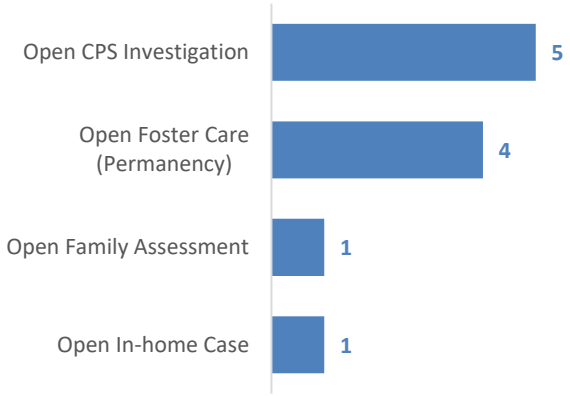
Table 4: Case Status at Time of Fatality (n=13)

	n	***%***
No Case Open	9	69
Open In-Home Administration	0	0
Open Family Assessment	0	0
Open Permanency Administration	4	31
Open CPS Investigation	0	0
Total	**13**	**100**

four child fatalities included abuse homicide, non-abuse homicide, accident, and undetermined.

A little over half (54 percent, n=7) of the 13 decedent families had CFSA involvement within 12 months of the fatality (Figure F). In total, five of the seven families (71 percent) had a CPS investigation within 12 months of the child fatality. One of the families had a family assessment referral. Four families had an open foster care case and one family had an open case with the In-Home Administration.

Figure F. CFSA Involvement within 12 Months of Fatality (n=7)



Of the seven families with recent CFSA involvement, three families (43 percent) had more than one case involvement with CFSA. All three families had a CPS investigation and a foster care case open within 12 months of the fatality; the third family also had an open in-home case within 12 months of the fatality.

Sleep-Related Factors for Infant Fatalities

Table 5: Three-Year Totals of Infant Fatalities (Birth to Age One) by Calendar Year – Children Known to CFSA / Sleep-Related Factors

Year	*2017*	*2018*	*2019*
# of Total Infant Deaths	14	11	4
# Sleep-Related	10	10	3
Percentage	71%	91%	75%

CFSA continues to address sleep-related fatalities for infants. The CFR Unit reviewed a total of four fatalities for infants under the age of one who died in CY 2019, which is less than the number of infant fatalities reviewed in CY 2017 and CY 2018. Three of the 4 infant fatalities (75 percent) involved unsafe sleeping arrangements. Each of the children resided in the home at the time of the fatality. The birth mother was the primary caregiver for two of the decedents while the birth father was the primary caregiver for one of the decedents. CFSA was involved with one family at the time of the death. That case involved an older sibling who was in a kinship care placement and the decedent was not a party to the case. Prior to the decedent's death, the father assumed care of the child due to the mother's ongoing drug use; the father was in the process of obtaining legal custody. Only one of the decedent's siblings was born with a positive toxicology.

CFSA and its partnering agencies continue to recognize the necessity for education for the community on safe sleeping habits. CFSA front-line social workers and CPS nurses repeatedly document ongoing counseling for clients to follow safe-sleeping procedures. Even still, CFSA social workers often observe parents or caregivers who do not follow safe sleeping practices. To help caseworkers reinforce safe-sleeping habits in CY 2019, CFSA's ICFR committee included several recommendations regarding the promotion of safe-sleeping habits both for CFSA families and the District of Columbia in general. The *Recommendations* section of this report details the outcomes of the ICFR committee proposals and suggestions.

In gathering information on the types of services received or needed, the CFR Unit focused on a family's needs from a child's birth to case closure, including a mother's prenatal services, services for families with positive toxicology results for newborns, children diagnosed as medically fragile, and children with behavioral health or learning diagnoses. The following sections highlight the resulting data.

III. Family Supports and Services

Over the course of CY 2019, the CFR Unit noted family involvement with other health and human service agencies in the District within five years of the child fatality. The following sister agencies were included:

- Department of Behavioral Health (DBH)
- DBH's Addiction, Prevention and Rehabilitation Administration (APRA)
- Department of Disability Services (DDS)
- Department of Health (DOH) for services related to infant support through WIC (Women, Infants and Children)
- Department of Health Care Finance (DHCF) for Medicaid services
- Department Human Services (DHS) for income maintenance, e.g., Temporary Assistance for Needy Families (TANF) and the Supplementary Nutrition Assistance Program (SNAP)
- Department of Youth Rehabilitation Services (DYRS) for juvenile justice
- District of Columbia Superior Court (adult criminal justice system)
- Health Services for Children with Special Needs (HSCSN)
- Office of the State Superintendent of Education (OSSE)

In addition to CFSA's sister agencies, the CFR Unit also examined family involvement with contracted providers, including CFSA's contracted partnership with the Healthy Families/Thriving Communities Collaboratives (Collaboratives), other community-based service providers, as well as DBH-contracted behavioral health providers. By examining family involvement with these other public and private service providers, the ICFR committee hopes to recognize trends that will help inform Agency leadership on distinct service areas that could be flagged for fatality prevention measures, particularly to address the highest percentages of fatalities, i.e., older youth from violence and sleep-related fatalities for infants. Sharing fatality data across CFSA program areas during the monthly ICFR committee meetings also provides information into some of the systemic challenges.

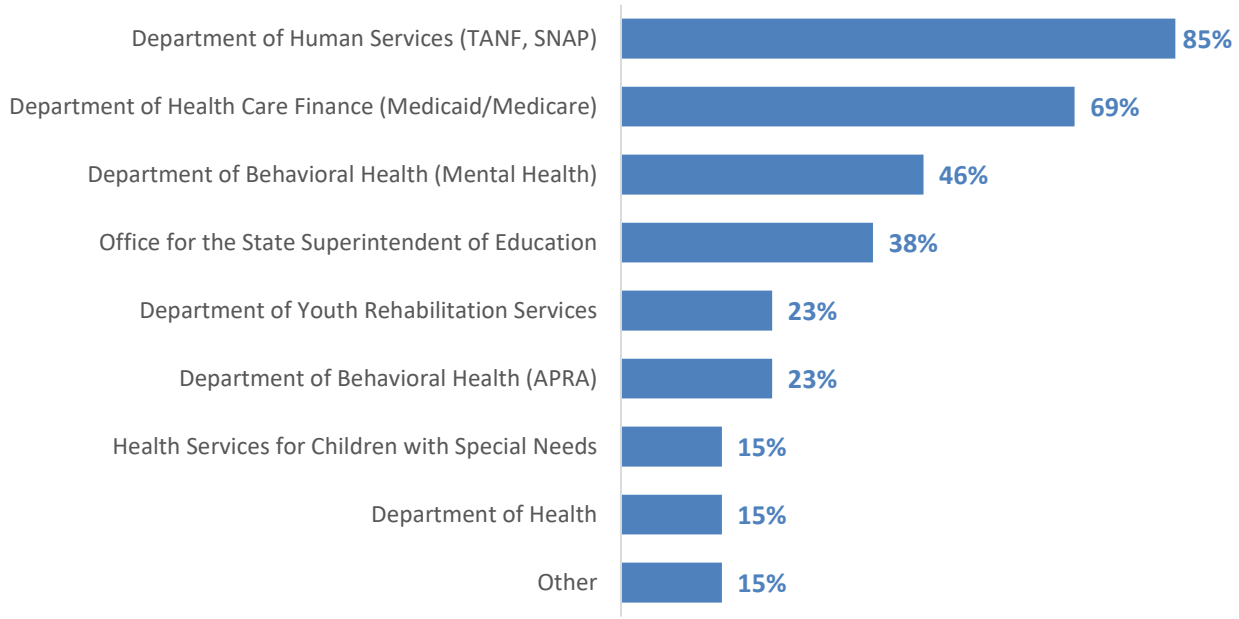
Family Involvement with Other Agencies within 5 Years of the Fatality

Many of the families involved with CFSA are also involved with other District agencies, i.e., receiving services specific to the individual agency (Figure G). CFSA recognizes that most of the families that come to the attention of the District's child welfare system experience financial struggles. Indeed, **most of the families (85 percent, n=11) of the CY 2019 fatalities were involved with DHS**, based on the need of financial assistance through programs like TANF and SNAP.

The second-highest agency involvement included DHCF for Medicaid services, accessed by 69 percent (n=9) of the families. Of the nine DHCF-involved families, 89 percent (n=8) also had DHS involvement. There were six families (46 percent) with a history of involvement with DBH, i.e., families receiving behavioral health services, which may include an array of therapeutic interventions; five of the six families also had DHS involvement. OSSE involvement (e.g., receipt of transportation services or truancy services) included 38 percent (n=5) of the families.[13] All five OSSE-involved families also had DHS involvement. For the three families (23 percent) with involvement with APRA (substance use prevention and treatment), two families were DHS involved.

[13] For purposes of a fatality review, OSSE involvement might include a family whose children received special education, transportation and truancy-related services; it does not reflect enrollment in a school governed by OSSE policies.

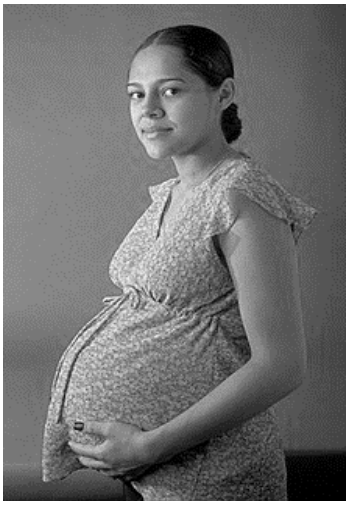
Figure G. Percentage of Families Involved with Other DC Government Agencies (n=13)



There were also three families (23 percent) involved with DYRS (i.e., the juvenile justice system for offenders under age 18) with two families involved with DHS services. All these families were DHS-involved. Another two families (15 percent) involved with contracted providers for services related to housing, mental health services, medication management and grief counseling.

For child-specific needs, HSCSN served 15 percent (n=2) of the families, all of whom were involved with DHS. For WIC services, two families (6 percent) were involved and both families were also involved with DHS. This level of cross-system involvement reveals the extent to which a family's economic circumstances (i.e., the family requires government-supported financial assistance) may often overlap with child welfare services.

Prenatal Services for Children under Age 2



Of the 13 child fatalities that occurred in CY 2019, almost half (46 percent, n=6) involved children ages two and younger. CFSA had knowledge of two mothers (33 percent) receiving prenatal care for their children. For these two mothers, their children were two months old when they died. One of the families had an open foster care case with CFSA. One of the children were born full-term while one is reported to have been premature. Neither child was born with a positive toxicology. There were no documented diagnoses for the two children. For both children, the official manner of death was "accident" with asphyxia as the cause, complicated by unsafe sleeping environments.

Children under Age 2 Born with Positive Toxicology

Of the six decedents who were ages two and younger, one child (17 percent) had a positive toxicology at birth (marijuana). The child was five months old at death. The child born with a positive toxicology was born prematurely; he did not have any confounding medical conditions. It is not known if the child's mother received prenatal services.

Birth Mothers with Previous Children Born with Positive Toxicology

CFSA had knowledge of one mother who birthed another child with positive toxicology. The sibling child was born with the positive toxicology results three years prior to the birth of the decedent. The mother had no documented history of substance use treatment or involvement with APRA.

Child Diagnostic History

Of the 13 child fatality cases reviewed, over half of the children (n=7) had documented diagnoses. Three children (23 percent) had one or more of the following medical-specific diagnoses: asthma, degenerative spinal muscular atrophy, diabetes, Down Syndrome or heart defects. Another two children (29 percent) had special education needs.

For mental health diagnoses, four of the 13 children (31 percent) had one or more of the following diagnoses: adjustment disorder, attention deficit hyperactivity disorder, bipolar disorder, disruptive behavior disorder, disruptive mood dysregulation disorder, and mood disorder. Of the four children with mental health diagnoses, two children (50 percent) also had special education needs.

IV. Family's Child Welfare History

Birth Parents' CPS History as Children

Six birth parents had CFSA history as an alleged child victim. Four of the six parents (66 percent) were birth mothers; two (33 percent) were birth fathers. There was no history of any birth parent being a victim child in another jurisdiction or state. For the mothers with a history as victims, CFSA placed two of the birth mothers in foster care as children. Of those two mothers, one mother had a new referral for their own children within 12 months of the child fatality; this mother also had an open foster care (permanency) case for another child at the time of the fatality. Although there was CFSA history for the two birth fathers, there was no documentation of foster care for the fathers as children.

Birth Parents' CPS History as Caregivers

Over three-quarters of decedents' birth parents had an open case or investigation within five years of the fatality. Of the 13 CY 2019 fatalities reviewed, 77 percent (n=10) had either an opened CPS investigation, family assessment (FA) referral, an in-home or foster care (permanency) case within five years of the fatality (Table 6). Eight households (62 percent) experienced at least one CPS investigation within five years of the fatality. Of these eight households, one family (8 percent) had a total of 10 investigations. Another family (also 8 percent) had a total of seven investigations. Two families (15 percent) had five investigations within the five-year-time span. One family (8 percent) had three investigations while two families (15 percent) had only one investigation within the five years.

Five of the 13 households that experienced a fatality during CY 2019 (38 percent) received FA referrals. Four families (31 percent) had one FA referral while one family (8 percent) had two FA referrals within five years.

Seven households (54 percent) had at least one screened-out referral within five years of the fatality; two families had four or more screened-out referrals within the five-year time span. One family had 10 CPS investigations and one FA referral within the five-year time span; the other family had five CPS investigations within the five-year time span.

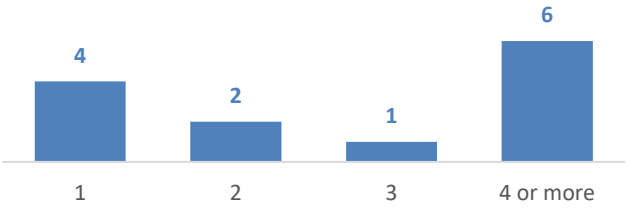
Table 6: Count of Caregiver CPS Referrals within Five Years of the Fatality

	1	2	3	4+	N/A	TOTAL
Screened-Out Referrals	3 (23%)	--	2 (15%)	2 (15%)	6 (46%)	**13 / 100%**
CPS Investigations	3 (23%)	--	1 (8%)	4 (31%)	5 (38%)	**13 / 100%**
Family Assessment (FA) Referrals	4 (31%)	1 (8%)	--	--	6 (46%)	**13 / 100%**
In-Home Case	1 (8%)	2 (15%)	--	--	10 (77%)	**13 / 100%**
Foster Care	5 (38%)	--	1 (8%)	--	7 (54%)	**13 / 100%**

Six of the 13 families (46 percent) had one foster care case opened within the five years. One family (8 percent) had three opened foster care cases within the same time frame. Three of the 13 families (23 percent) had an opened in-home case. Of these three, two families (15 percent) had two opened in-home cases while the remaining family (8 percent) had only one opened in-home case within five years of the child fatality.

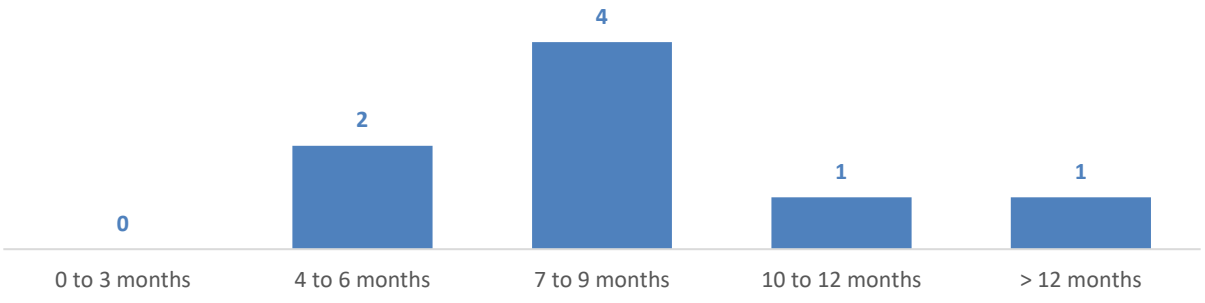
Approximately 70 percent of the decedents' families had multiple reports to CFSA within five years of the child fatality (Figure H). Four families (31 percent) had one report to CFSA within five years of the family while nine families (69 percent) had two or more reports to CFSA within five years. Of note, **more than half of the decedents' families (54 percent) had three or more reports to CFSA within five years of the fatality.**

Figure H. Frequency of CFSA Involvement within 5 Years of Fatality (n=13)



CFSA examined the time between a family's most recent case closure with CFSA in order to assess if additional services might have prevented the fatality or supported the family's stability towards overall safety and well-being (Figure I). Eight families (62 percent) had a CPS investigation, FA, or case closed within 5 years of the fatality. For those eight families, the time frame between case or investigation closure and the date of fatality ranged from 4 months to 13 months. Two of the eight families (25 percent) had a case closed within 4 to 6 months of fatality. Four families (50 percent) had their last case closed within 7 to 9 months of the fatality; one family (12 percent) had a case closed between 10 to 12 months. One family (12 percent) had a case closed 13 months prior to the fatality.

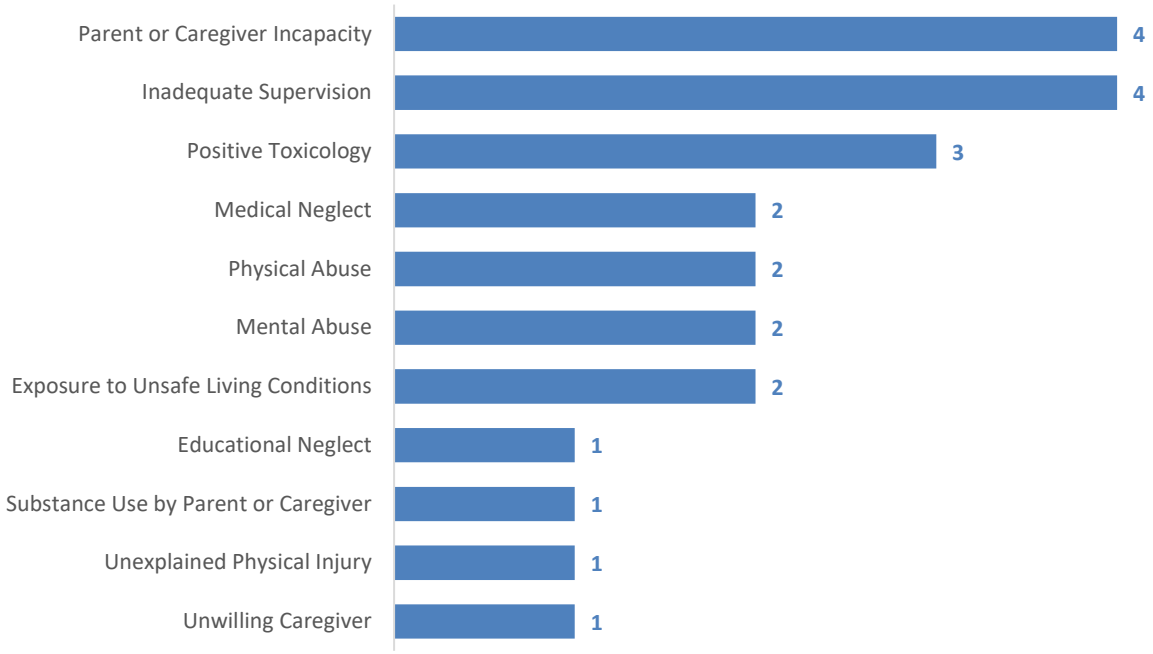
Figure I. Proximity of Most Recent Case or Investigation Closure to Child Fatality (n=8)



CPS Substantiations within Five Years of the Fatality

For the families with prior CPS investigations (n=8), all eight families had at least one allegation substantiated within five years of the fatality. Most substantiations were for neglect (Figure J). The neglect subcategories with the most substantiations were inadequate supervision (n=4; 50 percent) and parent or caregiver incapacity (n=4; 50 percent). The other substantiated allegations were for positive toxicology (n=3; 38 percent), medical neglect (n=2; 25 percent), physical abuse (n=2, 25 percent), mental abuse (n=2, 25 percent), exposure to unsafe living conditions (n=2, 25 percent), educational neglect (n=1, 12 percent), substance use by parent or caregiver (n=1; 12 percent), unexplained physical injury (n=1, 12 percent), and unwilling caregiver (n=1; 12 percent). **Six of the eight families (75 percent) had more than one substantiation during the five-year period.** Three families had three substantiations; three other families had four or more substantiations within five years of the fatality.

Figure J. CPS Substantiations within 5 Years of Fatality (n=8)



4+ Staffings within Five Years of the Fatality

CFSA conducts "4+ staffings" for families with four or more allegations with the last report occurring within the past 12 months. Staffing focus is on gaps in practice or service delivery that may have contributed to a family returning to CFSA's attention. Understanding the needs and gaps for these cases helps management take a closer look at strategies to prevent repeat referrals in the future.

CFSA's Hotline received four or more allegations for five families (38 percent). Of these five families, the four families (80 percent) were documented as having received a 4+ staffing. However, for the one family that did not receive a 4+ staffing, there was no explanatory documentation. Four of the five families had open foster care cases at the time of the fatality. For those four foster care cases, manner of death included one accidental death due to an unsafe sleeping environment, one abuse homicide, one homicide by a non-caregiver, and one unknown manner for a child who was declared "brain dead" upon arrival at the hospital.

CFSA opened five foster care cases out of the five families eligible for a 4+ staffing. One family received in-home services. Substantiations ranged from three allegations of inadequate supervision to four allegations for unwilling or unable caregivers. The Agency substantiated two of these families for medical neglect, and another two families for positive toxicology of a newborn. Of the two families substantiated for positive toxicology, both also had substantiations for inadequate supervision; one family had additional substantiations for substance use impacting parenting and unsafe living conditions.

Family Team Meetings (FTMs) within Five Years of the Fatality

FTMs are structured case planning and decision-making meetings that use skilled and trained facilitators to engage families and their informal supports (e.g., friends, clergy and substitute caregivers), resource parents (as applicable), guardian ad litem (if assigned), and other professional partners (e.g., service providers). CFSA encourages family members to take ownership of decision-making during the FTM in order to expedite and increase the potential for achieving a child's permanency. Per CFSA policy, the Agency conducts FTMs in the 72-hour period following a child being taken into custody, whenever a child is at risk of removal from the home, and at other points of critical decision-making, such as changing a permanency goal. Family members can request an FTM at any time throughout the life of the case. Social workers may schedule an FTM if a critical issue requires family involvement in case decision-making. All FTMs focus on making decisions to support children's safety, permanence, and well-being.

CFSA conducted FTMs for five of the 13 families (38 percent) within five years of the fatality. Ages of the children ranged from two months to 16 years old. All five families had either a CPS investigation, FA or case closed within five years of the fatality. Within 12 months of the fatality, all five families had an open permanency case; four families had an open permanency case at the time of the fatality. Manner of death for these fatalities included one natural death, one undetermined manner of death, one accidental death (complicated by unsafe sleeping behaviors), one homicide by a non-caregiver, and one abuse homicide.

V. Recommendations from CFSA's Internal Child Fatality Review

The CFSA ICFR committee makes recommendations concerning appropriate actions that may possibly avert future fatalities. In June 2019, the ICFR committee revised its protocol for reviewing potential recommendations related to child fatality prevention and general practice improvements (see Appendix B). Potential recommendations must be based on identified service gaps or areas for improvement related to programs, policies, accountability, or resources. When an idea for a potential recommendation is introduced during an ICFR meeting, members are asked to conduct research to provide additional information on the identified area of need. Once supporting information is presented, the committee will decide whether to approve the recommendation for the Agency's director to review. Recommendations related to fatality prevention are subject to the approval of the CFSA director and may be modified based on the director's feedback. While recommendations related to general practice improvements are shared with the director, the director's approval is required for recommendations that impact CFSA budgets, personnel, or policy.

During CY 2019, ICFR committee members provided quarterly updates to the director on recommendations presented in the 2018 Child Fatality Annual Report. The following themes were highlighted in the 2018 report:

- Safe Sleeping
- Medical Neglect
- Intervention Plans
- Four-Plus Staffings
- Multiple Prior Referrals

The committee also developed new recommendations during CY 2019 based on the following five themes:

- Communication with DC Health[14]
- ICFR Membership
- Communication with Local Jurisdictions[15]
- Electronic Recordkeeping for Critical Events and Unusual Incidents
- Evaluation of Environmental Risk Factors

Programmatic updates related to the 2018 ICFR recommendations were reported throughout CY 2019 at monthly ICFR committee meetings; new recommendations were proposed during monthly committee meetings and approved by the committee in March 2020. Updates and responses are current as of the writing of this year's report. Additional updates will be included in the 2020 report.

[14] The CFR unit has an established method of requesting death records from DC Health; however, the unit is investigating a potential update to an existing memorandum of understanding (MOU) to allow for additional data sharing. If the additional data is available to share between agencies, any amendments to the MOU would require director approval.

[15] Although the ICFR committee has approved a recommendation to improve interagency communication, the recommendation may be amended to include a potential policy change. If a policy change is recommended by the committee, the amended recommendation will require Director approval before implementation.

Updates on CY 2018 ICFR Recommendations

Safe Sleeping

Recommendation: Identify and remove communication and service gaps around safe sleeping as related to CFSA.

Status: Implementation complete.

Aligned Activities: The ICFR committee chair has attended monthly OCME Infant Mortality Review meetings to learn more about DC government agencies' involvement in infant fatality investigations and citywide recommendations related to preventing sleep-related deaths. The committee has also evaluated current safe sleeping strategies in the District, including materials disseminated to new parents and protocols for investigators & social workers who serve families with newborns and infants. The committee has also reviewed a summary of best practices as reported from other jurisdictions and published in evidence-based research articles.

CFSA's Health Services Administration (HSA) implemented the following activities related to safe sleep practices for families brought to the Agency's attention:

1. HSA partnered with DC Health for Safe Sleep training, which was provided to the nurses.
2. HSA ensured that moms have a Pack n' Play portable sleeper for safe sleeping. Moms must engage in one-on-one training with a nurse before receiving a Pack n' Play.
3. Nurses can now request return demonstrations by mothers to assess learning.
4. Nurses currently perform announced and unannounced follow-up visits to assess if guidelines are followed.
5. Nurses also provide educational materials on safe sleeping to families for reference.

In November 2019, the ICFR committee invited a representative from the National Institutes of Health to share safe sleeping best practices from other jurisdictions. The CARA[16] team has developed a brochure for parents about the impact of marijuana usage on babies. CFSA is in the discussion process for collaborating with other agencies and community-based partners to produce a short educational video (contingent to funding) for new and expecting parents about safe sleeping practices.

During CY 2020, the ICFR committee will continue its commitment to removing communication and service gaps around safe sleeping. Steps include inviting local partners who engage in safe sleeping work to present at an ICFR committee meeting to inform committee recommendations. In addition, the committee will be sharing ICFR recommendations with other local stakeholders who are interested in involved in promoting safe sleeping practices within the greater DC community.

Community Papering

Recommendation: Promote consistent protocols for elevating matters that warrant community papering.

[16] CFSA implemented new Hotline procedures for compliance with the Comprehensive Addiction and Recovery Act (CARA) of 2016. The procedures require investigations for every infant reported with positive toxicology and fetal alcohol syndrome. The CFSA CARA team includes representatives from the Health Services Administration, CPS Administration, Permanency Administration, In-Home Administration and OPPPS.

Status: Implementation complete.

Aligned Activities: The DC Office of the Attorney General reviews protocols with DC Family Court as part of regular meetings, providing updates to the ICFR committee when available. Community Partnerships has included guidance in a revised version of the In-Home Procedural Operations Manual.

Medical Neglect

Recommendation #1: Timely receipt of documentation from a provider regarding medical neglect, in order to determine the level of acuity necessary to appropriately identify next steps and to help motivate and align the necessary parties.

Status: Implementation complete.

Aligned Activities: In partnership with Children's National Medical Center, medical records' response time has improved significantly during CY 2019. Nurses are receiving records within 24-48 hours of submitting a request.

Recommendation #2: Assign the nurse care manager to all cases involving medical neglect.

Status: Implementation complete.

Aligned Activities: In 2018, HSA and CPS met to clarify and strengthen the partnership between the two administrations, including current processes. Progress is occurring through continued collaboration between both administrations. Nurse care managers are now assigned to all cases involving medical neglect.

Intervention Plans

Recommendation: Ensure that intervention plans have SMART goals,[17] and that they are appropriate for the family. SMART goals should be documented.

Status: Implementation complete.

Aligned Activities: Entry Services has been working with CFSA's Office of Planning, Policy and Program Support (OPPPS)on the revision and implementation of new intervention and safety planning protocols and trainings. The OPPPS' Policy Unit revised the Safety Plan Policy in May 2019. Policy roll-out included presentations to CFSA administrators and integration into the Agency's Child Welfare Training Academy curriculum for Safety and Risk Assessment.

4+ Staffings

Recommendation: Make 4+ staffings more consistent.

Status: Implementation complete.

[17] SMART goals are Specific, Measurable, Achievable, Relevant, and Time Limited.

Aligned Activities: During CY 2019, Entry Services developed a new 4+ staffing guidance document which aligns with the PCAP[18] model for documentation of cases, including new protocols for tracking cases. Staffings require over 12 months of involvement, including face-to-face meetings.

Multiple Prior Referrals

Recommendation: Explore protocols for receiving cases where multiple prior referrals have occurred (e.g., for educational neglect).

Status: Implementation complete.

Aligned Activities: Entry Services' Family Assessment Unit was eliminated, effective April 1st, with specialists reassigned to form additional units under CPS. New units have been specifically established for cases involving alleged institutional abuse and educational neglect. CPS is also implementing 4+ staffings more consistently to explore families that have received multiple prior referrals.

CY 2019 Recommendations Approved by the ICFR Committee

During CR 2019, the ICFR committee has approved five recommendations related to general practice improvements; none of the committee's recommendations were related to fatality prevention. Because the recommendations do not impact CFSA budget, personnel, or policy decisions, the director's approval was not required prior to implementation.

Communication with DC Health

Recommendation: Develop a process to obtain consistent and reliable information from DC Health on fatalities in the District so that decedents whose families have prior history with CFSA can be reviewed in a timely manner.

Status: Implementation in process.

Aligned Activities: The CFR Unit receives periodic information requests from OCME regarding child fatalities from prior calendar years. In many cases, the CFR Unit has been unaware of a fatality because the child's family did not have active CFSA involvement at the time of the child's death. CFSA has a memorandum of understanding with DC Health to provide birth and death certificates for children whose families were currently or previously involved with CFSA. During CY 2019, the CFR Unit developed a process for receiving decedents' information directly from DC Health for fatalities under the ICFR committee's review. Currently, a representative from the CFR Unit submits requests to DC Health to obtain death records for known decedents on a quarterly basis. The CFR Unit will continue to identify potential opportunities to improve the data-sharing process between the unit and DC Health.

ICFR Membership

Recommendation: Representatives from contracted placement provider agencies are invited to participate on the ICFR Committee.

[18] PCAP (Purpose, Content, Assessment, and Plan) is CFSA's new format for writing contact notes in the Agency's child welfare information system, FACES.NET. PCAP-based documentation effectively communicates a coherent and clinical narrative of client engagement, assessment, and progress towards safe case closure.

Status: Implementation ongoing (as needed).

Aligned Activities: In December 2019, the CFSA Child Fatality Review Policy was revised to include contracted child placing agencies as invited participants for all ICFR committee meetings. A representative from the National Center for Children and Families, one of CFSA's placement provider agencies in Maryland, has accepted an invitation to join the ICFR Committee. Children's Choice, one of CFSA's newest placement provider agencies, has also been invited to join the ICFR Committee and may join the committee in the future.

Communication with Local Jurisdictions

Recommendation: Establish notification protocols when Maryland and Virginia social service organizations are notified of deaths involving DC residents.

Status: Pending additional information.

Aligned Activities: Since July 2018, CFSA has engaged in quarterly meetings with representatives from Prince George's County, Maryland, to discuss collaboration and information sharing between counties. These formal meetings with Prince George's County were established due to the county's close proximity to the District of Columbia and the high number of children CFSA places in that county. CFSA staff will ask Prince George's County to determine if an official fatality notification protocol is in place at their next meeting in Spring 2020. CFSA reaches out to other local jurisdictions, including Maryland's Anne Arundel, Baltimore, and Charles Counties, as needed. If a new or revised protocol is recommended, a new recommendation will be submitted to the director for review.

Electronic Recordkeeping of Critical Events and Unusual Incidents

Recommendation: Establish consistent protocol for entering critical event information into the Agency's child welfare information system, FACES.NET, in addition to managing client files, responding to OCME information requests related to children with prior CFSA involvement, and logging follow-up activities stemming from unusual incident investigations by contracted providers.

Status: Implementation in process.

Aligned Activities: The Office of Planning, Policy, and Program Support (OPPPS) is working with the Contracts Monitoring unit to determine how and when information should be entered into FACES.NET and who is responsible for updating client notes. The teams are exploring potential training opportunities to brief private agency partners on how to enter follow-up notes in FACES.NET. At the present time, new information cannot be added to closed investigations and cases in FACES.NET; new information can only be attached to a closed investigation or case as an Information & Referral (I&Rs). The ability to add new information without re-opening a closed case or investigation has been communicated to CFSA's Child Information System Administrator for possible integration into CFSA's new computerized child welfare information system.

Evaluation of Environmental Risk Factors

Recommendation: Ensure that practitioners identify and evaluate all adults living (or potentially living) in the same home as a child in foster care.

Status: Implementation in process.

Aligned Activities: ICFR committee members share committee findings from monthly meetings with the program managers, supervisors, and administrators in their respective program areas. Through clinical supervision, supervisors will continue to work with social workers to identify adults who live or spend significant time in the home and ensure all adults are evaluated. Recommendations from current and prior annual reports will be shared with program areas.

VI. Conclusion

Child fatality reviews for CY 2019 reflect similar historical trends reported in previous years for families involved with the District's child welfare system. Although there was an increase in abuse and neglect homicides reviewed during CY 2019 (three in CY 2019 compared to zero in CY 2018), fatalities for the youngest and oldest populations remain highest. Fewer infant fatalities were noted in CY 2019 compared to 2018 (52 percent compared to 31 percent, respectively); additionally, the occurrence of sleep-related factors decreased from 91 percent in CY 2018 to 75 percent in CY 2019. For older youth fatalities, homicide continues to be the dominant manner of death.

Significant changes occurred in CY 2019 regarding the data gathering process for child fatality reviews. The CFR Unit improved its processes for requesting cause and manner of death information on decedents. The Unit also maintains a database that includes specific information on a family's service needs, a family's history with child protective services, and detailed demographics (e.g., caregivers' educational background, income, and housing). While not all of the information was included in this year's report, the CFR Unit will continue to refine data collection processes to discern how best to share relevant information for reducing child fatalities and improving practice both internally at CFSA and District-wide.

Appendix A: Program Descriptions

Entry Services

Child Protective Services (CPS) Administration

CPS Hotline

CFSA operates the District's Child Protective Services (CPS) Hotline for receiving child abuse and neglect reports on a 24/7 basis. Based on a screening of each report and using a structured decision-making tool, the Hotline workers determine the appropriate response pathway, e.g., Information and Referrals, CPS-Family Assessment and CPS-Investigations (CPS-I).

Hotline workers complete extensive training on how to respond to reports. This training includes Differential Response,[19] use of the structured decision-making (SDM™) Screening and Assessment Tool, and use of the SDM Hotline Screening and Assessment Tool.[20] In addition, the Hotline supervisors listen to Hotline recordings and calls in real time to ensure consistency with practice guidelines and requirements.

Information and Referrals (I&Rs)

I&Rs are calls that do not rise to the level of child abuse or neglect. With I&Rs, the Hotline worker may provide the caller with contact information for other District agencies, organizations, or service providers that can appropriately address the issue or concern. The following examples of calls may require consultation with a supervisor:

- A call has no allegations of child maltreatment involving a parent, but a caregiver desires to apply for legal custody or joint custody.
- A report involves a request for social services or information with no allegations of child maltreatment.
- A call from another jurisdiction requests a courtesy home assessment or interview for a family residing in the District. However, it is up to the discretion of the supervisor to send this referral type to a RED team[21] to determine if a screen-in is an appropriate response

CPS-Family Assessments (CPS-FA)

CPS-FA is a tailored response to certain initial reports of child neglect. During the CPS-FA response, the FA social worker partners with the family to identify strengths and needs so that the social worker can appropriately recommend service options for the family. Unlike an investigation, there is no finding

[19] Differential Response is an approach used by child welfare agencies under which severe allegations get a traditional investigation. When a child's safety is not immediately threatened, the alternative approach is a family assessment that looks at strengths and needs and then provides help outside the child welfare system.

[20] The SDM screening tool provides hotline staff with a clearly articulated and commonly understood process for gathering information and making decisions on how to respond to hotline reports. In developing the tool, CFSA reviewed allegation types currently in use by staff and further detailed definitions for each allegation. Staff access and review these definitions through the online version of the tool.

[21] RED (Review, Evaluate, and Direct) teams utilize the Consultation and Information Sharing Framework in a collaborative setting among multidisciplinary CFSA staff for decision-making. The framework allows for open discussion among participants while also providing the structure and consistency to ensure productivity and effective decision-making. Individual RED teams comprise six to eight individuals meet at key decision points in a case, such as home removal, placement changes, case assignment transfers, and permanency reviews.

(disposition) or entry of names into the District's Child Protection Register.[22] This non-adversarial CPS approach often results in families being more receptive to services. If a social worker identifies any safety concerns during the assessment, CPS-FA is converted to the investigation track (CPS-I).

CPS Investigations (CPS-I)
When the Hotline RED team determines that there are specific child safety concerns that require further investigation and analysis, an assigned CPS investigative social worker attempts to contact the family. Once face-to-face contact is made, the CPS social worker conducts a comprehensive investigation of the reported allegations. The social worker will also assess the family for risk and safety. If the child is not in imminent danger and therefore does not need to be removed from his or her family, but the risk is still high, the social worker develops a safety plan in partnership with the family and opens an in-home case. Otherwise, the family is referred to the Healthy Families Thriving Collaboratives, a community-based agency that will subsequently provide services and resources that address the family's unique needs and goals for stabilization.

In-Home Administration (IHA)
IHA social workers serve families in their homes in partnership with the Collaborative staff, providing community-based family support, preventative services, and comprehensive responses to families' needs. To better understand family functioning, the IHA social workers use the Caregivers Strengths and Barriers Assessment (CSBA) and the Risk Re-Assessment tool. IHA social workers also use three established standards based on assessment of family need (intensive, intermediate, and graduation) to determine the timeframe a family's case will receive intervention services.

Permanency Administration

The Permanency Administration provides support and direct case management to children in foster care with a permanency goal of reunification, guardianship, or adoption. This support includes consultation, technical assistance, and training for the ongoing social worker from the inception of concurrent permanency planning through the successful achievement of the permanency goal.

CFSA provides permanency supports and case management from the inception of concurrent permanency planning all the way through finalization of adoption or guardianship. During the concurrent planning process, the case management team develops and initiates a child-specific recruitment plans for these children while also generally laying the foundation for permanency options in the event that reunification becomes ruled out. For families and children who have reached permanency but might be experiencing challenges that threaten the permanent living arrangement, the Permanency Administration also provides temporary intervention and support services to stabilize crises.

Placement Services Administration (PSA)
Operating 24/7, PSA is responsible for identifying and facilitating placement of children in foster care, including all initial placements resulting from home removals and all replacement requests initiated by CFSA and private provider social workers.

[22] The Child Protective Registry (CPR) is an electronic database of names of individuals who have been substantiated for child abuse and neglect in the District of Columbia. Once CPR staff members receive substantiated reports from the CPS administration, staff makes appropriate entries, and releases information contained in the CPR database in a manner that is consistent with the law. CPR clearances are required for all resource parents and staff of child care institutions.

Foster Care Resources
To increase the likelihood that children are placed in the safest foster home possible, staff provides foster and adoptive resource recruitment and support services (i.e., licensing and training) to current and potential foster, kinship, and adoptive parents. In addition, through various outreach and public education campaigns and activities, Foster Care Resources ensures the availability of foster parents who are willing and able to meet the varied needs of children in the care of CFSA.

Office of Youth Empowerment (OYE)

OYE provides direct case management and concurrent permanency and transition planning services to older youth in foster care. OYE also works to achieve permanence for these older youth while providing life skills training, vocational and educational support, transitional assistance, and encouraging informal but committed relationships with safe, caring adults willing to act in a mentoring or parental capacity following a youth's exit from foster care.

Community-Based Contracted Services

Healthy Families/Thriving Communities Collaboratives
CFSA contracts with five community-based Collaboratives to provide a range of services that fall within three over-arching service categories: family support services, youth aftercare services, and community capacity building. As part of these contractual agreements, the Collaboratives must engage in (and report on) activities that encompass a wide range of efforts to strengthen and expand the neighborhood resources available to community residents. For each Collaborative, co-located CFSA in-home social workers partner with Collaborative family support workers to increase families' direct accessibility to services and referrals.

Appendix B: ICFR Committee Protocol for Recommendations

	Recommendations related to child fatality prevention	Recommendations related to general practice improvements
Focus of recommendation	Must relate to the direct or indirect prevention of future child fatalities due to abuse and/or neglect, based on a review of identified risk factors that may have contributed to child fatalities.	Can relate to any program, policy, resource availability or practice gaps and improvements.
Hypothetical example of the distinction between a fatality-related and a general practice recommendation	CFRC reviews a fatality involving a truant teenager and street violence during school hours. The discussion prompts follow-up information gathering efforts, which result in a recommendation for an MOA with DCPS to ensure prompt and reliable communication about attendance.	CFRC reviews a co-sleeping fatality and discovers evidence of an older sibling's truancy. The discussion prompts the committee member from the Office of Well-Being to follow up at the program level, in order to look for patterns and potential practice improvements to address the truancy issue. Any issues related to co-sleeping may result in a child fatality prevention recommendation.
Actual examples	CFSA should establish an MOA with DC Health to timely provide information on the cause and manner of death for all child fatalities CFSA should assign a nurse care manager to all cases involving medical neglect CFSA should revise safety and intervention planning protocols and training to promote consistent establishment of realistic and attainable goals	CFRC Chair will invite CFSA subject matter expert to upcoming committee meeting to explain FTM protocols and timeline Permanency program manager will instruct all supervisors to remind social workers of documentation requirements and best practices
Level of detail of recommendation	Must be based on identified service gaps or program, policy, accountability and/or resource areas for improvement (preferably data-driven) Must assign roles to responsible parties to act on recommendation Must establish an appropriate timeframe for implementation deliverables and updates	
	Should be conducive to measurable benchmarks and progress indicators (e.g., against national standards, mandated benchmarks or prior performance)	As with any CFSA activity, constructed based on common best practices, the expert judgment of assigned program deputies or administrators, and in accordance with applicable laws and regulations

	Recommendations related to child fatality prevention	Recommendations related to general practice improvements
CFRC Approval of recommendation to advance for the CFSA Director's Approval	When a recommendation is made during a CFRC meeting, all members must have an opportunity to provide feedback. Members not in attendance will be notified, via e-mail, within two business days of the meeting and asked to provide feedback. When an idea for a potential recommendation is introduced during a CFRC meeting, attending members can authorize a party or workgroup to complete preliminary activities in order to identify any potential recommendations to present to the CFRC for feedback and approval.	Will be implemented at the discretion of assigned deputies or administrators; however, any CFRC member may provide input At the next CFRC meeting, the assigned deputy or administrator will brief the committee on the status of the recommendation (i.e., whether it has been elevated for executive review, modified, or denied.)
Executive Review	In a quarterly report, the CFRC chair will notify the director of all recommendations and will provide progress updates on implementation.	
	Fatality prevention recommendations are subject to the Director's approval or modification. Changes will be shared with Committee members.	While the Director will be notified of recommendations through quarterly reporting, Executive approval will be obtained for recommendations that impact CFSA budgets, personnel, and/or policy.
Development, approval and implementation of recommendations	An idea for a recommendation - or for preliminary activities toward a potential recommendation - originates during a particular child fatality review or during general CFRC discussion CFRC chair confirms the recommendation or preliminary activities at the end of the CFRC meeting CFRC members classify the recommendation by domain (e.g., policy, practice, supervision, training, resource development, accountability, inter-agency activity, or suitable for the Citywide CFRC) When preliminary activities are needed (e.g., form a workgroup, conduct research, suggest implementation steps, develop possible benchmarks), committee members assign responsible parties and establish a timeframe for completion CFRC specialist records the recommendation or preliminary activities in the meeting minutes; sends reminders to responsible parties within two business days of the meeting and at least two business days prior to the subsequent meeting At subsequent meetings, responsible parties report back to CFRC members on progress (may submit materials prior to meeting)	

	Recommendations related to child fatality prevention	Recommendations related to general practice improvements
Development, approval and implementation of recommendations (cont.)	When discussing preliminary activities, which lead to a proposed recommendation, CFRC approves, modifies, or rejects proposal. Within two weeks, the CFRC Chair submits any approved recommendations to the Director in a memorandum. The Director approves, modifies, or rejects the recommendations and provides rationale for rejection or modification. Approved recommendations are implemented in accordance with CFSA work-plan protocols. The CFRC chair, in concert with the CFRC, will assign responsible administrations for implementation, communication, and monitoring, based on the scope, content, and nature of the recommendation.	Within the focus administration, recommendations are implemented based on common best practices, under the guidance of the deputy or administrator, and in accordance with applicable laws and regulations. Progress toward addressing and implementing the recommendations will be included in the CFRC quarterly report. (NOTE: Should a nexus to child fatality prevention be discovered during any phase of implementation, the CFRC may consider the activities for transfer to the protocol for recommendations related to child fatality prevention.)
Publication	All recommendations in both categories are included in quarterly reports to the CFSA Director	
	All recommendations must be reported in CFSA's Annual Child Fatality Report.	Observed trends and key practice changes that originated during CFRC discussions will be included in CFSA's Annual Child Fatality Report