Child and Family Services Agency Internal Child Fatality Report:

Statistics, Observations, and Recommendations

2020

Robert L. Matthews
Acting Director

Contents

I. Introduction

The 16th 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) 2020. Although CFSA reviews fatalities from prior calendar years as part of its internal continuous quality improvement (CQI) efforts, the 2020 Annual CFR Report focuses on fatalities that occurred during CY 2020.[2] Fatality reviews include only those children whose families were known to CFSA within five years of the child's death.

In March 2021, CFSA published the *2020 Child Fatality Review: Data Snapshot*, which presented a high-level data profile of child fatalities that were known to the agency as of the end of CY 2020. The present report provides additional information on the deceased children, their families, and their involvement with CFSA and other agencies within five years of the child's death.

Cases Reviewed

The 2020 Annual CFR Report includes findings from the CFR Unit's review of 40 families who experienced fatalities of children from ages 1 day to 24 years old[3] over the course of CY 2020, compared with 19 families in CY 2019 with children from 2 months to 20 years old. The CFSA CFR Unit examined demographic information, in addition to child welfare histories and receipt of documented services. As well, due to the Agency's specific focus on maltreatment and the increase in non-abuse youth homicides in CY 2020,[4] this report includes two new focus sections: (1) abuse and neglect homicides (n=3, ages 11 months – 7 years), and (2) non-abuse youth homicides caused by gun violence (n=20, ages 11-24).[5]

The CFR Unit presented the results of all fatality reviews to members of CFSA's monthly Internal Child Fatality Review (ICFR) Committee during monthly ICFR meetings. Committee members include the CFR Unit and manager, CFSA administrative leadership,[6] 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 known fatalities that occurred during CY 2020, 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

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

[2] In CY 2020, CFSA's Internal Child Fatality Review Committee reviewed an additional 15 fatalities that occurred during CY 2018 and CY 2019. Manner and cause of death, as well as CFSA involvement at the time of death are detailed in Appendix A. In total, there were 42 reviews in CY 2020. Appendix B includes a table of reviews and, specifically, abuse homicides since 2013.

[3] Although CFSA provides most child welfare services only until a youth reaches age 21, fatality reviews include youth past age 21 whenever a family was still involved within five years of the youth's death

[4] In CY 2020, there was an 85 percent increase (n=17) in the number of non-abuse homicides, compared to CY 2019 (n=3).

[5] The section on *Manner and Cause of Death* includes definitions of abuse or neglect versus non-abuse or neglect homicide.

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

the yearly data trends presented in this current Annual CFR Report to inform and guide recommendations for the 2021 report.

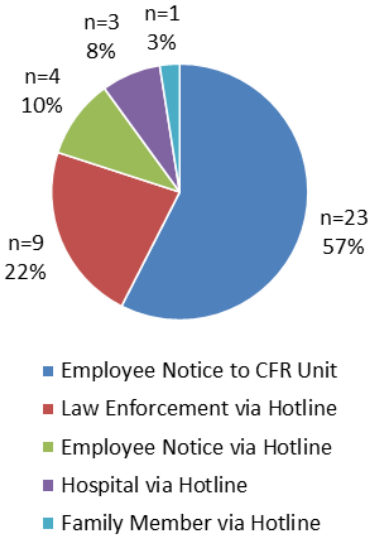
Case Review Methodology

The fatality review process is one of CFSA's strategies for examining and strengthening child protection. 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 of Columbia's Department of Health (DC Health), which is responsible for vital statistics. As a result, the CFR Unit now contacts DC Health 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, increasing data accuracy both for case presentation and the annual report. For the CY 2020 report, data is complete for manner and cause. "Cause of death" is defined by the "what," i.e., the specific disease or injury 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: (1) natural, (2) accidental, (3) suicide, (4) homicide, and (5) undetermined.[7]

The CFR Unit focuses first on whether a child's fatality occurred as the result of maltreatment by a parent, legal guardian, or a person acting in *loco parentis* (i.e., a person responsible for the child while the parents are absent). When CFSA or OCME deems a parent or caregiver is directly responsible for the death of the child, manner of death is labeled an abuse or neglect homicide. Non-abuse homicides apply only to a person not functioning as a caregiver, e.g., an individual in the community unknown to the child or family. Based on the available data for cause and manner of death of fatalities that occurred during CY 2020 (as of the writing of this report), CFSA has confirmed one neglect and two abuse homicides.

Figure A: CY 2020 Reporting Sources (N=40)



CFSA receives notification of fatalities from the District's 24-hour Child Abuse and Neglect Hotline. The Hotline receives notice from CFSA employees, local police, hospitals, and others. Of the 40 fatalities that occurred in CY 2020, CFSA learned of 23 (57 percent) from employees (Figure A). The CFSA Hotline learned of 17 specifically "critical event"[8] fatalities (43 percent) from the following sources:

[7] Source: https://ocme.dc.gov/sites/default/files/dc/sites/ocme/2017%20OCME%20Annual%20Reportupdated.pdf

[8] Per CFSA policy, "critical events" are events or incidents that threaten or compromise the well-being of a child or youth. Critical events require CFSA's immediate response and action.

- Police (n=9)
- Employees (n=4)
- Local hospitals (n=3)
- Family member (n=1)

The CFR Unit also looks at child and family involvement with CFSA at the time of the fatality. During CY 2020, CFSA was involved with 23 percent (n=9) of the 40 families with fatalities occurring in 2020.
In preparation for the 2020 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. That is, 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.

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[9] 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 40 known fatalities that occurred during CY 2020.

Table 1: Demographics According to Manner of Death

	Natural Causes	*Non-Abuse Homicide*	*Abuse or Neglect Homicide*	*Accident*	*Suicide*	*Undetermined[10]*	*Unknown*	*Total*
Age								
<1 year	6	0	1	4	0	1	1	13
1 – 5 years	2	0	1	0	0	0	0	3
6 – 12 years	0	2	1	0	1	0	0	4
13 – 17 years	0	4	0	0	0	0	0	4
18+ years	1	14	0	1	0	0	0	16
Total	**9**	**20**	**3**	**5**	**1**	**1**	**1**	**40**
Gender								
Male	5	16	2	5	0	1	1	28
Female	4	4	1	0	1	0	0	12
Total	**9**	**20**	**3**	**5**	**1**	**1**	**1**	**40**

Cause and Manner of Death

CFSA has partnered with the District of Columbia's Department of Health (DC Health) 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 98 percent (n=39) of the CY 2020 fatalities reviewed; cause and manner of death for one decedent was unknown because the fatality occurred outside of DC. The decedents ranged in age from one day to 24 years.

[9] 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.

[10] 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

Abuse and Neglect Homicides

There was one confirmed neglect homicide and two confirmed abuse homicides during CY 2020. The Agency learned of the neglect homicide of a 7-year-old African American male after out-of-state officials contacted the Hotline. The child and his two younger siblings were passengers in their mother's automobile during a long drive back to the local area from another jurisdiction. The family was then involved in an accident outside of the Metropolitan DC area. The 7-year-old child sustained major head trauma. Local physicians pronounced the child deceased at a hospital near the incident site. The other siblings suffered minor but non-life-threatening injuries. According to the report, none of the children were in car seats and local authorities confirmed alcohol in the mother's system. Law enforcement subsequently charged the mother with first-degree vehicular homicide, seatbelt violations for children under the age of five, and three counts of driving under the influence, endangering a child under 14 years old. Officials brought the mother into custody and released the surviving children to family members.

CFSA learned of the first abuse homicide when a Metropolitan Police Department (MPD) officer contacted the CFSA Hotline regarding the death of an 11-month-old African American female. The cause of death was blunt force trauma to the head. Law enforcement charged the birth mother with first degree felony murder and cruelty to children.

The Agency learned of the second abuse homicide when an MPD officer contacted the Hotline to inform CFSA that a two-year-old African American male was pronounced deceased. Cause of death was multiple blunt force injuries. Law enforcement officials arrested and charged the parents with first degree felony murder and cruelty to children.

Non-Abuse Homicides Caused by Gun Violence

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. **All 20 of the non-abuse homicides were caused by gun violence. DC Health confirmed cause of death by gun violence for 16 of the 20 decedents (80 percent), and MPD confirmed cause of death by gun violence for the remaining 4 of the 20 decedents (20 percent).** Among the 20 gun-related homicides, 16 decedents (80 percent) were male; the remaining four youths were female (20 percent).

Ages of the four females ranged from 21 to 24 years old. None of their families were involved with CFSA at the time of the fatality. Only one of the females (age 21) had confirmed knowledge of her assailant, a female who was arrested at the scene after shooting the decedent close-range in the head. The other three homicides related to presumedly "random" community violence. Two the female decedents were mothers: one had two children, ages two months and five years old, while the other mother had one child, aged two years.

Ages for the 16 male decedents ranged from 11 to 20 years old. Two of the male decedents (ages 18 and 20) had younger siblings in foster care at the time of the fatality. There is no evidence of any of the male decedents' having specific knowledge of their assailants. Ten of the 16 (62 percent) related to violence

in the community that was not specifically targeting the victim, including the 11-year-old who was caught in the crossfire of a gunfight. Two of the 16 decedents' fatalities (12 percent) related to criminal actions on the part of the decedents, one being shot by the intended victim of a robbery and one being shot by the police after the youth brandished a gun. Four of the 16 (25 percent) youths were known to have been involved with the juvenile justice system prior to their deaths. One youth of the 16 male decedents (6 percent) was a father. Reportedly, the youth had a one-year-old son as well as an unborn baby at the time of his death.

Natural Deaths

Twenty-three percent of the CY 2020 fatalities (n=9) were due to natural causes. Of the nine natural deaths, three fatalities were related to premature births. Three additional deaths were due to medical conditions at birth. A two-month-old decedent died of pneumonia of unknown onset. An 11-year-old child died due to complications from asthma. The death of a 22-month-old child was attributed to an intracranial hemorrhage unrelated to abuse.

Accidental Deaths

Five of the CY 2020 fatalities (13 percent) were deemed accidental. All five decedents were male. **Unsafe sleeping arrangements contributed to the cause of death for four of the five accidental deaths.** The exception was a 20-year-old male whose moped crashed into a car; the decedent was not wearing a helmet at the time of the accident.

Deaths by Suicide

One CY 2020 death was caused by suicide. A 12-year-old brother discovered his nine-year-old sister hanging by her bathrobe belt from the shower rod while their mother was at work. He immediately called 911. The child had not previously presented with any behavior that would have raised concern for suicide. The family received grief services.

Undetermined Deaths

Cause or manner of death is considered "undetermined" when autopsy findings are inconclusive. **One CY 2020 fatality was classified as "undetermined".** The decedent, a two-month-old infant, was found unresponsive after being swaddled for approximately two hours while resting in a motorized baby swing set. A blanket was placed in the motorized swing set to prop a pacifier so that it would stay in the baby's mouth. Although the cause and manner of death was deemed "undetermined," sleep-related factors may have contributed to the infant's death.

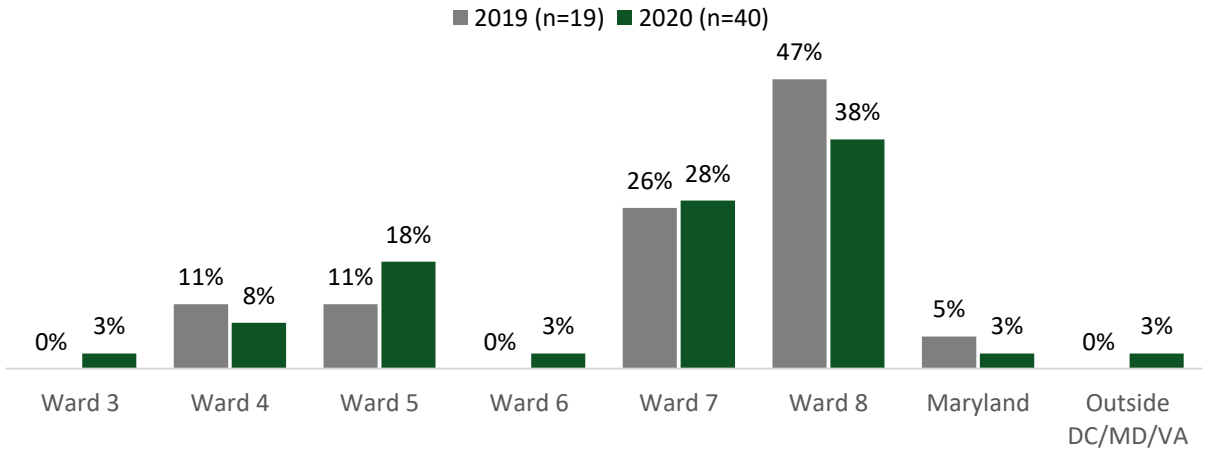
Child Welfare Involvement: Distribution by Ward

As shown in Table 2, the total number of children served by CFSA as of the end of CY 2020 was 1,909. Of these children, 673 (35 percent) were receiving foster care services and 1,236 (65 percent) were receiving services in the home. Collectively, the majority of children served were residing in Wards 5

Table 2: Children Served by CFSA as of December 31, 2020						
	Foster Care/Permanency		***In-Home***		***Total***	
Ward	n	%	n	%	n	%
1	30	4%	36	3%	66	3%
2	7	1%	12	1%	19	1%
3	8	1%	5	0%	13	1%
4	35	5%	83	7%	118	6%
5	123	18%	126	10%	249	13%
6	62	9%	77	6%	139	7%
7	180	27%	227	18%	407	21%
8	204	30%	407	33%	611	32%
Unknown	24	4%	263	21%	287	15%
TOTAL	**673**	**35%**	**1236**	**65%**	**1909**	**100%**

(n=249, 13 percent), 7 (n=407, 21 percent), and 8 (n=611, 32 percent).[11] Ward 6 represented the fourth highest number of children (n=139, 7 percent) followed by Ward 4 (n=118, 6 percent) and Ward 1 (n=66, 3 percent). Ward 2 (n=19, 1 percent) and Ward 3 (n=13, <1 percent) represented the smallest populations served by the agency.[12] These population percentages closely parallel the Ward distribution for the 2020 reviewed fatalities (see Figure B). The highest percentage of fatalities (38 percent, n=15) continued for Ward 8, despite Ward 8's 9 percentage-point drop from CY 2019. Of the 15 fatalities that occurred in Ward 8 in CY 2020, six decedents (40 percent) were under age 18. Ward 7 had the second highest Ward 7 had the second highest percentage of fatalities during CY 2020 (28 percent, n= 11). Of the 11 fatalities occurring in Ward 7 in CY 2020, eight decedents (73 percent) were under age 18. Ward 5 had the third highest number of fatalities for the District (18 percent, n=7) with three decedents (43 percent) under the age of 18. All three decedents were less than 1 year old. Two of the three infant

Figure B. Actual Child Fatalities by Ward Location - CY 2019 & CY 2020



[11] For additional data on CFSA's population, the agency provides a public data dashboard on CFSA's website. Interested parties can access the data dashboard here: https://cfsa.dc.gov/service/cfsa-data-dashboard

[12] Exact Ward residency was unknown for 287 children.

decedents died following complications related to premature births. The manner of death for the third infant fatality was abuse homicide, caused by blunt force trauma.

For Wards 3 and 6 (3 percent of CY 2020 fatalities, respectively), there was one fatality in each Ward. The Ward 3 decedent was under age 1 and died from complications of meconium inhalation at birth. The Ward 6 decedent was 24 years old and died from gunshot wounds.

There were three fatalities where birth parents and decedents were living outside of the District: two living in Maryland and one living in Pennsylvania. Of these fatalities, two of the decedents were under age 1. Manner of death was natural for both infants. Cause of death for one infant was pending at the time of this report; cause of death for the second infant was confirmed to be related to the infant's premature birth. The third fatality was a 24-year-old female whose cause of death was gunshot wounds.

In CY 2020, there were no child fatalities reviewed for Wards 1 and 2, compared to CY 2019 when there were no fatalities reviewed either outside of the District's Metropolitan area nor for Wards 1, 2, 3, and 6. Compared to CY 2019, fatalities in CY 2020 increased in Wards 3 (3 percentage points), Ward 5 (7 percentage points), and Ward 7 (2 percentage points). The proportion of fatalities decreased in Ward 4 (3 percentage points) and Ward 8 (9 percentage points), as well as in Maryland (2 percentage points). There was an increase (3 percent) in fatalities reviewed outside of the District's Metropolitan area for CY 2020.

Race and Ethnicity

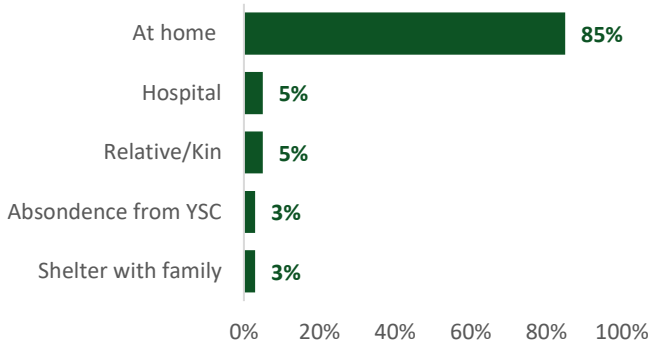
African Americans accounted for 98 percent of all child fatalities reviewed. Although African Americans accounted for 55 percent of the District's population under the age of 18 as of CY 2018,[13] African Americans disproportionately accounted for 98 percent (n=39) of the CY 2020 fatalities, compared to 95 percent (18 of 19) of fatalities in CY 2019. One decedent (3 percent) was of African origin with no known country of origin documented. None of the decedents were of Hispanic or Latinx ethnicity.

[13] U.S. Census Bureau, American Community Survey, *2018-2019 ACS 5-Year Data Profile:* https://datacenter.kidscount.org/data/bar/6747-population-by-age-group-by-ward?loc=10&loct=3#21/1852-1859/false/1729/838/13833.

Child Residency at the Time of the Fatality

Most children were living at home at the time of the fatality. Of the 40 child fatalities that occurred during CY 2020, 85 percent (n=34) were living at home at the time of the fatality (Figure C). Two children (5 percent) were living with relatives in a kinship placement. Two children (5 percent) resided at the Hospital for Sick Children while waiting for foster care placement. One child (3 percent) resided at a shelter with family. One youth (3 percent) committed to Youth Services Center (YSC) died while in abscondence.

Figure C. Child Residency at Time of Fatality (n=40)



Decedents in Foster Care Placements at the Time of the Fatality

Three decedents (8 percent) were in foster care at the time of their death. Two decedents were male and one was female. One child was less than one year old, and two children were less than two years old at the time of fatality. The manner of death for two children was natural causes. The manner of death for the third child is unknown because the fatality occurred out of jurisdiction.

Teen and Young Parenting as a Risk Factor

CFSA staff members have observed an age-related trend among parents of decedents, i.e., there are a significant number of parents who were under age 21 when the first child was born, regardless of how many additional children were born and not necessarily connected to the circumstances surrounding the manner and cause of death for the decedent. Of the 40 decedents reviewed in 2020, CFSA was able to gather data for 39 mothers and 33 fathers (n=72/80 parents, 90 percent).[14] Forty-three of the 72 parents (60 percent) had their first child when they were between the ages of 13 and 20. **Only two of the 43 parents were teens at the time of their child's death.** The two teen parents were the birth mother and birth father of the same child. The mother was 15 and the father was 16 when their newborn child died of complications from a premature birth. The remaining 41 parents were each over the age of 21 at the time of their child's death.

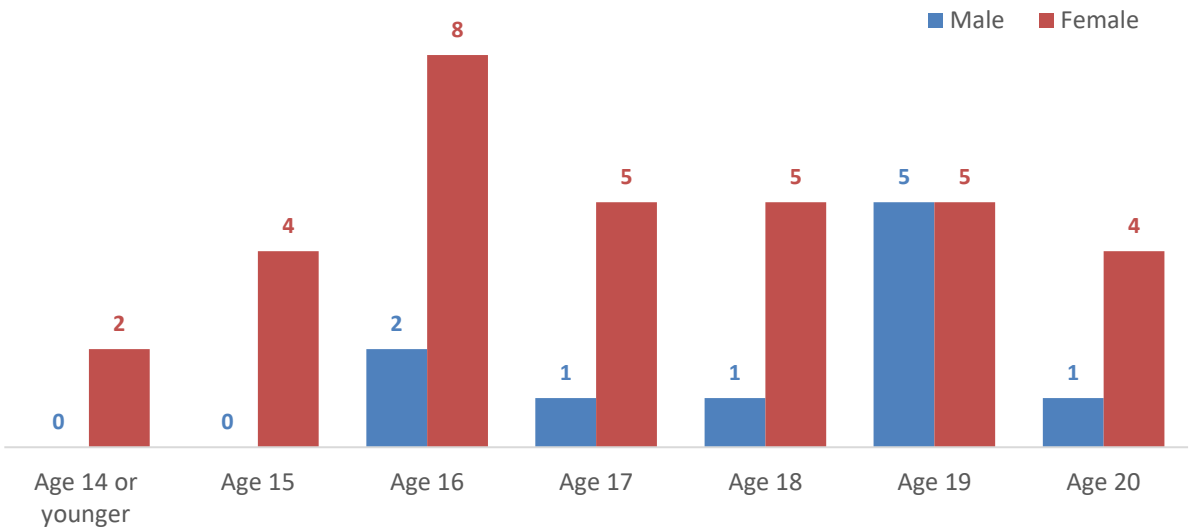
As Figure D shows for all 43 parents, there were 33 mothers (77 percent) and 10 fathers (23 percent) who were under the age of 21 when they birthed their first child. Two mothers were in the "14 and under" category when they first gave birth: the youngest was 13 and the other was 14. Four mothers were 15 years old when they gave birth to the first child. Twice that number gave birth to their first child at age 16 (n=8). For ages 17-19, there were five mothers each who had given birth to their first child. Four mothers gave birth to their first child at age 20.

[14] One of the mothers was deceased, and information for seven of the fathers was either unknown or the father was also deceased.

There are fewer fathers than mothers for all age categories. The youngest age for fathering was 16 years old. Including the 16-year-old father whose child died in 2020, there were two fathers who had their first child at age 16. There was one father each who first had a child at age 17, 18, and 20. Five fathers had their first child at age 19, the only age equaling the number for the mothers.

Ten of the 43 parents (23 percent) had history in the child welfare system as a victim child. Of these ten, one was a father. Four of the nine mothers had foster care history.

Figure D. Age Distribution of Young Parents When First Child was Born (n=43)

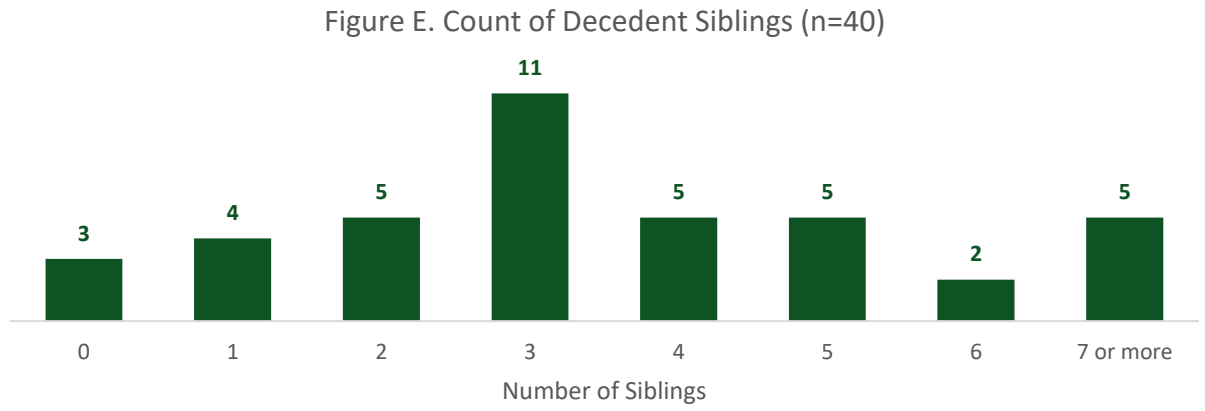


Based on information known about decedents' birth parents at the time of the fatality, seven of the 33 teen mothers (21 percent) graduated high school, one mother (3 percent) completed vocational school, and one mother (3 percent) obtained her GED. One of the 10 teen fathers graduated high school. Twenty-one percent of the mothers (n=7) and 40 percent of the fathers (n=4) were employed at the time of the fatality, and only two of the mothers had completed high school or vocational school.

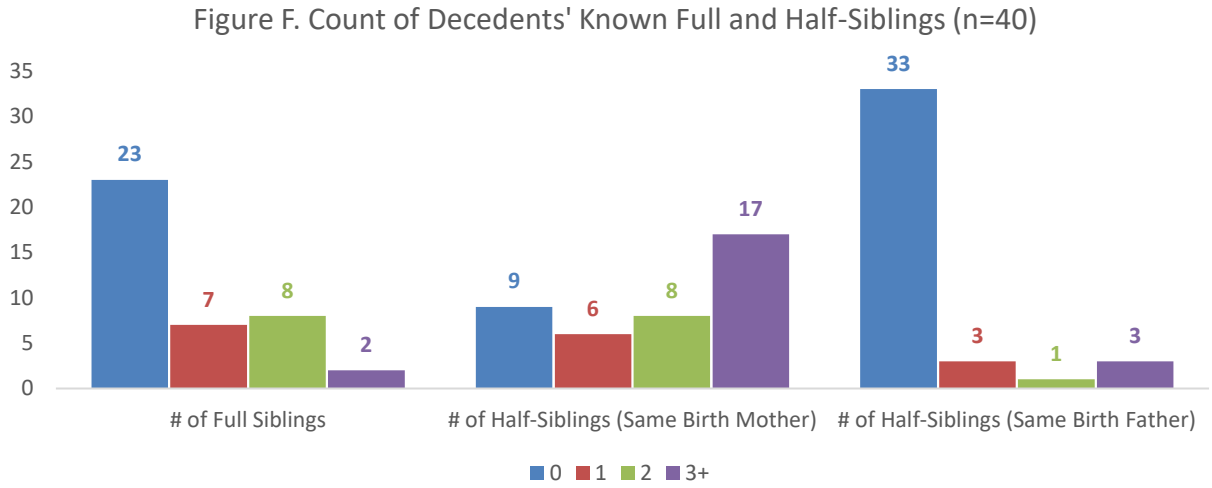
With many factors to consider, including education and child welfare history, CFSA is still in the process of exploring the implications for practice in light of the recurring age-based trends for parents who were under age 21 when their first was born and who also experienced a child fatality, sometimes years and many children later. As staff continue to analyze data, there may be future recommendations for specialized and culturally competent training and education of teen parents in CFSA's care.

Siblings

Seventy percent of decedents had three or more siblings (Figure E). Five decedents (13 percent) had two siblings. Four decedents (10 percent) had one sibling. Three of the decedents (8 percent) did not have any known siblings.



Full siblings and half-siblings:[15] Full and half sibling counts are presented in Figure F. Twenty-three of the decedents (58 percent) did not have any full siblings. Seven decedents (18 percent) had one full sibling, eight decedents (20 percent) had two full siblings, and two decedents (5 percent) had three or more full siblings. Thirty-seven decedents (93 percent) had at least one full or half-sibling. Three decedents (7 percent) did not have any known full or half-siblings.



Approximately 78 percent of the decedents had at least one half-sibling (n=31). Thirty-one decedents (78 percent) shared siblings from the same mother but different fathers. Seven decedents (18 percent) were known to share siblings from the same father but different mothers.

[15] 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, 10 percent of families (n=4) experienced a removal from the household where the fatality occurred. A total of eight children were removed: two were formally removed by Child Protective Services (CPS) and six were informally placed with relatives.

Table 3: Sibling Removals after Fatality		
# of Siblings Formally Removed	***# of Families***	***Total Siblings Removed***
One sibling	0	0
Two siblings	1	2
# of Siblings Informally Placed	***# of Families***	***Total Siblings Placed***
One sibling	0	0
Two siblings	3	6
Total	4	8

The manner of death of the decedent whose siblings were formally removed was abuse homicide caused by multiple blunt trauma injuries. The decedent's two older siblings were formally removed and placed in foster care. The three remaining decedents had two siblings each who were informally placed with relatives. For the first decedent, the manner of death was abuse homicide and caused by blunt force trauma to head. Manner of death for the second decedent was neglect homicide caused by trauma to head due to a car accident. The third decedent was a parent whose manner of death was homicide by gun violence; after the fatality, her two children were placed with a relative without CFSA involvement.

CFSA Involvement

The majority of families (78 percent, n=31) did not have active CFSA involvement at the time of the fatality. Nine of the 40 decedent families (22 percent) were involved with the District's child welfare system at the time of the decedent's death (Table 4). Two families (5 percent) had open CPS investigations. One family (3 percent) had an open In-Home case and an active CPS investigation. Five families (13 percent) had an open Permanency case. One family (3 percent) had an open Permanency case and an active CPS investigation.

Table 4: CFSA Involvement at Time of Fatality (n=40)		
	n	***%***
No Involvement	31	78
Open Permanency Case	5	13
Open CPS Investigation	2	5
Open In-Home Case and CPS Investigation	1	2
Open Permanency Case and CPS Investigation	1	2
Total	**40**	**100**

Of the CY 2020 fatalities reviewed, 43 percent of decedent families (n=17) had CFSA involvement within 12 months of the fatality. Eleven of the families (64 percent) had at least one investigation opened within 12 months of the child fatality while two families (12 percent) had a new or reopened Permanency case. Four families (24 percent) had a CPS investigation and a Permanency case opened within 12 months of the decedent's death.

Sleep-Related Factors for Infant Fatalities

Table 5: 3-Year Totals of Infant Fatalities[16] (Ages 2 and Under) by Calendar Year – Sleep-Related Factors			
Year	***2018***	***2019***	***2020***
# of Total Infant Deaths	16	7	16
# Sleep-Related	10	4	5
Percentage	63%	57%	31%

There has been a decrease in infant fatalities caused by sleep-related factors over the past three calendar years (Table 5). In CY 2020, there were 16 fatalities for infants aged two or younger. This is more than the number of infant fatalities reviewed in CY 2019 and equal to the number of infant deaths reviewed in CY 2018. Of the 16 infant fatalities that occurred in CY 2020, five fatalities (31 percent) involved unsafe sleep arrangements. This was lower in comparison to 63 percent in CY 2018 and 57 percent in CY 2019.

None of the five families with unsafe sleep-related fatalities were involved with CFSA at the time of the fatality. Two of the fatalities involved bed sharing of the infant with family members. Both families had Pack 'n Play bassinets in the homes at the time of the fatality. One fatality involved bed sharing in addition to an unsafe sleep surface on a couch. One fatality involved stomach sleeping and use of a pillow, and the fifth fatality involved the infant swaddled in a swing sleeper with a blanket cover. Two families had received safe sleep counseling during prior involvement with the Agency.

[16] Based on the additional CY 2018 and CY 2019 fatalities reviewed during CY 2020, the number of infant fatalities is higher than was reported in the 2019 annual report. Please refer to Appendix A for more information on these infant fatalities.

III. Family Supports and Services

Over the course of CY 2020, 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 that had contact with CFSA were also involved with multiple District agencies within five years of the fatality. Eighty-five percent of the families (n=34) of the CY 2020 fatalities were involved with at least one other District agency within the five-year period (Figure G). **Fourteen families (35 percent) were involved with four or more District agencies within five years of a child's death.**

Figure G. Linked DC Agencies within the Five-Year Period (n=40)

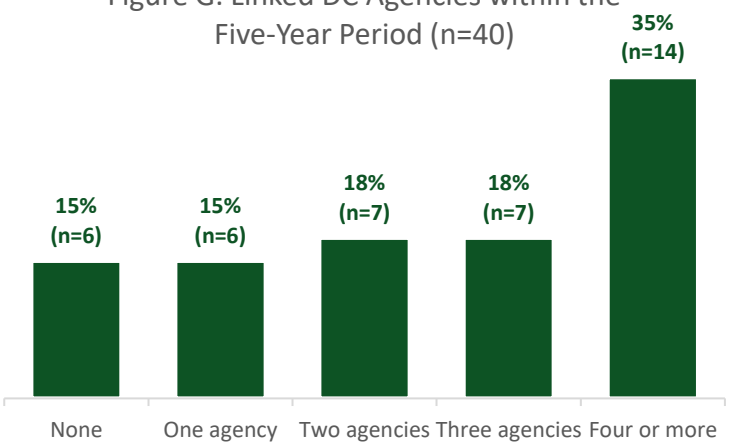
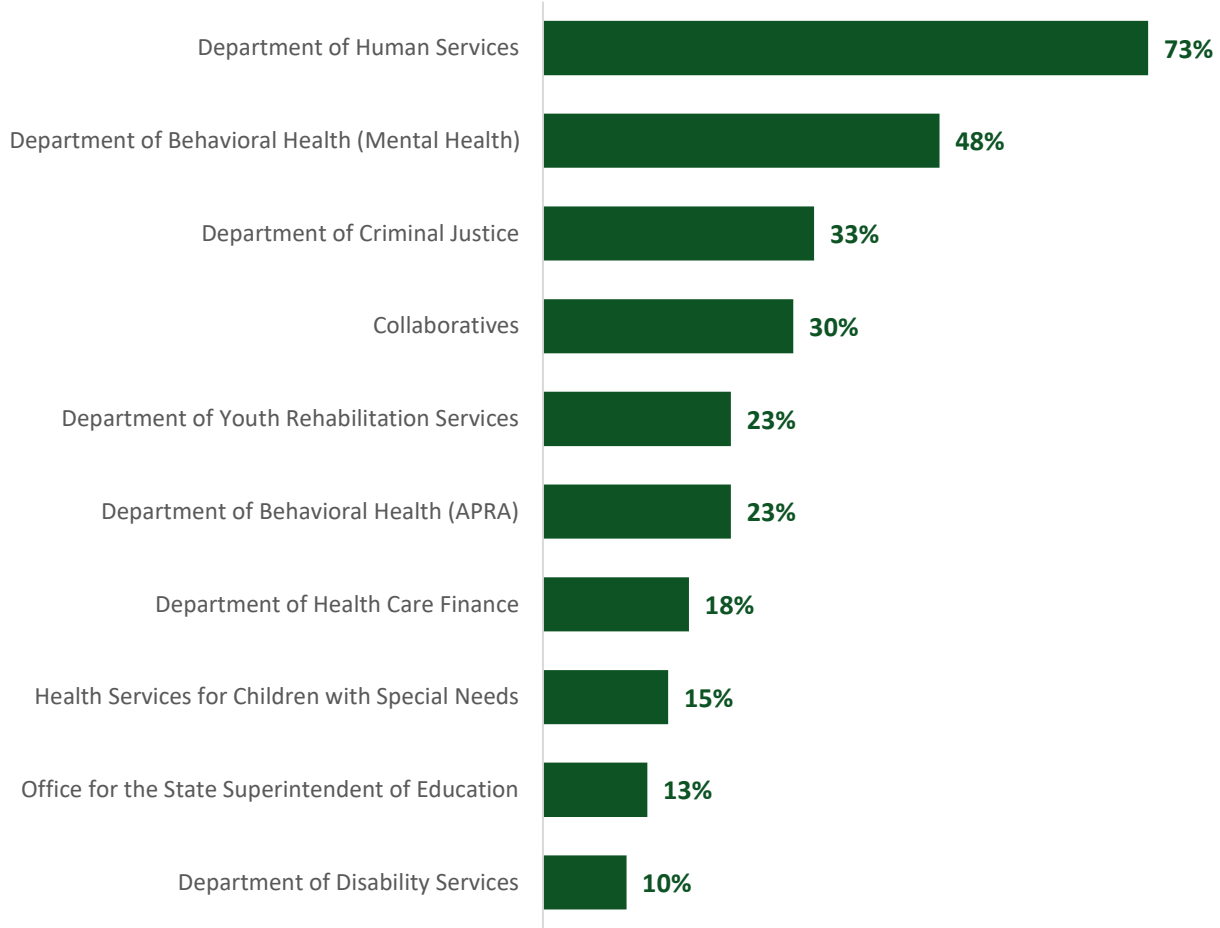


Figure H details the specific DC Government agencies that supported these families during the five-year review period. Most families (n=29, 73 percent) had financial insecurities and received housing, Temporary Assistance for Needy Families (TANF) and Supplemental Nutrition Assistance Program (SNAP) benefits through the Department of Human Services (DHS). Other agencies that supported these families during the five-year review period included Department of Behavioral Health (DBH; n=19, 48 percent) for mental health services, the Department of Criminal Justice (n=13, 33 percent) for youth ages 18 years or older, the Collaboratives (n=12, 30 percent) for supportive services, Department of Youth and Rehabilitation Services (DYRS; n=9, 23 percent) for juvenile justice, and DBH (n=9, 23 percent) for substance use. Eight of the nine families that were involved with DBH for substance use were also involved with DHS. All five families who received services through the Office of the State Superintendent for Education (OSSE) also had DHS involvement. Four families (10 percent) received support services through the Department of Disability Services.

Figure H. Percentage of Families Involved with Other DC Government Agencies (n=40)



Prenatal Services for Children Age 2 and under

Of the 40 fatalities that occurred in CY 2020, 16 children (40 percent) were ages two and under. Eleven of the children were male; five children were female. Six of the sixteen mothers (38 percent) received prenatal care for their children who ranged in age from 24 days to five months old when they died. Two of the mothers who received prenatal care had children that were born premature. Four of the six deaths were accidental with asphyxia as the cause due to unsafe sleep environments. One of the families had an open CPS investigation and an open foster care case with CFSA at the time of the child's death.

Decedents under Age 2 Born with Positive Toxicology

Of the 16 decedents who were ages two and under, four children (25 percent) had a positive toxicology at birth. Two decedents tested positive for THC/marijuana, one decedent tested positive for cocaine, and one decedent tested positive for both cocaine and marijuana. Only one of the four mothers received prenatal care.

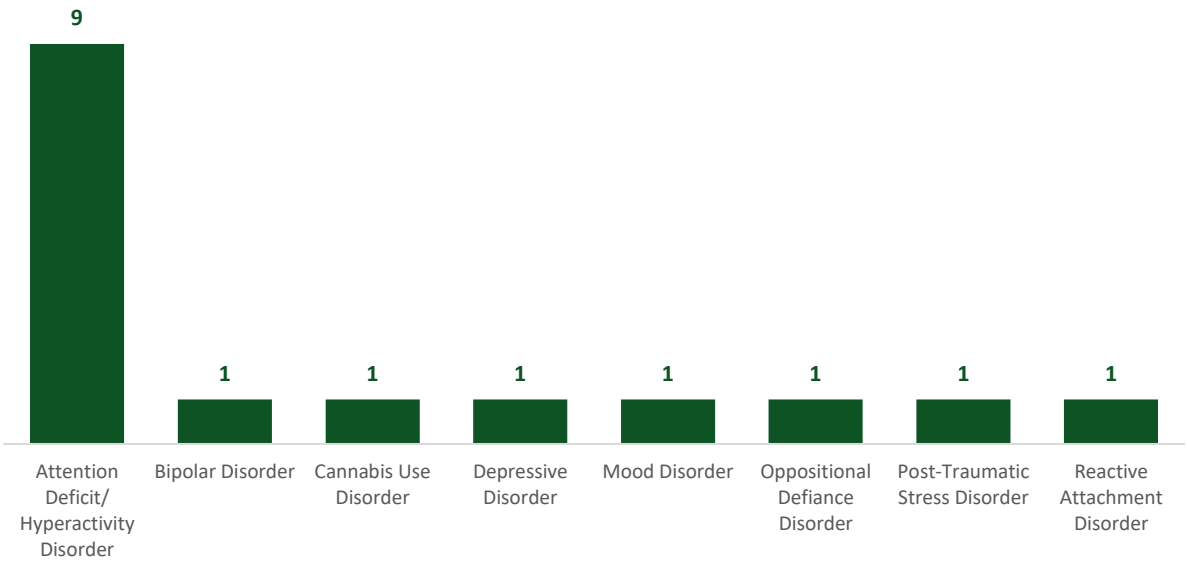
Birth Mothers with Previous Children Born with Positive Toxicology

CFSA had knowledge of four mothers who gave birth to a prior child (or prior children) who were born with positive toxicology. Two mothers (50 percent) had one child with a positive toxicology and their next child was also born with positive toxicology. All four mothers had their first child before they were 21 years old; only one mother was involved with DBH for substance use. Three mothers (75 percent) had one child with a prior positive toxicology in 2016 or 2017 and it was approximately 2.5 to 4 years before the birth of the decedent. One mother (25 percent) had four children, born in 2010, 2011, 2015 and 2019. This mother had a prior positive toxicology allegation that was only one year before the birth of the decedent. Only one of the four mothers who had a prior positive toxicology received prenatal care; the baby was born premature and also had a positive toxicology at birth.

Decedent Diagnostic History

Of the 40 child fatality cases reviewed, 10 children (25 percent) had documented mental health diagnoses (Figure I). Ninety percent (n=9) of the children had attention deficit hyperactivity disorder (ADHD) and thirty percent of them also had another DSM-5 diagnosis, i.e., bipolar disorder, depressive disorder, oppositional defiant disorder (ODD), or cannabis use disorder. Seven of the ten (70 percent) children with mental health diagnoses, also had special education needs.

Figure I. Mental Health Diagnoses of Decedents (n=10)



There were 10 children that had medical issues/diagnoses. 70 percent of the children (n=7) had birth related issues, i.e., prematurity, respiratory issues, Trisomy 18,[17] and microcephaly.[18] Three mothers (30 percent) had complications during pregnancy or delivery. Two children (20 percent) had asthma.

[17] Trisomy 18, also called Edwards syndrome, is a chromosomal condition associated with abnormalities in various body parts.
[18] Microcephaly is a condition where a baby's brain has not developed properly during pregnancy or has stopped growing after birth, resulting in a visibly smaller head size.

IV. Family's Abuse and Neglect History

Birth Parents' Abuse and Neglect History as Children

Eleven birth parents had abuse and neglect history as children. Nine of the 11 parents (82 percent) were birth mothers; two (18 percent) were birth fathers. Eight of the 40 decedents (20 percent) had birth mothers with prior CFSA history as children; the birth mother of the remaining two decedents had prior child welfare history in another state[19]. Both birth fathers had abuse and neglect history connected with CFSA. None of the decedents had both parents experience reported abuse or neglect as victim children.

Birth Mothers

Of the eight birth mothers with CFSA history as children, four mothers were placed in foster care through CFSA. One mother was placed in foster care at the age of 14 years due to parental substance use and aged out at the age of 21 years. Another mother was born with a positive toxicology for marijuana; her two younger two siblings were also born with positive toxicology for phencyclidine (PCP). All three children were removed from the home due to their mother's hospitalization for a PCP-induced episode. The third mother spent a considerable amount of time in foster care due to her mother's maltreatment. The fourth mother had a history of foster care placement as a child with no additional information available.

The other four mothers with CFSA history as children included: one mother who was removed due to history of sexual abuse by her stepfather when she was 13 years; one mother who had an extensive trauma history including sexual abuse, educational neglect, medical and mental health care neglect, lack of supervision and exposure to domestic violence; one mother who was hearing and speech impaired and had a history as a child for medical neglect; and one mother who had a child history for neglect and exposure to domestic violence.

Birth Fathers

Two fathers had CFSA history as children. One of the fathers resided with his maternal grandmother for an unspecified length of time. There was no additional information regarding the type of removal. No additional history information was available on the second father.

Birth Parents' CFSA History as Caregivers

Birth parents' CFSA history for the five-year period prior to the fatality were reviewed. This included CPS referrals screened out by the CFSA Hotline, CPS investigations, Family Assessments[20] (FAs), In-Home cases, and Permanency cases. An overview of decedent family involvement is provided in Table 6.

[19] Two of the CY 2020 decedents shared a birth mother but had different birth fathers. Their deaths did not occur on the same date and circumstances surrounding their deaths were unrelated. No additional information on the birth mother's child welfare history was available.

[20] CFSA discontinued the Family Assessment track as of April 1, 2019.

Table 6: Count of Birth Parents' CPS Referrals within 5 Years of the Fatality (n=40)					
	1	2	3	4+	TOTAL
Screened-Out Referrals	10 (25%)	7 (18%)	5 (13%)	16 (40%)	**38 (95%)**
CPS Investigations	12 (30%)	5 (13%)	6 (15%)	10 (25%)	**33 (83%)**
Family Assessment (FA) Referrals	13 (33%)	8 (20%)	5 (13%)	--	**26 (65%)**
In-Home Case	11 (28%)	6 (15%)	--	--	**17 (43%)**
Permanency Case	12 (30%)	1 (3%)	--	--	**13 (33%)**

Thirty-eight of the 40 decedent families (95 percent) had at least one referral screened out by the CFSA Hotline within five years of the fatality. Ten decedent families (25 percent) had one screen-out referral, seven (18 percent) had two screen-outs, five (13 percent) had three screen-outs, and 16 (40 percent) had four or more screen-outs.

Thirty-three decedent families (83 percent) had at least one CPS investigation opened within five years of the fatality. Twelve families (30 percent) had one CPS Investigation opened during the five-year period. Five families (13 percent) had two investigations, six families (15 percent) had three investigations, and ten families (25 percent) had four or more investigations.

Family Assessments were conducted for 26 decedent families (65 percent) during the five-year period prior to a fatality. Of these 26 families, 13 families (33 percent) had one FA, eight families (20 percent) had two FAs, and five families (13 percent) had three FAs.

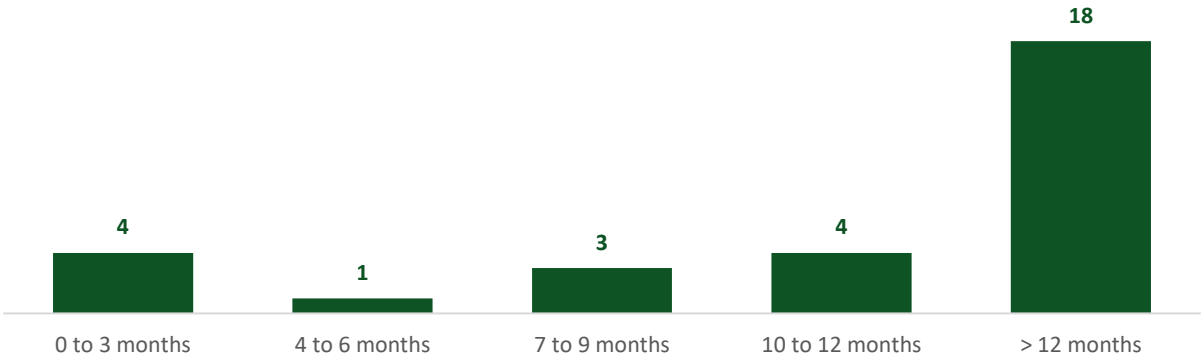
Twenty-three decedent families (58 percent) had at least one In-Home or Permanency Case opened within five years of the fatality. There were 11 decedent families (28 percent) that had an In-Home case opened within five years of the fatality; six families (15 percent) had two In-Home cases opened during the five-year period. Twelve (30 percent) of the 40 families had one Permanency case opened during the period, and one family (3 percent) had two Permanency cases. **Seven decedent families (18 percent) had at least one In-Home and one Permanency case opened within five years of the fatality.**

Figure J. Frequency of CFSA Involvement within 5 Years of Fatality (n=40)

All 40 of the birth parents' households (100 percent) had multiple reports (referrals and/cases) within five years of the child fatality (Figure J). Three families (8 percent) had two reports to CFSA within five years of the fatality; six families (15 percent) had three reports. Most notably, **31 families (77 percent) had four or more reports within five years of the fatality.**

For families without active involvement at the time of the fatality, CFSA examined the time between a family's most recent case or investigation closure with CFSA to assess if additional services might have prevented the fatality or supported the family's stability towards overall safety and well-being (Figure K). Thirty families (75 percent) did not have active CFSA involvement at the time of the fatality but had a CPS investigation, FA, or case closed within five years of the fatality.[21] For those thirty families, the time frame between case or investigation closure and the date of fatality ranged from 4 months to 56 months. **Sixty percent of families without active CFSA involvement at the time of the fatality (n=18) were last involved with the Agency at least one year prior to the fatality.** Four of the 30 families (13 percent) had a case or investigation closed within 3 months of fatality; one family (3 percent) had a case or investigation closed within 4 to 6 months. Three families (10 percent) had their last case or investigation closed within 7 to 9 months of the fatality; four families (13 percent) had a case or investigation closed between 10 to 12 months. Eighteen families (60 percent) had a case or investigation closed at least 13 months prior to the fatality.

Figure K. Proximity of Most Recent Case or Investigation Closure to Child Fatality for Families Not Involved with CFSA at Time of Fatality (n=30)

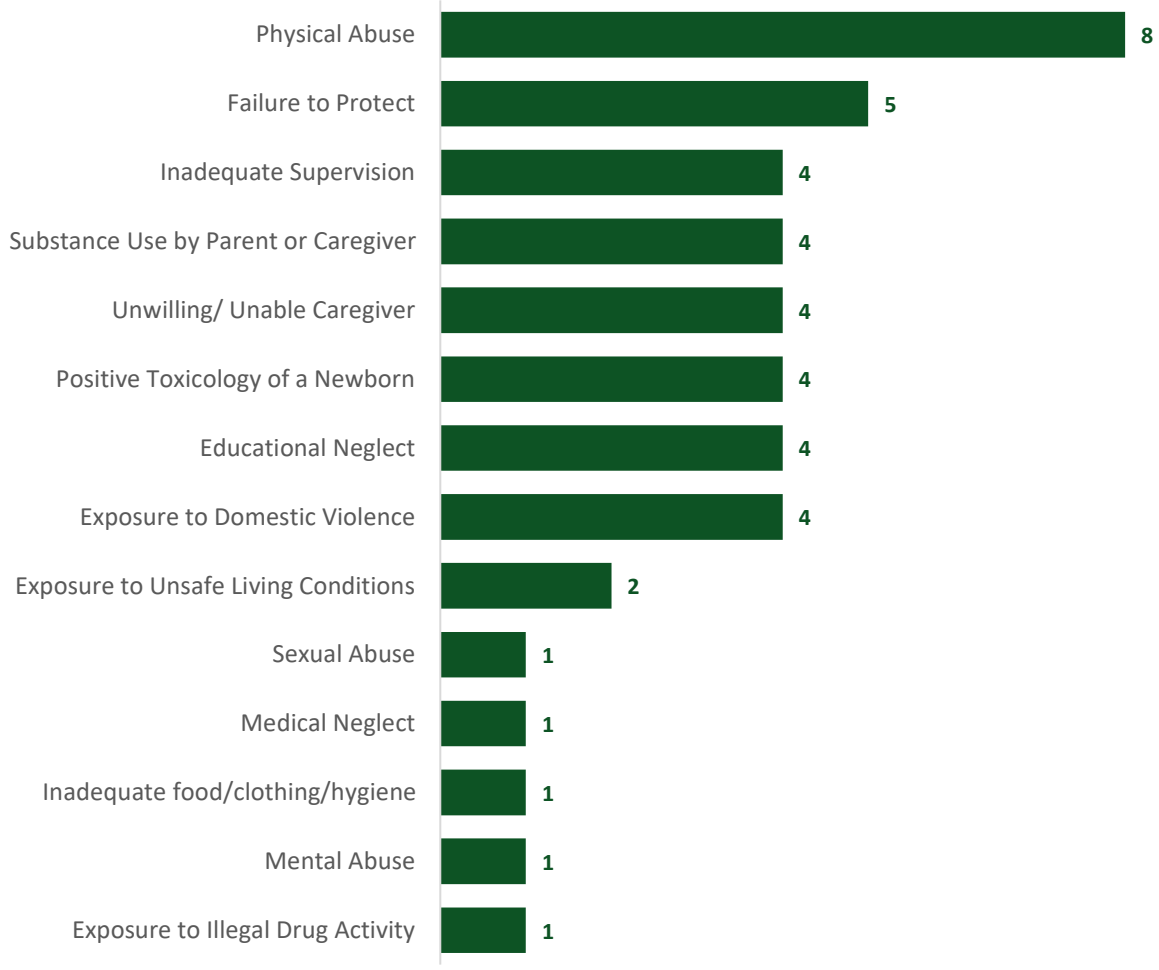


[21] Although 31 families did not have active CFSA involvement at the time of the fatality, one family did not have a CPS investigation, FA, or case closed within five years of the fatality. The family had four screen-outs during the five-year period.

CPS Substantiations within 5 Years of the Fatality

There were 19 families that had at least one substantiated allegation from a CPS investigation within the five years prior to the fatality.[22] Of these 19 families, eight families (42 percent) had one substantiation; four families (21 percent) had two substantiations; three families (15 percent) had three substantiations; two families (11 percent) had four substantiations, and two families (11 percent) had five substantiations. As shown in Figure L, there were a total of eight substantiated allegations for physical abuse; five substantiations for failure to protect; four substantiations for inadequate supervision, substance use by parent or caregiver unwilling/unable caregiver, positive toxicology of a newborn; four substantiations for educational neglect; four substantiations for exposure to domestic violence; two substantiations for unsafe living conditions; one sexual abuse substantiation; one medical neglect substantiation; one inadequate food/clothing/hygiene; one mental abuse; and one exposure to illegal drug activity.

Figure L. CPS Substantiations within 5 Years of the Fatality (n=19)



[22] A family may be substantiated for multiple allegations during one investigation or across multiple investigations.

Four-Plus (4+) Staffings within 5 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. Staffings focus 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.

Within five years before the date of the fatality, there were 15 of 40 families (38 percent) for whom the Hotline had received four or more allegations reported with the last report occurring within 12 months of the most recent allegation. **Of these 15 families, 100 percent received a 4+ staffing.**

At the time of the fatality, 4 of the 15 families (27 percent) had CFSA involvement. Of these four families, three included fatalities of infants under the age of 1 year. Two of the three infants were living at home, and one was living in foster care. The infant in foster care tested positive for cocaine at birth. His mother left the hospital without returning for her son. The agency substantiated the birth mother for substance use and positive toxicology, removing the child from the mother's care. Two of the infant fatalities were determined to be natural deaths; the manner and cause of death for the third infant was pending as of the writing of this report. The fourth fatality was a 20-year-old whose manner of death was homicide caused by multiple gunshot wounds.

Three of the four families had open foster care cases at the time of the fatality, one of which also had an open CPS investigation. The remaining family had an open CPS investigation at the time of the fatality.

Family Team Meetings (FTMs) within 5 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 13 of the 40 families (32 percent) within five years of the fatality. Ages of the children ranged from one day to 21 years old. Twelve of the 13 families (92 percent) had at least one substantiated allegation within five years of the fatality, including physical abuse, substance use impacting parenting, exposure to domestic violence, failure to protect, inadequate supervision, medical neglect, and positive toxicology results for infants. Within 12 months of the fatality, nine families (69 percent) had a new referral, including eight CPS investigations and four open foster care cases. Manner

of death for the nine fatalities included one abuse homicide, one neglect homicide, one non-abuse homicide, six natural deaths, and one death classified as undetermined. Five of the nine families had an open Permanency case at the time of the fatality.

V. Recommendations from CFSA's Internal Child Fatality Review

The CFSA ICFR committee makes recommendations concerning appropriate actions that may possibly avert future fatalities. 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 2020, ICFR committee members provided updates to the director on recommendations presented in the 2019 Child Fatality Annual Report. The following themes were highlighted in the 2019 report:

- Communication with DC Health
- ICFR Membership
- Electronic Recordkeeping for Critical Events and Unusual Incidents
- Evaluation of Environmental Risk Factors

The committee also developed new recommendations based on CY 2020 fatalities related to the following three themes:

- Primary and Secondary Traumatic Stress for Child Welfare Professionals
- Information Sharing Agreements with DC Government Agencies
- Tracking Patient Medical Histories and Providers

Programmatic updates related to the 2019 ICFR recommendations were reported throughout CY 2020 at monthly ICFR committee meetings; new recommendations were proposed during monthly committee meetings and approved by the committee in March 2021. Updates and responses are current as of the writing of this year's report. Additional updates will be included in the 2021 report.

Updates on CY 2019 ICFR Recommendations

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: 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 under the Agency's current memorandum of understanding (MOU) with DC Health. 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 is currently working with DC Health to develop a new MOU which will allow monthly data-sharing of fatalities of DC residents ages 26 and younger so that the unit can identify decedents whose families had CFSA involvement prior to their death and prepare fatalities reviews in a timelier manner. It is anticipated that the MOU will be finalized by the end of FY 2021.

ICFR Membership

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

Status: Implementation complete.

Aligned Activities: Representatives from the National Center for Children and Families and Children's Choice have accepted invitations to join the ICFR Committee and have attended ICFR committee meetings on a regular basis.

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: Currently, 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 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: Through clinical supervision, supervisors continue to work with social workers to identify adults who live or spend significant time in the home and ensure all adults are evaluated.

CY 2020 Recommendations Approved by the ICFR Committee

During CY 2020, new recommendations were proposed during monthly ICFR committee meetings related to CY 2020 fatalities and approved by the committee in March 2021. The ICFR committee approved one recommendation related to general practice improvements and two system-level recommendations related to sharing information related to interagency involvement and medical histories. Updates and responses are current as of the writing of this year's report. Additional updates will be included in the 2021 report.

Primary and Secondary Stress for Child Welfare Professionals

Recommendations: Provide support to child welfare professionals who experience client-related traumatic stress; report instances of stress within the Agency and document services rendered.

Status: Implementation in process.

Aligned Activities: CFSA convened a Secondary Traumatic Stress workgroup to examine the issue of traumatic stress across the agency and identify potential supports for Agency staff. Supports currently available to staff including training through CFSA's Child Welfare Training Academy (CWTA) on secondary traumatic stress and vicarious trauma; professional support and counseling through the INOVA Employee Assistance Program (EAP); and short-term, confidential, one-on-one or group intervention with a CFSA-contracted licensed clinical practitioner. Tip sheets were also developed for staff and supervisors on how to identify signs of traumatic stress, which resources are available to staff, and how staff can access resources and supports.

Information Sharing Agreements with DC Agencies

Recommendation: Improve information sharing between DC Government agencies to improve the quality of data available for investigations and case practice.

Status: Implementation in process.

Aligned Activities: A subcommittee of representatives from OPPPS, Entry Services, Permanency, the Office of Well Being, and the Office of Youth Empowerment have created an inventory of memoranda of understanding (MOUs) and memoranda of agreement (MOAs) with other DC Government agencies to determine what information-sharing protocols are currently in place. The subcommittee is also evaluating current gaps in information-sharing to inform potential updates to current MOUs and MOAs

and well as possible development of new MOUs and MOAs. Needs that are not currently addressed in existing MOUs and MOAs will be elevated if necessary.

Tracking Patient Medical Histories and Providers

Recommendation: Encourage use of a comprehensive medical information platform among hospitals and medical providers in the District of Columbia.

Status: System-level recommendation to be shared with the DC Citywide Child Fatality Committee.

Rationale: It has been observed that families may use different doctors in an attempt to hide patterns of abuse or neglect. The Chesapeake Regional Information System for Patients (CRISP) is the designated Health Information Exchange in Maryland and the District of Columbia, allowing for the electronic transfer of clinical information between health information systems; however, the system is not used by all medical providers. The use of a comprehensive medical information system across hospital and medical providers may allow providers to identify potential patterns of abuse or neglect, alert CFSA of new concerns, and possibly prevent abuse and neglect homicides.

VI. Conclusion

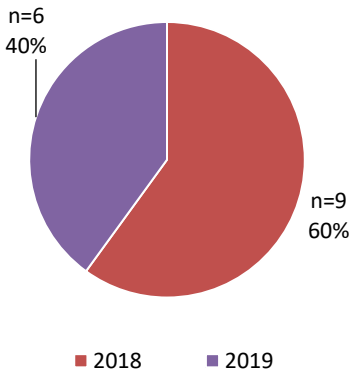
The child fatalities for CY 2020 reflect similar historical trends reported in previous years for families involved with the District's child welfare system. Compared to four abuse or neglect homicides occurring in CY 2019 (including one reviewed in CY 2020), there were three abuse or neglect homicides in CY 2020. Fatalities for the youngest and oldest populations remain highest with 16 of 40 fatalities (40 percent) accounting for children age 2 and under, which is an increase of 9 percentage points compared to CY 2019 (31 percent). The fatalities of 5 of the 16 children (31 percent) related to unsafe sleeping arrangements. All five of the children were under the age of 1. Youth aged 18 years or older accounted for another 40 percent of the fatalities that occurred in 2020 (n=16). For older youth fatalities, homicide continues to be the dominant manner of death.

The data gathering process for child fatality reviews continued to evolve in CY 2020. The CFR Unit reviewed and revised its processes again for the gathering of data and the quality control of that data. The Unit continues to maintain a database with specific information on a family's service needs, a family's history with the Agency, and detailed demographics (e.g., caregivers' educational background, income, and housing). Moving forward into CY 2021, the CFR Unit will also begin gathering data on the fatalities of older youth who may have also had children of their own. In addition, the ICFR Committee invited shared research on safe sleeping data and older youth homicides from other jurisdictions, as well as abuse and neglect homicides. CFSA as well as the CFR Unit is determined to ensure that accurate data continues to be disseminated and that transparency of data is accessible by all stakeholders, both internally at CFSA and district-wide.

Appendix A: Other Fatalities Reviewed during CY 2020

Historically, every CFR annual report has included review data outside of the calendar year, depending on when the CFR Unit received notification of a child's death. The ICFR Committee reviewed 42 fatalities during CY 2020; however, 27 fatalities (64 percent) occurred during CY 2020. The ICFR Committee reviewed all 42 fatalities to inform practice and policy recommendations to potentially reduce future child fatalities. The following data focuses on the 15 fatalities reviewed by the ICFR Committee which occurred prior to CY 2020.

Figure A1: Additional CY 2020 Reviews by Year of Fatality



Cases Reviewed

Of the 15 fatalities that occurred outside of CY 2020, nine fatalities (60 percent) occurred in 2018 with six additional fatalities (40 percent) occurring in 2019 (Figure A1). The CFR Unit presented the results of each of the 15 reviews to members of CFSA's ICFR Committee.

Demographics and Manner of Death

Table A1 provides an overview of the demographic information of the 15 decedents reviewed in CY 2020 who died prior to CY 2020. Of the nine fatalities occurring in CY 2018, only one of the decedents (11 percent) was a female. She died the same day as her birth. The manner of death was natural; the cause of death related to her premature birth. The other eight decedents (89 percent) were males. Four (44 percent) were infants under a year old. The manner of death for all four infants was natural. The cause of death for three of the infants related to complications from premature births; the cause of death for the fourth infant related to congenital defects. For the remaining four male decedents, the ages ranged from 15 to 18 years old. Manner of death for two of the males (age 17 and 18) was homicide; the cause of death was gunshot wounds. Manner of death for a 15-year-old male was determined to be accidental after the youth was thrown from a scooter that collided with a vehicle; cause was multiple blunt force injuries. Manner of death for the fourth male decedent, an 18-year-old, was natural; the cause of death was heart failure.

Of the six fatalities occurring in CY 2019, three were females and three were males. Of the three female decedents, two were infants under the age of one. The cause of death for both female infants was asphyxia. Manner of death was confirmed to be related to unsafe sleeping for one of the infants; the manner of death was officially undetermined (see Footnote 5) for the other female decedent. The third female decedent was 19 years old. Manner of death was homicide; cause of death was gunshot wounds. For the three male decedents, one of the decedents was under a year old. Manner of death was neglect homicide; the cause of death was asphyxia by drowning after the birth parent left the infant alone in the bathtub. Both of the other two male decedents were 17 years old. The manner of death for one of the

Table A1: Pre-CY 2020 Fatality Demographics According to Manner of Death								
	Natural Causes	***Non-Abuse Homicide***	***Abuse or Neglect Homicide***	***Accident***	***Suicide***	***Undetermined[23]***	***Unknown***	***Total***
Age								
<1 year	5	0	1	0	0	2	0	8
1 – 5 years	0	0	0	0	0	0	0	0
6 – 12 years	0	0	0	0	0	0	0	0
13 – 17 years	0	2	0	2	0	0	0	4
18+ years	1	2	0	0	0	0	0	3
Total	**6**	**4**	**1**	**2**	**0**	**2**	**0**	**15**
Gender								
Male	5	3	1	2	0	0	0	11
Female	1	1	0	0	0	2	0	4
Total	**6**	**4**	**1**	**2**	**0**	**2**	**0**	**15**

youths was homicide; the cause of death was gunshot wounds. The manner of death for the second 17-year-old youth was accidental; the cause of death was accidental when the youth was a passenger in an automobile crash.

Case Status

Fourteen of the 15 decedent families (93 percent) did not have active involvement with CFSA at the time of their death; the remaining family had an open Family Assessment at the time of the fatality. The one-day-old decedent died of natural causes due to extreme prematurity at 22 weeks of gestation. The Family Assessment social worker was not aware of the birth mother's pregnancy or the decedent's birth.

[23] See "II. Demographics and Findings," footnote 10 on p. 4 for more information about undetermined manner of death.

Appendix B: Fatality Reviews from CY 2016 to CY 2021 Q2

		Year of Internal Review*						# Abuse or Neglect Homicides***
		CY 2016	CY 2017	CY 2018	CY 2019	CY 2020	CY 2021**	
Year of Fatality	CY 2013	1						--
	CY 2014	3						--
	CY 2015	10	3	5	2			--
	CY 2016	**6**	5	5	1			2
	CY 2017		**18**	11	7			0
	CY 2018			**21**	10	9		0
	CY 2019				**13**	6		4
	CY 2020					**27**	13	3
	CY 2021**						**3**	0
	TOTAL	**20**	**26**	**42**	**33**	**42**	**16**	--

* Numbers in gray shaded boxes represent the number of fatalities that were reviewed during the calendar year in which the fatality occurred.

** CY 2021 totals represent reviews conducted as of March 30, 2021.

*** Abuse and neglect homicide counts are included from CY 2016 up to March 30, 2021. Note: there were no abuse or neglect homicides for the CY 2013, 2014, and 2015 fatalities reviewed since CY 2016.

Appendix C: 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 use of the structured decision-making (SDM™) Screening and Assessment Tool and use of the SDM Hotline Screening and Assessment Tool.[24] 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[25] to determine if a screen-in is an appropriate response

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

[24] 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.

[25] 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.

reported allegations. The social worker will also assess the family for risk and safety, partnering with the family to identify strengths and needs so that CFSA can appropriately recommend service options for the family. If the child is not in imminent danger and therefore does not need to be removed from his or her family, CFSA may refer the family to one of the Healthy Families Thriving Collaboratives, community-based agencies that will subsequently provide services and resources that address the family's unique needs and goals for stabilization. If the social worker identifies high risk for safety, the social worker develops a safety plan in partnership with the family and opens a case with CFSA's In-Home Administration.

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.

Office of Program Operations

The Office of Program Operations has oversight responsibility for CFSA's Placement Administration, Permanency Administration, and Office of Youth Empowerment. Each of these divisions and their respective services along the continuum are outlined in the following sections:

Placement Administration

The Placement Administration, which operates 24 hours per day, 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 or CFSA's contracted private social workers. This administration is also the principal purchaser of placement resources (in collaboration with CFSA's Contracts and Procurement Administration). As such, Placement is also responsible for managing those resources.

To increase the likelihood that children are placed in the safest foster home possible, CFSA's Family Resources division provides foster and adoptive resource recruitment and support services to current and potential foster, kinship, and adoptive parents. In addition, through various outreach and public education campaigns and activities, Family Resources works to increase the array of available resource parents who are willing and able to meet the varied needs of children in the care of CFSA.

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. To optimize their support capacity,

permanency case managers (and ongoing social workers) receive consultation, technical assistance, training, clinical supervision and coaching from the inception of permanency planning through the successful achievement of the child's permanency goal.

CFSA's permanency-focused teaming process consists of regularly scheduled team meetings that occur within the first seven months of a child's entry into foster care. Each of these meetings has distinct purposes, decision points and participants. For example, the meetings that occur during the hours and days following a child's removal from the home will focus on facilitating a smooth transition into care, identifying kin resources, and outlining specific action steps toward reunification. Meetings that occur in the following weeks and, if necessary, months, focus on developing a comprehensive case plan based on assessments and strategies developed in accordance with team members' clinical judgment.

The Permanency Administration provides supports and case management from the inception of permanency planning all the way through finalization of adoption or guardianship. In so doing, case practice specialists provide technical assistance to social workers who have children on their foster care caseload with permanency goals of adoption or guardianship. These professionals partner together to develop and initiate child-specific recruitment plans for these children while also generally laying the foundation for permanency options in the event that reunification becomes ruled out.

The Permanency Specialty Unit (PSU) provides both pre- and post-adoption support for families. PSU social workers assess the family's needs, refer the family to appropriate services, and provide support and crisis counseling services to help prevent disruptions during the family's transition into adoption. The unit also includes a family support worker who conducts adoption searches. 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.

CFSA does not handle nor case-manage any inter-country or private adoptions. The Agency serves only children in the District's foster care system (including cases managed by our private agency partners in Maryland). Within that parameter, individuals who contact CFSA regarding an inter-country adoption are referred to private agencies. Families who request adoption services may also be referred to the local Adoption Resource Center. For families who wish to adopt outside of the United States, there are a host of support groups and other resources available to them. Post-adoption support services are also offered by many of the area's private adoption agencies for these families.

Lastly, the Adoption and Guardianship Subsidy Unit makes post-permanency subsidies possible for children who might not otherwise achieve permanent homes. Subsidies cover maintenance and special services to meet the needs of the child until age 18. Families may also receive a one-time reimbursement of out-of-pocket expenses related to adoption finalization. Subsidies for adoptions and guardianships are funded for children eligible to receive Title IV-E monies, or through local funding for children who do not meet Title IV-E eligibility requirements.

Office of Youth Empowerment (OYE)

OYE provides direct case management and concurrent permanency and transition planning services to older youth in foster care (ages 15 up through age 20). OYE works to achieve permanence for these older youth while at the same time 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.

OYE administers the Chafee Foster Care Independence Program (CFCIP) and assists adolescents and young adults to acquire the skills and knowledge necessary to live independently. Through CFSA and community-based services, OYE promotes permanency; encourages lifelong connections to family, friends, and community; provides education and vocational opportunities, and supports the development of life skills that enable adolescents to achieve self-sufficiency.

Kinship

The Kinship Administration works with the assigned social worker and family members to identify and engage potential kinship resources. Kinship staff assess whether any identified relatives can be a viable placement and permanency option. In addition, kinship staff conducts the Family Team Meetings (FTM) that occurs throughout the life of a case. FTMs allows for more collaboration with parents for identifying case plan goals, including informal and formal supports for the parent and children, and as appropriate, parents also help to identify placement and permanency options.

Office of Well Being

CFSA's Office of Well Being (OWB) provides clinical supports and a service array that aligns with the health, wellness, educational, and other needs of children and families involved in the District's child welfare system. OWB further ensures effective teaming with social workers by obtaining pertinent information for children and families that will lead to effective and timely delivery of appropriate services and supports.

Within OWB, clinical staff include mental health therapists and a psychiatric mental health nurse practitioner who assess service needs for children and youth in foster care. In addition, there is a program specialist who leads a multidisciplinary team to decide when a child or youth potentially needs a higher level of care in a psychiatric facility and liaisons with the DC Department of Behavioral Health in that process (when required).

The OWB oversees domestic violence, substance use, mentoring, tutoring, CSEC, transportation contracts and services in addition to childcare vouchers and education supports. Educational specialists, resource development specialists for substance abuse and the program specialist for domestic violence provide supports to social work staff, youth, and families.

Within OWB, CFSA's Health Services Administration (HSA) has primary responsibility for assessing, coordinating, and maintaining the services to ensure optimal health and well-being of children. There are nurses specifically assigned to the Office of Entry Services to provide consultative support to CPS investigative social workers. HSA manages CFSA's Healthy Horizons Assessment Center (HHAC), an onsite, 12-hour (9:00 a.m. – 9:00 p.m.), 5-days-a-week clinic staffed with nurse practitioners and certified medical assistants who provide health screenings prior to placement. HHAC also provides on-call support after-hours, weekends, and holidays. In addition, CFSA has established the nurse care management program (NCMP) for children entering care that require medical oversight for chronic or complex medical conditions. Lastly, there are registered nurses assigned to support children and families and in-home community social workers (co-located at the Collaboratives).

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 D: 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