GOVERNMENT OF THE DISTRICT OF COLUMBIA
Child and Family Services Agency

2020 Child Fatalities Review: Data Snapshot

Review Period: January 1, 2020 – December 31, 2020

Purpose

Per DC Official Code §4-1371.05 (a) (2), the Child and Family Services Agency (CFSA) publishes an annual report on fatalities of children whose families were known to CFSA within five years of the child's death. The *2020 Child Fatalities Review: Data Snapshot* presents a high-level data profile in advance of the annual report, based on the 40 fatalities known to the agency by the end of calendar year (CY) 2020.

Notifications

CFSA receives notification of fatalities from the CFSA Child Abuse and Neglect Hotline. The Hotline receives information from several sources, including CFSA employees, local police, hospitals, and others. In CY 2020, CFSA learned of 23 fatalities (57 percent) through notification by employees *(Figure A)*. The CFSA Hotline learned of 17 fatalities (43 percent) through the following sources:

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

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

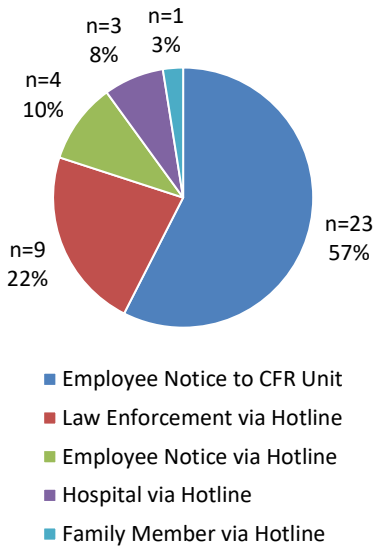
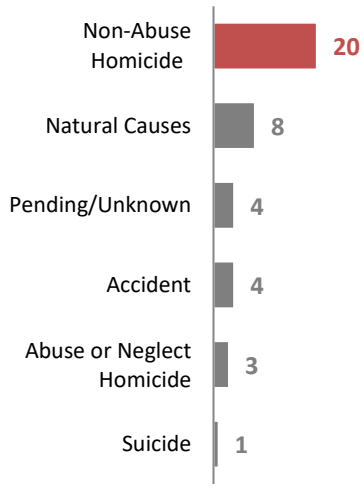


Figure B: Confirmed Manner of Death (N=40)



Analysis

Cause and Manner of Death[1]

Exactly half of the 40 fatalities were non-abuse homicides. 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. Among the 20 homicides, 16 decedents (75 percent) were male; the remaining youths were female (25 percent). All four of the accidental deaths were male, and unsafe sleeping arrangements contributed to cause of death for each accidental death.

[1] 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, accident, suicide, homicide, and undetermined). Source: https://ocme.dc.gov/sites/default/files/dc/sites/ocme/2017%20OCME%20Annual%20Reportupdated.pdf

As of February 2021, CFSA received notification of 40 fatalities that occurred during CY 2020; the decedents ranged in age from one day to 24 years. DC Health confirmed manner of death for 36 of the 40 fatalities that occurred during CY 2020:

- Twenty homicides of older youth, all gun-related and committed out in the community (ages 11 to 24 years)
- Eight natural deaths (ages one day to 11 years)
- Four accidental deaths (ages two to five months)
- Two abuse homicides (ages 11 months and two years)
- One neglect homicide (age seven years)
- One suicide (age nine years)

For the remaining four non-abuse homicide fatalities, manner of death was pending as of February 2021 *(Figure B)*.

Of the eight natural deaths, three fatalities were related to premature births. Three additional deaths were due to medical conditions at birth. One fatality was related to complications from asthma for an 11-year-old child, and one fatality was related to an intracranial hemorrhage unrelated to abuse.

Regarding the one suicide, a nine-year-old African American female hanged herself in the bathroom while her mother was at work. Her older minor brother discovered her and immediately called 911. The child had not previously presented with any behavior that would have raised concern for suicide. The allegations of neglect (inadequate supervision) and suspicious child death due to abuse or neglect were both unfounded. The family received grief services.

Abuse and Neglect Homicides

When CFSA or law enforcement officials deem that a parent or caregiver is directly responsible for the death of a child, CFSA considers this type of death as an abuse or neglect homicide.

Based on the available 2020 data for cause and manner of death, there were two confirmed abuse homicides and one confirmed neglect homicide. 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.

The agency learned of the neglect homicide of a seven-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

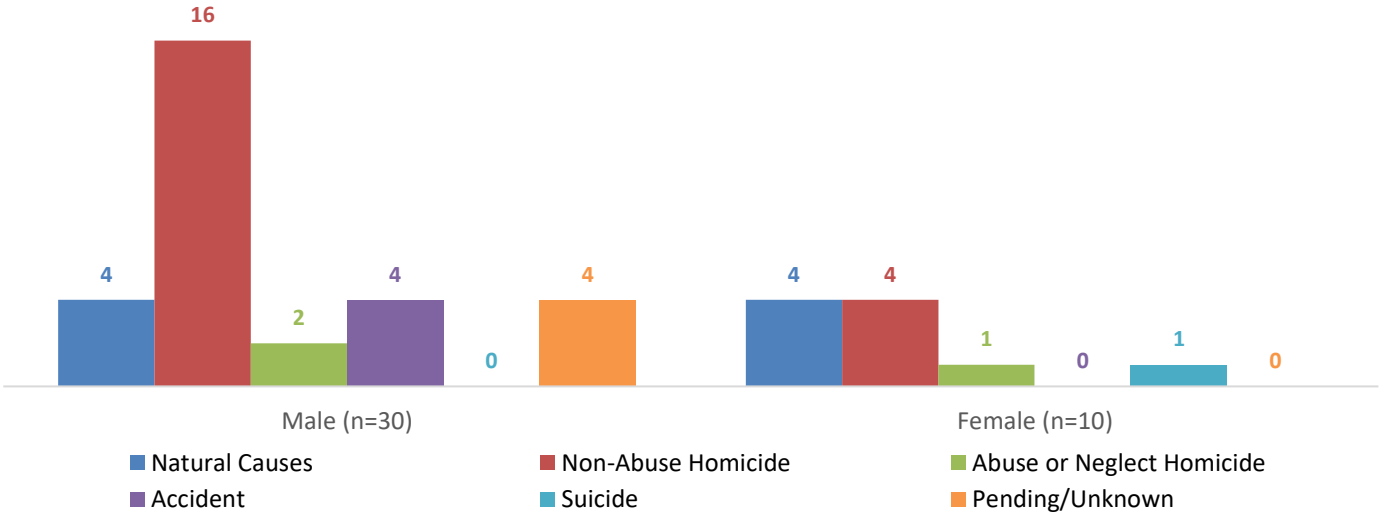
an accident outside of the Metropolitan DC area. The child sustained major head trauma and was pronounced deceased at a hospital local to the incident. The other siblings suffered minor but non-life-threatening injuries. According to the report, none of the children were in car seats and the local authorities 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.

Gender and Manner of Death

Regarding gender demographics, there were significantly more (75 percent) males (n=30) than females (n=10; *Figure C*). One two-year-old male died as the result of abuse homicide and one seven-year-old (3 percent) male died as a result of neglect homicide. Four of the 30 male deaths were accidental. Of the natural deaths, there were also four males. Sixteen male deaths were non-abuse homicides; 11 of the 16 were aged 18 or older. All of the non-abuse homicides are confirmed to be caused by gunshot wounds.[2] Manner of death was pending for four males as of the writing of this report.

For the 10 female decedents, manner of death includes four homicides in the community, one suicide, and one abuse homicide. Manner of death for the remaining four females was natural.

Figure C. Manner of Death by Decedent Gender

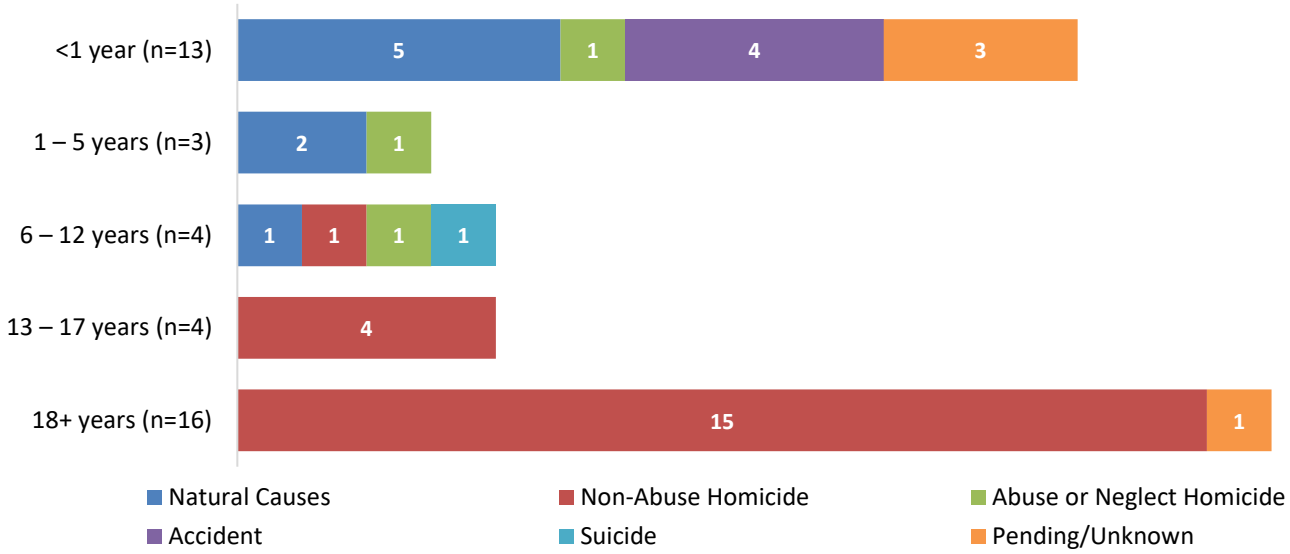


Age

Continuing the noted trends from previous years, the largest two age groups from the 40 child fatalities in 2020 are infants under age one (n=13, 32 percent) and young adults, ages 18 and older (n=16, 40 percent). In between these two age groups, there were three child fatalities for children between the ages of one to five years. For the two age groups between 6 and 12, and between 13 and 17, there were four fatalities each, equaling a total of eight. Figure D presents manner of death by age group.

[2] Percentages fall short of exactly 100 percent due to rounding.

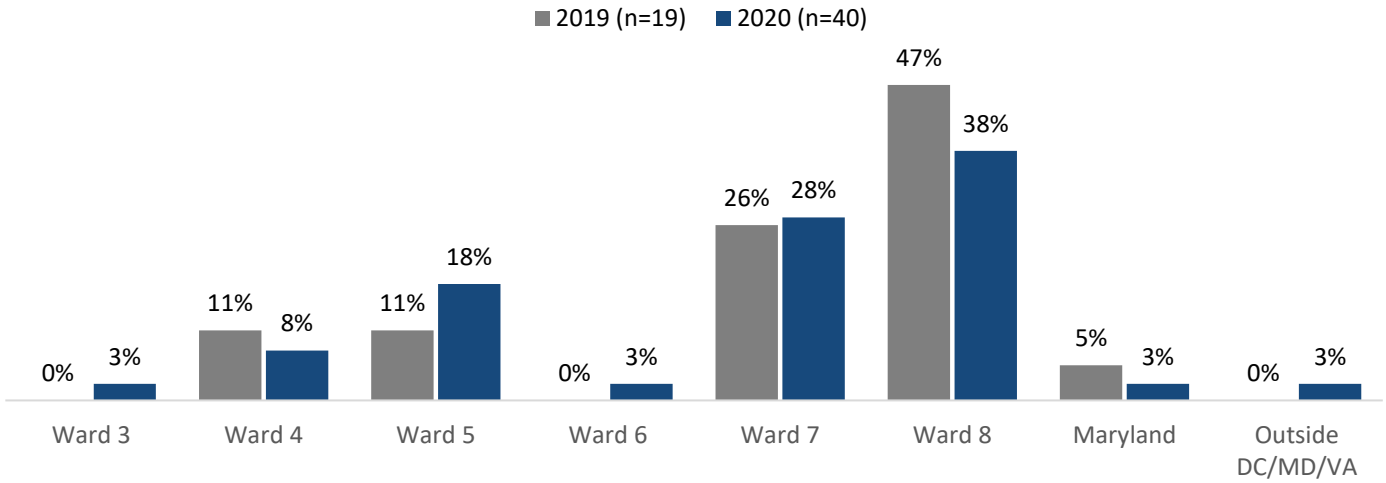
Figure D. Manner of Death by Decedent Age



Ward of Residency[3]

The 2020 Data Snapshot reveals ongoing historical trends whereby CFSA clients are known to predominantly reside in Wards 5, 7, and 8 *(Figure E)*. **Eighty-three percent of the child fatalities involved families living in Wards 5, 7, and 8.** Of the 40 child fatalities, 26 fatalities (65 percent) involved families that lived in Wards 7 and 8. Seven (18 percent) child fatalities were last known to reside in Ward 5. No children were living Wards 1 and 2 at the time of their death. One child lived in Ward 3 and one child lived in Ward 6, while three children resided in Ward 4. One child lived in an adjacent jurisdiction (Maryland), and another child lived outside of the Washington metropolitan area (i.e., outside of the District, Maryland, and Virginia).

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



[3] As a note, the 2019 count here (n=19) is higher than the count in the 2019 annual report (n=13) due to the additional 2019 fatalities reviewed during 2020. Information about these six fatalities will be included in the addendum to the 2020 comprehensive report.

Commensurate to the number of children living in Wards 5, 7 and 8, infant fatalities are also trending in those same three wards. For the 13 children under age one, four infants (30 percent) were residing in Ward 8 at the time of the fatality. Three infant fatalities were reported in Ward 5 (23 percent); three additional infant deaths were reported in Ward 7 (23 percent). One child (8 percent) under the age of one was living in Ward 3. Two decedents were not District residents at the time of their death: one child (8 percent) was living in Maryland, while another child (8 percent) was abandoned in the District of Columbia shortly after birth, but her mother's permanent residence was outside of the Metropolitan DC area.

For the three children between the ages of one and five, two resided in Ward 7 and one resided in Ward 5. In the next age category of four children aged 6 to 12, three of the four were living in Ward 8 while one was living in Ward 7 at the time of the fatality. For the four youths aged 13 to 17, two youth were living in Ward 7 at the time of the fatality, one youth lived in Ward 6, and the fourth youth lived in Ward 8. Lastly, for the 16 youths aged 18 and older, seven lived in Ward 8 while the remaining nine youth were evenly distributed among Wards 4, 5 and 6.

Race and Ethnicity

African Americans account for all but one of the child fatalities reviewed. Although the 2017 Census Bureau data reported that African Americans comprise 47 percent of the District of Columbia's population, African Americans disproportionately accounted for 97 percent (n=39) of the 40 fatalities that occurred during CY 2020. There was one child fatality (3 percent) reported from an African family but the exact country of origin was undocumented.

CFSA Involvement

At the time of the fatality, 9 (23 percent) of the 40 families were involved with the District's child welfare system *(Table 1)*. Seven of the nine families had open foster care cases; one of those families also had an open investigation pending at the time of the fatality. In addition to the family with an open investigation and foster care case, there were two additional families with open investigations (n=3).

Table 1: CFSA Involvement at Time of Fatality (n=40)[4]		
	n	***%***
No Investigation or Case Open	31	78
Open Permanency Case	6	15
Open CPS Investigation	2	5
Open Permanency Case & CPS Investigation	1	3
Total	**40**	**100**

Of the seven families that had open foster cases at the time of the fatality, three decedents were in foster care at the time of their death. The manner of death for two children was natural causes; the manner of death for the third child was pending as of the writing of this report.

Detailed information about known CY 2020 fatalities – including case histories, interagency involvement, and recommendations from the Internal Child Fatality Review Committee – will be presented in the Comprehensive 2020 Annual Child Fatality Report to be published in July 2021.

[4] Percentages exceed 100 percent due to rounding.