Child and Family Services Agency
Child Fatality Review Report

Statistics, Observations, and Recommendations

2021

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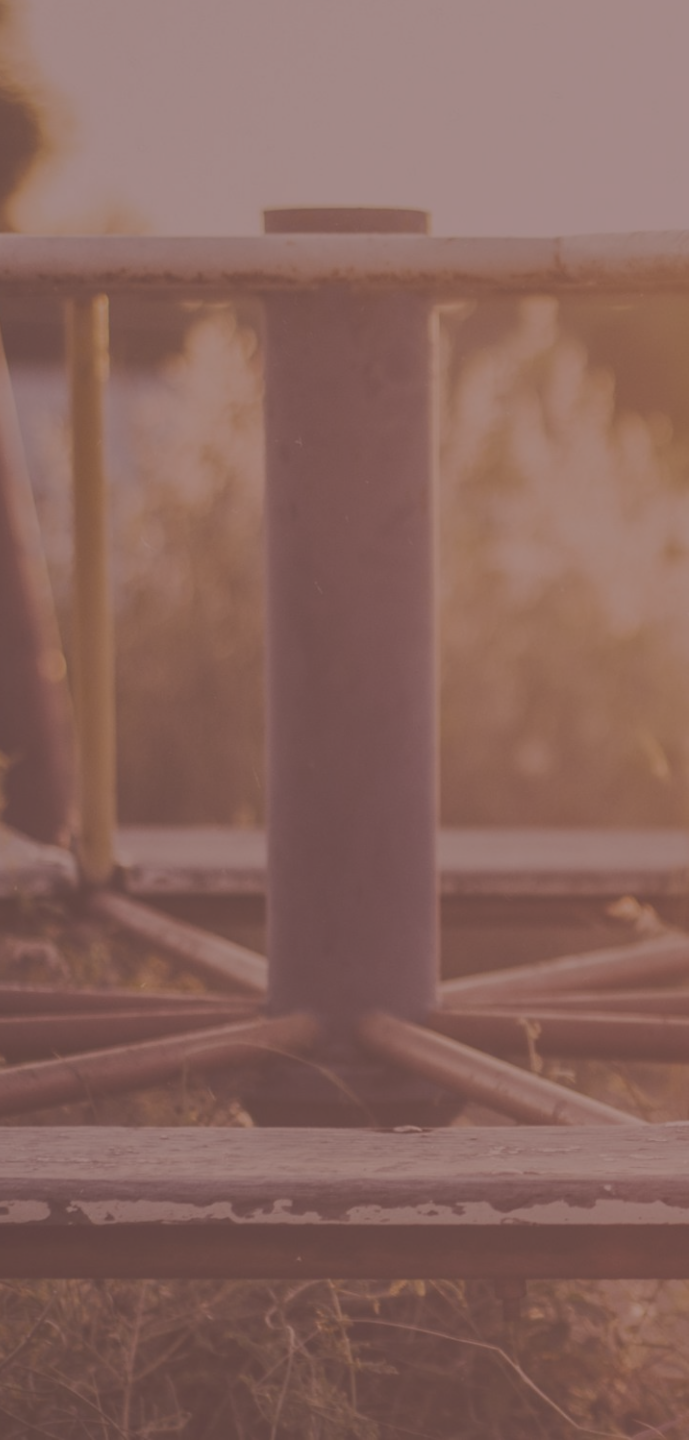
Director



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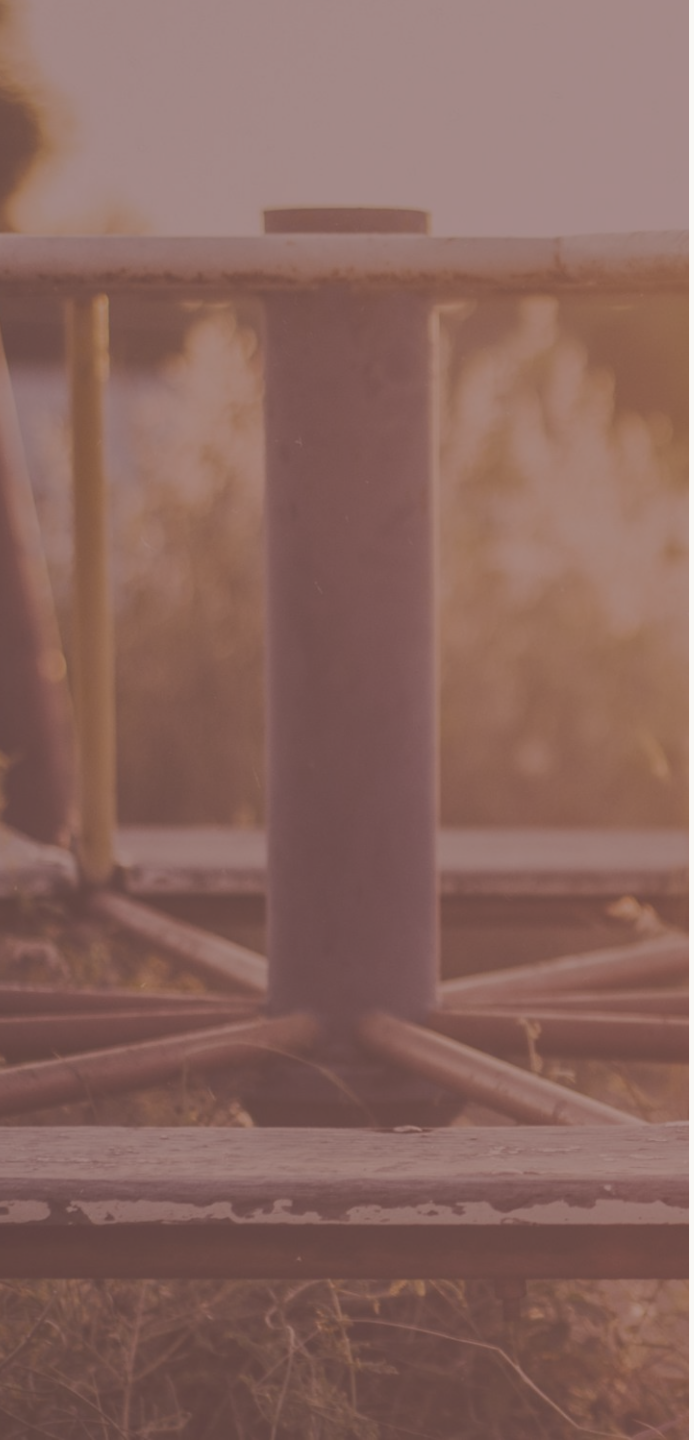
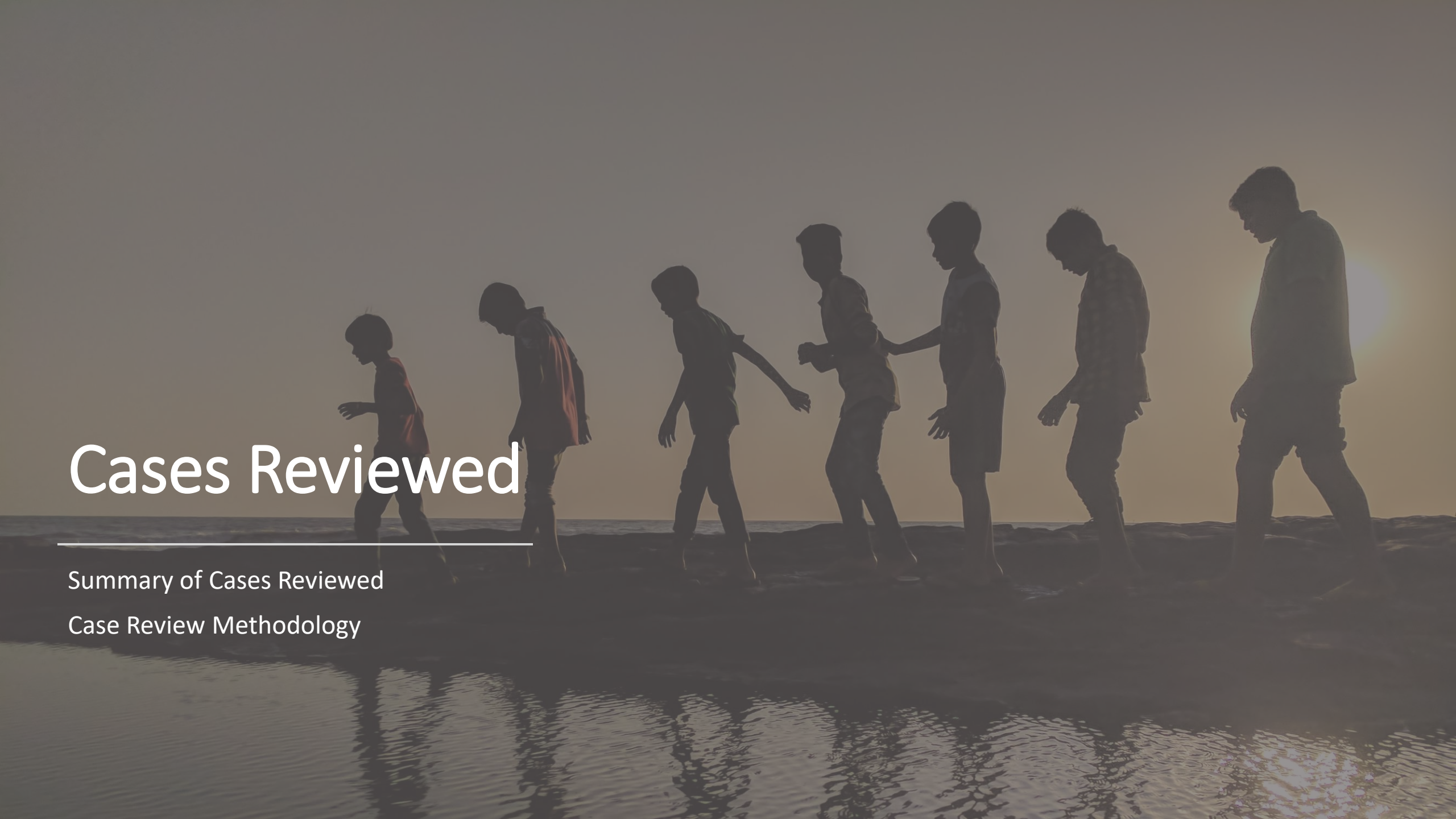


Purpose

The *17th Annual Child Fatality Review (CFR) Report* 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) 2021.[1] Fatality reviews include only those children whose families were known to CFSA within 5 years of the child's death.[2]

In April 2022, CFSA published a high-level preliminary data profile, the *2021 Child Fatality Review: Data Snapshot*. This *2021 Annual CFR Report* includes comprehensive, updated data along with additional details on the deceased children, their families, and their involvement with CFSA and other agencies.

1. DC Official Code §4-1371.05 (a)(2)
2. CFSA serves children from birth to age 20, excepting aftercare services for youth up until age 23 (see CFSA's Program Policy: Older Youth Services). Fatality reviews may include youth past age 20 when the Hotline referrals include younger siblings in the family within the last 5 years.



Cases Reviewed

Summary of Cases Reviewed

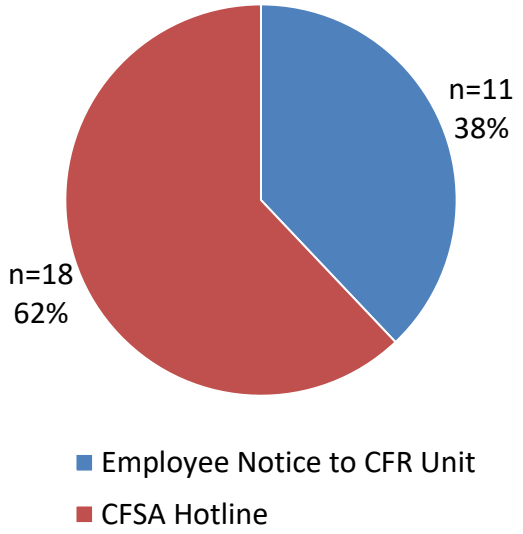
Case Review Methodology

Notification Sources

CFSA receives notification of fatalities from the District's 24-hour Child Abuse and Neglect Hotline. Of the 29 fatalities reported in CY 2021, Hotline workers received information from Agency employees and local police for 62 percent (n=18). These calls are designated as "critical events" (Figure A).[4]

The CFR Unit may also receive information directly and then report the fatality to the Hotline. Of the additional fatalities reported directly to the CFR Unit, 34 percent (n=11) were unrelated to critical events. Employees often learn about these children's deaths from media reports and the Office of the Chief Medical Examiner (OCME) when information is requested regarding CFSA's history with a family.

Figure A: CY 2021 Reporting Sources (N=29)



4. For definitions of a critical event, please see the CFSA Program Policy: Critical Events. After the Agency holds a critical event meeting, the CFR Unit must present the case review to the ICFR committee within 60 days. For fatalities that do not involve a critical event meeting (e.g., the CFR Unit learns of the fatality through a request for information from the Citywide Child Fatality Review Committee), the CFR Unit must present the case review to the ICFR committee within 180 days of notification of the fatality.

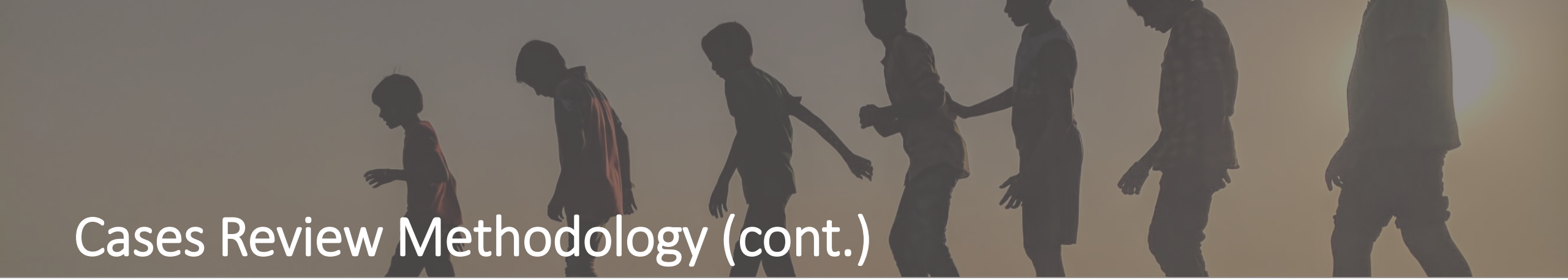
Case Review Methodology

Case reviews are one of CFSA's CQI methods for examining and strengthening child protection. For each fatality review, the CFR Unit examines the family's demographic information, child welfare histories, and documented receipt of services. The case reviews provide child fatality data and information used for practice, training, and policy recommendations to address areas in need of practice improvement and to identify any systemic factors that require citywide attention.

The CY 2021 case review methodology includes four new data sets that further examine family involvement: (1) Hotline calls and investigations of allegations involving the decedent as a victim child, (2) substantiated allegations involving the decedent as a victim child, (3) a summary of critical findings, and (4) CFSA's response to the critical findings. Due to the Agency's specific focus on maltreatment, the CFR Unit has also incorporated literature reviews (as applicable) to support CFSA's findings within the larger context of data trends across the nation.

When examining a child fatality, the CFR Unit seeks first to determine whether DC Health or OCME has provided the official cause and manner of the child's death. "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.[5]

5. For purposes of clarification, an undetermined death includes inconclusive information. For example, the medical examiner may document an unknown cause of death but with a known manner, or an unknown manner with a known cause, or both unknown. 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



Cases Review Methodology (cont.)

If official notification for cause and manner is not received (e.g., pending an autopsy), the CFR specialist will still present the case to the ICFR Committee with the timelines required by CFSA policy (i.e., within 90 days of a critical event or within 180 days of notification of the fatality). The ICFR Committee members will still discuss the circumstances surrounding the fatality. CFR specialists update the cause and manner as soon as both are received.

Once the CFR Unit confirms official cause and manner with the District of Columbia's Department of Health (DC Health), the CFR reviewers focus 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, OCME, or DC Health deems a parent or caregiver as 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., a drive-by shooting. In CY 2021, CFSA confirmed three neglect homicides (see *Abuse and Neglect Homicides* under *Section 2*). In addition to cause and manner, the CFR Unit looks at child and family involvement with CFSA at the time of the fatality. During CY 2021, 31 percent (n=9) of the 29 families were involved with CFSA at the time of the fatality (see *Demographics and Summary of Findings* under *Section 3)*.

Lastly, the *2021 Annual CFR Report* includes data on decedents' diagnoses, individual service history, and family involvement with other DC government agencies within the 5-year review period. CFSA and ICFR Committee members pay particular attention to service needs in order to discern and address gaps in practice standards and service delivery. Sharing fatality data and service needs across CFSA program areas during the monthly ICFR Committee meetings also provides information into some of the systemic challenges.

Cause and Manner of Death

Manner of Death by Age

Manner of Death by Gender

Abuse and Neglect Homicides

Non-Abuse Homicides

Natural Deaths

Accidental Deaths and Suicides

Undetermined, Unknown, and Pending Classifications

Demographics & Summary Findings:
Manner of Death by Age

Table 1 depicts the manner of death by age and gender for the 29 known fatalities that occurred during CY 2021. Of the 29 families whose children died during CY 2021, **ages ranged from 5 days to 22 years old**. These ages are relatively comparable to CY 2020 when the CFR Unit reviewed 40 families with children's ages ranging from 1 day to 24 years old.

Table 1: Manner of Death by Age

	Natural Causes	*Non-Abuse Homicide*	*Abuse or Neglect Homicide*	*Accident*	*Suicide*	*Undetermined*	*Unknown*	*Total*
Age (in years)								
<1	1		1	3		3	2	10
1 – 5	1		2	1				4
6 – 12	1	1				1	1	4
13 – 17		4		2				6
18+		5						5
Total	**3**	**10**	**3**	**6**	**0**	**4**	**3**	**29**

Demographics & Summary Findings:
Manner of Death by Gender

Table 2 depicts the manner of death according to gender for the 29 known fatalities that occurred during CY 2021.[6]

Forty-five percent (n=13) of the 29 decedents were female; **55 percent (n=16) were male.** Of the 10 infants under 1 year of age, six infants were female and four were male. All four children between the ages of 1 and 5 years were male, and all four children between the ages of 6 and 12 years were female. Of the six youth between the ages of 13 and 17 years, two were female and four were male. Lastly, of the five young adults ages 18 and above, only one young adult was female while the remaining four young adults were male. All five young adults were victims of non-abuse homicide.

Table 2: Manner of Death by Gender

	Natural Causes	*Non-Abuse Homicide*	*Abuse or Neglect Homicide*	*Accident*	*Suicide*	*Undetermined*	*Unknown*	*Total*
Gender								
Male	1	8	2	2		1	2	16
Female	2	2	1	4		3	1	13
Total	**3**	**10**	**3**	**6**	**0**	**4**	**3**	**29**

6. At present, the 2021 Annual CFR Report follows DC Health assignation of gender according to the child or youth's external anatomy.

Demographics & Summary Findings:
Abuse and Neglect Homicides

CFSA received three reports of confirmed neglect homicides during CY 2021. No abuse homicides were reported.

1. On July 15, 2021, a Metropolitan Police Department (MPD) officer contacted the Child Abuse and Neglect Hotline to report the death of a 17-month-old African American male. DC Health recorded the official manner of death as *neglect homicide* and the official cause to be complications from thermal and scald injuries. CFSA separated the decedent's four siblings from the birth mother and placed them in a foster home. The siblings' ages ranged from 5 months to 12 years old.
2. On September 4, 2021, an MPD officer contacted the Hotline to report the death of a 3-month-old African American female. Per the officer, the mother reported placing the baby in a playpen the previous evening before adding a blanket. When the mother awoke in the morning, she realized that the baby was not breathing. The parents contacted 911 and began performing cardiopulmonary resuscitation (CPR) until paramedics arrived. Based on the Child Protective Services (CPS) investigation, the social worker substantiated the mother for the *suspicious death of a child* pending autopsy results. On March 3, 2022, CPS re-opened the investigation and revised the earlier substantiation from *suspicious death* to *neglect homicide*, based on the medical examiner's official cause of death as synthetic opioid toxicity (eutylone and fentanyl). The Agency did not open a new case as there were no other children residing in the home.
3. On December 3, 2021, an MPD officer contacted the Hotline to report the death of a 3-year-old African American male. The investigative social worker substantiated the mother for the *suspicious death of a child* and for neglect related to unsafe living conditions. When CFSA received the results of the child's autopsy from the medical examiner, the official manner of death was listed as a *neglect homicide*, and the official cause as fentanyl toxicity.

Demographics & Summary Findings:
Abuse and Neglect Homicides (cont.)

Of the three families involved with neglect homicides, both the 17-month-old and the 3-year-old's families had extensive referral histories within the last 5 years, i.e., more than 10 Hotline calls. In addition, both mothers of those cases had histories as child victims of abuse and neglect. **Both families of the 17-month-old and the 3-year-old had open In-Home cases at the time of the fatality. The substantiated allegations specifically related to the deaths of the children**, i.e., lack of supervision and substance use impacting parenting, respectively.

All three victims of the neglect homicides were aged 3 or under. This age bracket falls within the national data set reported by the federal Children's Bureau in 2020, i.e., for fiscal year (FY), "2020 data show that 68.0 percent (67.8%) of all child fatalities are younger than 3 years old."[6] Overall data reported by the Children's Bureau noted that of the children who died in FY 2020, "73.7 percent suffered neglect and 42.6 percent suffered physical abuse either exclusively or in combination with another maltreatment type."[7] As in the three neglect homicides confirmed for CY 2021, the majority of perpetrators across the United States for child fatalities in FY 2020 (per the Children's Bureau), more than "80.0 percent (80.6%) of child fatalities involved parents acting alone, together, or with other individuals."[8]

All three victims of neglect homicide in 2021 were African American children. According to the same child maltreatment data from FY 2020, the rate of "African-American child fatalities (5.90 per 100,000 African-American children) is 3.1 times greater than the rate of White child fatalities (1.90 per 100,000 White children) and 3.6 times greater than the rate of Hispanic child fatalities (1.65 per 100,000 Hispanic children). American Indian or Alaska Native children had the second highest rate at 3.85 and children of two or more races had a rate of 3.27 per 100,000 children of their respective races."[9]

Overall, the District of Columbia's child fatality rate for neglect or abuse homicide in FY 2020 was 3.09 per 100,000 children compared to the national average of 2.38 per 100,000 children. The state of Massachusetts was the only state with no abuse or neglect fatalities reported. The state with the highest rate (5.49 per 100,000 children) was South Dakota.[10]

6. https://www.acf.hhs.gov/sites/default/files/documents/cb/cm2020.pdf
7-10 Ibid

Demographics & Summary Findings: Non-Abuse Homicides

In CY 2021, the number of non-abuse homicides (n=10) was half the number of non-abuse homicides reported in CY 2020 (n=20). Among the ten non-abuse homicides, eight decedents were male and two were female.

The ages of the 10 homicide victims ranged from 6 years to 22 years. The one 6-year-old child (female) was reportedly with her parents and three other adults walking to a liquor store late on a Friday evening when an unknown assailant targeted the group in a drive-by shooting. The child's mother had reportedly attempted to protect her daughter and was also shot. All five adults suffered non-life-threatening gunshot wounds and were later treated at local hospitals. Only the child succumbed to her injuries.

Only one of the 10 victims had an open foster care case with the Agency at the time of the homicide. The victim was an 18-year-old male who was separated from his home in 2015 after CPS substantiated his caregiver for physical abuse of the youth, in addition to a substantiation for being an unable or unwilling caregiver. At the time of the fatality, the youth was living in the home of a kinship caregiver. Per the CFR case summary, the caregiver believed the fatal shooting was connected to a CY 2020 murder charge still pending for the youth.

DC Health confirmed cause of death by gun violence for 9 of the 10 decedents and cause by stabbing wounds for the remaining one homicide. The one stabbing victim was a 15-year-old male in the ninth grade. The suspect in the victim's homicide was a 16-year-old student at the same school who admitted bringing a knife to school for protection. He reported being bulled and attacked by the victim over the course of the previous 2 school years. On the day of the fatality, the suspect had hidden the knife but retrieved it to defend his friend being attacked by the victim and another high school student. Police arrested the suspect and charged the youth with second-degree murder while armed and carrying a dangerous weapon.

Demographics & Summary Findings:
Non-Abuse Homicides (cont.)

The nine gun-specific homicides reviewed in CY 2021 are consistent with recent data published by the Centers for Disease Control and Prevention (as reported in the New England Journal of Medicine).[11] The rates are highest among males, specifically non-Hispanic African American males. Additional data indicate a shift of the leading cause of death for youth ages 1 to 19 from automobile accidents to gun-related homicide. Specifically, among children and adolescents, the increase (almost 30 percent) in gun-related deaths of all types (unintentional, homicide, and suicide) surpassed the increase in the overall United States' population between 2019 and 2020. These data also indicate an overarching increase in gun-related deaths throughout the pandemic, commensurate to the increase in non-abuse homicides reported through CFSA's CY 2020-2021 Annual CFR Reports.

Per police reports, suspected motives for five of the nine non-abuse homicides included retaliation for robbery and gang-related activities. In three of those homicides, police charged suspects with premeditated first-degree murder. Motives were unknown for the remaining four victims, including a 15-year-old youth shot outside of his grandmother's home, a 16-year-old youth shot while a passenger in a car, and a 22-year-old male shot during a drive-by mass shooting that included five individual victims standing outside a market mid-morning. The four other victims of the mass shooting survived the shooting.[12]

For the ninth homicide, family members reported that the 18-year-old female victim had been involved in a volatile relationship with her 21-year-old boyfriend. On the day of the fatality, the couple had been in the boyfriend's father's home for only a few moments when the father heard a gunshot and saw his son visibly distraught, holding the gun, and exclaiming the shot was an accident. Police subsequently charged the boyfriend with second-degree homicide.

11. https://www.nejm.org/doi/full/10.1056/NEJMc2201761
12. According to the peer-reviewed Health Affairs Journal, "mass shootings" are tragedies resulting in multiple victims of firearm-related violence in a single incident. Source: https://www.healthaffairs.org/content/briefs/mass-shootings-united-states-population-health-policy-levers

Demographics & Summary Findings:
Natural Deaths

Ten percent (n=3/29) of the CY 2021 fatalities were due to natural causes. The causes for all three related to the following congenital anomalies:

- Respiratory failure for a 4-day-old female who was also diagnosed with fluid on the brain at birth
- Fatal cardiac arrhythmia for a 3-year-old male who was diagnosed with a hole in his aorta at birth
- Asthma-induced respiratory failure for a 9-year-old female who was diagnosed with inflammation of the respiratory tract at birth

Both the 5-day-old and the 3-year-old were born prematurely. In addition to the 3-year-old's aortic hole, the child was medically fragile with diagnoses of severe chronic lung disease, high blood pressure, softening of white brain tissue near the ventricles, and an intraabdominal abscess. The child was dependent on a gastrostomy tube and a tracheostomy vent.

The families of both children also had open cases with CFSA. The 4-day-old's family had a case opened with the In-Home Administration based on a substantiated allegation unrelated to the decedent. The 3-year-old's family had a case opened with the Clinical Case Management and Support Administration due to a substantiated allegation against the mother for lack of supervision. The family was ill-equipped to ensure that the child's complex medical needs could be met on a 24-hour basis. CFSA placed the child with a foster mother with years of experience in caregiving for children who were diagnosed as medically fragile. There were no concerns for a suspicious death.

Demographics & Summary Findings:
Accidental Deaths and Suicides

DC Health determined the official manner of death to be accidental for 21 percent (n=6) of the CY 2021 fatalities. Unsafe sleeping arrangements contributed to the cause of death for three of the six accidental deaths. All three of the sleep-related accidental deaths included asphyxia as a cause for three infants whose ages ranged from 19 days old to 2 months old.[13] For the remaining three accidental deaths, one included a 4-year-old hit by a vehicle running a red light. The child had been crossing the street with his mother and two younger siblings. Per an eyewitness report, the 4-year-old boy wandered away from his mother into the street just prior to being hit by the car. The child was not in the cross walk. The driver remained on the scene and cooperated with police. An emergency crew performed life-saving efforts on the scene prior to transporting the child to the hospital where the attending physician pronounced the child as deceased. DC Health determined the cause of death to be blunt force trauma.

DC Health determined the cause of accidental death for two female teenagers (ages 16 and 17) as opioid overdoses, both involving fentanyl. There is no indication that the two teenage females were known to one another, nor is there is any indication that either youth attempted to die by suicide. Based on a spate of fentanyl deaths in the District within a short period of time during the last 2 weeks of June 2021, law enforcement officials who were interviewed by CFR specialists speculated that the two female teens had separately ingested a “tainted batch” of the synthetic opioid. The 16-year-old succumbed on June 17, 2021, and the 17-year-old succumbed on June 22, 2021.

There were no reported CY 2021 deaths by suicide for children whose families were known to CFSA.

13. For more details on the three infants who succumbed to unsafe sleeping arrangements, see *Sleep-Related Factors* in *Section 3*.

Demographics & Summary Findings:
Undetermined, Unknown, and Pending Classifications

DC Health classified the manner of death for four CY 2021 child fatalities as undetermined. For the four children with an undetermined manner of death, the autopsy findings were inconclusive. Three of the children were under one year of age: a 2-month-old female, a 9-month-old male, and an 11th-month-old female child. All three children were African American.

None of the families had current CFSA involvement at the time of their children's deaths. However, the Agency did open a case with the In-Home Administration for the family of the 11-month-old female after the child's death, due to the mother leaving the 11-month-old child and her 4-year-old brother sleeping in the home unsupervised while the mother left the home. When the mother returned, her 11-month-old daughter was reportedly unresponsive and foaming at the mouth. According to the CPS investigation, the mother re-enacted placing the child on her stomach with a bottle propped in her mouth in such a manner as to possibly block the infant's ability to breathe properly. While asphyxia may have contributed, the medical examiner was unable to confirm asphyxia as a cause. Within 6 months of the 11-month-old's fatality, the decedent's mother suffered the death of another child, a 3-year-old male, whose neglect homicide is described earlier under the *Abuse and Neglect Deaths*.

For the 2-month-old female, complicating unsafe sleep factors may have contributed to the child's death. Autopsy results did not confirm asphyxia by items in the sleeping environment as an official cause of death, but the infant had been sleeping with her mother. When the mother awoke the next morning, she found her infant daughter unconscious, unresponsive, and bleeding from the nose. Paramedic efforts to revive the child were unsuccessful.

Complicating unsafe sleep factors may also be noted for the death of the 9-month-old male. His mother reportedly gave him a bottle before placing him on his back (but tilted slightly to the side) to go to sleep for the evening. The mother reported that she also used a blanket to cover him up to his chest. Two or three pillows were on the bed which was pushed up against a wall. When the mother awoke in the middle of the night, she removed the blanket cover and saw her child face down on one of the pillows. Autopsy results were unable to confirm asphyxia as an official cause of death.

Demographics & Summary Findings:
Undetermined, Unknown, and Pending Classifications (cont.)

The fourth undetermined manner of death involved a 12-year-old female who was reportedly sipping soup midday when she began choking. The mother patted the child's back and the child vomited but then fainted. The mother called 911 and performed CPR on her daughter until the paramedics arrived. Despite maximum medical support and life-saving efforts, the 12-year-old succumbed at the hospital. Based on the physician's observations of bruising on the child's abdomen, back, and legs, the CFSA investigative social worker substantiated the mother for abuse and separated two siblings from the home: a female twin to the 12-year-old decedent, and a 10-year-old female. There was no evidence that connected the abuse to the child's death. DC Health recorded the official cause of death as an untreated bacterial infection paired with pneumonia. However, the official manner remained undetermined, i.e., the medical examiner was unable to determine how the bacterial infection caused her death).

As of the writing of this report, the manner of death for two decedents were unknown. The decedents included a 7-week-old male who was reported to the CFSA Hotline as missing 2 days after he was last seen by his father. The child is presumed deceased. Per the police record, the mother was charged with suspected concealment or removal of the body to prevent evidence for any official proceeding. CFSA subsequently separated three children from the mother's home. The children's ages ranged from 5 to 14 years old.

The second unknown manner and cause was related to a pregnant mother who contracted COVID-19 at her baby shower where some attendees were not wearing masks. Three days after the baby shower, the mother was admitted to a local hospital emergency room. When her vital organs began to shut down, the mother asked the doctors to "save the baby at all costs." Per the mother's request, physicians attempted to save the child through an emergency Caesarian section. The child survived the Caesarian but passed away 10 days later. His mother passed away 3 weeks later.

Demographics & Summary Findings:
Undetermined, Unknown, and Pending Classifications (cont.)

Cause and manner of death for one child was pending as of the writing of this report. CFSA is still awaiting autopsy results for a 7-year-old female who passed away due to a house fire. Fire officials determined the fire to be accidental. The family received temporary housing and other supports, including grief counseling, burial assistance, clothing vouchers, and therapy for the decedent's twin sister and two siblings.

For the undetermined and unknown manner of deaths, law enforcement and CPS investigations revealed complicating factors that the ICFR Committee both reviewed and discussed in detail during several of the Committee's monthly meetings. Committee members have demonstrated an unwavering awareness that successful prevention and reduction of fatality circumstances are contingent to active partnerships among CFSA, DC Government sister agencies, local hospitals, and private providers. To this end, future recommendations will focus more stringently on the combined practices of CFSA and its child welfare partners, along with expanded research into other jurisdictions' strategies, which may be suitable for adaptation to CFSA's population needs.

Demographics & Summary Findings

Child Welfare Involvement: Distribution by Ward

Race and Ethnicity

Child Residence at the Time of the Fatality

Decedents in Foster Care Placements at the Time of Fatality

Teen and Young Parenting as a Risk Factor

Siblings

Sleep-Related Factors for Infant Fatalities

Demographics & Summary Findings:
Child Welfare Involvement: Distribution by Ward

The total number of children served by CFSA at the end of CY 2021 was 1,856. Of these children, 33 percent (n=605) were receiving foster care services, a 2 percentage-point drop from CY 2020 (35 percent, n=673). Children receiving services in the home accounted for 67 percent (n=1251), a 2-percentage increase from CY 2020 (65 percent, n=1236). The respective decrease and increase in foster care and in-home services (respectively) reflect CFSA's ongoing commitment to promote family stability and to increase the prevention of children entering foster care.

Most children served by the Agency were residing in Wards 8 (30 percent, n=558), 7 (22 percent, n=415), and 5 (15 percent, n=275).[14] Ward 2 (25 percent, n=25, 1 percent) and Ward 3 (2 percent, n=32) represented the smallest populations served by the Agency.[15]

Table 3: Children Served by CFSA as of December 31, 2021 (N=1,856)

Ward	Foster Care/Out-of-Home		In-Home		Total	
	n	%	n	%	n	%
1	34	2%	39	2%	73	4%
2	6	0%	19	1%	25	1%
3	8	0%	24	1%	32	2%
4	40	2%	81	4%	121	6%
5	106	6%	169	9%	275	15%
6	54	3%	88	5%	142	8%
7	141	8%	274	15%	415	22%
8	187	10%	371	20%	558	30%
Unknown	29	2%	186	10%	215	12%
Total	**605***	**33%**	**1,251***	**67%**	**1,856**	**100%**

14. 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://cfsadashboard.dc.gov/
15. Exact Ward residency was unknown for 287 children.

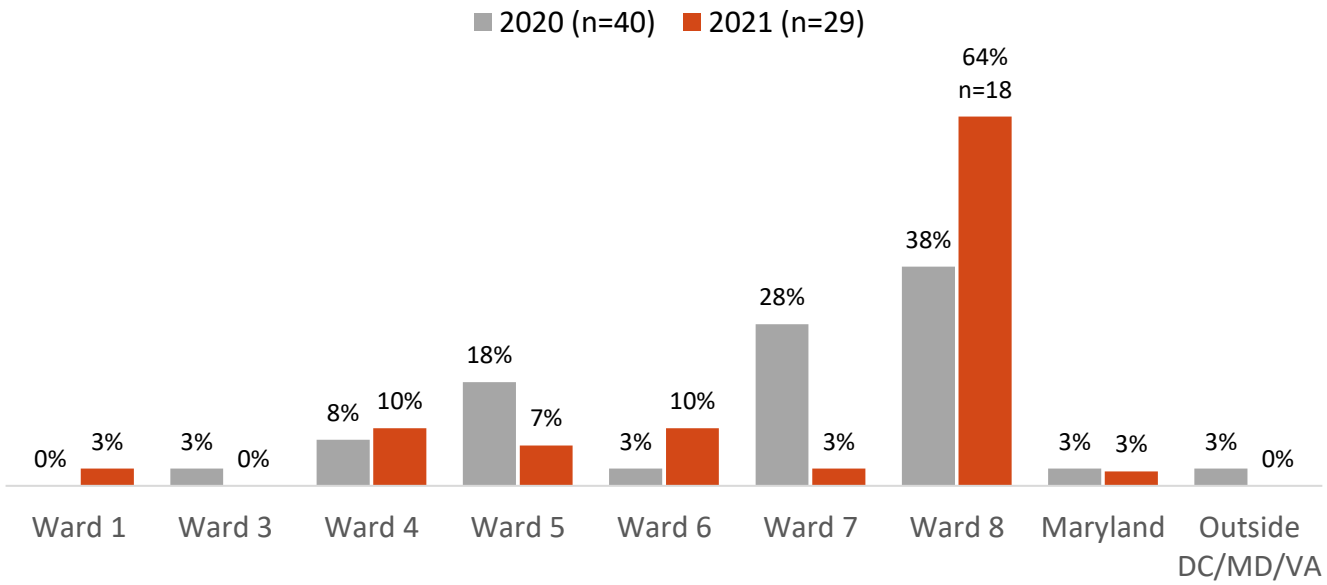
Demographics & Summary Findings:
Child Welfare Involvement: Distribution by Ward (cont.)

The CFSA population distributions closely parallel the distributions for the 2021 reviewed fatalities (see Figure B). Despite the difference in the number of fatalities reviewed between CY 2020 (n=40) and CY 2021 (n=29), the highest percentage of children (64 percent, n=18) continued to reside in Ward 8. Of the 18 fatalities that occurred in Ward 8, 83 percent (n=15) were under age 18.

Wards 6 and 4 shared the same percentage of fatalities (10 percent, n=3). Of the combined six child deaths for both wards, all six children were under age 18. Ward 5 had the third highest number of fatalities for the District (7 percent, n=2). Both decedents were young adults, aged 19 and 21. Wards 1 and 7 also shared the same percentage of deaths (3 percent, n=1). Both decedents were under age 18.

One child resided in Maryland at the time of the fatality (3 percent, n=1). The 3-year-old male was in foster care and had been diagnosed as medically fragile. His manner of death was natural. There were no child fatalities reviewed for Ward 3, and none for children who resided outside of the District's Metropolitan area.

Figure B. Actual Child Fatalities by Ward Location - CY 2020 & CY 2021

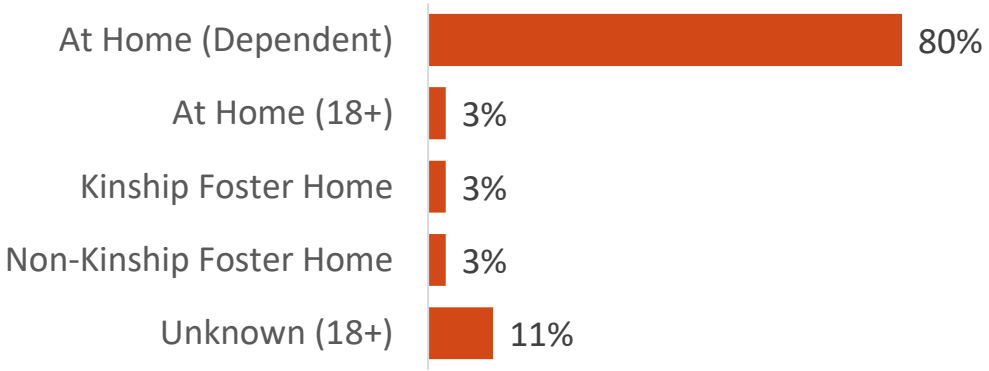


Demographics & Summary Findings:
Race, Ethnicity, and Residency

African Americans accounted for 93 percent (n=27) of all child fatalities reviewed. Although African American children under age 18 accounted for 52 percent of the District's population in CY 2020, African American children under age 18 disproportionately accounted for 76 percent (n=22) of the CY 2021 fatalities. One 17-year-old male decedent (3 percent, n=1) was listed as Latino and Spanish-speaking in the home. One 12-year-old female decedent (3 percent, n=1) was listed as biracial (Black and Chinese) but English speaking in the home. All decedents 18 and older were African American.

Most children were living at home at the time of the fatality. Of the 29 child fatalities that occurred during CY 2020, 80 percent (n=23) were living at home as a dependent at the time of the fatality (Figure C). Three percent (n=1) lived at home as an independent young adult (age 18+). Three percent (n=1) lived with relatives in a kinship placement and another 3 percent (n=1) lived in a non-relative foster care placement in Maryland. The permanent residencies of 11 percent (n=3) were unknown for young adults, ages 18+, i.e., neither the MPD investigation nor the DC Health vital statistic record shared or provided confirmed addresses.

Figure C. Child Residency at Time of Fatality (n=29)



Demographics & Summary Findings:
Decedents in Foster Care at the Time of the Fatality

Six percent (n=2) of the deceased children were in foster care at the time of their death. Both decedents were male.

- One of the males was an 18-year-old young adult living in a kinship caregiver's home. His manner of death was non-abuse homicide caused by gun violence. He was separated from his home in 2015 after CPS substantiated his caregiver for physical abuse of the youth, in addition to a substantiation for being an unable or unwilling caregiver. Per the CFR case summary, the caregiver believed the fatal shooting was connected to a CY 2020 murder charge still pending for the youth.

- The second male was 3 years old. The child died of natural causes complicated by a premature birth. In addition to having an aortic hole, the child had diagnoses of severe chronic lung disease, high blood pressure, softening of white brain tissue near the ventricles, and an intraabdominal abscess. The child was dependent on a gastrostomy tube and a tracheostomy vent.

Demographics & Summary Findings:
Teen and Young Parents

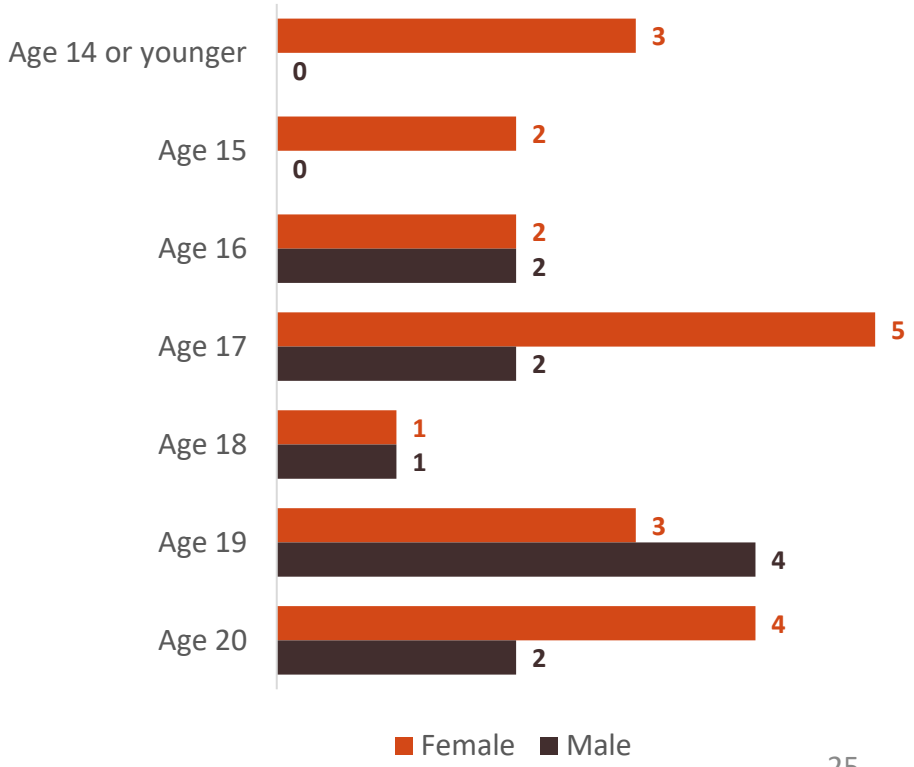
Of the 29 decedents reviewed in 2021, CFSA gathered data for all 29 mothers and 19 fathers (82 percent, n=48/58 parents). Thirty-one of the 48 parents (65 percent) had their first child when they were between the ages of 13 and 20. All parents were over age 21 at the time of their child's death.

Sixty-nine percent of mothers (n=20/29) and 58 percent of fathers (n=11/19) were under age 21 when they had their first child. The youngest mother was 13 (n=1) when she first gave birth. The youngest fathers were 16 years old (n=2).

Seven of the 20 teen mothers (35 percent) graduated from high school; seven of the teen mothers (35 percent) did not graduate from high school. Three of the teen fathers obtained a general education degree (27 percent). One teen father graduated from high school (9 percent) and four of the teen fathers did not graduate high school (36 percent).

Fifteen of the 58 parents (25 percent) had some level involvement in the child welfare system as a victim child. Of the 15, four were fathers and eleven were mothers. Four of the eleven mothers were in foster care as minors.

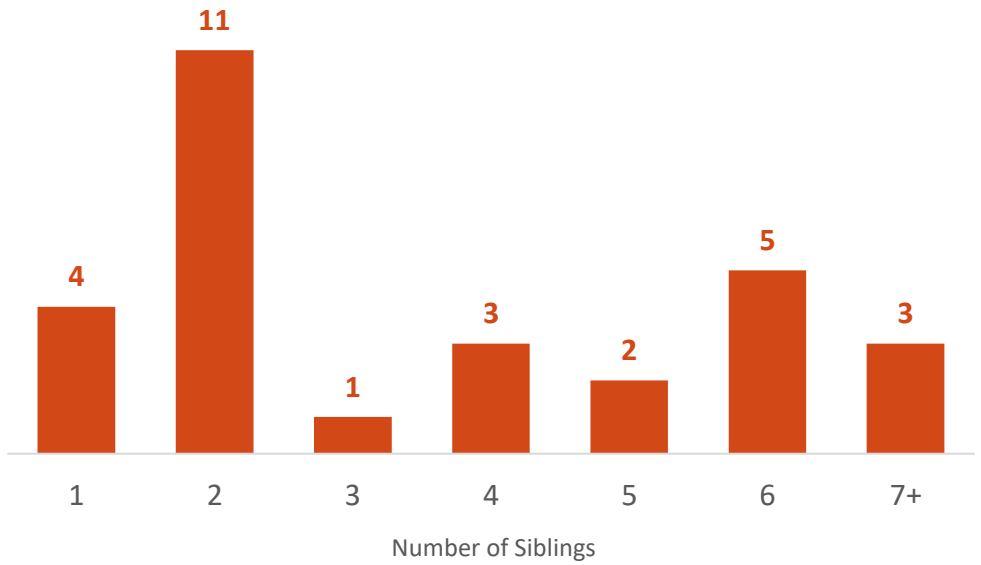
Figure D. Age Distribution of Young Parents When First Child was Born (n=48)



Demographics & Summary Findings: Siblings

Most child decedents (38 percent, n=11) had two siblings (Figure E). Seventeen percent (n=5) of the decedents had five siblings. Fourteen percent (n=4) had only one sibling. Ten percent (n=3) had three siblings while another 10 percent (n=3) had seven or more siblings. Of the latter group, two decedents had 12 siblings. One of these decedents also came from a polyamorous family (two mothers and one father) living the home with a combination of children. The second decedent had 10 siblings. There were no children in CY 2021 with no siblings.

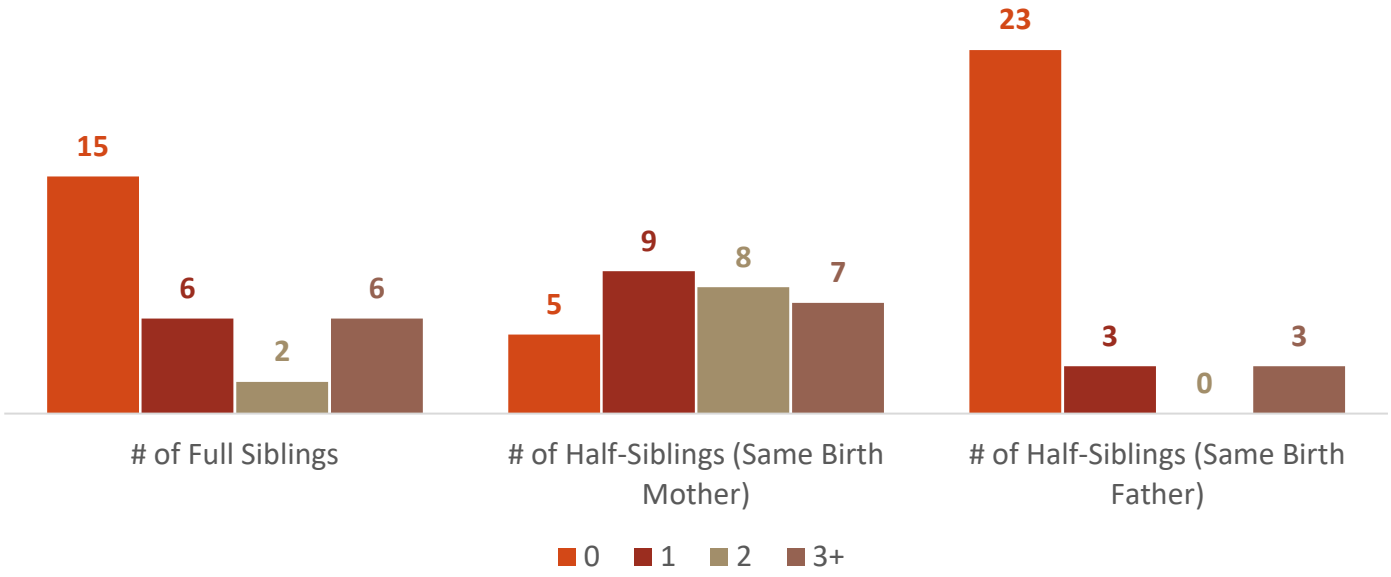
Figure E. Count of Decedent Siblings (n=29)



Demographics & Summary Findings:
Full & Half Siblings

Full and half-sibling counts are presented in Figure F.[16] Fifty-two percent (n=15) had full siblings. Twenty-one percent (n=6) had one full sibling, 7 percent (n=2) had two full siblings, and 21 percent (n=6) had three or more full siblings. All 29 decedents (100 percent) had at least one full or half-sibling.

Figure F. Count of Decedents' Known Full and Half-Siblings (n=29)



16. 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.

Demographics & Summary Findings:
Siblings Separated from the Home after Fatality

As the result of the fatality, 14 percent of families (n=4) 11 children experienced a separation of from the household where the fatality occurred.

Of the 11 separated siblings, the Agency separated siblings from the home of a decedent whose manner of death was determined to be neglect homicide caused by fentanyl intoxication. CFSA was able to place the children with kin under temporary emergency licensing requirements. As of the writing of this report, the children remain with kin with regular visits with the parent who is receiving services, including grief counseling for the loss of more than one child within a short time frame, as well as substance use and housing. The children are also participating in therapy. Their permanency goal is reunification, contingent to the parent's completion of services.

CFSA also separated two siblings from the home of a decedent whose manner of death was undetermined but whose cause was an untreated bacterial infection, complicated by pneumonia. When the child was examined at the hospital, the attending physician observed sufficient bruising consistent with maltreatment to support a CPS substantiation for physical abuse. As of the writing of this report, the siblings have been returned home, living with their mother under protective supervision. The mother and the children have all received mental health services, in addition to the mother completing court-ordered parenting education.

Table 4: Sibling Separations after Fatality

# of Siblings Formally Removed	# of Families	Total Siblings Removed
One sibling	0	0
Two siblings	2	4
Three siblings	1	3
Four siblings	1	4
Total	**4**	**11**

Demographics & Summary Findings:
Siblings Separated from the Home after Fatality (cont.)

CFSA separated three siblings (ages 5 to 14) from one family of an infant decedent whose body was never located. CFSA was able to place the 14-year-old with the birth father. The Agency placed the two younger siblings in foster care with a permanency goal of reunification. However, June 2022 court documentation indicated that CFSA was considering a goal change to adoption, based on the parents' lack of progress to achieve outcomes detailed in court-ordered services. The children continue to maintain visits with their parents.

Of the four siblings separated from another family, the ages ranged from 5 months to 12 years old. CPS determined their sibling decedent's manner of death to be neglect homicide caused by complications from thermal and scalding injuries. CFSA placed the 12-year-old and 5-month-old siblings with kin, and a 6-year-old and 5-year-old in a non-foster care placement.

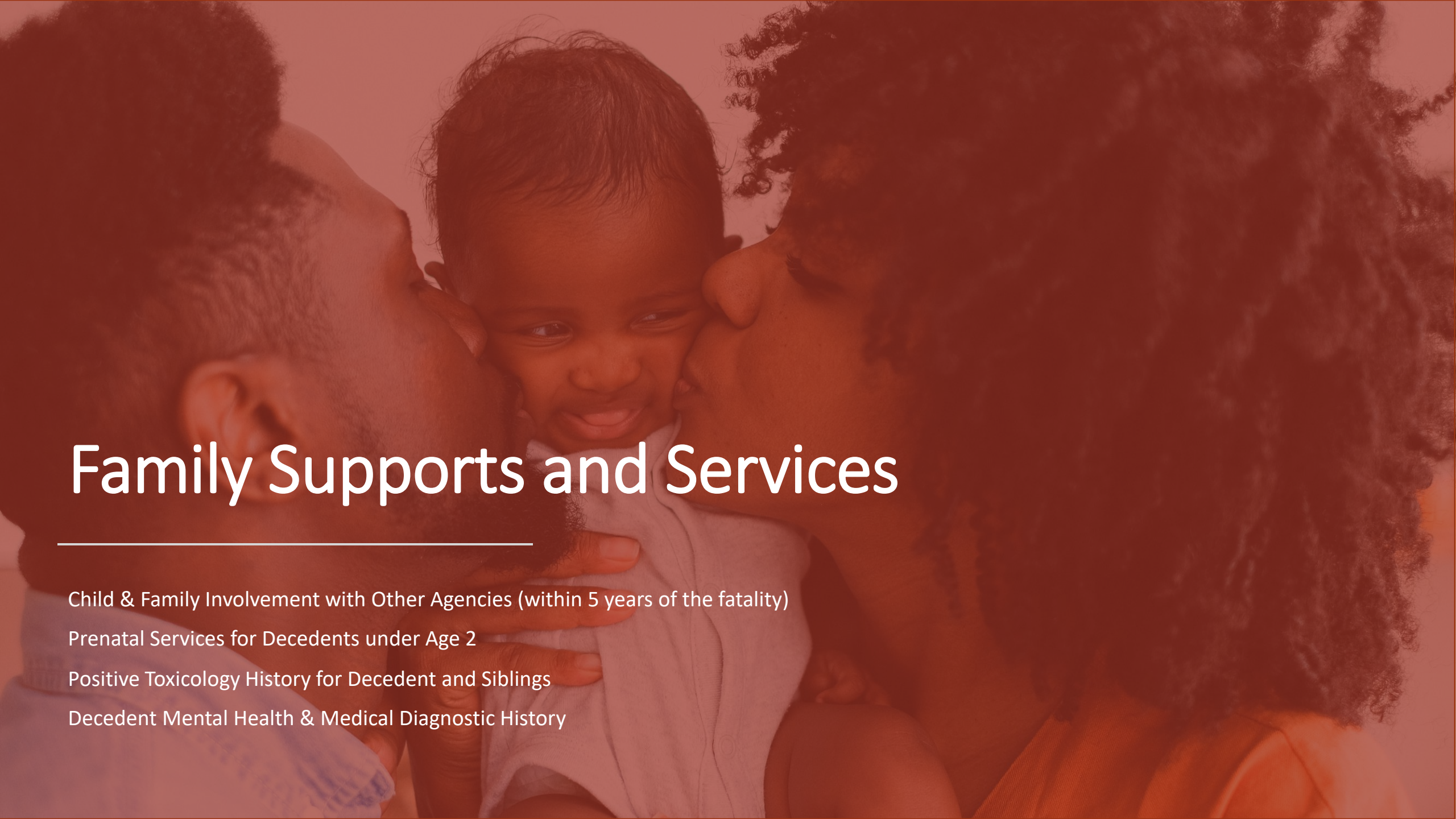
Demographics & Summary Findings:
Sleep-Related Factors for Infant Fatalities

There was a decrease in total infant fatalities in CY 2021; however, the proportion of infant deaths caused by sleep-related factors increased compared to CY 2020 and CY 2019 (Table 5). There were 10 fatalities for infants aged 2 or younger in CY 2021. Of these 10, 80 percent (n=8) involved unsafe sleeping arrangements. This percentage was higher in comparison to 31 percent in CY 2020 and 57 percent in CY 2019.

Three families with unsafe sleep-related fatalities were involved with CFSA at the time of the fatality. Two of these families each had an open CPS Investigation, and one family had an open In-Home case at the time of the fatality. Seven of the fatalities involved infant bed-sharing with family members. Of the fatalities involving bed-sharing, one involved bed-sharing in conjunction with parental substance abuse; one involved a blanket in the sleeping area, along with stomach sleeping; one involved bed feeding and stomach sleeping; and one involved non-supine sleeping, i.e., the infant was on his side and on a pillow. The eighth fatality involved a pillow in the sleeping area.

Table 5: 3-Year Totals of Infant Fatalities (Ages 2 and Under) by Calendar Year – Sleep-Related Factors

Year	2019	2020	2021
# of Total Infant Deaths	7	16	10
# Sleep-Related	4	5	8
Percentage	**57%**	**31%**	**80%**



Family Supports and Services

Child & Family Involvement with Other Agencies (within 5 years of the fatality)

Prenatal Services for Decedents under Age 2

Positive Toxicology History for Decedent and Siblings

Decedent Mental Health & Medical Diagnostic History

Family Supports & Services

During CY 2021, families were involved with the following entities within 5 years of the decedent's fatality:

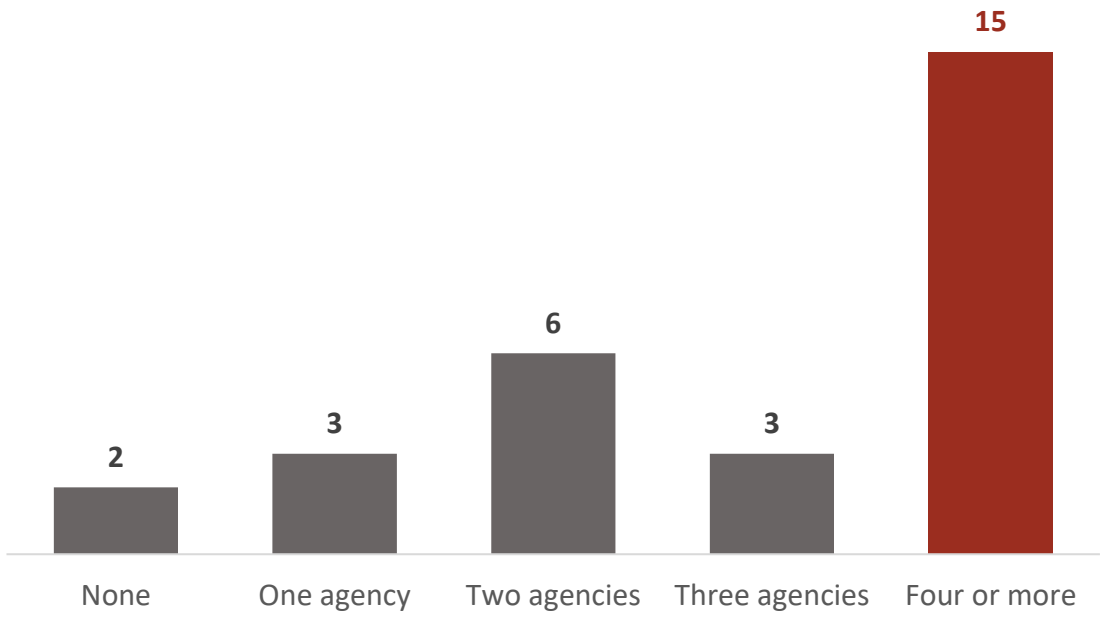
- DC Housing Authority (DCHA)
- Department of Behavioral Health (DBH)
- District of Columbia Courts
- Department on Disability Services (DDS)
- Department of Health (DC Health)
- Department of Health Care Finance (DHCF)
- Department of Human Services (DHS)
- Department of Youth Rehabilitation Services (DYRS)
- Health Services for Children with Special Needs (HSCSN)
- Office of the State Superintendent of Education (OSSE)
- US Attorney's Office – District of Columbia

The CFR Unit also noted family involvement with CFSA's contracted partnership with the Healthy Families/Thriving Communities Collaborative Council (Collaboratives) and other private agency providers. By examining family involvement with other entities, the ICFR Committee hopes to identify trends that may be useful for the development of fatality prevention measures. In particular, the identification of service needs and other agency involvement may help system-wide strategies to address the highest percentages of fatalities, i.e., older youth from violence and sleep-related fatalities for infants.

Family Supports & Services:
Child & Family Involvement with Other Agencies

As noted, many of the families involved with CFSA were also involved with multiple District entities within 5 years of the fatality. Ninety-three percent of the families (n=27) experiencing a CY 2021 fatality were involved with at least one other District entity within the 5-year period (Figure G). **Fifty-two percent (n=15) of the families were involved with four or more District entities within 5 years of a child's death.**

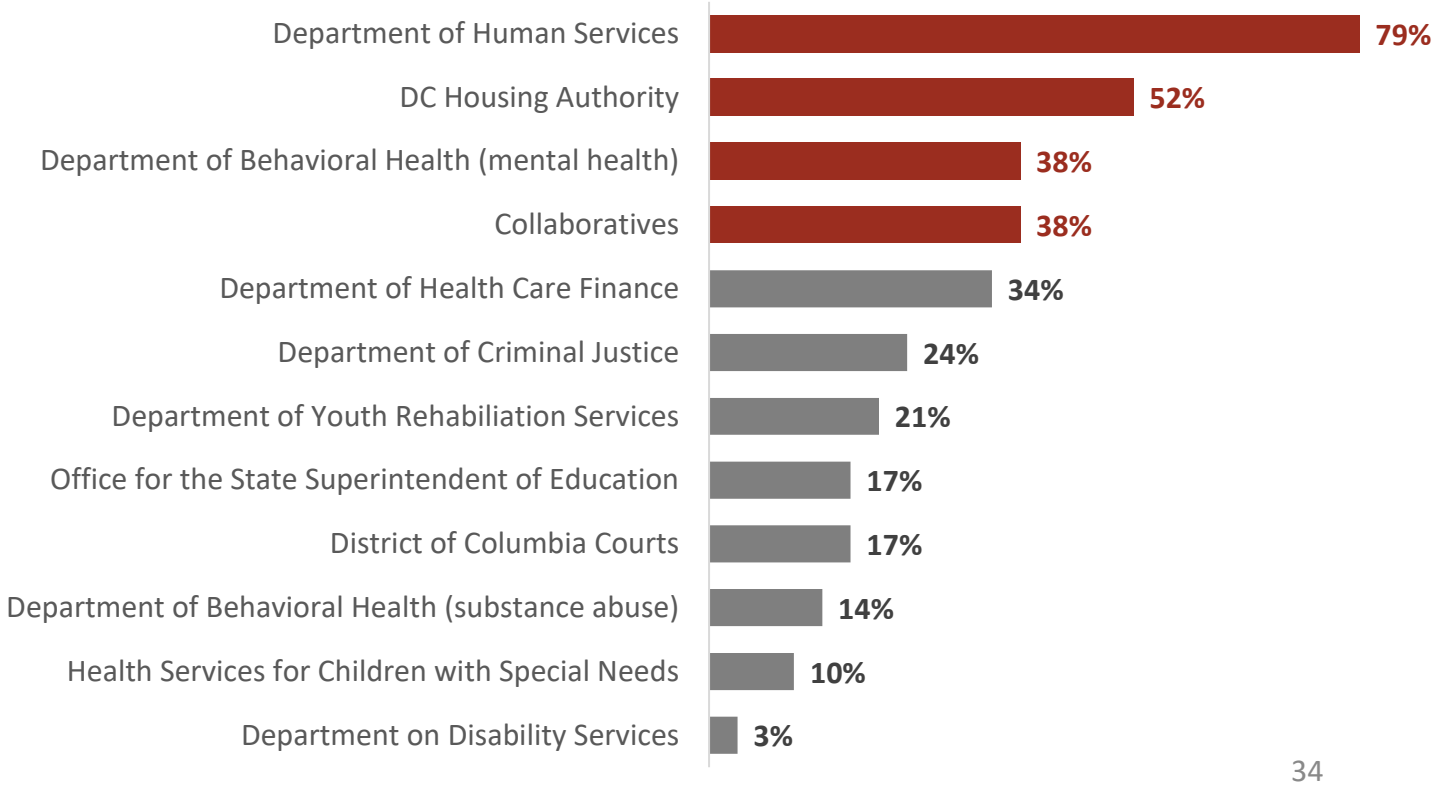
Figure G. Linked DC Agencies within 5 Years Prior to Fatality (n=29)



Family Supports & Services:
Child & Family Involvement with Other Agencies (cont.)

Most families (79 percent, n=23) experienced financial insecurities and therefore received benefits through DHS, e.g., housing, Temporary Assistance for Needy Families (TANF), and Supplemental Nutrition Assistance Program (SNAP). Other agencies that largely supported the families included DCHA (51 percent, n=15); DBH (38 percent, n=11) for mental health services; DBH (14 percent, n=4) for substance use treatment; the Collaboratives (38 percent, n=11); and DYRS (21 percent, n=6) for juvenile justice.

Figure H. Percentage of Families Involved with Other DC Agencies within 5 Years of Fatality (n=29)



Family Supports & Services:
Prenatal Services for Decedents Ages 2 and Under

Of the 29 child fatalities that occurred in CY 2021, 41 percent (n=11) involved children who were ages 2 and younger. Six of the children were female and five were male.

CFSA was aware of 55 percent (n=6) of mothers who received prenatal care for their children. The children's ages at the time of the fatality ranged from 5 days to 11 months old. One of the families had an open In-Home case with CFSA at the time of the fatality.

Four of the children were born prematurely. Two of the children had no known documented diagnoses. One child had fluid in the brain, and another child had polyhydramnios (excessive accumulation of amniotic fluid around the baby). The mother of one child contracted COVID-19 which resulted in the child experiencing a lack of oxygen *in utero*. One child was presumed deceased; however, his body was never located.

Family Supports & Services:
Positive Toxicology History for Decedent and Siblings

Children Under Age 2 Born with Positive Toxicology
Of the 12 decedents who were ages 2 and younger, **none of the children had a positive toxicology at birth**.

Birth Mothers with Previous Children Born with Positive Toxicology
While none of the 12 decedents under the age of 2 were born with positive toxicology, one mother (8 percent) did give birth to two prior children with positive toxicology results for phencyclidine (PCP). The first child was born in 2007 and the second child was born in 2015.

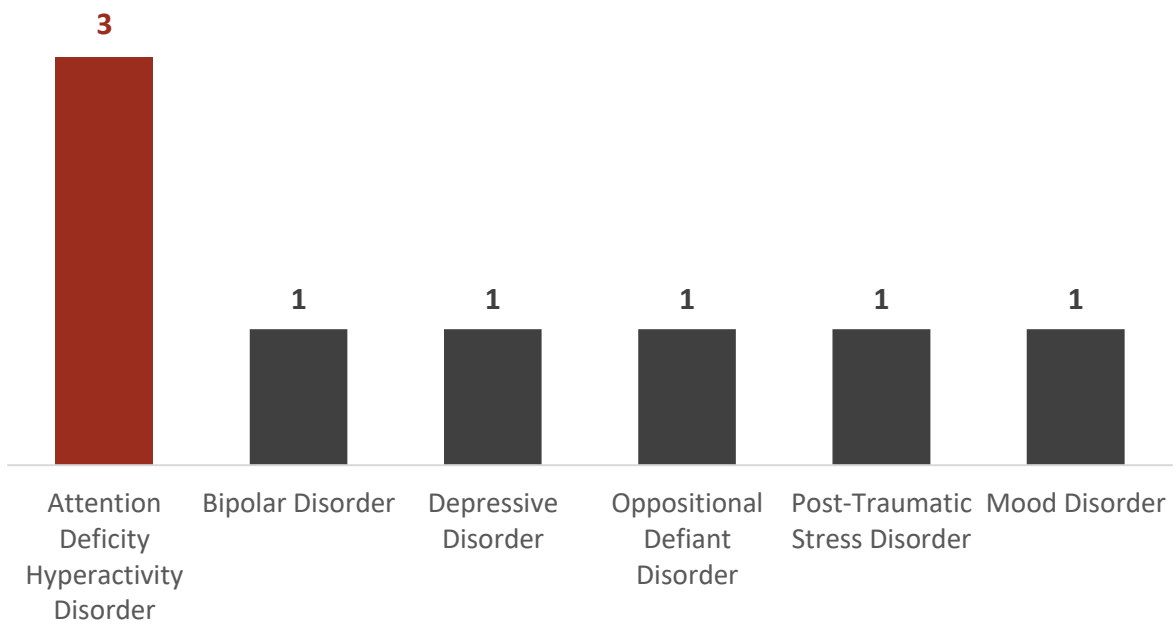
The children's mother reportedly began using drugs as a teenager and was later diagnosed with major depressive disorder, postpartum depression and substance use disorder. The mother worked with a community support worker for over 3 years but recently started meeting with an advanced practice registered nurse. The mother also received medication to treat the depression.

Family Supports & Services:
Decedent Mental Health & Medical Diagnostic History

Of the 29 child fatality cases reviewed, **17 percent (n=5) of the children had documented mental health diagnoses** (Figure I). Sixty percent (n=3) of the children had attention deficit hyperactivity disorder; 20 percent (n=1) of the children had oppositional defiant disorder. One child (20 percent) was diagnosed with bipolar disorder, depression, post-traumatic stress disorder and a mood disorder. There were two children who did not have specific diagnoses but experienced mental health crises: one experienced suicidal ideations and two psychiatric hospitalizations, and the other child had secondary trauma as he witnessed the murder of his best friend.

There were five children who had medical diagnoses. Forty percent (n=2) of the children had birth-related issues: one had a heart defect and one had severe bronchopulmonary dysplasia, severe chronic lung disease, and pulmonary hypertension. Forty percent (n=2) of the children had asthma. For one child, the mother experienced medical complications during her pregnancy and delivery of the decedent.

Figure I. Mental Health Diagnoses of Decedents (n=5)



Family Abuse and Neglect History

CFSA Involvement

Birth Parents' Abuse and Neglect History

Decedents' Abuse and Neglect History

Birth Parents' CPS Substantiations

Substantiations Involving Decedents

Family Abuse and Neglect History:
CFSA Involvement within 12 Months of Fatality

Most families (69 percent, n=20) did not have active CFSA involvement at the time of the fatality (Table 6). Of the nine families with involvement, 7 percent (n=2) of the families had an open CPS investigation at the time of the fatality. Seventeen percent (n=5) of the families had a case opened with the In-Home Administration, and 7 percent (n=2) of the families had a case opened with the Office of Out-of-Home Support (see *Appendix C*). None of the families had an active CPS investigation.

Within 12 months of the fatality, 35 percent (n=10/29) of the decedents' families had CFSA involvement (Table 7). All 10 families had an open CPS investigation within 12 months of the fatality. Fourteen percent (n=4) of the families also had an open In-Home case within 12 months of the fatality, while 3 percent (n=1) had an open Out-of-Home case during the same time frame. Ten percent (n=3) had an open CPS Investigation and an open In-Home case during the 12 months. Another 3 percent (n=1) had an open CPS Investigation, an open In-Home case, and an open Out-of-Home case during the 12 months prior to the fatality.

Table 6: CFSA Involvement at Time of Fatality (n=29)

	n	%
No Involvement	20	69
CPS Investigations	2	7
In-Home Cases	5	17
Foster Care/Out-of-Home Cases	2	7
Total	**29**	**100**

Table 7: CFSA Involvement within 12 months of Fatality (n=29)

	n	%
No Involvement	19	66
CPS Investigation Only	6	21
CPS Investigation and In-Home Case	3	10
CPS Investigation, In-Home, Foster Case	1	3
Total	**29**	**100**

Family Abuse and Neglect History:
CFSA Involvement within Five Years of Fatality

Of the 29 families, 17 percent (n=5) had one report (referral or case), 10 percent (n=3) had two reports, 14 percent (n=4) had three reports, and **59 percent (n=17) had four or more reports within 5 years of the fatality** (Figure J).

While 41 percent (n=12) of the families had direct CFSA involvement at the time of the fatality, 59 percent (n=17) were not involved with CFSA at the time of the fatality. For those 17 families, CFSA examined the time frames between the date of the child fatality and the family's *most recent* investigation, family assessment (FA), or case.[17] Those time frames ranged from 1 month to 56 months. **Most families (65 percent, n=11) were last involved with CFSA more than 18 months prior to the fatality.** Three percent (n=1) had its last contact with CFSA within 6 months of the fatality, while 7 percent (n=2) were last involved within 7 to 12 months. Ten percent (n=3) were last involved within 12 to 18 months of the fatality.

Figure J. Frequency of CFSA Involvement within 5 Years of Fatality (n=29)

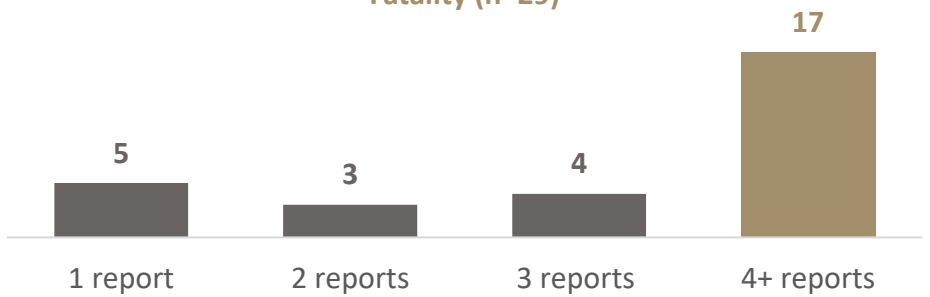
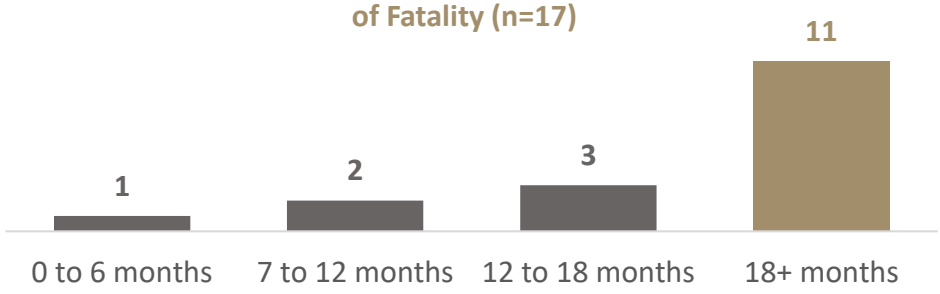


Figure K. Proximity of Most Recent Contact to Child Fatality for Families Not Involved with CFSA at Time of Fatality (n=17)



17. On April 1, 2019, CFSA discontinued the FA pathway and reinstated the protocol of referring all accepted reports for an investigation. However, since the CFR Unit examines family history within 5 years, FA cases may still be included in fatality reviews up until April 1, 2024.

Family Abuse and Neglect History:
Birth Parents' Abuse and Neglect History

Birth Parents' Child Welfare History as Minors

Seventeen birth parents had history with the child welfare system as minor children. Of these 17, 76 percent (n=13) were birth mothers and 24 percent (n=4) were birth fathers. In addition, five birth mothers had child history of foster care placement. Both birth parents of two decedents had child welfare history as minor children.

Birth Parents' CFSA History as Parents

CFSA reviewed birth parents' CFSA history for the 5-year period prior to the fatality. These histories included screened-out CFSA Hotline reports, CPS investigations, FAs, In-Home cases, and Out-of-Home cases. An overview of the birth parents' history is provided in Table 8:

Table 8: Count of Birth Parents' CFSA History within 5 Years of the Fatality (n=29)

	1 Report	2 Reports	3 Reports	4+ Reports	TOTAL
Screen-Outs	7 (24%)	5 (17%)	1 (3%)	12 (41%)	**25 (86%)**
CPS Investigations	11 (38%)	6 (21%)	1 (3%)	5 (17%)	**23 (79%)**
Family Assessments (FA)	10 (34%)	1 (3%)	1 (3%)	--	**12 (41%)**
In-Home Cases	8 (28%)	3 (10%)	1 (3%)	--	**12 (41%)**
Foster Care/Out-of-Home Cases	2 (7%)	--	--	--	**2 (7%)**

Family Abuse and Neglect History:
Birth Parents' Abuse and Neglect History (cont.)

- **Eighty-six percent (n=25) of the 29 decedents' birth parents' households had at least one report screened out by the CFSA Hotline within 5 years of the fatality.** Of these 25, 24 percent (n=7) of the birth parents had one screen-out report, 27 percent (n=5) had two screen-outs, 3 percent (n=1) had three screen-outs, and 41 percent (n=12) of the families had four or more screen-outs.

- **Seventy-nine percent (n=23) of the decedents' birth parents' households had at least one CPS investigation opened within 5 years of the fatality.** Of these 23 households, 38 percent (n=11) had one CPS investigation opened during the 5-year period. Twenty-one percent (n=6) had two investigations, 3 percent (n=1) had three investigations, and 17 percent (n=5) had four or more investigations.

- **Forty-one percent (n=12) of the decedents' birth parents' households participated in FAs during the 5-year period prior to a fatality.** Of these 12 households, 28 percent (n=10) of the birth parents participated in one FA while 10 percent (n=3) participated in two FAs, and 3 percent (n=1) participated in three FAs.

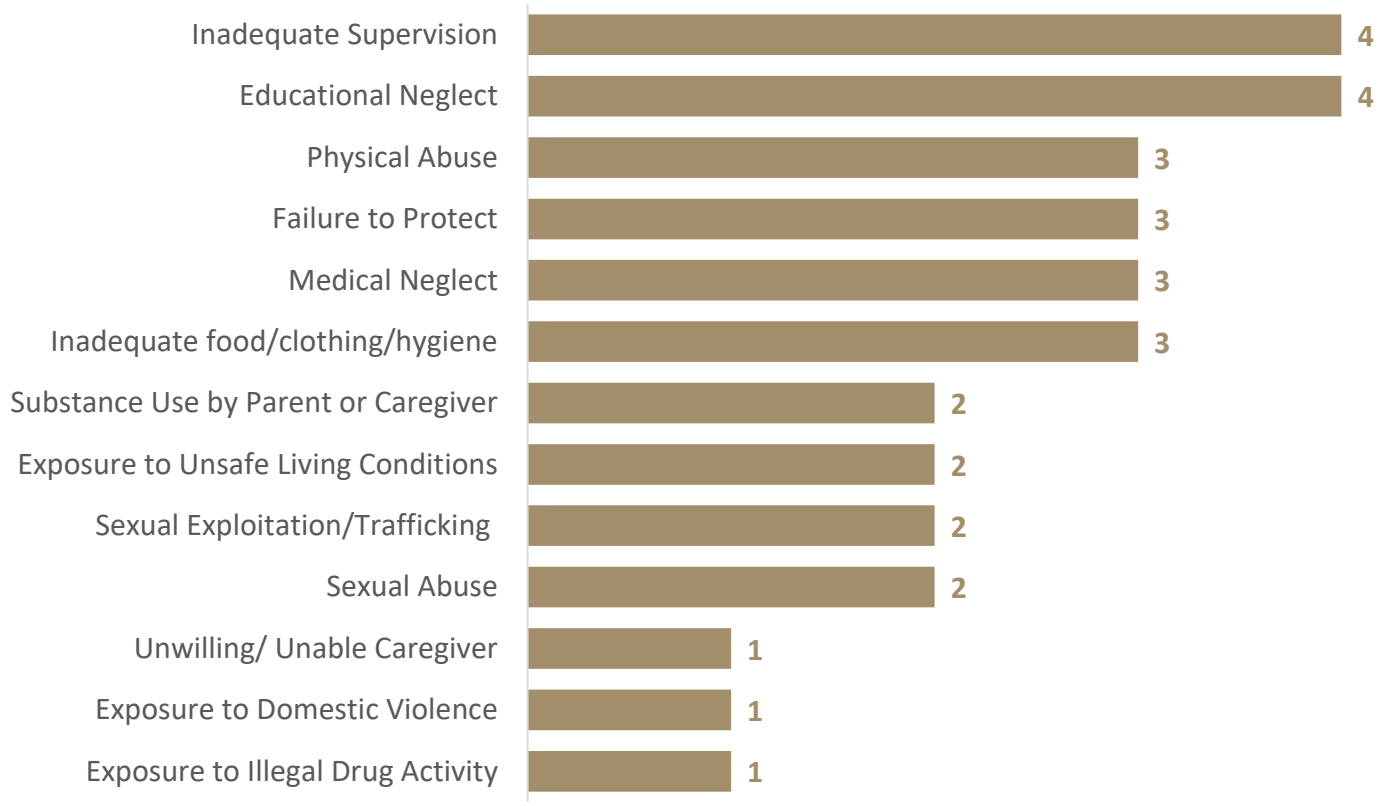
- **Forty-eight percent (n=14) of the decedents' birth parents' households had at least one In-Home or Out-of-Home case opened within 5 years of the fatality.** Of these 14 households, 28 percent (n=8) birth parents had an In-Home case opened within the 5 years while 10 percent (n=3) of the birth parents had two In-Home cases opened. Three percent (n=1) had three In-Home cases opened during the 5-year period while 7 percent (n=2) each had one Out-of-Home case opened during the 5-year period.

Family Abuse and Neglect History:
CPS Substantiations within 5 Years of Fatality

Of the 29 families, there were 16 with at least one substantiated allegation from a CPS investigation within the 5 years prior to the fatality.[18] Sixty-three percent (n=10) of the 16 families had one substantiated allegation while 19 percent (n=3) had two substantiated allegation. Six percent (n=1) had three substantiated allegations while 12 percent (n=2) of the families had four substantiated allegations.

An overview of the substantiated allegations for the 16 families is provided in Figure L.

Figure L. Substantiations within 5 Years of the Fatality (n=16)



18. Families may have had more than one substantiated allegation during an investigation.

Decedent Abuse and Neglect History:
Hotline Calls and Substantiations within 12 Months of Fatality

Within 12 months of the fatality, CFSA Hotline referrals identified 28 percent (n=8) of the decedents as an alleged victim child in at least one report. For all eight decedents, there was a total of ten Hotline reports. Six of the decedents had one Hotline report each, while two decedents had two Hotline reports each. Eight of the 10 Hotline reports resulted in a CPS Investigation.

Twenty-one percent (n=6) of the decedents were identified as a victim child in at least one substantiated allegation. Investigation dispositions identified four decedents as victim children in one substantiated allegation and two other decedents in two substantiated allegations. There were eight substantiated allegations with six decedents as victim children. The substantiations included two abuse allegations (physical) and six neglect allegations (three inadequate supervision, one inadequate clothing/ hygiene/food, and two substance use impacting parenting). While none of these specific substantiations resulted in a fatality, CFSA substantiated one family for inadequate supervision related to a neglect homicide. Similarly, of the substance use allegations, CFSA substantiated one family for substance-related neglect homicide.

Figure M. Decedents with Hotline Call within 12 Months of the Fatality (n=29)

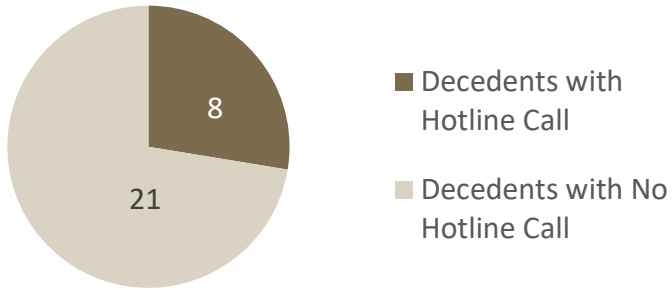
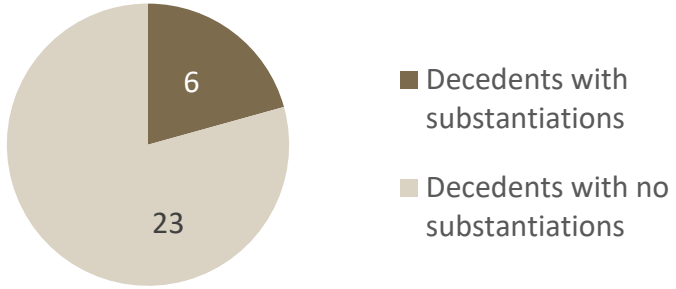


Figure N. Decedents with Substantiations within 12 Months of the Fatality (n=29)



Decedent Abuse and Neglect History:
Hotline Calls and Substantiations within 5 Years of Fatality

Within 5 years prior to the fatality, 59 percent (n=17) of the decedents had at least one CFSA Hotline report identifying them as an alleged victim child. There were a total of 53 Hotline reports made to the CFSA Hotline involving the 17 decedents. Of the 53 reports, 53 percent (n=28) involved 14 decedents and resulted in a CPS Investigation. Five of the 17 decedents had one Hotline report each as a child victim; four had two reports; two had three reports; two had four reports; one had five reports; two had six reports; and one decedent had nine reports.

Twenty-eight percent (n=8) of the decedents had at least one CPS substantiation identifying them as a victim child. Among the eight decedents, there were a total of 11 substantiated allegations, including five for abuse (two physical, two sex trafficking, one sexual) and six for neglect (one failure to protect, two inadequate supervision, and three substance use impacting parenting). While none of these specific substantiations resulted in a fatality, CFSA substantiated one family for inadequate supervision related to a neglect homicide. Similarly, of the substance use allegations, CFSA substantiated one family for substance-related neglect homicide.

Figure O. Decedents with Hotline Call within 5 Years of the Fatality (n=29)

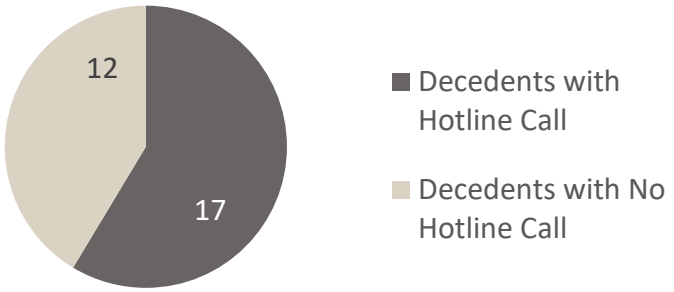
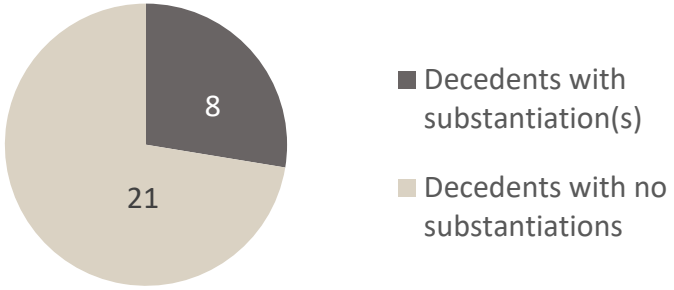


Figure P. Decedents with Substantiations within 5 Years of the Fatality (n=29)



Family Abuse and Neglect History:
Four-Plus (4+) Staffings

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 families helps management take a closer look at strategies to prevent repeat referrals in the future.

Thirty-four percent (n=10) of the families that suffered a child fatality in CY 2021 were eligible for a 4+ staffing. Of these 10 families, 70 percent (n=7) received a 4+ staffing. For the three families that did not receive a 4+ staffing, each had a history of substantiated allegations for educational neglect within 5 years. One family also had substantiated allegations for physical abuse, inadequate supervision, and child exposure to illegal substances. There were no neglect homicides among the three families.

One of the three families that did not receive a 4+ staffing was actively involved with CFSA at the time of the fatality. The In-Home Administration had opened a case for the family in 2020, based on a substantiated allegation for inadequate supervision. The 4-year-old decedent's manner of death was accidental, due to a hit-and-run car accident that resulted in multiple blunt-force injuries. A 6-year-old decedent's manner of death was non-abuse homicide caused by gunshot wounds. The family was not involved with the Agency at the time of the fatality. The third child, a 9-year-old female, died a natural death from congenital abnormalities of the heart. None of the decedents' manner or cause of death was related to the family's history with the Agency. There were also no sibling removals for the families that did not receive a 4+ staffing.

Family Abuse and Neglect History:
Family Team Meetings (FTMs)

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's safety is at risk and there is a probability of the child being separated 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 34 percent (n=10) of the 29 families within 5 years of the fatality. Ages of the children ranged from 2 months to 18 years old. Seventy percent (n=7) of the 10 families had at least one substantiated allegation within 5 years of the fatality, including abuse (physical) and neglect (substance use impacting parenting, inadequate supervision, educational neglect, medical neglect, exposure to unsafe living conditions, and exposure to illegal substances).

Within 12 months of the fatality, 86 percent (n=6) of the seven families had a new referral resulting in a CPS investigation. Of the six families, CFSA opened three cases with the In-Home Administration, and one case with the Office of Out-of-Home Support. Of the new referrals, four CPS investigations involved the decedent as a victim child, including three cases with the In-Home Administration. Of those three cases, one family also had a case opened with the Office of Out-of-Home Support.

For the six child fatalities of these families, two included neglect homicide as the manner of death. Of the remaining four child fatalities, there were two accidental deaths, one natural death, and one death undetermined due to the lack of the body being available for an autopsy.

Summary of Critical Findings

Summary of Critical Findings

Actions Taken by CFSA to Address Critical Findings

Summary of Critical Findings

CFSA focuses on the strength and resilience of families while continuing to provide protections to those most vulnerable in the District of Columbia. The CFR Unit analyzes data to determine areas of success and systemic challenges. Based on the findings and recommendations from the 2020 ICFR Annual Report, as well as a review of the literature, the following areas received additional focus during CY 2021:

- **Screened-out referrals**
- **Families with active CFSA involvement at the time of the fatality**
- **Educational neglect referrals**
- **Unsafe sleeping environments**
- **Ghost guns and teen violence**

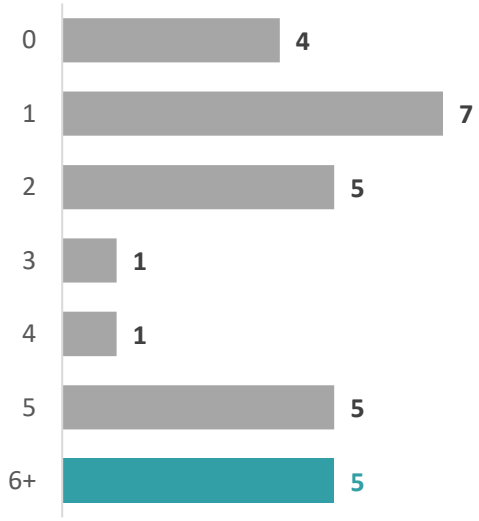
Screened-Out Referrals

The CFSA Hotline utilizes the Structured Decision Making (SDM™) risk and safety assessment tool to determine whether a report of abuse or neglect meets the following criteria for a CPS investigation:

1. Information of suspected maltreatment meets the District's legal definition of abuse or neglect.
2. Alleged victims are under the age of 18 years old (or if between 18 and 21, the older youth is a ward of the District and has an open ongoing foster care case with CFSA).
3. Perpetrator is the child's parent, guardian, custodian, or adult household member; or anyone legally responsible for the child's welfare (i.e., acting in *loco parentis*); or any individual who causes a child to be trafficked.
4. Sufficient identifying information exists to locate the victim or the family.
5. Report is made in good faith.

The Hotline screens out any reports that do not meet the above criteria. Whenever the Hotline screens out a report, CPS will not investigate the allegations associated with the report. **Of the 29 fatalities reviewed in 2021, 86 percent (n=25) of the families had at least one screened-out referral during the 5 years prior to the fatality. Seventeen percent (n=5) of the families had six or more screened-out referrals during the 5-year period (Figure Q).**

Figure Q. Count of Families with Screened-Out Referrals during 5-Year Review Period (n=29)



Screened-Out Referrals (cont.)

For over a decade, CFSA has invested in safely keeping families together and developing robust prevention strategies to help support them. In 2021, CFSA developed the *Engage and Connect* program to support families referred by District schools, or referred by the community, for concerns of educational neglect. When these referrals indicate no safety risk, the CFSA Hotline may screen out the calls. To ensure these families still receive needed services, CFSA is working to establish a community-based *Warmline.* The Warmline will address calls to the Hotline that are not safety-related, ensuring that families still receive critical supports and services, ultimately reducing their risk for future maltreatment.

State-level data indicates that families with screened-out referrals are at higher risk for new referrals. Intervention research is minimal and mixed, but there are indications that family engagement with community-based services may reduce future CPS involvement.[19] To achieve these outcomes, CFSA currently relies upon services provided by its contracted partnership with the Healthy Families/Thriving Communities Collaboratives. The following five Collaboratives serve seven of eight Wards in the District of Columbia: **East River Family Strengthening Collaborative** (Ward 7), **Edgewood/Brookland Family Support Collaborative** (Wards 5 and 6), **Far Southeast Family Strengthening Collaborative** (Ward 8), **Georgia Avenue Family Support Collaborative** (Ward 4), and **Collaborative Solutions for Communities** (Wards 1 and 2).[20] Additionally, with the support of the federal Family First Prevention Services Act, CFSA has expanded the array of prevention services to include Families First DC, a neighborhood-based, whole-family approach to providing primary prevention services and neighborhood-driven resources.

19. A Review of Screened-Out Families and Child Protective Services Involvement: A Missed Opportunity to Prevent Future Maltreatment With Community-Based Services - James D. Simon, María Gandarilla Ocampo, Brett Drake, Melissa Jonson-Reid, 2022. Retrieved from https://responsiblehomeschooling.org/research/current-policy/educational-neglect-statutes/#:~:text=According%20to%20the%20Child%20Welfare,New%20Mexico%2C%20New%20York%2C%20North

20. Due to multiple factors, including socioeconomic and racial disparities, Ward 3 has not been historically represented within the population served by the District's child welfare system.

Families with Active Involvement at the Time of the Fatality

Of the 29 fatalities that occurred during CY 2021, 31 percent (n=9) were involved with CFSA at the time of the fatality. Eight of the nine decedents were under the age of 5 at the time of their death. For the three fatalities classified as abuse or neglect homicides, the decedents were all under the age of 3.

A recent study conducted by the California State University School of Social Work analyzed the deaths of children younger than 5 years of age with active child welfare involvement at the time of death. The analysis focused on characteristics that might be associated with increased risk of fatality based on a history of child maltreatment. The sample included 2,513 cases from 2004 – 2016, all pulled from the database of the National Center for Fatality Review and Prevention – Case Review System.[21] Those who died from maltreatment were older, had experienced prior maltreatment, lived in an overcrowded residence, and had a caregiver with prior child welfare involvement. The prior child welfare involvement included histories of substance abuse, interpersonal violence, criminal delinquency, and the caregivers' histories of maltreatment as victim children. These risk factors and others may be associated with a higher likelihood of fatalities consequent to abuse or neglect for children who already have an open CPS case.

21. Factors Associated with Child Maltreatment Fatality among Young Children with an Open Child Protective Services Case at Death. Batra, E. K., Palusci, V. J., and Berg, A. Child Abuse Rev (2021). Retrieved from doi: https://doi.org/10.1002/car.2734

Educational Neglect Referrals

The COVID-19 pandemic illuminated health and educational disparities across the nation as well as across the District of Columbia. For example, CFSA received over 8,000 education neglect referrals during the first year of the pandemic (2020). DC Code requires local education agencies (LEAs) to report to CFSA 10 or more unexcused absences for students aged 5 to 13. For youth aged 14 to 17 who have more than 15 unexcused absences, LEAs refer the student to the Family Court Social Services Division of the Superior Court of the District of Columbia and to the Office of the Attorney General Juvenile Section.[22] LEAs include the District of Columbia Public Schools (DCPS), District of Columbia Public Charter Schools (DCPCS), and DC private schools.

Upon receipt of an educational neglect referral, CFSA's Educational Neglect Unit (under the purview of the Office of Well-Being) triages an assessment of the information received, contacting both the school reporter and the student's caregivers, and determining whether the referral requires a CPS investigation (e.g., additional information concerns a child's safety). The Educational Neglect Unit has received funding from LEAs for four resource development specialists focused on this area.

Educational neglect referrals in CY 2021 identified 7 percent (n=2) of the 29 decedents as alleged victim children. The Hotline screened out the referrals within 9 months of the children's deaths; both decedents died of natural causes.

22. DC Code § 38–208 (Truancy Procedures; Inter-Agency Coordination)

Unsafe Sleep Fatalities

In the CY 2021 review of fatalities, unsafe sleeping conditions contributed to the fatalities of eight out of ten infants.

Risk factors associated with unsafe sleeping environments may vary among different age groups. According to the American Academy of Pediatrics, the predominant risk factor for younger infants (0-3 months of age) is bed-sharing, whereas rolling to a prone position with objects in the sleep area is the predominant risk factor for older infants (4 months to 364 days).[23]

23. Sleep Environment Risks for Younger and Older Infants | Pediatrics | American Academy of Pediatrics (aap.org)

Ghost Guns and Teen Violence

Of the 29 reviewed decedents, 31 percent (n=9) died from gun violence in the community.

Literature suggests that firearm violence is an epidemic in the United States, and that interpersonal gun violence is a leading cause of morbidity and mortality. Some researchers postulate that engaging the survivors of firearm violence could help identify individual themes and community-level factors that contribute to ongoing violence. In addition, researchers have noted that interpersonal violence is strongly associated with the social determinants of health, requiring community-specific solutions to address root causes.[24]

CFSA endeavors to address root causes and to improve family resilience through community engagement via CFSA's Community Partnerships Program, the Office of Youth Empowerment, the Office of Well-Being, the Collaboratives (referenced earlier) and the District's 10 Family Success Centers which provide direct services within neighborhoods demonstrating need. In particular, the Office of Youth Empowerment (OYE) has added assessments of youth to identify those youth who have experienced gun violence and survived and to engage them in activities that may possibly improve outcomes, i.e., using their experiences to develop opportunities for change and to decrease interpersonal violence.

24. Empowering the affected: Informing community-based solutions through interviews with survivors of interpersonal firearm violence-Perspectives of survivors of firearm injuries. | EBSCO Essentials

Recommendations from CFSA's Internal Child Fatality Review

Updates on CY 2020 ICFR Recommendations

2021 Recommendations Approved by the ICFR Committee

Updates on CY 2020 ICFR Recommendations

Throughout CY 2021, CFSA implemented three main recommendations endorsed by ICFR Committee members during CY 2020's monthly meetings.

CY 2020 RECOMMENDATION 1:
PRIMARY AND SECONDARY STRESS FOR CHILD WELFARE PROFESSIONALS

Recommendation: 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 ongoing.

Aligned Activities: CFSA currently offers the following supports for staff who experience primary or secondary stress: (1) in-house training on secondary traumatic stress and vicarious trauma; (2) professional support and counseling through the Agency's Employee Assistance Program; and (3) short-term, confidential, one-on-one or group intervention with a CFSA-contracted licensed clinical practitioner. CFSA also provides tip sheets for staff and supervisors on how to identify signs of traumatic stress, how to identify resources that are available to staff, and how staff can access resources and supports.

Updates on CY 2020 ICFR Recommendations (cont.)

CY 2020 RECOMMENDATION 2:
INFORMATION SHARING AGREEMENTS WITH DC AGENCIES

Recommendation: Improve information sharing between DC Government agencies to advance the quality of data available for investigations, case practice, and child fatality reviews.

Status: Implementation complete.

Aligned Activities: The ICFR Committee established a subcommittee with membership representing the Office of Planning, Policy, and Program Support; Entry Services; the Office of Clinical Case Management and Support; the Office of Well-Being; and the Office of Youth Empowerment. Subcommittee members first determined the extent to which information-sharing protocols already existed with other DC Government agencies, e.g., inventorying memoranda of understanding (MOUs) and memoranda of agreement (MOAs). The subcommittee also evaluated current gaps in information-sharing to inform potential updates to current MOUs and MOAs as well as possible development of new MOUs and MOAs. Subcommittee members also elevated a major need to access vital records from DC Health to inform child fatality reviews.

Updates on CY 2020 ICFR Recommendations (cont.)

CY 2020 RECOMMENDATION 3:
TRACKING PATIENT MEDICAL HISTORIES AND PROVIDERS

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

Status: Implementation complete.

Aligned Activities: ICFR members shared this recommendation with the DC Citywide Child Fatality Committee following the October 2021 release of CFSA's comprehensive of the *2020 Annual Child Fatality Review Report*.

CY 2021 Recommendations Approved by the ICFR Committee

During CY 2021, ICFR Committee members proposed and approved three recommendations related to CY 2021 fatalities.

CY 2021 RECOMMENDATION 1:
REVISION OF THE CRITICAL EVENT & CHILD FATALITY REVIEW POLICIES

Recommendation: Update the current Critical Event to match the Child Fatality Review policies, including overall changes in practice and processes for reviewing near-fatalities.

Status: Implementation to begin in CY 2023.

Aligned Activities: Members of the ICFR along with external stakeholders participated in a LEAN event in September 2021 to evaluate the Agency's current processes related to critical events and child fatalities.[25] Participants in the LEAN event identified practices that were outdated for both policies, based on changes in the Agency's organizational structure. In addition, participants recommended modifying the policies in alignment with the federal Child Abuse Prevention and Treatment Act, i.e., integrating new processes for reviewing and reporting near-fatalities caused by abuse or neglect. As a result of the LEAN events, CFSA will convene a work group to review both policies and suggest changes in alignment with current and new practices.

25. LEAN events are designed as a "plan, act, do, and check" model to help government systems identify then implement the most efficient, value-added way to provide services.

CY 2021 Recommendations Approved by the ICFR Committee (cont.)

CY 2021 RECOMMENDATION 2:
INTEGRATION OF CHILD FATALITY DATA INTO STAAND

Recommendation: Ensure that fatality review data and reporting are integrated into the Agency's new computerized child welfare information system, STAAND (Stronger Together Against Abuse and Neglect).

Status: Implementation in process.

Aligned Activities: Participants in the September 2021 LEAN event developed recommendations for how to integrate into STAAND the data collection and reporting related to critical events and child fatalities. The STAAND Development Team is now aware and working on the feasibility of implementing the recommendations. As part of implementation work, the STAAND Development Team is developing a Child Fatality & Critical Event Dashboard that will identify all critical events and child fatalities reported to CFSA through the Hotline, Agency employees, and other formal notification measures. The dashboard will further allow information to be housed centrally within STAAND, in contrast to the current practice of maintaining a manual database outside of the Agency's present electronic information system.

CY 2021 Recommendations Approved by the ICFR Committee (cont.)

CY 2021 RECOMMENDATION 3:
IMPROVED DATA SHARING WITH DC HEALTH'S VITAL RECORDS DIVISION

Recommendation: Finalize the MOU with DC Health to provide monthly data on applicable fatalities to CFSA to facilitate the timely review of child fatalities.

Status: Implementation complete.

Aligned Activities: Since 2020, CFSA has worked with DC Health to develop an MOU for sharing monthly data related to death records for any DC residents who are aged 26 and younger and who died within any given calendar month. After the CFR Unit reviews data to see if the resident had prior involvement with the Agency, the CFR Unit would request the full death records for confirmed clients. Receipt of monthly data directly from DC Health would allow CFSA to review more fatalities of past clients during the year of the fatality versus delaying reviews until a new year. The MOU has been finalized with the first data share anticipated in early 2023.

Conclusion

The child fatalities that occurred during CY 2021 reflect similar historical trends reported in previous years for families involved with the District's child welfare system. There were three neglect homicides in CY 2021, which matched the number reported in CY 2020 (one neglect and two abuse homicides). Fatalities for the youngest population remained highest with 34 percent (n=10/29) accounting for children aged 2 and under, which is a decrease of 6 percentage points compared to CY 2020 (40 percent). Youth aged 18 years or older accounted for 17 percent (n=5) of the fatalities that occurred in CY 2021, a decrease from 40 percent in CY 2020. For older youth fatalities, homicide continues to be the dominant manner of death.

The data gathering process for fatality reviews continued to evolve in CY 2021. Based on feedback from external stakeholders, the CFR Unit revised its processes again for the gathering and quality control of data while maintaining effective procedures, e.g., maintaining 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). In addition, the CFR Unit began tracking the number of reports for child and family histories as well as allegations and substantiations identifying decedents as alleged victim children. Both CFSA leadership and the CFR Unit are determined to ensure that accurate data continues to be disseminated and that transparency of data is accessible by all stakeholders, both internally District-wide.

Appendices

Appendix A. Other Fatalities Reviewed during CY 2021

Appendix B. Fatality Reviews from CY 2017 to CY 2022 Q2

Appendix C. Program Descriptions

Appendix D. ICFR Protocols

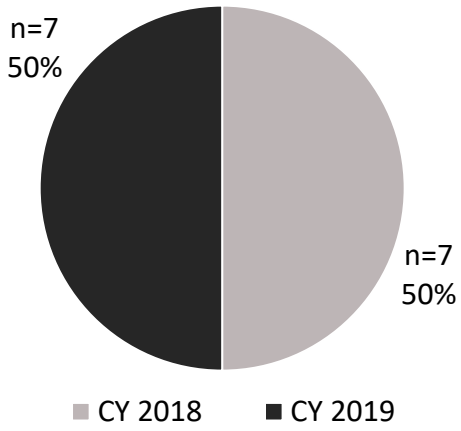
Appendix A. Other Fatalities Reviewed during CY 2021

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 51 fatalities during CY 2021; all 51 fatalities helped to inform practice and policy recommendations that potentially reduce future child fatalities. Twenty-six percent (n=13) of the non-2021 fatalities occurred during CY 2020; relevant findings and recommendations for the CY 2020 fatalities were included in the *2020 Annual CFR Report*. The following data focuses on 14 fatalities reviewed by the ICFR Committee which occurred prior to CY 2020.

Cases Reviewed

Of the 14 fatalities that occurred outside of CY 2021, 50 percent (n=7) occurred in 2018 with another 50 percent (n=7) occurring in 2019 (Figure A1). The CFR Unit presented the results of each of the 14 reviews to members of CFSA's ICFR Committee during CY 2021.

Figure A1: Additional CY 2021 Reviews by Year of Fatality (N=14)



Appendix A. Other Fatalities Reviewed during CY 2021: Demographics and Manner of Death by Age & Gender

Tables A1 and A2 provide an overview of the demographic information of the 14 decedents who died prior to CY 2021. Of the seven fatalities occurring in CY 2018, 43 percent (n=3) were female; the other 57 percent (n=4) were male. Fifty-seven percent (n=4) of the CY 2018 decedents were infants under the age of 1. Three of the infants were female; one infant was male. The manner of death for all four infants was natural and related to complications from premature births. For the remaining three CY 2018 male decedents, the ages were 12 months, 17 years, and 21 years. Manner of death for the 12-month-old male was natural due to hypoxic anoxic brain injury. Manner of death for the 15-year-old male was classified as undetermined due to an epileptic seizure of unknown causes. The death of the 21-year-old male was due to non-abuse homicide caused by multiple gunshot wounds.

Of the seven fatalities occurring in CY 2019, 29 percent (n=2) were females and 71 percent (n=5) were males. The two female decedents were 19 and 20 years old. The cause of death for the 19-year-old was unknown; the 20-year-old female died by suicide due to a drug overdose. The five male decedents ranged in age from 8 years to 22 years. Manner of death for the 8-year-old male was natural, caused by cerebral herniation, increased intracranial pressure, and anoxic brain injury; another significant condition was muscle eye brain disease. The remaining four male decedents were over the age of 18: three were 19 years old and the fourth was 22 years old. The manner of death for the two 19-year-old male decedents was non-abuse homicide; the cause of death for both decedents was gunshot wounds. Manner of death for the third 19-year-old male was accidental; the cause of death was blunt force injuries of the abdomen due to a motor vehicle collision. The manner of death for the 22-year-old male was suicide by hanging.

Appendix A. Other Fatalities Reviewed during CY 2021: Demographics and Manner of Death by Age & Gender (cont.)

Table A1: Manner of Death for Pre-CY 2021 Fatalities by Age								
	Natural Causes	*Non-Abuse Homicide*	*Abuse or Neglect Homicide*	*Accident*	*Suicide*	*Undetermined*	*Unknown*	*Total*
Age (in years)								
<1	4							4
1 – 5	1							1
6 – 12	1							1
13 – 17						1		1
18+		3		1	2		1	7
Total	**6**	**3**	**0**	**1**	**2**	**1**	**1**	**14**

Table A2: Manner of Death for Pre-CY 2021 Fatalities by Gender								
	Natural Causes	*Non-Abuse Homicide*	*Abuse or Neglect Homicide*	*Accident*	*Suicide*	*Undetermined*	*Unknown*	*Total*
Gender								
Male	3	3		1	1	1		9
Female	3				1		1	5
Total	**6**	**3**	**0**	**1**	**2**	**1**	**1**	**14**

Appendix A. Other Fatalities Reviewed during CY 2021: Case Status

Of the 14 decedents' families, 93 percent (n=13) did not have active involvement with CFSA at the time of their death; the one remaining family had an open foster care case at the time of the fatality. For this family, their 1-day-old decedent died of natural causes due to extreme prematurity at 23 weeks of gestation. The infant's mother was 17 years old and in foster care at the time of her child's birth. During her pregnancy, her ongoing social worker documented concerns about the teen mother missing her regularly-scheduled prenatal appointments despite the Agency's provision of transportation. The mother's foster care case was closed 9 months after her child's death.

Appendix B. Fatality Reviews from CY 2017 to CY 2022 Q3*

		Year of Internal Review					# Abuse or Neglect Homicides to Date
		CY 2017	CY 2018	CY 2019	CY 2020	CY 2021	
Year of Fatality	CY 2015	3	5	2			--
	CY 2016	5	5	1			2
	CY 2017	**18**	11	7			0
	CY 2018		**21**	10	9	7	0
	CY 2019			**13**	6	7	4
	CY 2020				**27**	13	3
	CY 2021					**24**	3
	TOTAL	**26**	**42**	**33**	**42**	**51**	--

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, or CPS-Investigations (CPS-I).

Hotline workers complete extensive training on how to respond to reports. This training includes use of the SDM Screening and Assessment Tool and use of the SDM Hotline Screening and Assessment Tool.[26] In addition, the Hotline supervisors listen to Hotline recordings and calls in real time to ensure consistency with practice guidelines and requirements.

26. 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.

Appendix C. Program Descriptions

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[27] 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 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.

Appendix C. Program Descriptions

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 OUT-OF-HOME SUPPORT

The Office of Out-of-Home Support has oversight responsibility for CFSA's Clinical Case Management and Support Administration (formerly the Placement and Permanency Administrations) and the Office of Youth Empowerment. Each of these divisions and their respective services are outlined in the following sections:

Clinical Case Management and Support (CCMS) Administration

Regarding placement of children, CCMS operates 24 hours per day to identify and facilitate matching placements for children entering foster care. Responsibilities include all initial placements resulting from children separated from the home and all re-placement requests initiated by CFSA or CFSA's contracted private social workers. CCMS is also the principal purchaser of placement resources (in collaboration with CFSA's Contracts and Procurement Administration). As such, CCMS 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.

Appendix C. Program Descriptions

CCMS, cont.

CCMS 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 7 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.

CCMS also 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 while also generally laying the foundation for permanency options should reunification no longer be an appropriate goal for the child.

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, PSU also provides temporary intervention and support services to stabilize crises.

Appendix C. Program Descriptions

CCMS, cont.

CFSA does not handle or 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 transition planning services to older youth in foster care (ages 15 up through age 20), including 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.

Appendix C. Program Descriptions

The Administration for Kinship and Placement

The Administration for Kinship and Placement 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 (OWB)

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).

OWB oversees domestic violence, substance use, mentoring, tutoring, Commercial Sexual Exploitation of Children, 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 also provide supports to social work staff, youth, and families.

Appendix C. Program Descriptions

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 business hours, weekends, and holidays. In addition, the nurse care management program (NCMP) provides medical oversight for children with chronic or complex medical conditions. Lastly, there are registered nurses assigned to support children and families and community-based social workers (co-located at the Collaboratives) case managing families receiving services in the home.

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 Protocols

	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

Appendix D. ICFR Protocols (cont.)

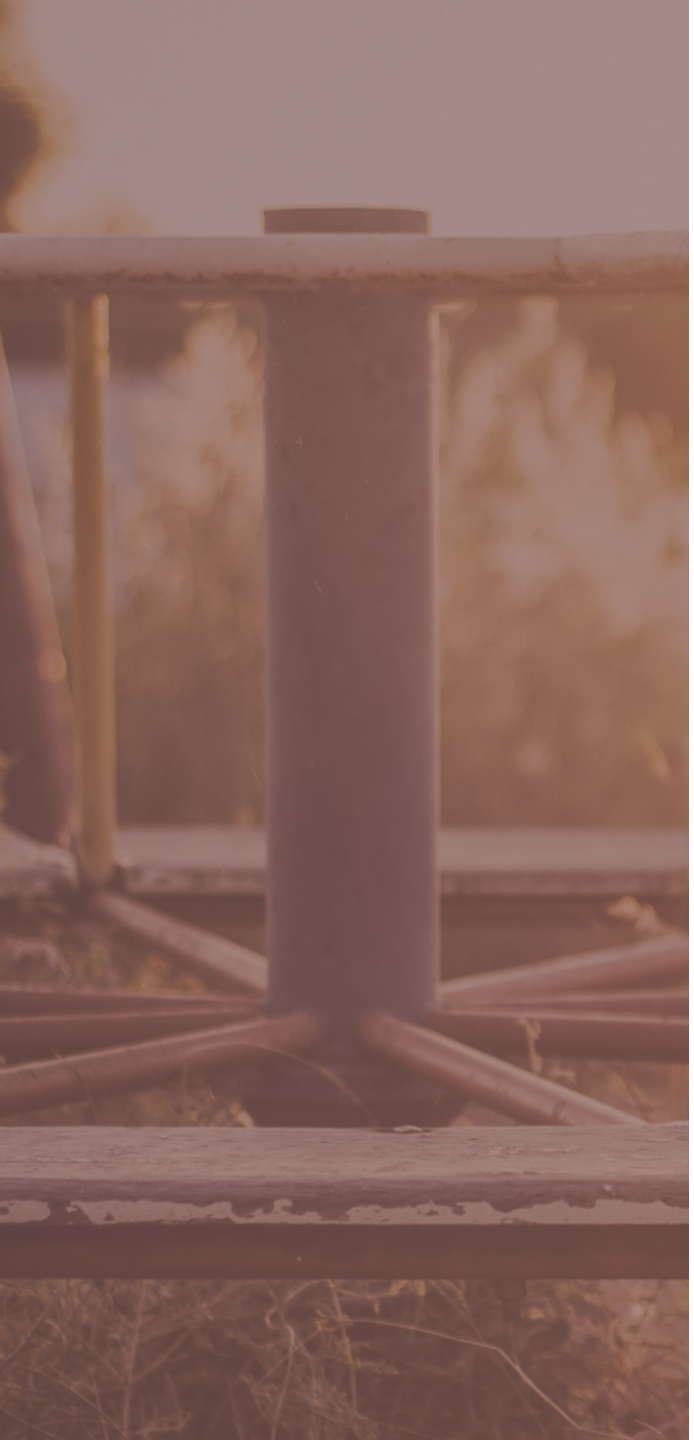
	Recommendations related to child fatality prevention	Recommendations related to general practice improvements
Level of detail of recommendation	Must be based on identified service gaps or program, policy, accountability and/or resource areas for improvement (preferably data-driven) Must assign roles 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
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.)

Appendix D. ICFR Protocols (cont.)

	Recommendations related to child fatality prevention	Recommendations related to general practice improvements
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)	

Appendix D. ICFR Protocols (cont.)

	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, ICFR Committee approves, modifies, or rejects proposal. Within two weeks, the ICFR Committee chair submits any approved recommendations to the Director in a memorandum. The CFSA 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 ICFR Committee chair, in concert with the ICFR Committee, 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 ICFR Committee quarterly report. (NOTE: Should a nexus to child fatality prevention be discovered during any phase of implementation, the ICFR Committee may consider the activities for transfer to the protocol for recommendations related to child fatality prevention.)
Publication	Prior to publication, the CFSA director must approve all recommendations in both categories included in quarterly reports.	
	All recommendations must be reported in CFSA's Annual CFR Report.	Observed trends and key practice changes that originated during CFRC discussions will be included in CFSA's Annual CFR Report.



Acknowledgements

The mission of the CFSA Child Fatality Review Unit is to reduce the number of preventable child fatalities in the District of Columbia through identifying, evaluating, and improving programs and systems responsible for protecting and serving children and their families.

CFSA Senior Leadership and Staff
Internal Child Fatality Review Committee

With Special Acknowledgements:
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