GOVERNMENT OF THE DISTRICT OF COLUMBIA
Child and Family Services Agency

2021 Child Fatalities Review: Data Snapshot

Review Period: January 1, 2021 – December 31, 2021

Purpose

The DC Child and Family Services Agency (CFSA) publishes an annual report on data reviewed from fatalities of children whose families were known to CFSA within five years of the child's death, pursuant to D.C. Official Code §4-1371.05(a)(2). This ***2021 Child Fatalities Review: Data Snapshot*** presents a high-level data profile on the 29 child and youth fatalities that occurred during calendar year (CY) 2021.The families each have varied histories of involvement in CFSA that will be analyzed more comprehensively in the forthcoming *2021 Annual Child Fatalities Review (CFR) Report* published on September 30th each year.

Notifications

CFSA receives notification of fatalities through the CFSA Child Abuse and Neglect Hotline. During CY 2021, the Hotline received information on 15 fatalities (52 percent) from CFSA employees, local police, and hospitals. The Child Fatality Review (CFR) Unit may also receive information directly, which is then reported to the Hotline.

The CFR Unit learned of 14 additional fatalities (48 percent) through notification by employees *(Figure A)*, i.e., fatalities not reported to the Hotline and unrelated to critical events. For these fatalities, employees often learn about the children's deaths from media reports. Additionally, CFR Unit employees learn of fatalities through 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)

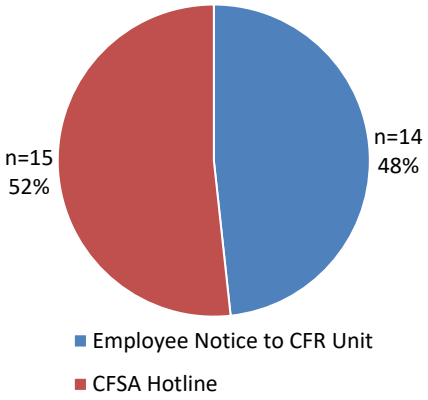
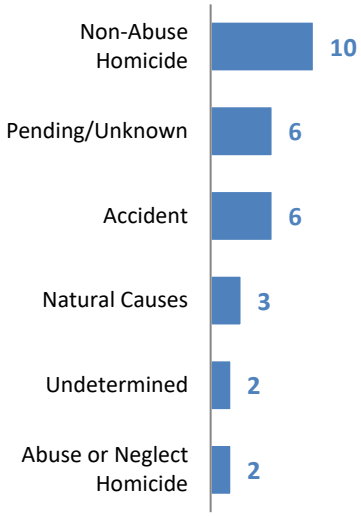


Figure B: Confirmed Manner of Death (N=29)



Analysis

Manner and Cause of Death[1]

As of the writing of this report, **CFSA had received the confirmed manner of death for 79 percent (n=23/29) of the fatalities that occurred during CY 2021**

[1] Cause of death is defined by the "what", i.e., the specific disease, injury or poison that led to the child's death. Manner of death is defined by the "how", i.e., the circumstances that caused the death. There are five manners of death (natural, accident, suicide, homicide, and undetermined). Source: https://ocme.dc.gov/sites/default/files/dc/sites/ocme/2017%20OCME%20Annual%20Reportupdated.pdf

(Figure B). The remaining fatalities included two children whose death records were not on file with DC Health. Four requests for official cause and manner of death information from DC Health were pending at the time of this report.

- **A little over one-third (34 percent, n=10) of fatalities were non-abuse homicides**[2] of children and youth ages 6 to 22 years. Causes for nine were gun-related with one cause due to stabbing. All of these homicides occurred in the community.
- **Twenty-one percent (n=6) of the CY 2021 fatalities were accidental** for infants and youth ages 21 days to 17 years. Three of the accidental deaths were complicated by unsafe sleeping arrangements. Cause for all three deaths included asphyxia. Two of the accidental deaths were caused by overdoses by older youth ingesting the drug fentanyl. The cause of the sixth accidental death was vehicular. The young child was hit by a car running a red light while the family was crossing the street.
- **Ten percent (n=3) were natural deaths**, including one 5-day-old infant, one 9-year-old child, and one 3-year-old child. All three deaths were complicated by congenital abnormalities, including two that led to respiratory failures and a third that led to fatal cardiac arrhythmia.

Abuse and Neglect Homicides

Three percent (n=1) of the CY 2021 fatalities included abuse homicide and another 3 percent (n=1) included a neglect homicide. The child victim of abuse homicide was a 17-month-old male sleeping too close to an electric space heater, unsupervised. The official cause of death was complications of thermal and scald injury. The agency substantiated the toddler's birth parents for the allegations of neglect – exposure to unsafe living conditions, inadequate supervision, and inadequate clothing or hygiene and medical neglect (due to the mother delaying medical treatment). The agency further substantiated the allegation of suspicious child death due to abuse or neglect. However, due to family members providing inconsistent versions of circumstances surrounding the death during the investigation, the maltreater was listed as unknown. As a result of the fatality, the agency removed four siblings from the household; two were placed in a kinship home and two were placed in a non-relative foster home. The Metropolitan Police Department (MPD) has not initiated a homicide investigation or charged the parents as of the writing of this report.

The child victim of the neglect homicide was a 3-month-old female whose official cause of death was intoxication from Eutylone (a synthetic stimulant) and Fentanyl (a synthetic opioid). During the initial police investigation, Narceine (opioid) wrappers were also found in the home. Both birth parents had reported histories of substance abuse. After the fatality, CFSA made concerted but unsuccessful efforts to contact the birth parents for grief and loss counseling. For over a month, the fatality investigation remained open with CPS as the investigative social worker continued efforts to contact the parents and await official manner and cause of death. CFSA closed the investigation after the family was not receptive to engagement and there were no other minor children in the home. Once official cause and manner of death were received, the investigation was reopened. The birth parents were substantiated for suspicious death of a child due to controlled substance in the system of a child.

[2] Non-abuse homicide applies only to persons who are not in a caregiving capacity, e.g., an acquaintance, visitor, or a person in the community unknown to the child or family. When CFSA or law enforcement officials deem that a parent or caregiver is directly responsible for the death of a child, CFSA considers this type of death as an abuse or neglect homicide.

The Metropolitan Police Department (MPD) has not initiated a homicide investigation or charged the parents as of the writing of this report.

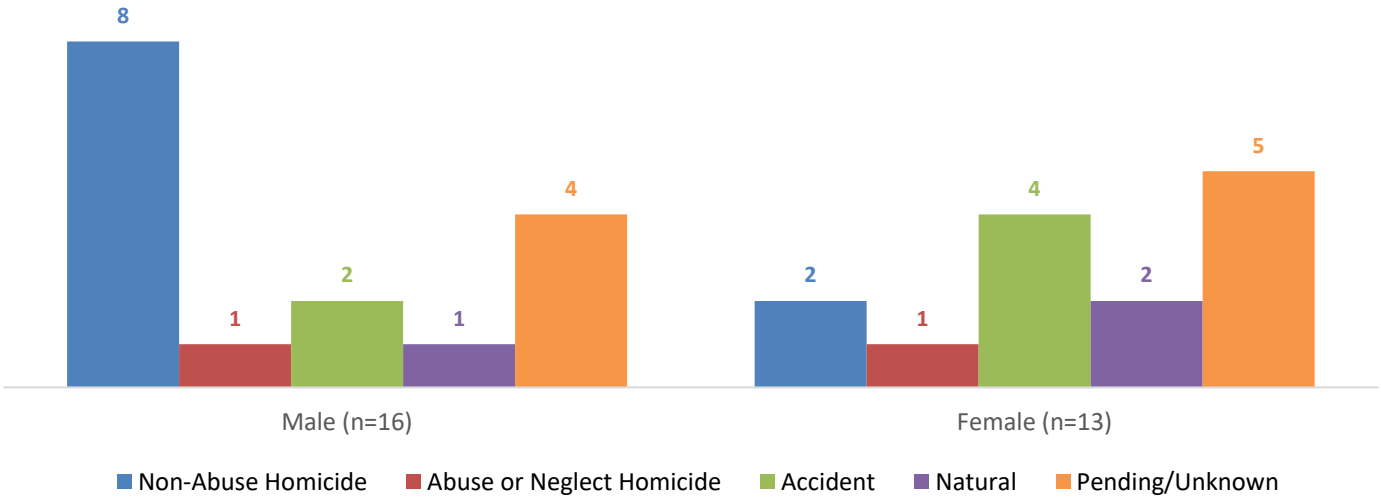
Gender and Manner of Death

Regarding gender demographics *(Figure C)*, 55 percent (n=16) of the fatalities include male children and youth; 45 percent (n=13) were females.

Of the 16 males, half (n=8) died by non-abuse homicide. Thirteen percent (n=2) were accidental deaths. One death (6 percent) was a natural death; another death (6 percent) was classified as an abuse homicide. For a quarter of the cases (25 percent, n=4), manner was not yet confirmed at the writing of this report.

Of the 13 females, thirty-two percent (n=4) died by accidental death. Fifteen percent (n=2) died from natural causes, and another 15 percent (n=2) died by non-abuse homicide. Manner of death was undetermined for 15 percent (n=2) of female deaths. One death (7 percent) was classified as a neglect homicide. For 15 percent (n=2), manner was not yet confirmed at the writing of this report.

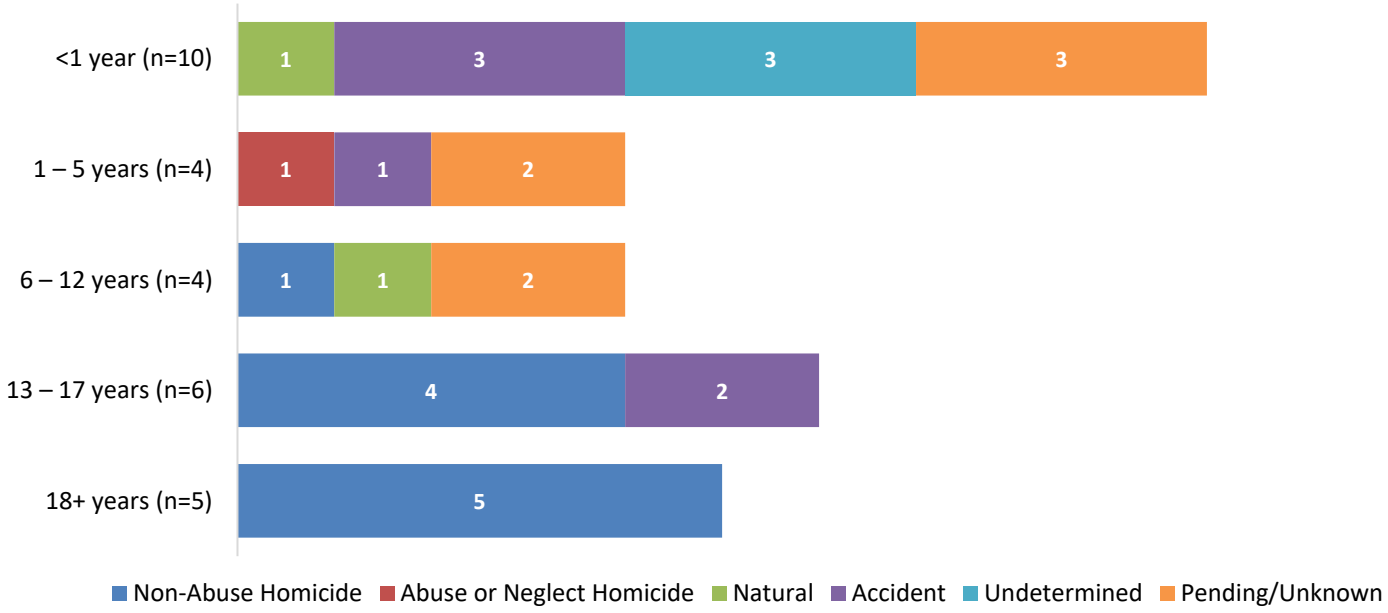
Figure C. Manner of Death by Decedent Gender (N=29)



Age

The largest two age groups from the 29 child fatalities in CY 2021 are infants under age one (34 percent, n=10) and older youth, ages 13 to 17 (21 percent, n=6). The third largest age group was for young adults, ages 18 and older (17 percent, n=5). Fourteen percent (n=4) of the children were between the ages of 1 and 5 years old, while another 14 percent (n=4) accounted for children between 6 and 12 years old. Figure D presents manner of death by age group.

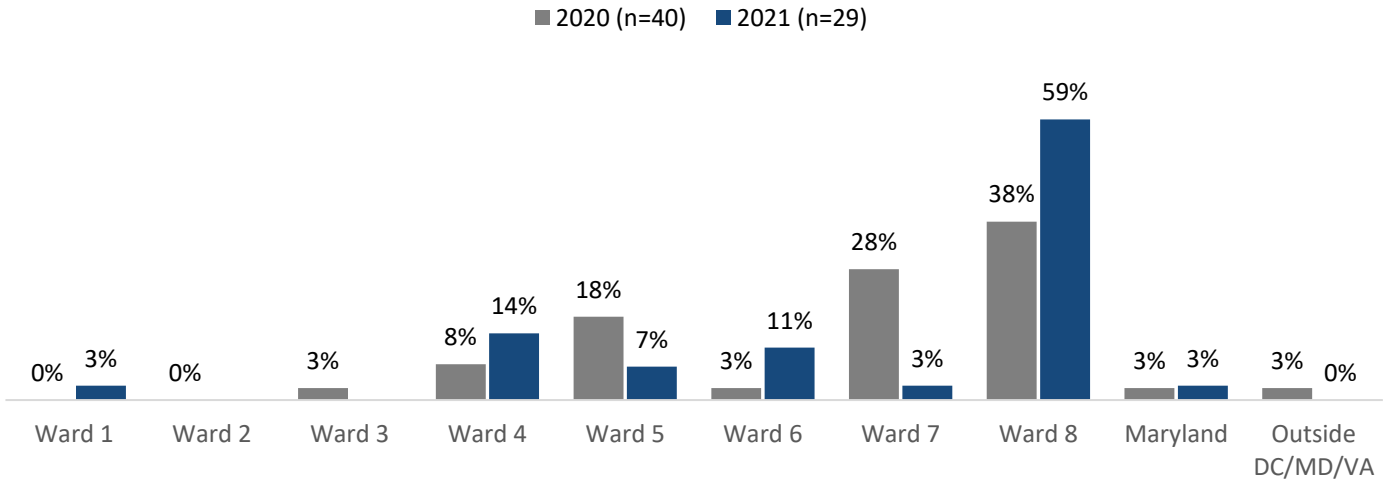
Figure D. Manner of Death by Decedent Age (N=29)



***Ward of Residency*[3]**

The *2021 Data Snapshot* reveals ongoing historical trends whereby CFSA clients are known to predominantly reside in Ward 8 *(Figure E)*. **Fifty-nine percent (n=17) of the child fatalities involved families living in Ward 8.** Of the remaining 12 children, 14 percent (n=4) lived in Ward 4 while 11 percent (n=3) lived in Ward 6. Seven percent (n=2) of the children lived in Ward 5. Three percent (n=1) each lived in Wards 1 and 7, and Maryland. No children were living in Wards 2 or 3 at the time of their deaths.

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



[3] Ward of residency represents the last known ward of residence for the decedent child and/or their family. For families that were not involved with CFSA at the time of the child's death, the family's last known ward of residence is included in Figure E.

Of the 17 children who resided in Ward 8 at the time of their death, 53 percent (n=9) were under 2 years old. Eighteen percent (n=3) of the children in Ward 8 were between the ages of 15 and 17 while another 18 percent (n=3) were young adults between the ages of 18 and 22 years old. Eleven percent (n=2) of the children were between ages 3 and 6.

Of the four children residing in Ward 4 at the time of their deaths, there were no infants. The youngest child was age 4 while the remaining three youths were between ages of 12 and 17. For the three children living in Ward 6 at the time of death, there were two infants (ages 10 days and 2 months) and one 16-year-old youth. Residing in Ward 5 were two young adults, ages 19 and 21 at the time of death. The one child residing in Ward 1 was 7 years old at the time of death. The one child residing in Ward was age 9 at the time of death. The one child living in the state of Maryland was age 3 at the time of death.

Race and Ethnicity

African Americans account for all but two of the child fatalities reviewed. Although the 2017 Census Bureau data reported that African Americans comprise 47 percent of the District of Columbia's population, African Americans disproportionately accounted for 93 percent (n=27) of the 29 fatalities that occurred during CY 2021. One child (3 percent) was identified as multiracial; another child (3 percent) was identified as Hispanic.

CFSA Involvement

At the time of the fatality, 24 percent (n=7) of the 29 families were involved with CFSA *(Table A)*. Five of the seven families had open cases with CFSA's In-Home Administration. The remaining two families had open cases with the Clinical Case Management & Support Administration (CCMSA; formerly the Permanency Administration).

Table A: CFSA Involvement at Time of Fatality (n=29)		
	n	***%***
No Open Investigations or Cases	22	76
Open In-Home Administration Case	5	17
Open CCMSA Case (Permanency)	2	7
Open CPS Investigation	0	0
Total	**29**	**100**

Of the five families with open In-Home cases at the time of the fatality, one 5-day-old child died of natural causes, based on multiple congenital anomalies. One 4-year-old child died accidentally after being hit by a car whose driver ran a red light. No additional information is available on the driver (e.g., whether the driver was under the influence). The manner of death was undetermined for a 3-month-old infant and pending for a 3-year-old child (as of the writing of this report). The fifth child was 17 months old at the time of death, purportedly a substantiated abuse homicide due to the child sleeping too close to an electric space heater without proper supervision.

Detailed information about known CY 2021 fatalities – including case histories, interagency involvement, and recommendations from the Internal Child Fatality Review Committee – will be presented in the Comprehensive 2022 Annual Child Fatality Report to be published in September 2022.