DC Child and Family Services Agency

Child Fatality Report

2022

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Director

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I. Introduction

The Child and Family Services Agency (CFSA or Agency) annually reviews child fatalities of families known to the Agency within 5 years of the child's death. These reviews provide CFSA with an open forum to consider strategies that may help reduce preventable deaths, particularly if a fatality resulted from neglect or abuse, or when a child's family was involved with the child welfare system at the time of death. The *18th Annual Child Fatality Review (CFR) Report* (2022 Report) presents the trends, data analyses, and collective practice recommendations identified for 49 reviews presented by CFSA's CFR Unit to the CFSA Internal CFR (ICFR) Committee during calendar year (CY) 2022.[1, 2]

This 2022 Report includes two new sections: *Neglect and Abuse as Contributing Factors* and *Family Risk Factors*. Both sections deepen analyses and intentionally expand transparency of practice across systems. For both sections, the 2022 Report protects the confidentiality of the children and families served by the District of Columbia's (District or DC) evolving child and family well-being system.

In addition to the new sections, the 2022 Report includes a numbered listing of the 49 children (*see Appendix A*). This numbering system is not intended to reduce the humanity or vulnerability of a child's death, but rather intends to provide a respectful strategy to assist the readers to fully absorb the interfacing components of circumstances surrounding a fatality. Children's assigned numbers range by age from youngest to eldest and include the individual child's manner and cause of death.[3] Throughout the relevant sections, references to "Child 9" or "Child 28" (for example) provide sufficient clarity for the reader to understand when several sections apply to one child.

Similar to previous reports, the 2022 Report covers methodology, demographics, manner of death, and data analyses for family histories and for family involvement with CFSA, other government agencies, and community-based service providers. The 2022 Report also looks at diagnoses (physical and mental), and CFSA involvement at the time of death. Further, the 2022 Report provides a summary of

[1] Based on public feedback from the previous two Annual CFR Reports, the 2022 Report returns to analyzing the data for all fatalities reviewed in CY 2022, not just the fatalities that occurred in 2022. In 2022, 61 percent (n=30) of the reviews covered children who died in 2022, while 18 percent (n=9) covered child deaths in 2020, and 20 percent (n=10) for deaths in 2019.
[2] CFSA's ICFR Committee membership comprises CFSA leadership across program areas as well as representatives from the CFR Unit, the Agency's Policy Unit, the Office of General Counsel, and the Diversity Equity Administration, which includes the Child Welfare Training Academy. External representatives include the Office of the Chief Medical Examiner, the Office of the Ombudsperson for Children, the Office of the Attorney General, and CFSA's contracted Maryland child-placing partner, the National Center for Children and Families. In 2022, the ICFR Committee received 54 child fatality cases for review. Of those 54 cases, data from five were previously included in the 2021 Annual CFR Report (published in late 2022). To protect data integrity (i.e., to prevent data duplication), the 2022 Annual CFR Report covers only the remaining 49 cases.
[3] Note: The terms "child" and "children" are inclusive of birth through age 22, based on the age of the oldest individual in the CY 2022 data set.

ICFR recommendations. Appendices include the numbered listing of children (as noted above) as well as the DC Code's definitions of neglect.[4]

Lastly, the 2022 Report acknowledges inherent limitations to linking fatality data with concrete steps to prevent or reduce certain child fatality risk factors. Often external factors that put children at risk are beyond the control of CFSA, including those associated with neighborhood crime, poverty levels, housing issues, pandemic "fall-out" related to educational progress, age and racial disproportionalities, and so on. A specific example includes the data trends on co-sleeping risk factors which have resulted in several interagency and District-wide campaigns devoted to educating all DC parents on the importance of safe sleeping environments. Despite these concerted efforts, unsafe sleeping environments continue to impact child fatality data. Similarly, data trends on complex family risk factors reveal intergenerational challenges with housing, education, mental health, substance use, teen parenting, and employment.

With the above limitations in mind, the primary purpose of the internal CFR process is to recognize and understand both the causes and the risk factors behind the deaths of the children whose families have interfaced with the DC child welfare system within the last 5 years. In so doing, ICFR Committee members examine and highlight systemic issues and trends across cases. Whenever applicable, those trends and systemic issues also inform recommendations. In summary, the CFR process is an integral component of CFSA's continuous quality improvement (CQI) feedback loop, prompting the Agency to develop and implement viable CQI-informed recommendations for reducing preventable child deaths.

II. Methodology

Notification Sources

CFSA receives notification of fatalities from two sources: (1) DC's 24-hour Child Abuse and Neglect Hotline (Hotline), which may include reports from CFSA or CFSA-contracted agency employees, local hospitals, and law enforcement; and (2) the District's Office of the Chief Medical Examiner (OCME), which is also responsible for facilitating the Citywide CFR Committee (Citywide Committee).[5] As a permanent member of the Citywide Committee, CFSA is assured notification of all child fatalities, including maltreatment-related deaths.[6]

OCME sends monthly requests to CFSA's CFR Unit regarding DC children who have died. These requests seek information on any prior family involvement with CFSA. Once the CFR Unit confirms such

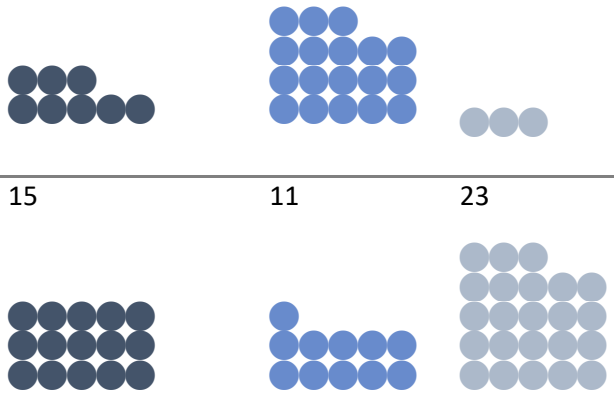
[4] Although the Agency typically refers to abuse and neglect as separate, "abuse" is a legal subset of "neglect" (*Appendix B*).
[5] When the Hotline receives reports that the death of a child known to CFSA has occurred within the last 24 hours or even several days, these calls are typically designated as "critical events". For more information on critical events, please see the CFSA Program Policy: Critical Events.
[6] In addition to CFSA, Citywide Committee membership includes interagency representation from across the DC Government.

involvement, CFSA adds these cases to the roster of fatalities eligible for review. The CFR Unit subsequently shares all data related to the decedent, including in-depth case summaries whenever available, for the Citywide Committee to glean valuable information, including data used by OCME.

In CY 2022, the CFR Unit learned of 47 percent (n=23) of its reviewed fatalities from OCME.[7] Thirty-one percent (n=15) were notifications from Agency or contracted agency personnel, who often learn of a fatality from local news. The remaining 22 percent (n=11) were Hotline calls from police, hospitals, or others.

Figure 1: Notification Sources CY 2021 (n=29) and CY 2022 (n=49)

CY Year	Agency Personnel	Hotline	OCME	Total
2021	8 notifications	18	3	29
2022	15	11	23	49



CFR Unit Research and Case Summaries

CFR specialists receive case review assignments, including critical events, on a rotating basis. If the CFR specialist is assigned to a critical event, the specialist attends the critical event meeting.

The data collected for each fatality follows an internal online tool that asks for specific information on the child and the family's history. To complete the tool, each child fatality review requires an exhaustive examination of a family's history with the child welfare system, often including intergenerational histories for parents, grandparents and, on occasion, great grandparents. Review specialists must often review multiple allegations, including associated investigation summaries and lengthy contact notes, to

[7] Between 2019 and 2021, OCME requests averaged around 25 to 30 per year. Compared to 31 requests in 2021, the CFR Unit received 85 requests in 2022. The increase is directly related to legislation requiring the Citywide Committee to review fatalities within 6 months of OCME's determination for manner and cause. Of the 85 notifications eligible for review, 50 of the children died in 2022. Of these, 30 are included in this 2022 Report. The remaining children will be carried over into the 2023 Report, i.e., 2021 (n=3), 2020 (n=28), and 2019 (n=4).

develop a comprehensive view of a family's social history. The reviews are often intensive, as the specialists must sift through details to pull out salient information that will be summarized for the report's presentation to the monthly ICFR meeting. Every year, the ICFR Committee and the CFR Unit review the information gathered for applicability, refinement, and consistency of data reporting.

During their research, the CFR specialists seek to identify risk factors related to the manner of death. The "manner of death" is defined by the "how" while the "cause of death" is defined by the "what". A manner of accidental death might be caused by a drowning versus a natural death that might be caused by a congenital heart ailment.

The CFR Unit receives official manner and cause of death through DC's Department of Health Vital Records Division. If the manner of death is "homicide," the CFR specialist may confer, when applicable, with the assigned Child Protective Services (CPS) investigative social worker to learn whether the child's fatality was the result of maltreatment by a parent, legal guardian, or any other person responsible for the child while the parents are absent. In CY 2022, the ICFR Committee reviewed one critical event with the manner of death officially determined by OCME to have been caused by maltreatment (physical abuse). Further discussion is found under *Section IV: Manner of Death*.

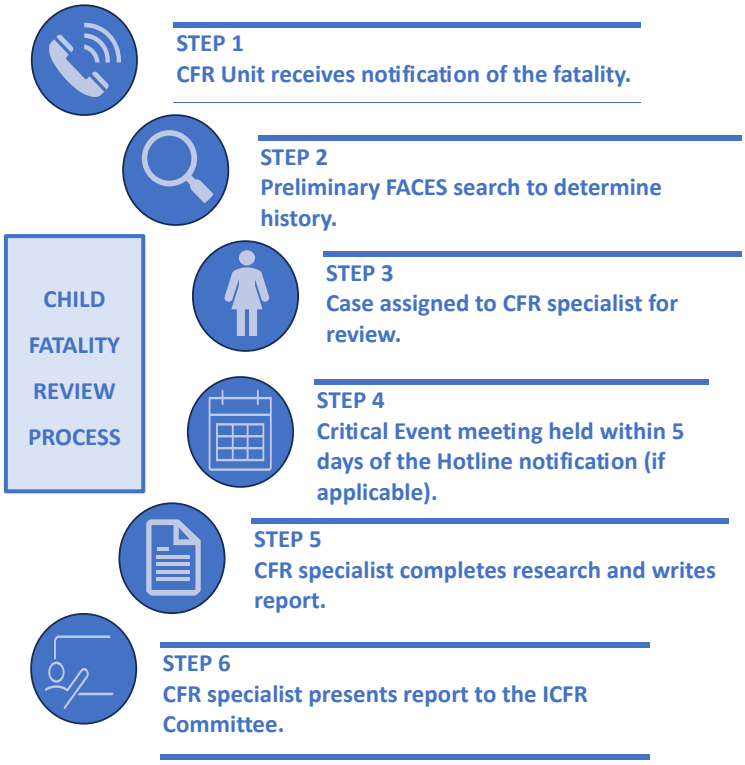
If official notification for manner and cause is unavailable, e.g., due to a pending autopsy or an out-of-jurisdiction death, the CFR specialist will still present the case to the ICFR Committee members who will discuss the circumstances surrounding the fatality based on the information available. If DC Health confirms an official manner and cause, the CFR specialist will update the case summary and inform the ICFR Committee.

The CFR Unit presents all critical event fatalities to the ICFR Committee within 60 days of notification, per CFSA policy. For fatalities that are not critical events, e.g., when the CFR Unit learns about a fatality from an OCME request, the CFR Unit makes every effort to present the case within 180 days of notification. However, as foot-noted earlier, the CFR Unit experienced a significant increase in notifications in 2022, versus actual deaths, and has not been able to review all fatalities as quickly as the notifications are received.

ICFR Monthly Case Presentations

As foot-noted earlier, the ICFR monthly meeting includes representatives from CFSA's senior leadership, the CFR Unit, Policy Unit, Office of General Counsel, and the Diversity Equity Administration, which includes the Child Welfare Training Academy. Additional members include external partners from the Office of the Chief Medical Examiner, the Office of the Ombudsperson for Children, the Office of the Attorney General, and CFSA's contracted Maryland child-placing partner, the National Center for Children and Families. All ICFR Committee members receive an agenda and narrative summaries for case presentations a few days prior to the monthly meeting. By reviewing cases in advance of the meeting, members are prepared for concrete discussion on whether practice, policy, and training gaps impacted CFSA's service to the family prior to the fatality.

The CFR Unit prioritizes all ICFR case presentations according to critical and non-critical events. For all fatality reviews, ICFR Committee members thoughtfully and carefully consider system-wide practice that might have increased a protective factor for prevention of the fatality. Whenever possible, ICFR Committee members recommend concrete steps to address specific risk factors. Nevertheless, often external factors that put children at risk are beyond the control of CFSA, e.g., those associated with neighborhood crime, poverty levels, housing issues, pandemic "fall-out" related to educational progress, age, and racial disproportionalities, and so on. The ICFR Committee shares these types of high-level concerns with the Citywide Committee for a comprehensive dialogue among participating agencies.



CFSA's Office of the Director reviews and approves the recommendations submitted by the ICFR Committee prior to publication in the Annual CFR Report. If the "owner" of the recommendation is a CFSA administration, proposed actions steps are documented and tracked for the upcoming Report. External ICFR Committee members may also "own" a recommendation and be responsible for documenting steps, tracking, and reporting back to membership during the monthly meeting.

III. Demographics

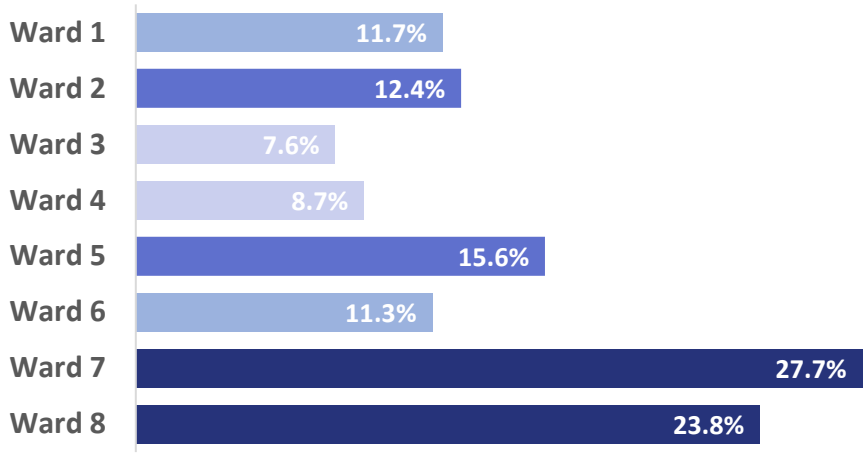
Child Welfare Involvement per Ward

According to the American Bar Association's publication, *Representing Parents in Child Welfare Cases*, "families living below the poverty line are 22 times more likely to be involved with the child protection system than families with incomes slightly above the line."[8] In the District of Columbia, poverty levels and child welfare involvement support the data.

[8] Guggenheim, Martin, and Sankaran, Vivek (eds.). *Representing Parents in Child Welfare Cases:* American Bar Association, 2015.

The District of Columbia divides residential boundaries into eight geographic Wards. Of these eight Wards, poverty levels in 2022 were highest for Wards 7 and 8 (23.8 percent and 27.7 percent, respectively, for residents living below 100 percent of the federal poverty level).[9,10] Ward 5 followed with 15.6 percent, and then Ward 2 with 12.4 percent. Wards 1 and 6 were next and close to being even with 11.7 percent and 11.3 percent, respectively. Ward 4 followed with 8.7 percent and then Ward 3 with the lowest percentage (7.6 percent).

Figure 2: 2022 Poverty Levels by Ward

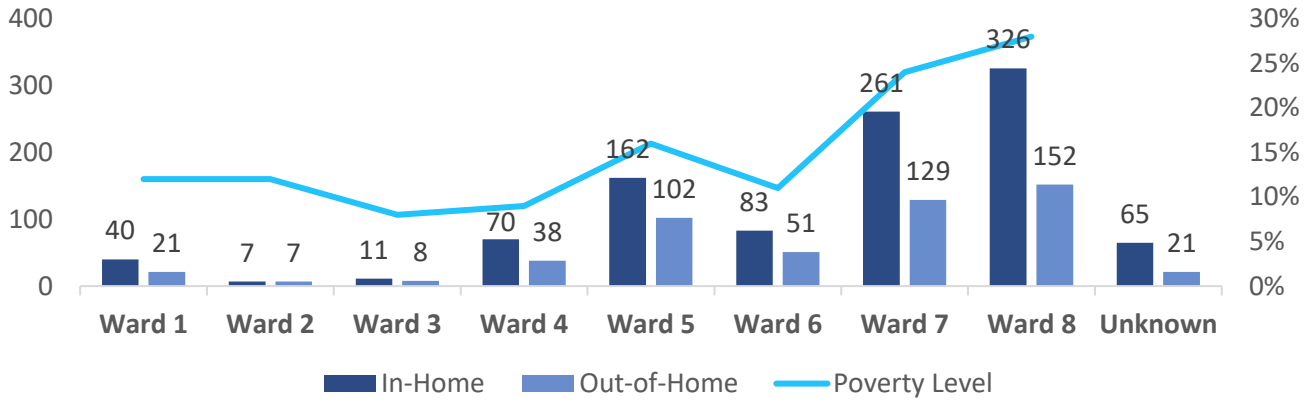


Data outlined in Figure 3 shows child welfare involvement for the eight Wards to be closely comparable with the poverty levels for Wards 5, 7 and 8. Wards 7 and 8 share the highest percent of involvement (25 and 31 percent respectively), followed by Ward 5 with 17 percent involvement. Ward 6 (9 percent) followed Ward 5, and Ward 4 (7 percent) followed Ward 6. Wards 2 and 3 were nominally involved in terms of CFSA's overall population.

[9] A CY 2022 Ward-by-Ward listing of poverty levels (percentage of residents) can be found here: https://datacenter.aecf.org/data/tables/9070-poverty-by-ward#detailed/21/1852-1859/false/1095,2048,574,1729,37,871,870,573,869,36/any/18053

[10] In CY 2022, the federal poverty level was $13,590 (for a single person); each additional person is $4,720. Source: https://aspe.hhs.gov/sites/default/files/documents/4b515876c4674466423975826ac57583/Guidelines-2022.pdf

Figure 3: CY 2022 Child Welfare Involvement by Ward

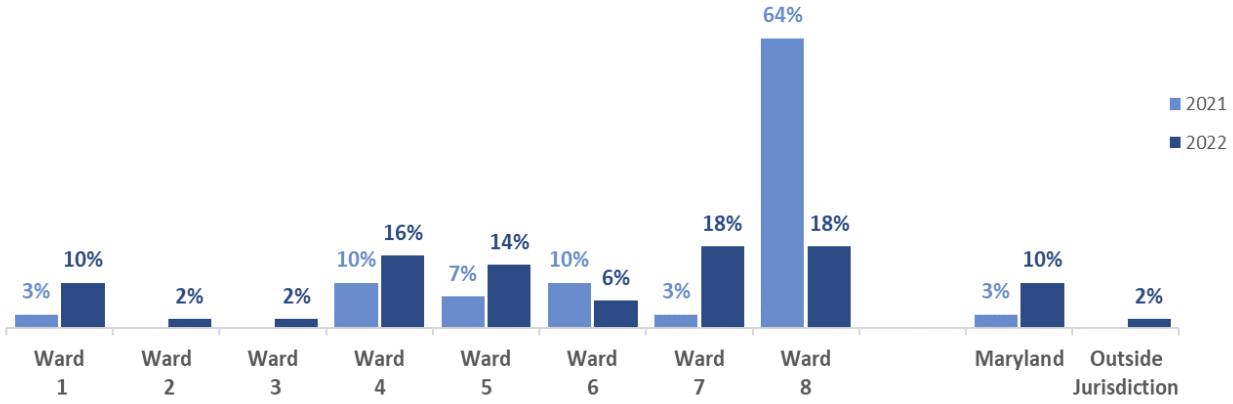


The total number of children served by CFSA at the end of CY 2022 was 1564. Of these children, 34 percent (n=539) were receiving out-of-home services, a 1 percentage-point increase from CY 2021 (33 percent, n=605). Children receiving services in the home accounted for 66 percent (n=1025), a 1-percentage increase from CY 2021 (67 percent, n=1251).

Child Fatalities by Ward Location

In addition to child welfare involvement by Ward, the CFR Unit gathered information on the Ward location of the 49 children whose deaths were reviewed in CY 2022.

Figure 4: Location of Child Fatality by Ward CY 2021 - CY 2022



The Ward location for the 49 reviewed fatalities differs slightly from the CFSA population distributions. While Ward 8 represents the highest percent (31 percent, n=488) of children served in CY 2022, the most frequent location of fatalities for CY 2022's reviews were equally distributed between Ward 8 and Ward 7 (18 percent each, n=9 each). Ward 4 accounted for 16 percent (n=8) of the fatalities' location, even though it only represented 6 percent (n=121) of all children served by CFSA in CY 2022. Ten percent (n=5) of the children resided in Maryland at the time of their death.

Notification Source by Year of Death

As foot-noted earlier, 61 percent (n=30) of the children died in 2022, while 18 percent (n=9) of the children died in 2020, and 20 percent (n=10) died in 2019. CFSA learned of all the 2019 and 2020 fatalities through requests for information from OCME. For the 30 deaths that occurred in 2022, OCME requests accounted for 13 percent (n=4). The CFR Unit learned of the remaining 87 percent (n=26) through the Hotline. Of those 26 Hotline reports, CFSA or private agency staff notification accounted for over half (58 percent, n=15).

Age

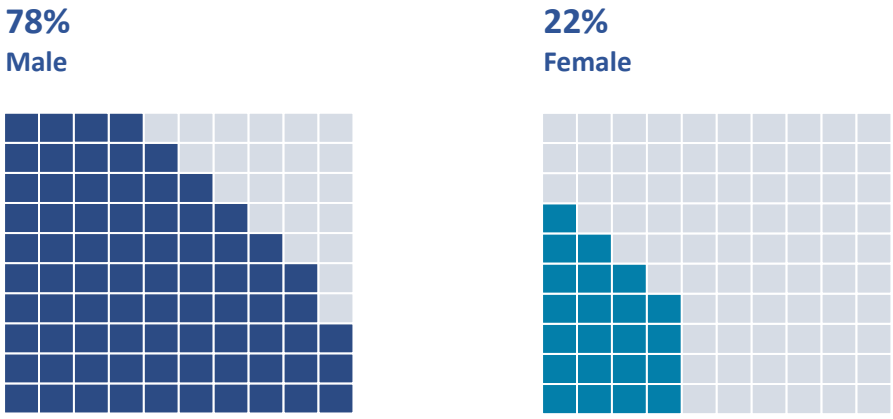
Due to the 5-year window for reviewing fatalities, some annual reviews include young adults who are aged 21 or older but who may still have been involved with the system prior to their 21st birthday, or who may have had a younger sibling involved with CFSA. In CY 2022, the ICFR Committee reviewed 21 young adults (43 percent) from ages 18 to 22.[11] The second largest age group included teens, ages 13 to 17 (25 percent, n=12), followed by infants under age 1 (18 percent, n=9). Toddlers and young children, ages 1 to 5 years old, accounted for 8 percent (n=4) while older children, ages 6 to 12 years old, accounted for 6 percent (n=3).

Gender

The CFR Unit was unable to determine whether any child or youth self-identified as transgender. Accordingly, the 2022 Report follows DC Health assignation of gender according to the child or youth's external anatomy.

For the fatalities reviewed in CY 2022, 22 percent (n=11) of the children were female. The majority of children (78 percent, n=38) were male.

Figure 5: Percentage of Males and Females for CY 2022 Fatalities



[11] See *Section IV: Manner of Death* for breakdowns by manner, age, and gender.

Race

Although African Americans accounted for 45 percent of DC's population in CY 2022,[12] African American children and older youth disproportionately accounted for 90 percent (n=44) of the fatalities reviewed. Families who identified as biracial accounted for 6 percent (n=3) of the fatalities. The remaining two families identified as Caucasian (2 percent, n=1) and Hispanic (2 percent, n=1).

IV. Manner of Death

Definitions

As previously noted, "manner of death" is defined by the "how," i.e., the circumstances that caused the death. There are five manners of death as defined by the Office of the Chief Medical Examiner (OCME): (1) natural, (2) accidental, (3) suicide, (4) homicide, and (5) undetermined.[13]

Manner of Death	Definition
Natural	**Death caused by the natural disease process and not an accident or act of violence.**
Accidental	**Deaths caused unintentionally, excluding natural causes, suicide, or murder.**
Suicide	**Deaths caused by self-inflicted behavior with the intent to die.**
Homicide	**The deliberate and unlawful killing of a person by another person.**
Undetermined	**Following a thorough medical and legal investigation, a conclusive manner of death is not determined.**

In addition to the above official definitions for manner of death, CFSA's 2022 Report includes a category of "unknown," based on six fatalities for which the CFR Unit did not receive an official manner of death from DC Health.[14]

Manner of Death by Age Group and Gender

Of the 49 families whose children died during CY 2022, ages of the children and youth ranged from 1 month to 22 years old. The majority of the children and youth (78 percent, n=38) were male.

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[12] Source: https://www.census.gov/quickfacts/fact/table/DC/PST040222#PST040222

[13] https://ocme.dc.gov/sites/default/files/dc/sites/ocme/publication/attachments/CFRC%202020%20Annual%20Report-FINAL%20WEBv2.pdf

[14] CFSA currently relies upon a memorandum of agreement with DC Health for quarterly confirmations on a child's manner and cause of death. Out-of-jurisdiction fatalities or medical conditions may impact the CFR Unit's receipt of an official manner of death.

Figure 6: Manner of Death by Age Group

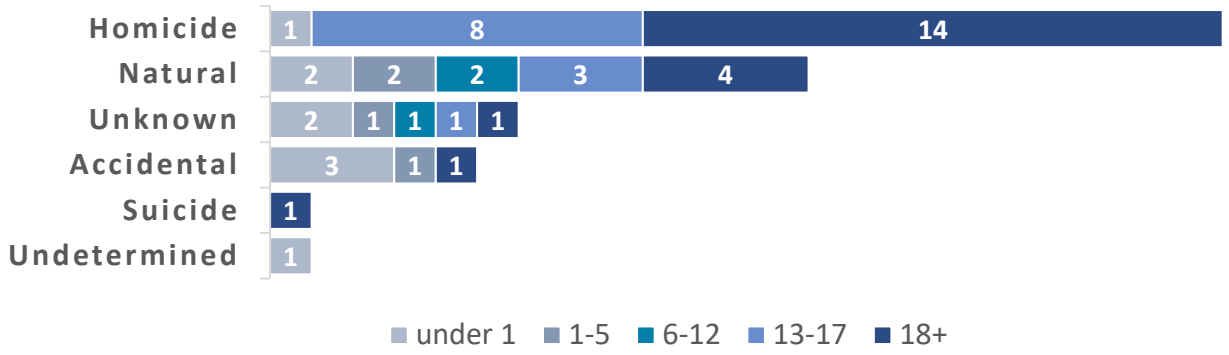
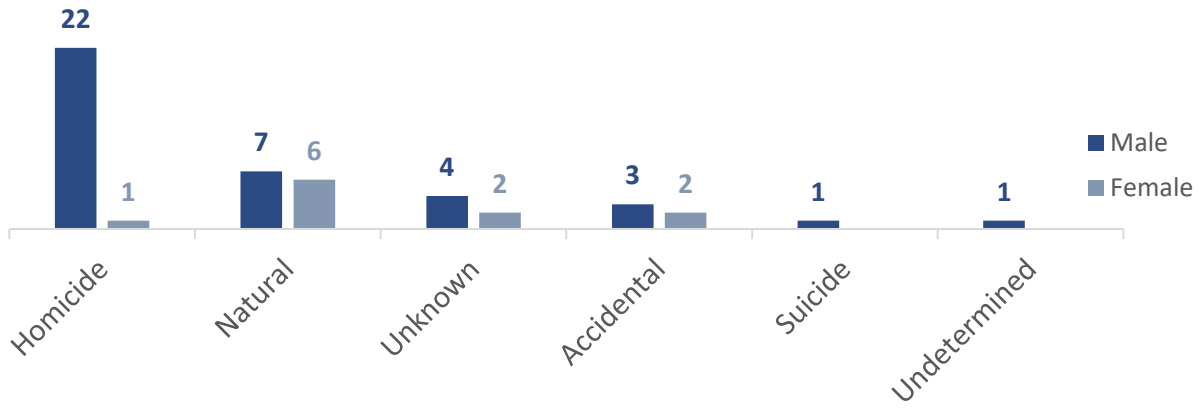


Figure 7: Manner of Death by Gender (n=49)



Manner of Death by Type

Section V: Fatality Risk Factors and *Section VI: Neglect and Abuse as Contributing Factors* provide analyses and considerations for individual circumstances surrounding the types of manner of death for the CY 2022 reviewed fatalities.

Natural

Of the 13 fatalities with a natural manner of death, two of the decedents were under 1 year old. The cause of death for one was a birth defect impacting blood flow through the heart. The other child died due to cardiac arrest and respiratory failure. The infant was diagnosed as medically fragile at birth with a life expectancy prognosis of less than a year.

For children between ages 1 and 5, there were two natural deaths. One death was caused by an upper respiratory virus, complicated by pneumonia. This child was diagnosed as medically fragile at birth with several diagnoses. A second child's cause of death was officially determined to be bleeding into the lower respiratory tract of the lungs. For children between 6 and 12, there were two 8-year-old children whose manners of death were also natural. One child died from cardiac arrest and the other died from complications related to cerebral palsy.

The remaining seven natural deaths involved youth ages 13 to 20 years old. The cause of death for two of the youth related to pre-existing heart conditions. One youth died due to brain cancer and another died due to a progressive nervous system disease, impacting brain function. Two additional causes of death involved seizure disorders. One cause was related to morbid obesity.

Accidental

The ICFR Committee reviewed five accidental deaths. Three of the children were under the age of 3. The contributary cause for two of those children concerned unsafe sleeping environments. The third child died as result of heat exposure (hyperthermia). The cause of death for a fourth child, a 3-year-old, was exposure to fentanyl. The fifth accidental death also involved fentanyl for a 19-year-old who died from an overdose.

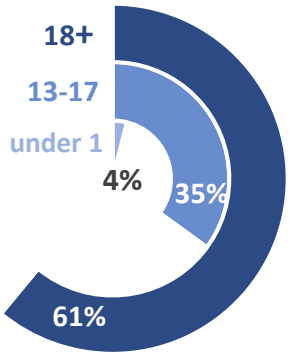
Death by Suicide

Death by suicide accounted for one fatality in 2022. The cause of death for the 19-year-old young adult was attributed to a gunshot wound to the head.

Homicide

Homicide accounted for almost half (47 percent, n=23) of the 49 fatalities reviewed in 2022. The majority of these homicides (96 percent, n=22) were perpetrated in the community and not the result of child maltreatment by a parent or individual responsible for caregiving in place of a parent. However, the ICFR Committee did review the homicide of a 1-month-old infant (Child 2) who died from causes attributed to physical abuse, resulting in bleeding on the brain (see *Section VI: Neglect and Abuse as Contributing Factors*). For the community-based homicides, 95 percent (n=21) were related to gun violence and 5 percent (n=1) involved a stabbing.

Figure 8: Homicide Percentages by Age



Sixty-one percent (n=14) of the homicide victims were over the age of 18 at the time of their death. Thirty-five percent (n=8) were between the ages of 13-17. As noted, one victim (4 percent, n=1) was 1 month old. The 21 homicides by gunshot involved eight minors aged 15 to 17 years, and 13 adults aged 18 to 22 years. The one homicide by stabbing involved a 21-year-old adult.

Of the total 23 homicide victims, 70 percent (n=16) occurred in CY 2022. Eight percent (n=2) occurred in 2020, and 22 percent (n=5) occurred in 2019. Regarding gender, males accounted for 96 percent (n=22) of the homicides. Only one victim (4 percent) was female.

Undetermined

DC Health classified one manner of death as undetermined. By definition, as noted earlier, the undetermined manner of death was due to the medical examiner being unable to establish a conclusive manner of death. However, upon review of the fatality, the CFR Unit did learn of significant conditions

related to the 1-month-old infant's death, including a bacterial infection of ear and lungs and an unsafe sleep environment.

Unknown

In CY 2022, there were six fatalities with unknown official manners of death. Of the six fatalities, five occurred out of jurisdiction. For the one unknown manner of death that occurred in DC, DC Health had no identifying data for the child and therefore no official manner of death.[15] The CFR Unit's research revealed that Child 11 suffered from an unexplained lack of oxygen. Local physicians declared the child brain dead. The child passed away 3 days later. Physicians found no medical findings of maltreatment and OCME declined to autopsy the child based on pre-existing medical conditions.

As for the remaining five unknown official manners of death, the CFR Unit was able to gather some information on cause. The reported cause of death for Child 43 was blunt force trauma from a vehicular hit-and-run. For Child 16, the cause was drowning and the cause for Child 6 was suffocation (with no additional information). The cause of death for Child 27 was unknown but the manner was reportedly a suspected homicide.

The fifth unknown manner of death concerned Child 9 whose preliminary out-of-jurisdiction autopsy report indicated fentanyl in the 10-month-old's system. CFSA was unaware of the child's death until notification 3 months later via an out-of-jurisdiction police report to the CPS Hotline. The CPS disposition for its own subsequent investigation was inconclusive for maltreatment.

V. Family Risk Factors

The CFR Unit compiled several data sets on recurring risk factors impacting families with CFSA involvement, protective capacities, and the family histories for CY 2022 fatalities. While the risk factors may not be a direct cause of a fatality, there is sufficient evidence that these factors can contribute to the risk of maltreatment.[16] Based on this information, the CFR Unit considers the identification of risk factors as an opportunity to promote individual, family, and community protective factors. In addition, there is an opportunity to explore increasing supports that may minimize the likelihood of children being exposed to maltreatment or neglect.[17]

The following risk factors are generally in chronological order of a life cycle, beginning with parental history, then prenatal care, positive toxicology, etc. Some risk factors include both parent and child, e.g., mental health, substance use, and criminal histories.

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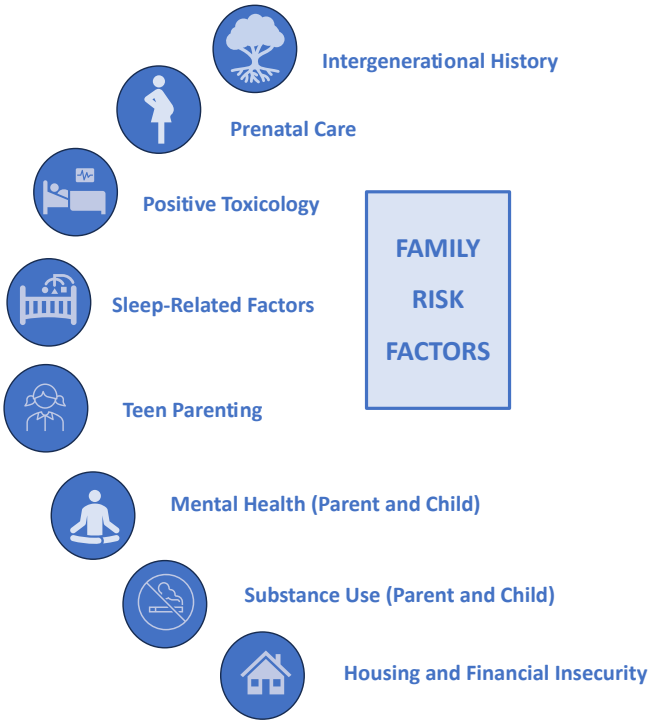
[15] The CFR Unit was unable to determine the reasons why the child's vital records were absent from DC Health's database.
[16] https://www.cdc.gov/violenceprevention/childabuseandneglect/riskprotectivefactors.html
[17] https://friendsnrc.org/prevention/protective-factors/

While the ICFR Committee examines risk factors, emphasis is on neglect and abuse as contributing factors (*Section VI* following).



Data limitations exist for the fatality risk factors in this section, especially for families not involved with the Agency at the time of the fatality. Even for families with CFSA involvement, not all risk factors are reported for every fatality, e.g., documentation or knowledge of a mother's prenatal care or a parent's mental health diagnosis. Based on other case review processes within the Agency, there is a statistical likelihood that there are more families with undocumented risk factors that could have been included in the data set for this section had those factors been documented and confirmed.

Intergenerational History of Child Welfare Involvement

For the data set on intergenerational history, the CFR Unit examines birth parent involvement with the child welfare system as minors. By extension, the birth parents' parents (i.e., the decedent child's grandparents) were also involved with CFSA. However, the CFR Unit does not collect that level of data and therefore does not provide an exhaustive analysis of how deep intergenerational histories may go.

Of the 49 families involved in the CY 2022 fatality review process, 18 percent (n=9) of the birth mothers had child welfare involvement as a minor. Two of the nine mothers specifically had a history in foster care. Six of the nine mothers were identified as the primary caregivers of the children who died. Relatives were identified as caregivers for two of the children. One mother was deceased. At the time of the fatality, one child was 18 years old and homeless.

For birth fathers, limited data was available. A majority of the birth fathers (51 percent, n=25) were unknown (or not identified by the birth mother). Of the 24 known birth fathers, 20 percent (n=5) had child welfare involvement as a minor. Three of the five specifically had a history in foster care. Two of the fathers were living in the home with the child at the time of the fatality while two were living out of the home but had regular contact with the child. Child involvement was unknown for the fifth father.

Prenatal Care

Sufficient evidence exists to reinforce the importance of prenatal care for better outcomes for children, physically as well as developmentally, emotionally, and intellectually. When disabilities or chronic

physical illnesses are related to a lack of prenatal care, caregiver burdens are increased. These burdens become risk factors for child maltreatment.[18]

For CY 2022, of the 49 mothers of children who died, there was no documentation as to whether or not prenatal care occurred for 73 percent (n=36). Of the remaining 27 percent (n=13), there were three mothers with documented prenatal care. Of the three children with known prenatal care, an accidental manner of death officially accounted for Child 1. Manner of death for Child 7 was natural. Manner of death for Child 2 was homicide (see *Section VI*).

Of the 10 children who did not have prenatal care, one child was age 20 with homicide as manner of death. Of the remaining nine, all the children were age 2 and under. Three of the manners of death were natural. Two manners of death were determined to be accidental, Child 5 and Child 8. Neglect may have been a contributing factor for both children (see *Section VI*). Manner of death was unknown for three. One manner of death was undetermined for Child 9. However, neglect may have contributed (see *Section VI*).

Positive Toxicology

Children born with positive toxicology results are vulnerable to short- and long-term physical and emotional implications, depending on the amount and type of drugs in the newborn's system.[19] Infants who show symptoms of withdrawal can also be fussier, which can increase parent stress, thereby increasing risk of maltreatment.

Per CFSA policy, the CPS Hotline screens in and CPS management assigns an investigative social worker for all reports of positive toxicology results for newborns. CPS investigated two families whose children identified with positive toxicology results at birth.

Children born with positive toxicology results are vulnerable to short- and long-term physical and emotional implications, depending on the amount and type of drugs in the newborn's system.

One child was born prematurely, weighed approximately 4.5lbs at birth, and tested positive for heroin and cocaine at birth. His manner of death, determined to be an accident, was not documented to be directly related to his positive toxicology results. However, cause of death was related to an unsafe sleeping environment (see *Sleep-Related Factors for Infant Fatalities,* following).

The other child was born at 38 weeks. There were no documented delivery complications, but the newborn tested positive for THC. Hospital staff reported there were no symptoms of withdrawal and

[18] https://www.nichd.nih.gov/health/topics/pregnancy/conditioninfo/prenatal-care

[19] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6986376/#:~:text=Prenatal%20exposure%20to%20alcohol%2C%20cigarettes,in%20adolescence%20and%20young%20adulthood.

after discharge, the child continued to develop normally with no documented concerns. Manner of death was natural, caused by a viral respiratory infection when the child was 1 year old. There is no evidence that the positive toxicology results were a factor in the child's death.

Sleep-Related Factors for Infant Fatalities

Abundant evidence exists regarding sleep-related factors for infant fatalities. In the citywide 2020 Annual Child Fatality Review Report, OCME reported the following DC-specific data:

> *UNSAFE SLEEP ENVIRONMENT*
>
> *As noted in previous Child Fatality Review Committee Annual Reports, unsafe sleep continues to be the leading contributory factor for Undetermined or Accidental infant deaths in the District of Columbia. Out of the nine (9) full case reviews completed in 2020, seven (7) decedents did not sleep in their own AAP-approved crib or sleep environment, were not alone in the bed, and slept on an adult mattress. Those seven cases also had an AAP-approved safe sleep environment, "pack and play," or "cribette" found on the premises during the medicolegal investigation, which was not in use at the time of the fatality.*
>
> *As mentioned, Unsafe Sleep environments as a contributory cause of death have been observed in Undetermined and Accidental infant deaths and have been steadily increasing during the review of cases*.[20]

Among CFSA's CY 2022 fatality reviews, there were three confirmed sleep-related fatalities identified for infants: Child 1 (age 1 month), Child 3 (age 1 month), and Child 8 (age 6 months). For Child 1 and Child 8, the official manner of death was determined to be accidental, both caused by asphyxia. Child 1's fatality was complicated by the child sleeping while swaddled in a car seat placed atop the mother's bed. Child 8's fatality was complicated by a body pillow and blanket covering. The official manner of death for the third child (Child 3) was undetermined but the mother admitted the child had been sleeping on a nursing pillow.

[20] https://ocme.dc.gov/sites/default/files/dc/sites/ocme/publication/attachments/CFRC%202020%20Annual%20Report-FINAL%20WEBv2.pdf

CPS and the DC Metropolitan Police Department (MPD) jointly investigated the first two deaths as suspicious due to abuse or neglect. For Child 1, medical information indicated the child was born with a genetic disorder that impacted oxygen levels, although the disorder was not confirmed to have been the cause of the death. Investigators jointly determined the allegation to be unfounded against the caregiver, based on interviews, re-enactments, assessments, and information obtained throughout the investigation.

As noted in previous [OCME] Child Fatality Review Committee Annual Reports, unsafe sleep continues to be the leading contributory factor for Undetermined or Accidental infant deaths in the District of Columbia.

In another case involving Child 8, the investigative social worker substantiated the infant's caregiver for the allegation of neglect (inadequate supervision), resulting in the death of a child. Additional details for Child 8's death are included in *Section VI: Neglect and Abuse as Contributing Factors*.

Child 3's official manner of death was undetermined, but details are also included in Section VI. The CFR Unit noted during the child's fatality case presentation to the ICFR Committee that the mother had been co-sleeping with the infant, and that the infant had been sleeping on a nursing pillow. There were also indications of respiratory difficulties from the birth, reportedly 2 weeks before the due date. The results of the CPS investigation were inconclusive for the allegation of a suspicious death due to neglect or abuse. OCME stated that there were no signs of abuse and neglect and no signs of outward trauma.

Child 6's death occurred in another jurisdiction and therefore the CFR Unit did not receive an official manner or cause of death for the infant. However, the mother reported to her therapist that the child had suffocated. Additional information indicated that the child might have been sleeping on a bed full of blankets and pillows, but this information could not be confirmed.

Teen Parenting

Research provides sufficient evidence for consideration of teen parenting as a legitimate risk factor when considering healthy outcomes for children. According to The Urban Child Institute,

> *When a baby is born to a teenage mother, he is likely to have more difficulty acquiring cognitive and language skills as well as social and emotional skills like self-control and self-confidence. Research shows that children born to adolescent mothers are more inclined to repeat their parents' behavior. They are more likely to drop out of school, have more health problems, face unemployment, and become teen parents themselves*.[21]

[21] http://www.urbanchildinstitute.org/articles/editorials/how-adolescent-parenting-affects-children-families-and-communities#:~:text=When%20a%20baby%20is%20born,are%20essential%20for%20school%20readiness

In addition, there is research indicating poverty among teen mothers, and an increase in the number of children born subsequently to the mothers. These risk factors also increase the need for system-wide focus on protective capacities for these young parents.

> *Adolescent parenthood is associated with a range of adverse outcomes for young mothers, including mental health problems such as depression, substance abuse, and posttraumatic stress disorder. Teen mothers are also more likely to be impoverished and reside in communities and families that are socially and economically disadvantaged. These circumstances can adversely affect maternal mental health, parenting, and behavior outcomes for their children.*[22]

Just over half (51 percent, n=25) of the 49 fatality reviews included birth mothers who had their first child at age 19 or younger. Ages for the 25 mothers at the time of first birth ranged from 11 years old to age 19. Of the known fathers (51 percent, n=25), 20 percent (n=5) were teenagers when their first child was born. Ages ranged from 15 to 19.

Mental Health

Parents

Parental involvement in mental health treatment or documented mental health diagnoses accounted for 36 percent (n=18) of the 49 fatality reviews in CY 2022. However, as noted in the preface to this section, data limitations include the probability that not all involvement or diagnoses are documented. Further, documented diagnoses do not always confirm mental health treatment.

For the 18 fatalities with documented parental mental health diagnoses, the total number of parents identified included 16 mothers and five fathers (n=21). Of these parents, depression accounted for the majority of diagnoses (67 percent, n=14). The second most common diagnosis was bipolar disorder, which accounted for 43 percent (n=9), followed by schizophrenia (24 percent, n=5). Anxiety accounted for 19 percent (n=4) of the diagnoses. Post-traumatic stress disorder (PTSD) and mood disorder diagnoses accounted for two parents each (19 percent, n=4). One parent received a diagnosis of panic disorder. Documentation indicated that two parents were psychiatrically hospitalized.

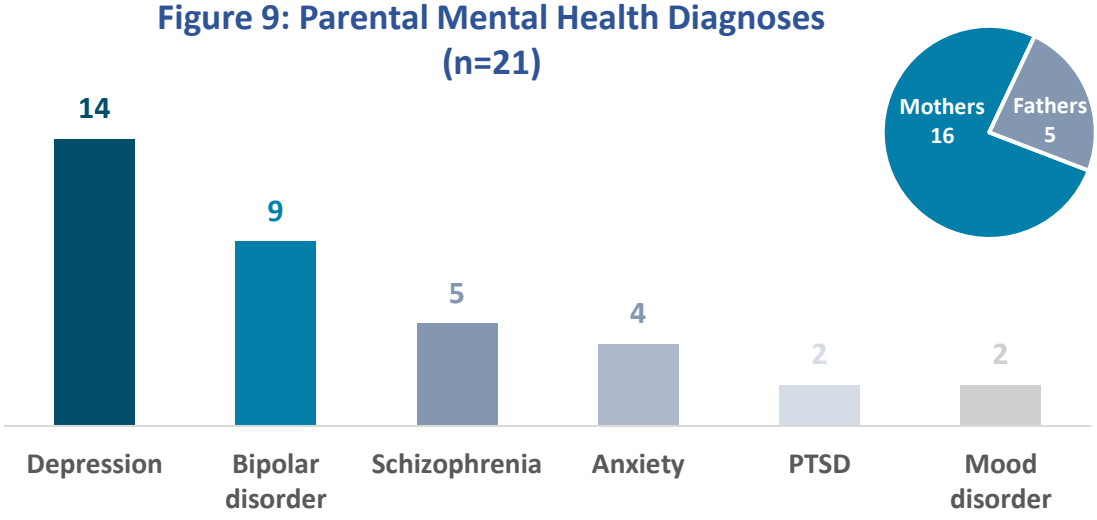
Three children had parents who were both diagnosed with a mental health disorder. For one child, the mother and the father received a documented diagnosis of schizophrenia. The mother's history also included suicidal and homicidal ideations while the father's history included PTSD and bipolar disorder. For another child, both parents received a diagnosis of bipolar disorder. The mother's history included

[22] Hodgkinson S, Beers L, Southammakosane C, Lewin A. Addressing the mental health needs of pregnant and parenting adolescents. Pediatrics. 2014 Jan;133(1):114-22. doi: 10.1542/peds.2013-0927. Epub 2013 Dec 2. PMID: 24298010; PMCID: PMC3876179.

depression and PTSD. Documentation on the parents of one young adult, whose manner of death was homicide, included "mental health illness" but without diagnoses.

Child 2, whose manner of death was homicide, was living with both parents as primary caregivers. The mother had no documented diagnoses, but the father had documented diagnoses of bipolar disorder, panic disorder, and PTSD. The father also had a history of attempted death by suicide as a youth, along with psychiatric hospitalizations as a youth and as an adult.

Figure 9: Parental Mental Health Diagnoses (n=21)



Parents may have more than one diagnosis.

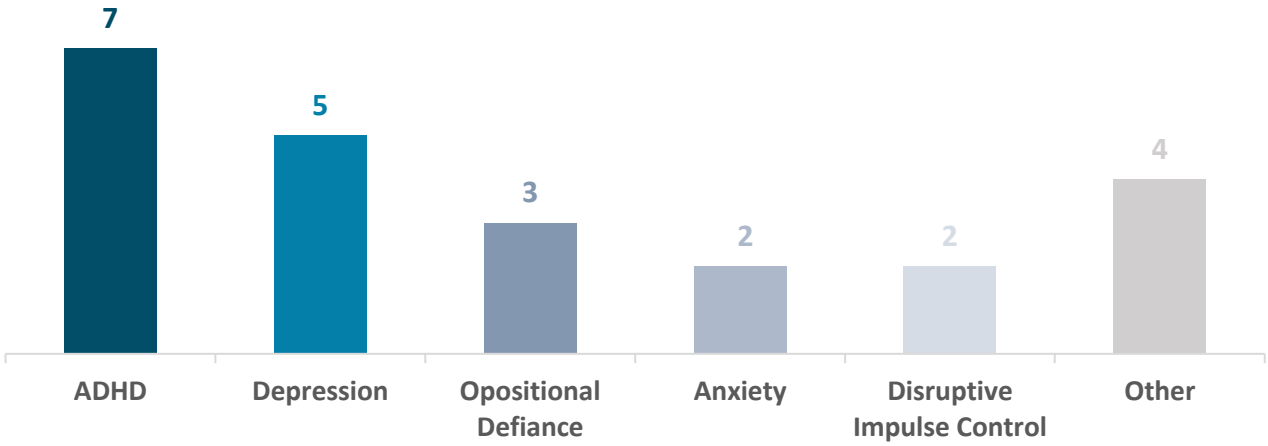
Children

Of the 49 child fatality cases reviewed, 31 percent (n=15) had mental health diagnoses. For those 15 children, the most common diagnosis (47 percent, n=7) was attention deficit hyperactivity disorder (ADHD), followed by depression (33 percent, n=5). For the seven children with ADHD, three had concurrent diagnoses of oppositional defiance disorder (ODD).

For the five children with depression, two of the children also had at least one parent diagnosed with depression. Three of the five children had concurrent diagnoses of ADHD. One child, who died of natural causes, had concurrent diagnoses of ODD and an eating disorder. Another child had a concurrent diagnosis of disruptive behavior disorder and still another had a concurrent diagnosis of PTSD and anxiety. Only one child had a single diagnosis of depression.

While there are no direct correlations between diagnosis and manner of death, most of the 15 children with diagnoses (87 percent, n=13) were older teenagers or young adults (ages 15 to 22). Further, most of the children (80 percent, n=12) were males. The official manner of death was homicide for 67 percent (n=10). Official manner of death for the five remaining fatalities included three natural deaths due to medical conditions, one accidental overdose, and one unknown due to the fatality occurring out of jurisdiction.

Figure 10: Children Mental Health Diagnoses (n=15)



Children may have more than one diagnosis.

Substance Use

Parents

Parental substance use is well researched as a risk factor for child maltreatment. These data are not limited to the United States. The risks extend across countries and cultures.[23]

Although the District of Columbia legalized the use of marijuana for adults over the age of 21, use of the drug is still a federal offense and impact of usage on parenting and protective capacity can be difficult to assess.[24] Of the 49 families reviewed, one mother had a medical marijuana card issued by DC Health. This mother is not included in the data for this section on substance use. Aside from marijuana, other identified "drugs of choice" included crack, cocaine, ecstasy, heroin, and PCP.

Of the 49 percent (n=24) of parents with reported substance use, nine of the mothers were teenagers when their first child was born. Six of the mothers delivered children (not necessarily the decedent) with positive toxicology results.

Data on substance use treatment was inconsistently reported. However, there were six families confirmed to have had some involvement with assessments and intake through the DC Department of Behavioral Health's Addiction Prevention and Recovery Administration.

[23] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7033710/
[24] DC Code § 48–904.01(a)(1)(A)

Children

As with other data sets, there is inconsistent documentation on actual usage of drugs by children (or older youth). Of the 49 families reviewed, 18 percent (n=9) of the children were reported to have used marijuana. No other drug usage was reported.

Six of the nine youth also had parents who reported marijuana use. Of those parents, one reported also using PCP.

Housing and Financial Insecurity

Poverty, including homelessness or housing instability, has been identified for years as a consistent risk factor for neglect, especially when housing is unsafe, or CPS substantiates for lack of food and proper nutrition, and even clothing. There is also the nuanced stress of poverty impacting protective capacity.[25] However, as risk factors, housing and financial insecurity are not always known or documented.

Of the 49 cases reviewed, 20 families had housing instability. The family either previously experienced homelessness or had subsidized housing.

Documentation indicated that 57 percent (n=28) of the families reviewed had financial insecurity. They reported reliance on public assistance such as Temporary Assistance for Needy Families (TANF); Supplemental Nutrition Assistance Program (SNAP); Women, Infants and Children (WIC); and Social Security Income (SSI). Some did not have any income and did not receive public benefits.

VI. Neglect and Abuse as Contributing Factors

Historically, the Agency has relied on the medically and legally determined official manner of death for the annual CFR reports. For the 2022 Report, this section addresses several challenges with a fatality review when CFSA may have identified contributing factors not otherwise revealed from an OCME official determination for manner of death. These challenges are not in isolation. The OCME 2020 Annual Child Fatality Review Report also addresses these same challenges:

> *Several themes were discussed during the abbreviated meeting schedule conducted in 2020. 1. Prosecuting cases when the Manner of Death is determined to be an Accident or Undetermined, from the perspective of the United States Attorney's Office (USAO) and the Office of the Attorney General (OAG), was discussed when contributory conditions –overlay, unsafe sleep environment, lack of supervision, or caregiver impairment are present. The USAO and the OAG indicated their offices have*

[25] https://www.childwelfare.gov/topics/safety-and-risk/poverty-and-neglect/

minimal impact in pursuing criminal charges in these cases. The IMRT continued to discuss the lack of a clear negligence statute in the District of Columbia, which can only be addressed by members of the City Council. Presently the District of Columbia has a First-Degree Cruelty to Children Statute, which is used to prosecute cases.[26]

CFSA leadership maintains an intrinsic commitment to examining whether or not neglect or abuse were possible contributing factors to a child's fatality, even when the manner of death does not directly implicate neglect or abuse. For example, a child may have died in a car accident but a CPS investigation may substantiate an allegation of neglect if evidence confirmed the parent was driving under the influence. In CY 2022, the ICFR Committee identified five fatalities where neglect may have directly or tangentially impacted a child's death.

This section includes a sixth fatality, addressed at the end of this section, where the manner of death, homicide, directly involved physical abuse. As a result, there were no barriers to legal action for the relative perpetrator. In October of 2022, shortly after OCME confirmed the official manner of death, law enforcement officials offered a reward for information on the location of both parents. At the time of this 2022 Report, no documented arrests were made.

Accidental Deaths

For three of the five fatalities, OCME determined the manner of death to be accidental. However, circumstances surrounding all three fatalities included indicators of limited or missing parental protective capacities. From a quality assurance perspective, the ICFR Committee carefully examined these deaths to understand if there were opportunities to improve CFSA's practice, i.e., to better assess, identify, and address a family's protective factors whenever those children and families become known to the Agency.

The official OCME cause for the accidental death of Child 5 was heat exhaustion (hyperthermia) due to the child being left in a car during summer months. The cause for Child 8 was asphyxiation related to an unsafe sleeping environment. The cause for Child 13's death was fentanyl intoxication.

Child 5 (age 3 months)

On the day of Child 5's death, the family had diverted from a daily routine regarding transportation of the child and two older siblings. When the family returned home, the siblings exited the family car, but the 3-month-old child remained for several hours until the family realized what had happened. The family contacted 911 and performed CPR. However, the paramedics did not arrive until 13 minutes after the 911 call, due to miscommunications between receipt of the call and the dispatcher contacting

[26] IMRT refers to the DC Infant Mortality Review Committee. Source: https://ocme.dc.gov/sites/default/files/dc/sites/ocme/publication/attachments/CFRC%202020%20Annual%20Report-FINAL%20WEBv2.pdf

the medical team. A DC public safety official conceded internal miscommunication and confirmed an internal investigation into the dispatching procedures.

Case documentation indicated that both parents had CFSA involvement as children. However, within 5 years of the fatality, the family had minimal involvement with the system with some service delivery during two family assessments. There were no open cases. Documentation also indicated a history of parental use of marijuana, although there was no documented evidence of drug use on the day of the child's death.

ICFR Committee discussions focused on the need for public messaging on risk factors that may contribute to preventable infant deaths, such as the risk of leaving children in a hot car. The ICFR Committee also discussed the difficulties of assessing the impact of marijuana usage on parenting.

CPS investigated the fatality and substantiated the driver of the car for inadequate supervision. The Agency opened an in-home case to support the family and to address the needs of the siblings. The in-home case later closed with no concerns for the safety or well-being of the other children.

Child 8 (age 6 months)

Due to Child 8's positive toxicology results for heroin and cocaine, and the mother's ongoing struggle with drug use, CFSA opened an in-home case for the family to monitor safety for the infant and to support the relative caregiver who assumed care of the infant. Both the mother and the caregiver had child welfare involvement as children, and both had mental health diagnoses. Case documentation also indicated a history of substance use for both.

Case documentation for the open in-home case indicated that the caregiver expressed concerns that the infant was not sleeping at night and screamed whenever she tried to place the child in the available and accessible Pack 'n Play. The caregiver also relayed a discussion with the child's pediatrician who stated that the child's reaction was due to the drugs lingering in the infant's system. The Agency thoroughly discussed safe sleep with the child's caregiver, including a safe sleep video and a safe sleep flyer. During the CPS investigation into the child's death, the caregiver admitted that the child should have been sleeping in the Pack 'n Play. She reiterated the infant's crying episodes.

The ICFR Committee discussed the possible expansion of safe sleep protocols in policy and in the Agency's procedural operations manuals. In particular, the discussion explored the efficacy of requiring consistent documentation of follow-up counseling and education. As noted earlier in the 2022 Report, despite documented efforts of CFSA and CFSA-contracted social workers repeatedly counseling young parents on safe sleep, CFSA still receives notifications of deaths where sleep risk factors are identified.

The CPS investigation into Child 8's death resulted in a substantiated disposition against the caregiver for inadequate supervision and a suspicious child death due to abuse or neglect. CFSA subsequently closed the mother's in-home case as a result of the child's death.

Child 13 (age 3 years)

For Child 13, within 5 years of the fatality, the family history included three CPS investigations, one family assessment, three screened-out referrals, and two open in-home cases. There were no open investigations or cases at the time of the fatality.

Previous documented case notes indicated the mother's history of drug use, including unprescribed narcotics and marijuana. While the Agency did not observe any evidence of drug use or concerns for supervision during the two open in-home cases, case notes indicated the mother resisted the Agency's efforts to engage her and she was inconsistent with participation in services. At the time of the fatality investigation, CPS learned that the mother was living with a known drug dealer and admitted to the use of unprescribed drugs. The mother failed to secure the drugs in the home, and allowed Child 13 and a sibling access to the room where the unsecured drugs were ingested by the child. The CPS fatality investigation substantiated the mother for inadequate supervision, substance use, and a suspicious death of a child due to abuse or neglect. The Agency further separated the sibling who entered foster care. Per the law, the mother's name is now included in the DC Child Protective Register.

During CFSA's ICFR Committee discussions, leadership agreed that the community papering process should have been considered for the family's earlier in-home cases, given the known risk factors related to drug use and the mother's resistance to services.[27] However, the discussion also acknowledged the difficulty of demonstrating legal sufficiency for court involvement when there are no active signs of child abuse or neglect.

In an effort to address the difficulty, CFSA established an additional teaming forum for in-home social workers with complicated cases. Further, toward the end of CY 2022, the Office of the Attorney General assigned a dedicated assistant attorney general (AAG) to work solely with in-home families. The AAG will answer social workers' legal questions and help to address relevant legal issues that come up in a social worker's day-to-day work. The AAG may also analyze the legal sufficiency of evidence for in-home cases and provide next steps to strengthen cases for court involvement as needed.

Undetermined

Child 3 (age 1 month)

Although the cause of death was undetermined, OCME identified significant conditions, including an unsafe sleep environment and a bacterial infection in the 1-year-old's ear and lungs. The child was born

[27] Community papering is a process by which CFSA may seek court oversight and initiate a neglect case for a family without separating the child from their caregiver. Through the community papering process, Agency social workers work with the Office of the Attorney General to determine the legal sufficiency and appropriateness of a neglect case. Once the court is involved, the DC Superior Court judge who presides over the case may decide to separate the child, or they will determine that the child is safe in the care of their parents. In that instance, the court will allow the child to remain in the home with a list of conditions agreed upon and signed by the parties. Through the community papering process, the court has jurisdiction over the family, including the ability to order services and impose requirements until the neglect has been ameliorated or the child achieves permanency.

prematurely and presented with respiratory challenges since birth, but without a documented respiratory illness.

The evening prior to Child 3's death, the mother had placed the child on a nursing pillow designed to provide ergonomic support for a breastfeeding mother. The pillow is not designed for support of a sleeping child. Both mother and child were sleeping in the same king-size bed. When the mother awoke, she found the child unresponsive and called 911. The paramedics were unable to revive the child.

The family included eight children, ages ranging from 1-month-old (Child 3) to 18 years old. Within the 5-year period for fatality reviews, the family had extensive involvement with the Agency, including 16 referrals, five investigations, two family assessments, and nine screened-out referrals. Case documentation indicated mental health diagnoses for the mother (psychotic disorder with hallucinations, suicidal and homicidal ideation, and history of schizophrenia). Although the mother received medications for her diagnoses, she was reportedly inconsistent with medication compliance. There was no evidence that her diagnoses had impacted the fatality. The allegation for suspicious death of a child was determined to be inconclusive.

During case presentation to the ICFR Committee, the reviewer noted that during the family's history with CFSA, the Agency had conducted a 4+ staffing.[28] In addition, CPS developed intervention plans with the family, safety plans, and contingency plans to ensure the safety of the children. The Agency did not open any cases on the family.

Unknown

Child 9 (age 9 months)

The mother of Child 9 was living with a known drug dealer who was also a caregiver for the child. Although the CFR Unit did not receive an official manner of death due to the autopsy being conducted out of state, documentation received by the CFR Unit confirmed fentanyl in the 9-month-old's system.

The mother had one previous investigation with no substantiations. At the time of the fatality, an older sibling from another father was also living with the mother. After the fatality, the child remained in the home of the birth father who had joint custody.

During the case presentation to the ICFR Committee, discussion addressed challenges related to data sharing across jurisdictions. Although DC police had requested the autopsy results, those results were still not received as of the writing of this 2022 Report. Despite the unknown official manner and cause of death, the issue of the mother's lack of or failed protective capacity was evident.

[28] The Agency conducts 4+ staffings when families receive four or more reports of maltreatment with the most recent report occurring within the last 12 months. The staffing must include the social worker and supervisor and occur as close to the start of the new CPS investigation as possible to identify historic concerns that must be addressed during the investigation.

CFSA opened a CPS investigation for allegations of controlled substance in the system of a child and suspicious death of child due to abuse or neglect. However, the investigation disposition was inconclusive from a legal perspective due to a lack of concrete evidence for how the fentanyl entered the child's system.

Homicide

Child 2 (age 1 month)

At the time of the fatality, Child 2's father contacted 911 to report the 1-month-old as unresponsive. When the paramedics and police arrived at the home, both expressed and documented concerns for the parents' behaviors, i.e., the parents appeared under the influence of drugs and alcohol, and neither was capable of driving. Police noted that the parents presented as "inappropriately" calm under the circumstances, i.e., the mother was outside smoking a cigarette and the father was eating a pizza.

Child 2 was not known to CFSA prior to the fatality, and the mother had no CPS history as a parent. CFSA involvement in the 5 years prior to fatality was related to the father alone and focused on his other children with his previous partners. The father also had CFSA history as a child victim, including physical and sexual abuse. The father had mental health issues and an extensive complex behavioral history, including criminal behavior beginning as early as age 10, and past homelessness. Both parents had a history of heroin use, but the father also had documented use of marijuana, synthetic marijuana (K2), ecstasy, and PCP.

Discussions during the ICFR Committee meeting included findings on previous investigations of the father, specifically opportunities for practice improvement. The ICFR Committee further discussed reinforcement of documenting efforts and challenges with engaging fathers in general, as well as locating fathers, and serving fathers when they live out of the jurisdiction.

During the fatality investigation, CPS learned that Child 2 had been reportedly dropped several times prior to the fatality, but the family did not seek medical treatment. In addition, a toxicology report indicated that there was fentanyl in the child's system, although the official cause of death was determined to be internal bleeding from physical abuse. The investigative social worker substantiated both parents for medical neglect, substance use, and a suspicious death of a child due to abuse or neglect. As noted in the beginning of this section, the whereabouts of both parents were unknown at the time of the official determination that the child's death was a homicide.

VII. Family and Child Service History

This section of the 2022 Report separates data on family involvement with CFSA into four primary categories: (1) involvement at the time of the fatality, (2) within 12 months of the fatality, (3) within 5 years of the fatality, and (4) CPS involvement resulting in substantiated allegations.[29]

Overarching data sets for families may or may not include the decedent as a victim child in a referral. However, the data sets for child involvement specifically do include decedents identified as victim children in a referral, investigation, or case at the time of the fatality. Data on child involvement further include Hotline referrals and substantiated allegations with the child identified as a victim within 12 months of the fatality and within 5 years of the fatality. Analyses and considerations for risk factors of individual cases are included in *Section V: Fatality Risk Factors* and *Section VI: Neglect and Abuse as Contributing Factors*.

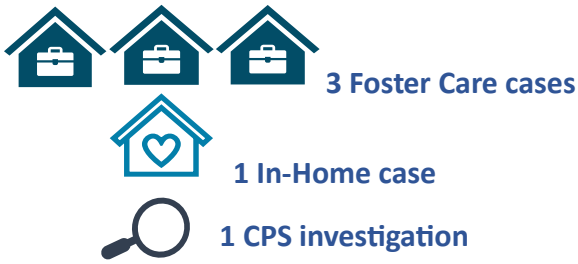
This section also includes data on family involvement with CFSA's sister agencies, including community-based organizations. The sister agency data intentionally focuses on the broader picture of a family's efforts to engage in or decline services tailored to stabilize, improve, and otherwise address circumstances that may or may not have contributed to the fatality.

Family Involvement with CFSA

Family Involvement at the Time of Fatality

The majority of families (90 percent, n=44) did not have CFSA involvement at the time of the fatality (Figure 11). Of the 10 percent (n=5) that did have CFSA involvement, 6 percent (n=3) had an open out-of-home case, and 2 percent (n=1) had an open CPS Investigation. Two percent (n=1) had an open in-home case. However, the involvement for these families did not necessarily include the decedent.

Figure 11: Family Involvement at Time of Fatality



Family Involvement within 12 months of Fatality

The majority of families (67 percent, n=33) were not involved with CFSA within 12 months of the child's fatality (Figure 12). Of the 16 families that were involved (33 percent), 21 percent (n=10) had an open CPS Investigation. Eight percent (n=4) had an open in-home case and 2 percent (n=1) had an open out-of-home case. Another 2 percent (n=1) had a family assessment (FA) opened during the 12-month

[29] For details of the Hotline decision-making process for screening in or screening out a referral, please refer to the Hotline Procedural Operations Manual.

period. Although CFSA discontinued the FA process in April of 2019, based on the 5-year window for review of fatality cases, FA referrals will be included in the CFR data until CY 2024.[30] Again, the involvement for these families did not necessarily include the decedent.

Figure 12: Family Involvement within 12 months of Fatality

Family Involvement within 5 years of Fatality

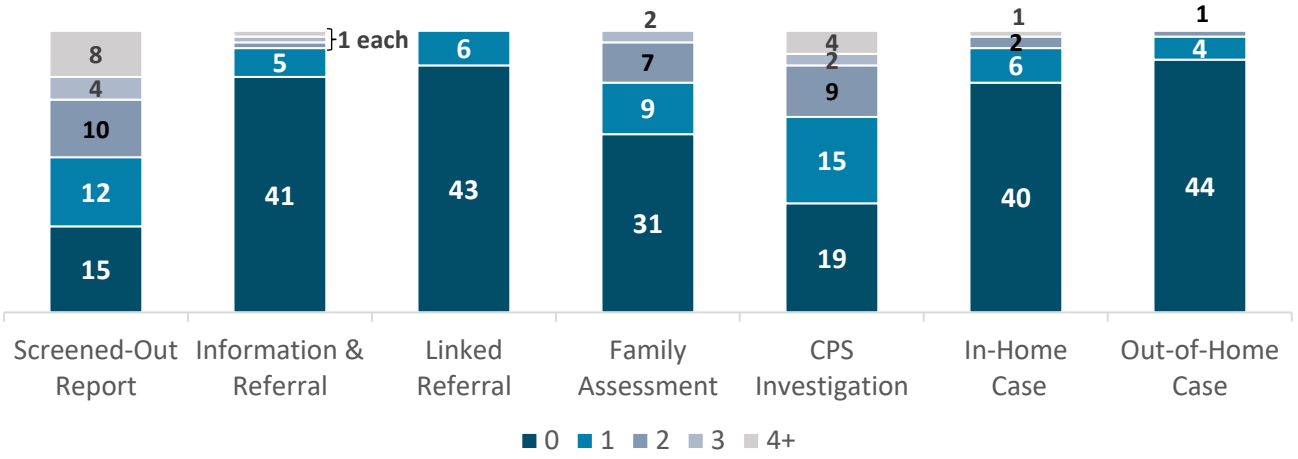
Data on family involvement for the 5-year period of review include all possible CPS scenarios: screened-out Hotline reports, Information and Referrals (I&Rs), screened-in referrals, CPS investigations, linked referrals, opened in-home and out-of-home cases, and Family Assessments (FA).[31]

As Figure 13 reveals, the majority of families (90 percent, n=44) had no open out-of-home cases and no open in-home cases (82 percent, n=40) within the 5-year window. At least one CPS investigation occurred for 31 percent (n=15) of the families and at least one screened-out referral occurred for 24 percent (n=12).

[30] CFSA initiated the Differential Response (DR) model and the FA Unit in 2011 to address certain abuse and neglect referrals where there was no immediate risk to a child's safety. In 2019, CFSA integrated the DR approach into the traditional CPS investigative process, ending the need for the FA Unit while protecting the integrity and benefits of the DR approach and the FA process.

[31] For specific definitions, please see the Hotline Procedural Operations Manual (POM), the Investigation POM, and the In-Home/Out-of-Home POM.

Figure 13: Family History within 5 years of Fatality (n=49)



Regarding screened-out reports in particular, 16 percent (n=8) of the families had four or more screened out referrals within 5 years of the fatality. Concerns about these screened-out calls necessitated several discussions during the ICFR Committee monthly meetings, i.e., whether or not screening in those referrals would have made an impact on mitigating or preventing a fatality. However, those correlations are very difficult to prove since a screened-out report offers no details outside of the referral, i.e., no documented risk and safety assessments that could inform a connection. In addition, each Hotline worker follows the evidence-based structured decision making (SDM®) tool, prior to screening. The SDM tool guides the determination for whether the information provided includes sufficient facts to warrant screening in the referral.

Examining correlations between screened-out referrals and circumstances surrounding the fatalities are not readily evident. For one victim of a gun-related homicide, for example, the screened-out referrals were predominantly (n=5/6) for educational neglect. The homicide did not occur during school hours nor was there a specific identifier for school peers. Rather, the homicide occurred on a weekend when several homicides occurred in DC. For this particular youth, a dispute between neighborhood groups resulted in the youth's death.

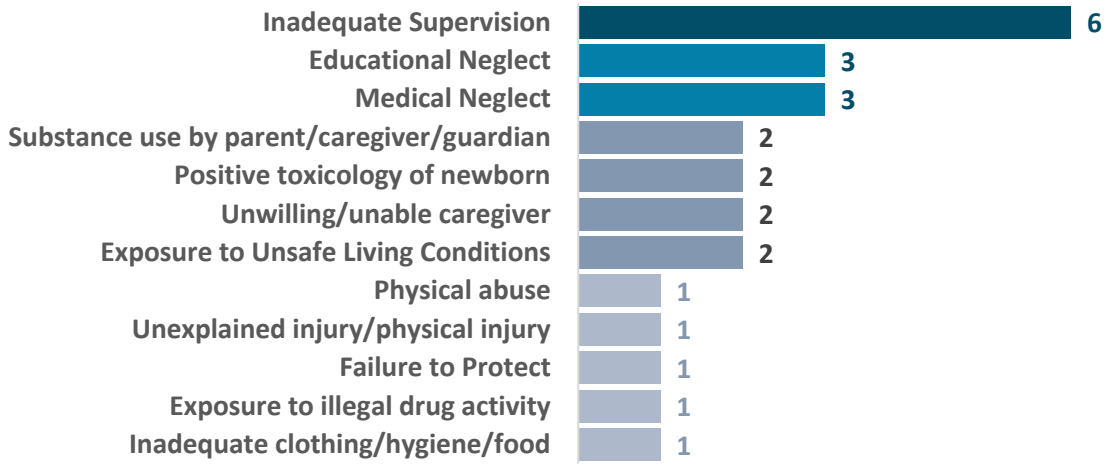
In contrast, for a 16-year-old homicide victim, the youth was identified as a victim child in five of the family's 11 screened-out referrals. Those five referrals included four allegations of physical abuse and one allegation against a parent for exposing the child to domestic violence (DV).

During the entire 5-year period, CPS opened one or more investigations for 61 percent (n=30) of the families while 36 percent (n=18) of the families participated in the FA process. Linked referrals, meaning that new allegations were added to an open investigation, accounted for 12 percent (n=6) of family involvement. I&Rs accounted for 16 percent (n=8) while screened-out reports accounted for 69 percent (n=34) of family involvement.

CPS Involvement Resulting in Substantiated Allegations within 5 years of the Fatality

CPS substantiated at least one allegation within 5 years for 51 percent (n=25) of the 49 families reviewed over CY 2022.[32] Of those 25 families, CPS substantiated 24 percent (n=6) for inadequate supervision, 12 percent (n=3) for educational neglect and another 12 percent (n=3) for medical neglect. CPS also substantiated twice each for four different types of allegations (24 percent total): exposure to unsafe living conditions, substance use impacting caregiver capacity, unwilling or unable caregiver, and positive toxicology of a newborn. There were five types of allegations for which CPS substantiated one family each (20 percent total): physical abuse, unexplained injury, failure to protect, exposure to illegal drug activity, and lastly, inadequate food, clothing, and hygiene.

Figure 14: CPS Substantiations within 5 Years of the Fatality



Child Involvement with CFSA

Child Involvement at the Time of the Fatality

Of the total 49 children, two children were identified as child victims with active CFSA involvement at the time of the fatality. The youngest of the two, a 6-month-old (Child 8), was born with positive toxicology results for illegal drugs. CPS substantiated the child's mother for the allegation of neglect and opened an in-home case. The in-home case was still opened when the child died from asphyxia due to an unsafe sleep environment. The official manner of death was accidental.

For the second child, a 16-year-old youth with active involvement, CPS substantiated the youth's father for medical neglect related to the youth's diagnosis of a chronic medical condition. CFSA subsequently

[32] CPS may have substantiated a single family for more than one allegation during one investigation or across multiple investigations.

opened an out-of-home case that was still open at the time of fatality. The youth had absconded from the placement at the time of his fatality. The manner of death was homicide caused by a gunshot wound to the head.

Figure 15: Decedents with Hotline Calls within 12 months of fatality (n=49)

Child Identification as Victim in Hotline Referrals within 12 months of the Fatality

Twenty-two percent (n=11) of the 49 children were identified as child victims for at least one Hotline report. Of the 11 children, seven were identified as victims for one Hotline report, three were identified in two Hotline reports, and one decedent identified in three Hotline reports. Of the seven children identified as victims in a referral, CPS investigated the referral for five of the children, substantiating one allegation for positive toxicology.

Decedents Identified as a Victim in Hotline Referrals within 5 Years of the Fatality

When the Hotline receives a report, all children in the family are not necessarily identified as a "victim child," e.g., there are referrals where the allegation may be specific to one child in a family. Other referrals may allege abuse or neglect for all children in the family.

Figure 16: Victim Child with Hotline Calls within 5 years of fatality (n=49)

Data on children identified as victims for Hotline referrals and substantiations within the 5-year window overlaps with the same 11 children identified as victims within 12 months of the fatality. Of those 11 children, documentation identified three as victims in two Hotline referrals, overlapping data for two of those three children as victims within 12 months. CPS only investigated the two referrals for one child with no substantiations. CPS did substantiate the caregiver of another child for one educational neglect allegation.

The CFR Unit identified both two children as victims for three Hotline referrals each. CPS investigated all three referrals for one child with substantiations for two of the allegations: unwilling or unable caregiver and medical neglect. CPS only investigated two of the three referrals involving another child and also substantiated two allegations: inadequate supervision and substance use impacting caregiving.

Figure 17: Victim Child in Substantiated Allegations within 5 years of fatality (n=49)

For children identified as victims for five referrals, the data included only one child. CPS investigated four of the five referrals with no substantiated allegations. There were six referrals identifying another child as a victim. CPS investigated one of the referrals within the 5-year window but substantiated no allegations.

Family Member Involvement with Sister Agencies and Community-Based Organizations within 5 Years of Fatality

CFSA's sister agencies include both DC Government agencies and community-based providers, as well as CFSA's contracted partners, the Healthy Families/Thriving Communities Collaboratives (Collaboratives).[33] For all fatalities reviewed by the ICFR Committee in CY 2022, sister agency involvement comprised 20 different agencies (listed in Figure 18 following). However, any individual family may have been involved with more than one of these agencies.

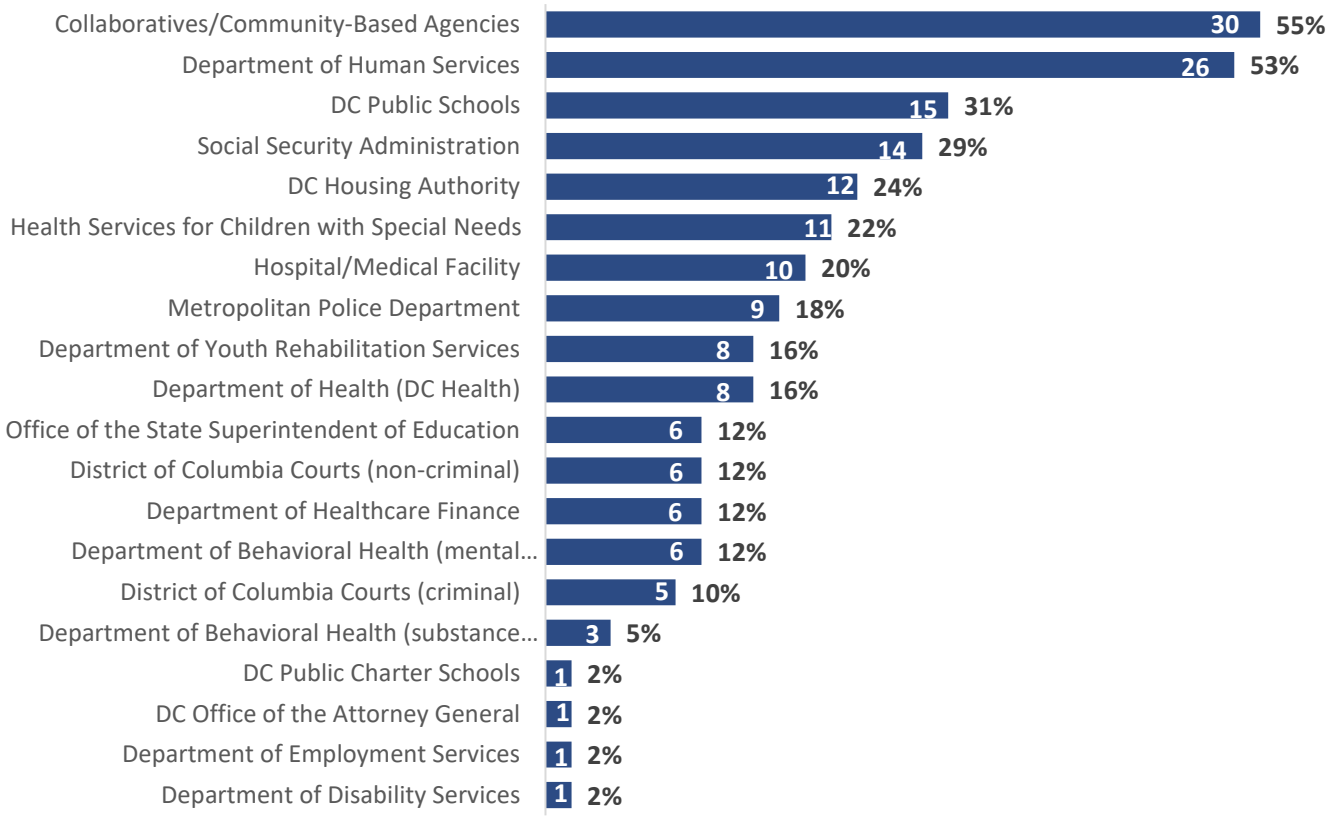
Over half the families (55 percent, n=30) received supportive services from the Collaboratives or other community-based agencies. The Department of Human Services served 53 percent (n=26) of the families, providing Temporary Assistance for Needy Families (TANF), Supplemental Nutrition Assistance Program (SNAP), and housing assistance. DC Housing Authority (24 percent, n=12) accounted for additional housing assistance while the DC Department of Healthcare Finance accounted for 12 percent (n=6) of the families involved with services. Two percent (n=1) of the families included involvement with DC's Department of Employment Services.

Other system agencies serving families comprised education-based services through DC Public Schools, including DC Public Charter Schools and the Office of the State Superintendent of Education (31 percent, n=15).[34] Health-related service agencies included the Social Security Administration (29 percent, n=14), Health Services for Children with Special Needs (22 percent, n=11), other hospitals or medical facilities (20 percent, n=10), and DC Health (16 percent, n=8). The Department of Behavioral

[33] The Agency's partnership with the five neighborhood-based Collaboratives is a key component of CFSA's prevention and family-strengthening network. Each Collaborative is an independent 501(c)(3) led by a community-based board of directors.
[34] Per the federal Individuals with Disabilities Education Act, education-based services include individualized education programs to support academic progress for eligible children. Per the federal Rehabilitation Act (Section 504), 504 plans ensure an eligible child experiences the same access to an educational environment as their peers.

Health accounted for 12 percent (n=6) for families accessing mental health services and 6 percent (n=3) for families accessing substance use treatment services. The DC Department of Disability Services accounted for 2 percent (n=1) of the families involved with sister agencies.[35]

Figure 18: Percentage of Families Involved with Other Agencies within 5 years of Fatality



Law enforcement and legal systems included the DC Superior Court (22 percent, n=11), MPD (18 percent, n=9), Department of Youth Rehabilitation Services (16 percent, n=8), and the Office of the Attorney General (2 percent, n=1).[36]

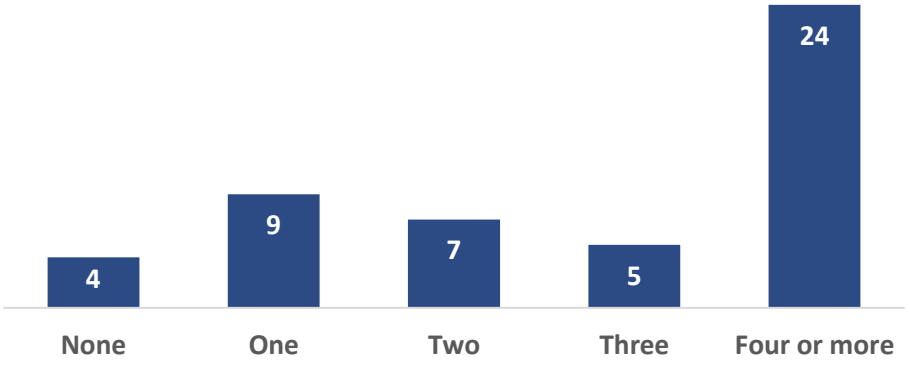
Families Involved with More than One Agency within 5 Years

The majority of families (92 percent, n=45) were involved with at least one other District agency within 5 years of the fatality. Of these 45 families, percentage of involvement steadily declines from one other agency involvement (18 percent, n=9) to two other agencies (14 percent, n=7) and finally to three other

[35] The Social Security Administration distributes funds through the Supplemental Security Income program. These funds apply to children with medical conditions whose families have income and resources below specific financial limits,
[36] The Department of Youth Rehabilitation Services provides services to youth involved in the juvenile justice system. The DC Superior Court included both criminal (caregiver incarceration) and non-criminal involvement (e.g., Family Treatment Court for caregivers participating in substance use treatment).

agencies (10 percent, n=5). However, as shown in Figure 19, involvement with four or more agencies dramatically increases to 49 percent (n=24) of the families with other agency involvement within 5 years of the fatality. These data reveal the extent to which a statistically viable number of families struggled with multiple needs to be addressed for stability and overall well-being.

Figure 19: Families Linked to DC Agencies within 5 years of Fatality (n=49)



VIII. ICFR Committee Recommendations

2022 Recommendations

CFSA continues to advance from a compliance-driven agency to an agency driven by best practice and strong continuous quality improvement (CQI), which has allowed the Agency to successfully exit the 32-year class action lawsuit, *LaShawn* v. Bowser in 2021.[37] As a critical component to the CQI process, the CFSA ICFR Committee creates an intentional learning environment for in-depth case reviews, data analysis, and the examination of circumstances surrounding a child's death.

The strength and power of the CFR process exists in the understanding of complex systems and where within those systems the child welfare professional can identify opportunity to effect change and increase safety for children. At times, this process will result in tangible recommendations, such as

[37] After first entering a Settlement Agreement on August 7, 2020, CFSA then agreed to an Addendum to the Settlement Agreement on April 22, 2021, prior to the lawsuit being dismissed on June 1, 2021. Once the lawsuit was dismissed, the terms set forth in the Settlement Agreement and Addendum to the Settlement Agreement became enforceable as a contract, which covered performance during January 2021-December 2021

increasing safe sleep education. However, more often, the process creates a forum for the Agency and its partners to examine various opportunities for increasing CFSA and system-wide accountability.

The CFR Unit and ICFR Committee partnered diligently in 2022 to manage the 166 percent increase in death notifications during the year.[38] Nevertheless, the Agency had to confront the facts: completion of as many reviews as possible would not leave adequate time for reflective conversation. As such, the 2022 recommendations from the ICFR Committee expose intentional space to weigh the impact of several emerging themes, specifically around interagency coordination and information sharing, community safety, and safe sleep.

CY 2022 RECOMMENDATION TOPIC 1: ***Inter-agency service coordination and information sharing.***

The 2022 fatality reviews highlighted consistent challenges for CFSA social workers to obtain vital client information from partner agencies. Obtaining this information is critical for leveraging resources and coordinating services that best serve the unique needs of individual children and families.

Recommendation: Establish a subcommittee to further identify gaps, determine needs, and propose next steps for affecting more effective service coordination and information exchange.

Status: In progress

Aligned Activities: A subcommittee comprising front-line staff, CFSA and contracted agency managers, and lCFR Committee members explored opportunities to support social workers with service coordination and information sharing. Surveys and focus groups with in-home social workers revealed social workers' specific challenges with referrals for services, interventions and supports, collaboration and teaming, and delays in service. The in-home survey in particular was incorporated into CFSA's *2023 Needs Assessment,* which informs the Agency's *Resource Development Plan*. Separately, the Agency is working to support social workers through CFSA's Office of Thriving Communities with the development and pilot of a "Service Navigator" model. The Service Navigator includes designated points of contact from partner agencies to assist with identifying needs and tracking referrals. These partner agencies include but are not limited to the Department of Behavioral Health, Department of Human Services, the Collaboratives, community-based organizations, and the DC Housing Authority. The Agency plans to embed this model in its comprehensive child welfare information system, STAAND, and to expand the Service Navigator model to other program areas.[39]

[38] As referenced in footnote 7, between 2019 and 2021, OCME requests averaged around 25 to 30 a year. Compared to 31 requests in 2021, the CFR Unit received 85 requests in 2022.

[39] STAAND (Stronger Together Against Abuse and Neglect in DC) replaces CFSA's previous child welfare information system, FACES.NET.

CY 2022 RECOMMENDATION TOPIC 2: ***Inform District-wide discussions and programs to promote a safer community****.*

Homicides related to community violence continue to be the leading (45 percent, n=22) manner of death for children reviewed in 2022.

Recommendation: Identify ways that the ICFR Committee and CFSA can leverage their unique clinical perspectives and understanding of trends to further inform District-wide discussions and programs geared towards reducing community violence.

Status: In progress

Aligned Activities: The ICFR Committee developed a working subcommittee that met throughout CY 2023 to explore opportunities to increase community safety. The subcommittee comprises CFSA staff, community partners, and invited guests from the Criminal Justice Coordinating Council. Discussions on root causes of community violence included truancy, suspensions, homelessness, and the effects of abuse and neglect on child and adult behaviors. As of the writing of this report, the subcommittee is finalizing their recommendations to be shared with the ICFR Committee.

CY 2022 RECOMMENDATION TOPIC 3: ***Support the revitalization of safe sleep campaigns in the District.***

Despite well documented efforts by CFSA and partner agencies to educate parents on the importance of safe sleep, CFSA continues to see significant evidence of unsafe sleep as a contributory factor for undetermined or accidental infant deaths.

Recommendation: Conduct an environmental scan of CFSA and District agency efforts to revisit safe sleep messaging campaigns and to develop culturally competent updates to current guidance, especially around the legalization of marijuana use.

Status: Implementation to begin in CY 2024

Aligned Activities: The ICFR Committee invited the safe sleep program coordinator from DC Health to learn more about current District efforts to promote safe sleep. The ICFR Committee also developed a subcommittee of case-carrying social workers, legal partners, representatives from the Health Services Administration, and members of the ICFR to explore expansion of CFSA's own current safe sleep practices. The subcommittee discussed the development of surveys and focus groups for parents of infants to receive direct feedback. The subcommittee hopes that this CQI feedback loop will facilitate a more concrete understanding of the challenges or reasons for parents not consistently using the portable cribs that are distributed freely by the District. In addition, the subcommittee membership discussed opportunities to engage the Collaboratives, Family Resource Centers, and other family service organizations in educating parents and caregivers on safe sleep. The subcommittee presented these discussion results to the ICFR Committee for consideration of future recommendations.

Updates on CY 2021 Recommendations

The first recommendation from CY 2021 has been completed. The 2023 Report will update the two CY 2021 recommendations that are ongoing.

CY 2021 RECOMMENDATION TOPIC 1: ***Improve data sharing with DC Health's Vital Records Division*****.**

Recommendation: Finalize the proposed memorandum of understanding (MOU) with DC Health to allow for receipt of monthly manner and cause data for applicable fatalities, which will directly facilitate the timely review of those children's fatalities.

Status: Complete

Aligned Activities: Since 2020, CFSA has worked with DC Health to develop an MOU for sharing monthly data related to deaths for any DC residents who are aged 26 and younger and who died within any given calendar month. The MOU was fully implemented in 2023, which has since resulted in timely data sharing between CFSA and DC Health. The CFR Unit is now able to request full death records for confirmed clients. Receipt of monthly data for manner and cause of death, along with more timely notifications of deaths, is an essential improvement to the child fatality review process.

CY 2021 RECOMMENDATION TOPIC 2: ***Revision of the Critical Event and Child Fatality Review policies*****.**

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

Status: Implementation began in CY 2023 and is in process.

Aligned Activities: The ICFR Committee and the CFR Unit continue to thoughtfully consider how to deepen the child fatality review process and how to maximize the impact of that process on practice and policy procedures. In 2023, the ICFR Committee designated quarterly meetings to explore potential recommendations based on trends and issues that arise with individual fatality reviews. Additionally, the CFR Unit focused on deepening the critical analysis of the child fatality reports. The intent of these in-depth analyses has been to facilitate introspective and productive conversation during the ICFR Committee meetings. Discussions have focused on utilizing the protective factors framework to build capacity at the family, community, and systemic levels.

CY 2021 RECOMMENDATION TOPIC 3: ***Integration of child fatality data into STAAND.***

Recommendation: Ensure that fatality review data and reporting standards are integrated into STAAND.

Status: In progress

Aligned Activities: During the development of STAAND in 2021, the CFR Unit shared its needs and recommendations with CFSA's Child Information Systems Administration (CISA) for integration of child fatality and critical event data collection. The initial hope was for CISA to include a STAAND-supported Child Fatality & Critical Event Dashboard that would identify and track all critical events and child fatalities reported to CFSA. However, competing CISA priorities prevented development of such a

dashboard for the near future. Once STAAND is fully operational in 2024, creation of a CFR-specific dashboard may be reconsidered. In the meantime, the CFR Unit will continue to maintain a manual database outside of the Agency's present electronic information system.

IX. Conclusion

The nature of a child fatality evokes strong emotional responses for every individual involved, beginning with the families of the children who died and extending to others, including CPS and law enforcement investigating the fatality, social workers who may have case-managed for the family, the CFR specialists researching the family, the ICFR Committee members invested in prevention, and the public at large. If true system reform is to become a reality, the child welfare system must forego the tendency to focus solely on culpability and to replace that focus with a genuine pledge to understand the nuanced as well as the complex factors that may have contributed to the death of a child.[40] In this manner, there is some hope for mitigating preventable deaths.

The CFSA child fatality review process does not occur in isolation as there is no one singular entity capable of addressing the myriad of complicated factors that culminate in a child fatality. The Agency therefore is invested in the development of a child and family well-being system. Such a system will need an intentionally coordinated effort from all human service-based agencies to secure children's safety and protection, and a family's well-being needs. This collective includes internal and external members of the ICFR Committee, CFSA's sister agencies, community-based organizations, the DC Council, and the public.

Child fatality reviews are an integral component of CFSA's internal continuous quality improvement (CQI) efforts. To further these efforts, CFSA is expanding its own education through a newly established membership in the National Partnership for Child Safety (NPCS).[41] NPCS was launched in 2018 with support from Casey Family Programs to further key recommendations of the federal Commission to Eliminate Child Abuse and Neglect Fatalities. NPCS membership comprises jurisdictional teams of child welfare systems committed to "safety science". CFSA anticipates that this upcoming national partnership will result in innovative practices that strengthen families' protective capacities, improve child safety, and prevent child fatalities whenever possible.

[40] https://www.casey.org/critical-incident-reviews/
[41] https://nationalpartnershipchildsafety.org/

X. Appendices

Appendix A: List of Unnamed Decedents by Age, Manner, and Cause of Death

Child	Age	Manner of Death	Cause of Death
Child 1	1 month	Accident	Positional Asphyxia. Other significant conditions - unsafe sleep environment
Child 2	1 month	Homicide	Acute Subdural Hematomas
Child 3	1 month	Undetermined	Undetermined. Other significant conditions: unsafe sleep environment, bacterial infection of ear and lungs
Child 4	2 months	Natural	Cardiac arrest, respiratory failure, campomelic dysplasia
Child 5	3 months	Accident	Hyperthermia
Child 6	5 months	Unknown	
Child 7	6 months	Natural	Complications of tetralogy of fallot
Child 8	6 months	Accident	Asphyxia, overlay and smothering
Child 9	9 months	Unknown	Fatality did not occur in DC
Child 10	1 year	Natural	Haemophilus influenzae and respiratory syncytial virus pneumonia
Child 11	1 year	Unknown	
Child 12	2 years	Natural	Pulmonary hemorrhage, fungal sepsis
Child 13	3 years	Accident	Fentanyl and Fluorofentanyl intoxication
Child 14	8 years	Natural	Hypoxic cardiorespiratory arrest
Child 15	8 years	Natural	Complications of cerebral palsy (other significant conditions: history of aortic stenosis, tracheomalacia, spastic quadriplegia)
Child 16	8 years	Unknown	
Child 17	13 years	Natural	Cardiogenic shock, hypovolemic shock, viral sepsis, rhinovirus infection. Other significant conditions: Cornelia De Lange Syndrome
Child 18	15 years	Homicide	Gunshot wound of abdomen
Child 19	15 years	Homicide	Multiple gunshot wounds
Child 20	15 years	Natural	Non-traumatic seizure disorder. Other significant conditions: morbid obesity
Child 21	15 years	Homicide	Gunshot wound to head
Child 22	16 years	Homicide	Gunshot wound of head
Child 23	16 years	Homicide	Multiple gunshot wounds
Child 24	16 years	Natural	Anoxic brain injury, progressive central nervous system disease, metastatic alveolar rhabdomyosarcoma
Child 25	16 years	Homicide	Gunshot wound to head
Child 26	16 years	Homicide	Gunshot wound of head

Child	Age	Manner of Death	Cause of Death
Child 27	17 years	Unknown	
Child 28	17 years	Homicide	Gunshot wound to the head
Child 29	18 years	Homicide	Gunshot wounds to the neck
Child 30	18 years	Natural	Complications of morbid obesity
Child 31	18 years	Homicide	Multiple gunshot wounds
Child 32	18 years	Homicide	Gunshot wound of torso
Child 33	18 years	Homicide	Gunshot wound of abdomen
Child 34	19 years	Suicide	Gunshot wound to the head
Child 35	19 years	Accident	Alprazolam and fentanyl intoxication
Child 36	19 years	Natural	Brain Cancer (diffuse intrinsic pontine glioma, localized in the brain stem)
Child 37	19 years	Homicide	Gunshot wound to the back
Child 38	20 years	Homicide	Gunshot wound to chest
Child 39	20 years	Natural	Idiopathic epilepsy and epileptic syndromes with intractable seizures
Child 40	20 years	Homicide	Gunshot wound to right arm
Child 41	20 years	Homicide	Gunshot wound of the left chest
Child 42	20 years	Homicide	Multiple gunshot wounds
Child 43	20 years	Unknown	
Child 44	20 years	Natural	Cardiac arrhythmia (other significant conditions: Neurofibromatosis Type 1)
Child 45	20 years	Homicide	Stab wound of left chest
Child 46	20 years	Homicide	Multiple gunshot wounds
Child 47	21 years	Homicide	Multiple gunshot wounds
Child 48	21 years	Homicide	Multiple gunshot wounds
Child 49	22 years	Homicide	Gunshot wounds of trunk and extremities

Appendix B: DC Code – Legal Definitions of Neglect and Abuse

DC OFFICIAL CODE § 16-2301(9)(A) (i)-(x)

DC Official Code contains 10 legal definitions of a neglected child. NOTE: "abuse" is a subset of "neglect". The first definition of a neglected child includes both an "abandoned or abused" child. In addition, parents, guardians, or custodians are not "charged with" or "responsible for" neglect but rather, the child is found to be a "neglected child".

One: The term "neglected child" means a child …

DC Official Code § 16-2301(9)(A)(i)

> … who has been abandoned or abused by his or her parent, guardian, or custodian, or whose parent, guardian, or custodian has failed to make reasonable efforts to prevent the infliction of abuse upon the child. The term "reasonable efforts" includes filing a petition for civil protection from intra-family violence.

"Abandoned" is defined in DC Official Code § 16-2316(d)(1) in four parts:

> (A) The child is a foundling whose parents have made no effort to maintain a parental relationship with the child and reasonable efforts have been made to identify the child and to locate the parents for a period of at least four (4) weeks since the child was found.
>
> (B) The child's parent gave a false identity at the time of the child's birth, since then has made no effort to maintain a parental relationship with the child and reasonable efforts have been made to locate the parent for at least four (4) weeks since his or her disappearance.
>
> (C) The child's parent, guardian, or custodian is known but has abandoned the child in that he or she has made no reasonable effort to maintain a parental relationship with the child for at least four (4) months.
>
> (D) The child has resided in a hospital located in the District of Columbia for at least 10 calendar days following the birth of the child, despite a medical determination that the child was ready for discharge from the hospital, and the parent, guardian, or custodian of the child did not undertake any action or make any effort to maintain a parental, guardianship, or custodial relationship or contact with the child.

"Abuse" is defined in DC Official Code § 16-2301(23)(A) in three parts:

> i. The infliction of physical or mental injury upon a child;
>
> ii. Sexual abuse or exploitation of a child; or
>
> iii. Negligent treatment or maltreatment of a child.

If there is an unexplained injury the child may be found to be an abused child under DC Official Code § 16-2301(9)(A)(i). "Unexplained injury" is defined in DC Official Code § 16-2316(c) as…

> where the petition alleges a child is a neglected by reason of abuse, evidence of illness or injury to a child who was in the custody of his or her parent, guardian, or custodian for which the parent, guardian or custodian can give no satisfactory explanation shall be sufficient to justify an inference of neglect.

"Failure to protect" is another way of saying that the caregiver "has failed to make reasonable efforts to prevent the infliction of abuse on the child" and that an example of a reasonable effort would be the filing of a petition for a civil protection order.

Note: According to DC Official Code § 16-2301(23)(B), abuse does not include discipline administered to a child by a parent, guardian, or custodian provided that the discipline is reasonable in manner and moderate in degree and otherwise does not constitute cruelty. Case law indicates it must be more than transient pain and temporary marks.

When determining abuse based on a caregiver's claim that he or she was disciplining the child, discipline does not include the following examples:

> (I) burning, biting, or cutting a child
> (II) striking a child with a closed fist
> (III) inflicting injury to a child by shaking, kicking, or throwing the child
> (IV) nonaccidental injury to a child under the age of 18 months
> (V) interfering with a child's breathing
> (VI) threatening a child with a dangerous weapon or using such a weapon on a child

DC Code notes that the above listing is only illustrative of unacceptable acts of discipline and is not intended to be exclusive or exhaustive.

Two: The term "neglected child" means a child …

DC Official Code § 16-2301(9)(A) ii

> …who is without proper parental care or control, subsistence, education as required by law, or other care or control necessary for his or her physical, mental, or emotional health, and the deprivation is not due to the lack of financial means of his or her parent, guardian, or custodian.

This section encompasses many types of neglect. Some examples are a dirty house, educational neglect, improper supervision, unmet medical or mental health needs of a child, inappropriate living environments, and exposure to domestic violence. In order to demonstrate neglect based on this definition, the neglect must be unrelated to financial means. If the sole reason for the neglect is lack of money, the child may not fit this definition of neglect.

Three: The term "neglected child" means a child …

DC Official Code § 16-2301(9)(A) iii

> … whose parent, guardian, or custodian is unable to discharge his or her responsibilities to and for the child because of incarceration, hospitalization, or other physical or mental incapacity.

The third definition demonstrates that child neglect is a "no fault" process in that it does not look to blame the parent, guardian, or custodian for that behavior that brought the family to CFSA's attention. Rather, the process looks to how the behavior has impacted the safety and well-being of the child. The above section applies when a parent, guardian, or custodian is not able to care for the child due to being in jail, being in the hospital, or having a physical or mental incapacity.

Regarding incapacity, substance use and the mental health of a parent may also fit this definition but only when the substance or mental health impacts the child's safety and well-being. Under this provision, there must be a connection between the parent, guardian, or custodian's substance use or mental health and the child's safety and well-being.

Four: The term "neglected child" means a child …

DC Official Code § 16-2301(9)(A) iv

> … whose parent, guardian, or custodian refuses or is unable to assume the responsibility for the child's care, control, or subsistence and the person or institution which is providing for the child states an intention to discontinue such care.

This section is a two-part test where both parts must apply. The first part requires a parent, guardian, or custodian either to refuse or to be unable to assume care for the child. The second part is that the person or institution who is caring for the child must state that they (the person or institution) will no longer care for the child. This situation often arises when a parent leaves a child with someone else who agreed to care for the child but the parent does not return for the child over a longer period than expected, and the caregiver becomes unwilling to continue to care for the child. In some cases, the "unwilling caregiver" might be a hospital that has notified the caregiver that the child has been ready for discharge, but no parent has been available to take the child home.

Five: The term "neglected child" means a child …

DC Official Code § 16-2301(9)(A) v

> … who is in imminent danger of being abused and another child living in the same household or under the care of the same parent, guardian, or custodian has been abused.

This fifth definition of neglect applies when there is a substantiated abuse allegation for at least one child in the home and the CPS worker determines that there are other children in the home who are at serious risk of immediate harm. There must be at least one child who has been abused for this section to apply.

Six: The term "neglected child" means a child …

DC Official Code § 16-2301(9)(A) vi

> … who has received negligent treatment or maltreatment from his or her parent, guardian, or custodian.

This section generally applies to a child who has not received doctor-recommended medical treatment or serious forms of medical neglect. It is not often used as an allegation to investigate, "two" is more often used.

Seven: The term "neglected child" means a child …

DC Official Code § 16-2301(9)(A) vii

> … who has resided in a hospital located in the District of Columbia for at least 10 calendar days after being born, despite a medical determination that the child is ready for discharge from the hospital, and the parent, guardian, or custodian of the child has not taken any action or made any effort to maintain a parental, guardianship, or custodial relationship or contact with the child.

This definition also applies to "boarder baby" cases. Current case law does not focus on whether the newborn was ready for discharge after 10 days; rather the law focuses on whether 10 days have passed since the child's birth and the child is ready for discharge.

Eight: The term "neglected child" means a child …

DC Official Code § 16-2301(9)(A) viii

> … who is born addicted or dependent on a controlled substance or has a significant presence of a controlled substance in his or her system at birth.

The eighth definition of neglect applies when a medical professional has determined that the baby was born addicted to or dependent on a controlled substance or there is a significant presence of a controlled substance in the infant's system. In such a case, the law requires hospitals to call the CPS Hotline whenever a child's system reveals the presence of a controlled substance (i.e., "positive toxicology"). Seek legal guidance when necessary.

For a neglect finding based on positive toxicology, the judge must find that the child has been negatively affected because of the drugs (see DC Official Code § 16-2317(b)) or that the child is neglected based on another Code section.

Nine: The term "neglected child" means a child …

DC Official Code § 16-2301(9)(A) ix

> … in whose body there is a controlled substance as a direct and foreseeable consequence of the acts or omissions of the child's parent, guardian, or custodian.

This section applies when there is a drug in the child's system that was not prescribed to the child and the parent, guardian, or custodian could or should have prevented the child from ingesting the drug. This is often a case when a toddler puts a controlled substance in their mouth and swallows it.

Ten: The term "neglected child" means a child …

DC Official Code § 16-2301(9)(A) x

> … who is regularly exposed to illegal drug-related activity in the home.

This section is used when a child is living in a home where illegal drug-related activity takes place (e.g., selling, purchasing, using, and manufacturing) and the child is around this illegal activity.