

# Child Fatalities, 2012

Statistics, Analyses, and Recommendations

March 2013



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## Introduction

This is the eighth annual report of trends, findings, and recommendations about fatalities of children and youth in the District of Columbia whose families had contact with the Child and Family Services Agency (CFSA) within four years of their death. This report includes children and young people meeting these criteria who died in 2012. The term “contact” includes (1) current, active cases; (2) cases active in the past but now closed; (3) reports to CFSA’s 24-hour child abuse and neglect hotline that we investigated<sup>1</sup> but that did not result in CFSA opening an ongoing case; and (4) reports to CFSA’s 24-hour hotline to which we responded by conducting a family assessment. Throughout this report, “known children” and “known fatalities” refer to deaths that meet these criteria. The current report examines fatalities that occurred in calendar year (CY) 2012, and which were known to CFSA’s Child Fatality Review (CFR) unit as of March 1, 2013.

Several trends in deaths of children known to CFSA continued in 2012, while other trends appear to reverse. A key trend is that fatalities of children and youth known to CFSA have now declined for four consecutive years (Table 1). Currently, the number of deaths in 2012 marks the lowest number of deaths in the last nine years<sup>2</sup>. Although this is occurring at a time of decreasing caseloads for CFSA, the decline in the number of deaths of known children is more rapid than the decline in number of children served by the agency. Deaths of known children declined 48 percent between 2009 and 2012; in the same time frame, the foster care population declined 36 percent, and there was a 24 percent drop in the number of families served in their homes.<sup>3</sup>

**Table 1: Nine-year Trend in Deaths of Children Known to CFSA**

<b>Table 1: Nine-Year Trend in Deaths of District Children and Youth</b>									
Year:	2004	2005	2006	2007	2008	2009	2010	2011 <sup>4</sup>	2012
Total DC child deaths	159	156	143	158	178	133	122	119	N/A <sup>5</sup>
Portion known to CFSA	59 (37%)	53 (34%)	59 (41%)	44 (28%)	68 (38%)	50 (38%)	33 (27%)	26 (22%)	24
Number from abuse	4	2	0	0	8	4	4	0	1

Tables 2 through 5, below, briefly describe some of the characteristics of the fatalities from 2012.

<sup>1</sup> In September, 2011, CFSA initiated a differential response practice which allows the Agency to respond to some reports with a Family Assessment rather than a traditional child protective services investigation. Thus far, we have not been notified of any fatalities of children in families who received an assessment. Those children will count as known children and have the potential to be included in future counts.

<sup>2</sup> We acknowledge that the number of fatalities for 2012 may not be complete. In recent years CFSA has historically been notified of some fatalities months after the child’s death. However, CFSA is committed to making the information in this report available as early as possible so that the findings and conclusions may lead to prompt action where necessary.

<sup>3</sup> Source: Management Report CMT 232, run March 15, 2009 and March 15, 2013.

<sup>4</sup> In 2011, the Office of the Chief Medical Officer (OCME) changed the way it reports child deaths in the District.

<sup>5</sup> CFSA relies on data collected by the OCME for this statistic. As of this writing, the official number of child deaths in the District for the calendar year 2012 is not yet available.

**Table 2: MANNER OF DEATH***The manner of death is pending for more than a third of all fatalities.*

Natural	5(21%)
Homicide	3 (13%)
Abuse Homicide	1 (4%)
Accident	2 (8%)
Suicide	0 (0%)
Undetermined	4 (17%)
Pending	9(38%)

**Table 3. CHILD WELFARE CASE STATUS***CFSA was currently involved with one-fifth of families at the time of the fatality.*

Closed case	8 (33%)
Active case	2 (8%)
Closed investigation, no case	11 (42%)
Active investigation	3 (12%)

**Table 4. AGE OF DECEDENTS***More than half of decedents were younger than age 2 or older than age 16.*

<24 months	11 (42%)
2-6 years	2 (8%)
7-12 years	1 (4%)
13-16 years	7 (29%)
17+ years	3 (12%)

**Table 5. GENDER OF DECEDENTS***The decedent was male in more than half of the fatalities*

Males	14 (58%)
Females	10(42%)

### Significance of Pending Reports

As Table 2 indicates, the Office of the Chief Medical Examiner (OCME) has determined causes and manners of death for 11 of the 24 children in this report at the time of this writing. Four other fatalities have been officially declared “undetermined.” Nine fatalities remain pending, four of them dating from the first quarter of CY 2012. Without complete findings from the OCME, we do not have complete data to analyze and cannot make comparisons with previous years based on causes or manners of death. In this report, we provide all findings possible with the limited data available.

### Overview of Continuing Trends

While some of the data from 2012 show departure from prior patterns, a number of trends from previous years continue to be seen.

- **More than four-fifths of the children who died in 2012 were African Americans.** Over 90 percent of children in the District’s foster care population are African American. Twenty (83 percent) of the children who died were African Americans. Two (8.3 percent) were identified as Hispanic and the remaining two (8.3 percent) were biracial. Although the percentage of African-American children in this fatality report is close to that of CFSA’s service population, they are nevertheless overrepresented for the district as a whole. According to estimates for 2007-2011, 67 percent of the child population in DC is African-American<sup>6</sup>.
- **Few fatalities occur on open cases or active investigations.** Table 3 indicates that CFSA

<sup>6</sup> Source: US Census Bureau, ACS Children Characteristics 2007-2011 ACS 5-year Estimates

had active involvement with only 5 families at the time of the child's death.

- **Abuse homicides continue to be rare.** Fatalities that occur at the hands of a parent, legal guardian, or other caregiver are considered abuse homicides. These incidents make up a small portion of the total number of fatalities known to CFSA. However, they are of the greatest concern because the mission of public child welfare is to protect children from harm by those entrusted with their care.

Of the 24 District children and youth who had contact with CFSA at any time since 2007, one (1) child died from abuse. CFSA was investigating an allegation regarding neglect of the child at the time of death.

- **The youngest continue to be most vulnerable.** As shown in Table 4, eleven (46 percent) of these 24 children were younger than age 2.
- **Males are more vulnerable,** as indicated in Table 5
- **Inappropriate sleeping or bed sharing were involved with a significant number of infant deaths.** Four infants ranging in age from two weeks to six months died while bed sharing. In 2011, by contrast, there were no infant deaths related to bed sharing or inappropriate sleeping arrangements. As is common in these situations, three of these were attributed to Sudden Unexplained Infant Death associated with bed sharing; however, the medical examiner could not determine the manner of death. The OCME declared one death to be due to asphyxia due to overlay, an abuse homicide.

## Background and Methodology

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The fatality review process is a vehicle for assisting CFSA in improving case practice, correcting deficiencies, strengthening child protective performance, and identifying systemic factors that require citywide attention—all with the goal of reducing preventable child deaths. The report also informs the public of CFSA efforts to ensure the safety of children in District custody. Unless otherwise noted, fatality data presented here represent information known as of March, 2013.

The District has a two-tiered process for reviewing child fatalities.

At the macro level, the citywide Child Fatality Review Committee (CFRC) under the auspices of the DC Office of the Chief Medical Examiner (OCME) identifies broad systemic issues that influence child fatalities. Its multidisciplinary review team is composed of representatives from public and private agencies working in education, health and mental health, human services, jurisprudence, law enforcement, public safety, and from the community. The OCME issues annual reports of citywide statistics and recommendations regarding child fatalities as well as fatalities involving domestic violence.

At the micro level, District child-serving agencies conduct internal reviews of deaths of children known to them. CFSA’s Internal Child Fatality Review Team includes employees from several programs and functions and representatives from the CFRC, Center for the Study of Social Policy, and the community.

### Overview of CFSA Child Fatality Review Process

CFSA internally reviews all deaths where we had contact with the child or the child’s family within the current year or previous four years. The term “contact” includes (1) current, active cases; (2) cases active in the past four years but now closed; and (3) reports to CFSA’s 24-hour abuse and neglect hotline that we investigated but that did not result in CFSA opening an ongoing case.

#### **Immediate First-Level Review**

CFSA’s Child Fatality Review Unit (CFRU) convenes a Child Fatality Critical Event Meeting within 24 hours of receiving notice of a recent child fatality<sup>7</sup>. While this meeting explores circumstances surrounding the child’s death, the focus is on the immediate needs of the family (in particular any surviving children); on assessing the level of risk, if any, to other children in the home; and to recommend immediate and next steps for the investigators or other currently involved personnel, as appropriate. Participants include representatives from relevant CFSA program areas.

#### **CPS Investigation of Fatalities**

If the information the Agency receives suggests that the fatality may have been a result of abuse or neglect, the circumstances around the death may be investigated by the Child Protective Services (CPS) administration. A small number of fatalities are investigated by CPS, and even fewer result in a finding

#### **Focus of Internal Child Fatality Review**

1. Did CFSA take every action and make every reasonable effort to ensure the safety of the child and other children in the household?
2. Does this child fatality reveal any practice, training, or policy issues that we need to resolve? Are there other systemic issues such as supervision, staffing, access to records etc.?
3. Knowing what we know now, what would we do differently?
4. What interagency issues should we present to the Citywide Child Fatality Review Committee?
5. Did parental or familial behavior factors contribute to the fatality?

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<sup>7</sup> Generally CFSA does not hold a Critical Event Meeting when the fatality involves a former CFSA client who is legally an adult (age 21) at the time of death or when we learn of the death weeks or months after the fatality. CFSA also does not hold a Critical Event Meeting when it receives notification of the death of a child who has no history with CFSA.

regarding the allegation<sup>8</sup>. Frequently these investigations are closed without a finding, and the role of the investigator is more to offer services to the family and to ensure that any surviving children in the home have no unmet needs.

### **Monthly Second-Level Review**

CFRU staff prepares a written report for internal review. It is based on a comprehensive review of information about the decedent and family. Sources include the CFSA investigative or case record (hard copy and electronic data in FACES.net, CFSA's automated case management system); the Automated Client Eligibility Determination System (ACEDS) of the DC Department of Human Services; interviews with current and past social workers, when possible; and information available from the OCME, Metropolitan Police Department, and media coverage.

These reports serve as the basis for the monthly Internal Child Fatality Review Meetings with CFSA's Internal Child Fatality Review Committee (CFRC). A multidisciplinary panel of representatives from CFSA (Training, Child Health Services, Program Operations, Quality Assurance, Policy, and Office of the General Counsel) and external stakeholders (CSSP, CFRC, and the community) reviews child welfare involvement with the child and family; identifies issues; and recommends immediate actions and long-term strategies for improving case practice, enhancing child protection, and minimizing preventable deaths. The goal is to conduct the review within 45 days of receiving notification of the child's death.

On a quarterly basis, the CFRU reviews the recommendations and findings from the reports and meetings and incorporates the information in the Quarterly Trend Analysis Report. Issues which are felt to require more immediate attention are elevated to the Deputy Director for Planning, Policy and Program Support.

### **Notification of Child Fatalities**

When CFSA receives immediate notification of a child fatality, it generally comes through one of two sources. Law enforcement officers or CFSA employees notify the District's child abuse and neglect hotline (202-671-SAFE) of any fatality involving a child or former child client. This prompts CPS to ensure the safety of other children in the home and to assist the family in addressing immediate needs, if any.

CFSA learns about some District child fatalities well after the deaths. Generally, these notifications are about children or families who were involved with CFSA in the past. CFSA typically gets these notifications from the CFRC. Through research into other District agency records and the list of citywide fatalities from Vital Statistics, the CFRC learns about all fatalities in the District.

Of the 24 fatalities discussed in this report, the Child Fatality Review Unit received thirteen fatality notifications from the CFSA Hotline, four reports through media outlets, one report from Homicide Watch ([homicidewatchdc.org](http://homicidewatchdc.org)), one from the Interstate Compact for Juveniles' contact, and five through the CFRC. Sometimes, the CFRC reports these deaths to CFSA several months after the fact, reflecting the time lag they experience in receiving information from Vital Statistics. In a few instances, CFSA did not learn about a fatality until well after the child or youth's death. The number of known death notifications received from the CFRC has decreased over the past two years.

### **Sources of Information**

To prepare this report, the CFSA Child Fatality Review Unit analyzed information from the following

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<sup>8</sup> In CY2012, CPS completed 15 child fatality investigations, some of which are not included in this report as the family had no prior history with the agency. Source: FACES.net report INV084, run 1/1/2013.

sources:

*DC Office of the Chief Medical Examiner (OCME), Citywide Child Fatality Review Committee (CFRC), Metropolitan Police Department, and CFSA.* CFSA's Child Fatality Review Unit worked closely with CFRC staff to obtain valid cause and time of death information through autopsy reports from the OCME and to reconcile statistical data on fatalities.

*CFRU's own reports concerning the 24 fatalities in 2012 of children known to CFSA during the past five years.* The CFRU also maintains a database of basic information about fatalities of children who had contact with CFSA, such as date and cause of death (if determined), circumstances surrounding the death, and pertinent demographics.

*Interviews and direct contact with social worker, service providers, attorneys, administrators, and others who had past involvement with the child or family.*

*MPD and local news media, in combination with information from the CFRC,* provided time and location of death for violent homicides.

## Fatalities of Children Who Had Contact with CFSA

A total of 24 of the District children and youth who died in 2012 or their immediate families had had contact with CFSA within the four years before they died. These numbers reflect a continuous decrease from 2008, which represented the highest number of overall child deaths in the District and of those known to CFSA in the eight years CFSA has been preparing these reports.

### Overall Findings

Following are major findings about the deaths in 2012, of the 24 District children and youth who had contact with CFSA at any time since 2007.

**As in previous years, more than half of the children who died in 2012 were males.** Following a trend from 2004, a disproportionately high number of the children who died were males. Males account for 67 percent (286) of the fatalities for the nine-year period, and females for 33 percent (138). In 2008, the ratio of male to female deaths was almost 2:1 and in 2011 it was almost 3:1. The 2012 ratio of males and females matched that of 2010.

**Table 6: Gender of Decedents Known to CFSA, 2004-2012**

Year	2004	2005	2006	2007	2008	2009	2010	2011	2012	Total
Male	37 (63%)	53 (72%)	41 (71%)	26 (59%)	45 (66%)	32 (72%)	19 (58%)	19 (73%)	14 (58%)	286 (67%)
Female	22 (37%)	15 (28%)	17 (29%)	18 (41%)	23 (34%)	12 (28%)	14 (42%)	7 (27%)	10 (42%)	138 (33%)

**For the first time in 2012, youth ages 17 and older comprise less than a quarter of the decedents known to CFSA.** The number of older youth who died in 2012 was small compared to past years. This was the first year since these reports began where youths age 17 and above constituted less than a quarter of the known fatalities (3 or 12.5 percent) of the total. In past years this age group has represented as much as half of the number of known children, as was the case in 2011.

**Table 7: Death of children known to CFSA by Age, 2004-2012**

	0-24 months	2-6 years	7-12 years	13-16 years	17+ years
<b>2012</b>	11 (46%)	2 (8%)	1 (4%)	7 (29%)	3 (13%)
<b>2011</b>	9 (35%)	2 (8%)	0	2 (8%)	13 (50%)
<b>2010</b>	11 (33%)	2 (9%)	0	8 (24%)	11 (33%)
<b>2009</b>	22 (44%)	2 (4%)	4 (8%)	5 (10%)	17 (34%)
<b>2008</b>	26 (38%)	7 (10%)	6 (9%)	8 (12%)	21 (31%)
<b>2007</b>	19 (43%)	5 (11%)	3 (7%)	5 (11%)	13 (30%)
<b>2006</b>	24 (41%)	2 (3%)	5 (8%)	9 (15%)	19 (32%)
<b>2005</b>	24 (45%)	1 (2%)	3 (6%)	9 (17%)	16 (30%)
<b>2004</b>	20 (34%)	3 (5%)	8 (14%)	11 (19%)	17 (29%)

**The percentage of fatalities of children ages 13-16 years rose significantly this year and surpassed the number of deaths of youths age 17 and older.** For the first time in eight years, there were more fatalities in the 13-16 year age group (7 or 29 percent) than in the 17 and above group. This is the first time since these reports began that this age group has made up more than a quarter of the

total number. Although it is possible that this is simply an aberration, we note that the next highest spike for this age group was also recent, in 2010 (24 percent). However, it is too early to say if this can be called a trend.

**Fatalities that occurred when CFSA was actively involved with the family were all infants.**

Four fatalities occurred while CFSA was currently involved with a family. All four children were infants, ranging in age from newborn to 17 months. Two involved active ongoing cases, and two were active CPS investigations.

**No child died while in foster care in 2012.** This is the first year since reporting began where no child died in an out-of-home placement. There were two such deaths in 2011 and four in 2010.

**No child known to CFSA committed suicide in 2012.** Suicides of CFSA children are rare; the last one known to the Agency was in 2010.

**Almost a quarter of the children died from accidental deaths in 2012.** Five of the youth who died in 2012, all ages 13- 16 years died from accidents involving motor vehicles; one was a pedestrian, two were passengers, one was the driver of the vehicle and the fifth was killed in a scooter accident<sup>9</sup>. The last time five accidental child deaths were reported was in 2009; there were two in 2011 and four in 2010. Vehicle accidents have historically been the leading factor in accidental deaths of our children and youth.

**Less than a quarter of the children who died in 2012 were victims of non-abuse homicide.**

Reversing a long-standing trend, a very small number of children who died in 2012 were victims of non-abuse homicide (i.e. were killed by someone not a parent or guardian). All were at least 17 years old. As in previous years, all three were violent homicides and all involved gunfire. However, homicides as a percentage of total known fatalities were at its lowest level in 2012 than at any time in the last eight years and continued the decreasing trend from 2011<sup>10</sup>. A suspect has been charged in one of the murders. Neither of the remaining two homicides is listed in the unsolved homicides web page of the MPD.

In 2012, three children (13 percent of the total) died as a result of non-abuse homicide. This was a substantial decrease compared to 21 children (31 percent) in 2008, 9 children (27 percent) in 2010 and 10 children (38 percent) in 2011. This continues to be the leading manner of death for male youth over age 17.

**CFSA Involvement**

CFSA was actively involved with four victims or their families at the time of death in 2012<sup>11</sup>.

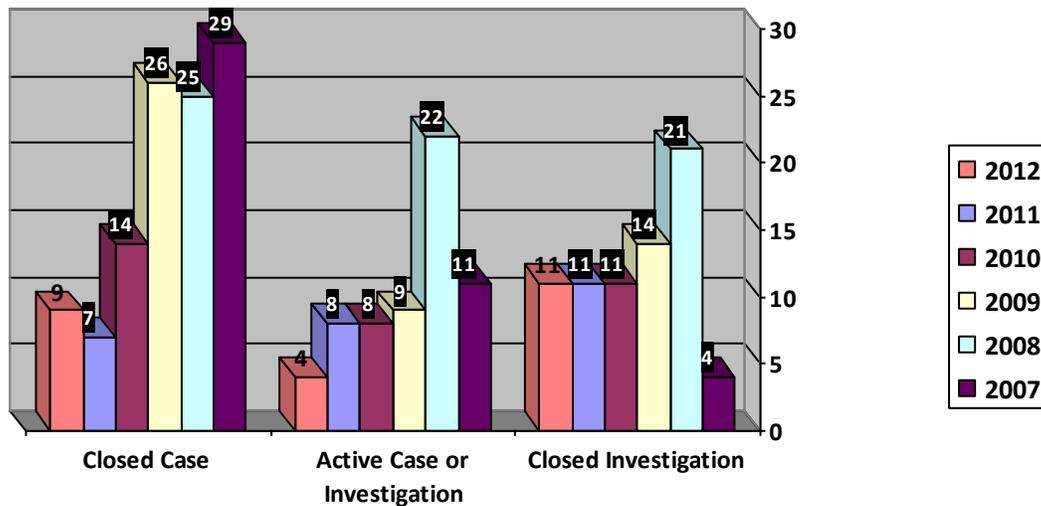
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<sup>9</sup> We note that three of the youth whose manner of death remains pending as of this writing died in an automobile crash that occurred during a police chase.

<sup>10</sup> This reflects a trend throughout the District, where 2012 had the smallest number of homicides since 1961. <http://mpdc.dc.gov/release/mayor-vincent-c-gray-and-metropolitan-police-chief-cathy-l-lanier-announce-historic-low-20-0>

<sup>11</sup> CFRU has only tracked active cases separate from active investigations since 2008.

**Figure A. Six Year Trend, Status of Children at Time of Death**



For the first time, all the fatalities that occurred when CFSA was involved with the family were infants. There were four fatalities that occurred during CFSA involvement, two active cases and two active investigations<sup>12</sup>. The decedents were infants who ranged from birth to 17 months old.

The first active investigation involved a 5-month-old male. The first report on the child came in when a caller reported neglect of the child because he fell off the bed while bed sharing with the mother. The mother admitted that the child had rolled off of the bed but denied that she was sleeping, saying that she was changing the child's sibling at the time. Nineteen days into the investigation, CFSA learned that the family found the infant not breathing and had him transported to the hospital where he died.

The mother had left the infant in the care of his step-father while she went to work. The step-father placed the child on a sofa to sleep with a 22-month-old sibling. The stepfather then went to sleep on an air mattress on the floor next to the sofa. When the step-father awoke two hours later, he checked on the infant and found him lying between the sofa and the air mattress but unresponsive. The step-father performed CPR and had a relative call 911. A voluntary case was opened for the family and in-home services were offered including assessment of the step-father for substance abuse, psychological evaluation of the parents, grief counseling, housing assistance, a day-care voucher, and a crib or toddler bed. At the time of the internal review the family was reportedly cooperating with services and was making good progress.

Other children in this category are described in more detail elsewhere in this report.

### **Analyses of Specific Categories of Child Decedents**

This section takes a closer look at specific circumstances related to the 24 children and youth known to CFSA who died 2012 in terms of age, medical condition, or cause of death when known.

<sup>12</sup> In addition, there was one situation where CPS received a report of suspected abuse that resulted in the child being hospitalized. The child died a few days later from the injury. CPS opened an investigation on the report but because the fatal incident did not occur during CFSA's involvement, we are not including it in this count. The child is considered a known child as there were previous investigations on the family which did not result in a case being opened.

**Table 8: Manner of Death and Demographics for 24 Children Who Died in 2012 and Whose Family Had Contact with CFSA at any Point in the Preceding Four Years**

Manner of death:	Natural Cause	Non-abuse Homicide	Abuse Homicide	Accident	Suicide	Undetermined**	Pending	Total
<b>AGE</b>								
<24 months	1	0	1	0	0	4	5	11
2-6 years	1	0	0	0	0	0	1	2
7-12 years	1	0	0	0	0	0	0	1
13-16 years	2	0	0	2	0	0	3	7
17+ years	0	3	0	0	0	0	0	3
<b>GENDER</b>								
Male	2	3	0	1	0	2	6	19
Female	3	0	1	1	0	2	3	7
<b>STATUS WITH CFSA AT TIME OF DEATH</b>								
Closed case	2	2	0	0	0	0	4	8
Active case	0	0	1	0	0	1	0	2
Closed investigation, no case opened	3	1	0	2	0	3	2	11
Active investigation	0	0	0	0	0	0	3	3
<b>PLACEMENT LOCATION AT TIME OF DEATH</b>								
Not applicable: case closed	5	3	0	2	0	3	6	19
In home	0	0	1	0	0	1	3	5
Out-of-home placement	0	0	0	0	0	0	0	0
<b>Total</b>	<b>5 (21%)</b>	<b>3 (13%)</b>	<b>1 (4%)</b>	<b>2 (8%)</b>	<b>0</b>	<b>4 (17%)</b>	<b>9 (38%)</b>	<b>24</b>

**Age 17 and above**

As stated above, in 2012 there were three deaths of youth 17 years and older who had involvement with CFSA in the previous four years. All three were the victims of non-abuse homicide. However, homicides as a percentage of total known fatalities were at its lowest level in 2012 than at any time in the last eight years and continued the decreasing trend from 2011.

Although this number of homicides is low, we see some of the same risk factors we have noted in previous reports. We include this information not to blame the victims but rather to identify some common factors that appear to place too many District young people (not just those known to the child welfare system) at risk.

- The majority of these youth had minimal involvement with their birth fathers and few, if any, positive male role models.
- Two of the homicide victims had criminal histories and were assigned probation officers.
- Two youths were suspected of gang involvement.

By themselves, none of these factors is a predictor of violent death, but they each raise the likelihood that a young man or woman may find himself or herself in a dangerous situation.

**Ages 13 to 16**

Breaking a trend of the past eight years, seven of the 24 decedents (29 percent) were youth ages 13 to 16, making up the second largest category of decedents known to CFSA in 2012.

- Five (71 percent) of these youth died from accidents involving motor vehicles; one was a pedestrian, two were passengers, one was the driver of the vehicle and the fifth was killed in a scooter accident. This occurs at a time when traffic related deaths in the District have declined for

- three years<sup>13</sup>.
- The two remaining youth died of natural causes.

### **Infant Fatalities**

In 2012, there were eleven (45.8 percent) fatalities of known children under two years of age<sup>14</sup>. Although this is the same number as in 2010, the gender demographics have largely reversed. In 2010, seven (64 percent) of the infants were males and four (36 percent) were females. In 2012 six (55 percent) of the infants were female and five (45 percent) were males.

One death was ruled abuse homicide/ asphyxia due to overlay.

Seven of the cases where the cause and manner of death are still pending were children in this age group. There were four additional infants for whom the Medical Examiner listed the final cause and manner as ‘undetermined’. Three of these infants’ deaths were related to sudden unexpected/ unexplained infant death associated with inappropriate and unsafe sleep environment/ bed sharing.

Families of two (18 percent) infants had active cases with CFSA at the time of death and families of 3 (27 percent) had active investigations. One family had a closed case, and six (55 percent) had closed investigations.

Fatality review reports for these infants further indicated that:

- Six mothers (55 percent) were age 18 or younger at the time of their first pregnancy resulting in a birth.
- Three mothers and four fathers had a known history of using substances including cocaine, marijuana, PCP, ecstasy and alcohol.
- One father was described as mildly mentally retarded.
- Four mothers and two fathers had criminal history.
- Two mothers had multiple medical conditions that included diabetes and seizures. One father had cognitive difficulties that resulted from a head injury.
- Four mothers had history of mental illness.
- Seven fathers were involved with their children; three of them lived in the home, two of them were employed.
- One mother was in foster care at the time of the child’s birth and death.

While none of these factors are known to have contributed directly to the child’s death, we report them here to indicate the types of stressors and complications that parents of young children associated with CFSA. The cause and manner of death of five of the eleven fatalities in this age group are still pending.

The District of Columbia has seen improvements in the child mortality rate in recent years. In 2010, the rate was at a historic low of 8 per 1000 live births, down from 9.9 per 1000 just a year earlier<sup>15</sup>. This overall decrease may be behind the smaller percentage of infant deaths in this report. Nevertheless the city’s infant mortality rate is higher than the national average of 6.14 per 1,000 live births.

<sup>13</sup> <http://washington.cbslocal.com/2013/01/09/dc-highway-deaths-drop-significantly-in-2012/>

<sup>14</sup> Although the age category encompasses two years, the age range was birth to 17 months old.

<sup>15</sup> DC Department of Health, *2010 Infant mortality Rate for the District of Columbia* .[http://newsroom.dc.gov/show.aspx?agency=doh&section=2&release=23327&year=2012&file=file.aspx%2frelease%2f23327%2f2010%2520Infant%2520Mortality%2520FINAL%2520\(05%252014%25202012\\_MAPS\\_edited\)%2520.pdf](http://newsroom.dc.gov/show.aspx?agency=doh&section=2&release=23327&year=2012&file=file.aspx%2frelease%2f23327%2f2010%2520Infant%2520Mortality%2520FINAL%2520(05%252014%25202012_MAPS_edited)%2520.pdf). This is the most recent information available at the time of this writing.

### **Medically Fragile Children, Youth, and Young Adults**

Some children and youth involved with the child welfare system have serious, chronic medical conditions. Medical fragility makes these youngsters vulnerable to abuse and neglect, and CFSA intervention generally focuses on ensuring they are safe and receiving appropriate medical care consistently. In 2012, six (25 percent) of the 24 decedents known to CFSA, ages 1 month to 15 years, died from a serious medical condition. At this writing, the OCME has determined two were natural causes and has four pending. Three of these children had tracheotomies and were dependent on tube feeding.

The fatalities on active cases include the following:

- In February 2012, a 15-year-old youth with spina bifida, who was dependent on a tracheotomy, ventilator, and respirator, passed away. She had received nebulizer treatments every six hours and received 20 hours of in-home nursing care per day. She was able to say only a few words and was home schooled for only a few hours a day.
- In June a 15-year-old youth with type 2 diabetes died, just months after the agency monitoring his care closed his case. He had been diagnosed with type 2 diabetes when he was 11 years old and also had a history of significant social and developmental stressors since early childhood, including anxiety and behavioral problems. The youth was removed from home after being physically abused by his step-father for not following his prescribed diet. Once in foster care, the youth continued to sneak food and lie about it as well as his diabetes reading. He spent most of his years in denial of his diagnosis and he was frequently hospitalized and was unable to safely remain in his home. Although CFSA arranged for the youth to spend time in residential settings where his diet and medication was controlled for a time, the youth's internal struggle and his inability to accept and deal with his diabetes was reported to have played a critical role in his death. At the time of his death he was staying with his grandmother, who had received some training from the youth's medical staff.
- A 5-year-old male diagnosed as G-tube dependent and unable to eat at birth died in October 2012. The child spent most of his life time in the hospital and was placed in a long term facility. He had a history of aspiration pneumonia, spasticity, seizure disorder, meningitis, chronic emesis, global developmental delay, hearing loss on the right ear, mental retardation and a history of respiratory failure and rhinovirus infection. We opened two cases on the family. An older sibling who was placed in care and reunified with the mother within 5 months. The mother had support from the maternal grandmother and also utilized a representative payee. The parents were mentally retarded and the mother has a history of alcohol abuse. Several of the referrals were due to her difficulty understanding or following through with medical requirements, such as signing consents for surgery.
- A 12-year-old male died in July 2012. He suffered from Lymphoma and received chemotherapy every week through a port that he had in his chest. He also had a visiting nurse that assisted with administering his medications in their home.
- A 17-month-old female born to a teen in foster care swallowed and choked on a lithium button battery from a remote car alarm while in the care of a relative. Surgery was performed to remove the battery; however, the child's esophagus suffered severe burns. She was treated with tracheotomy, and fed by G-tube. CFSA received reports regarding concerns with the mother's ability to provide appropriate care for the child upon discharge because the mother has not been

compliant with the child's feeding instructions. Nursing services were in place to monitor the child in the home; however, the mother initially blocked the nurses' phone number and was not cooperating with the medical services needed for the child's care. An investigation concerning the mother's non-compliance with services for the child was opened. Twenty-four days into the investigation, the child died.

At one time (often years before), CFSA had substantiated neglect in the families of all these young people and one family had a prior physical abuse substantiation.

### **Abuse Homicides**

Fatalities that occur at the hands of a parent, legal guardian, or another person responsible for the child's care are abuse homicides. These incidents make up a small portion of the total number of fatalities known to CFSA. However, they are of the greatest concern because the mission of public child welfare is to protect children from harm by those entrusted with their care.

In 2012, one child known to CFSA died from abuse. CFSA had known about the family for three years and there was an open case on the family at the time.

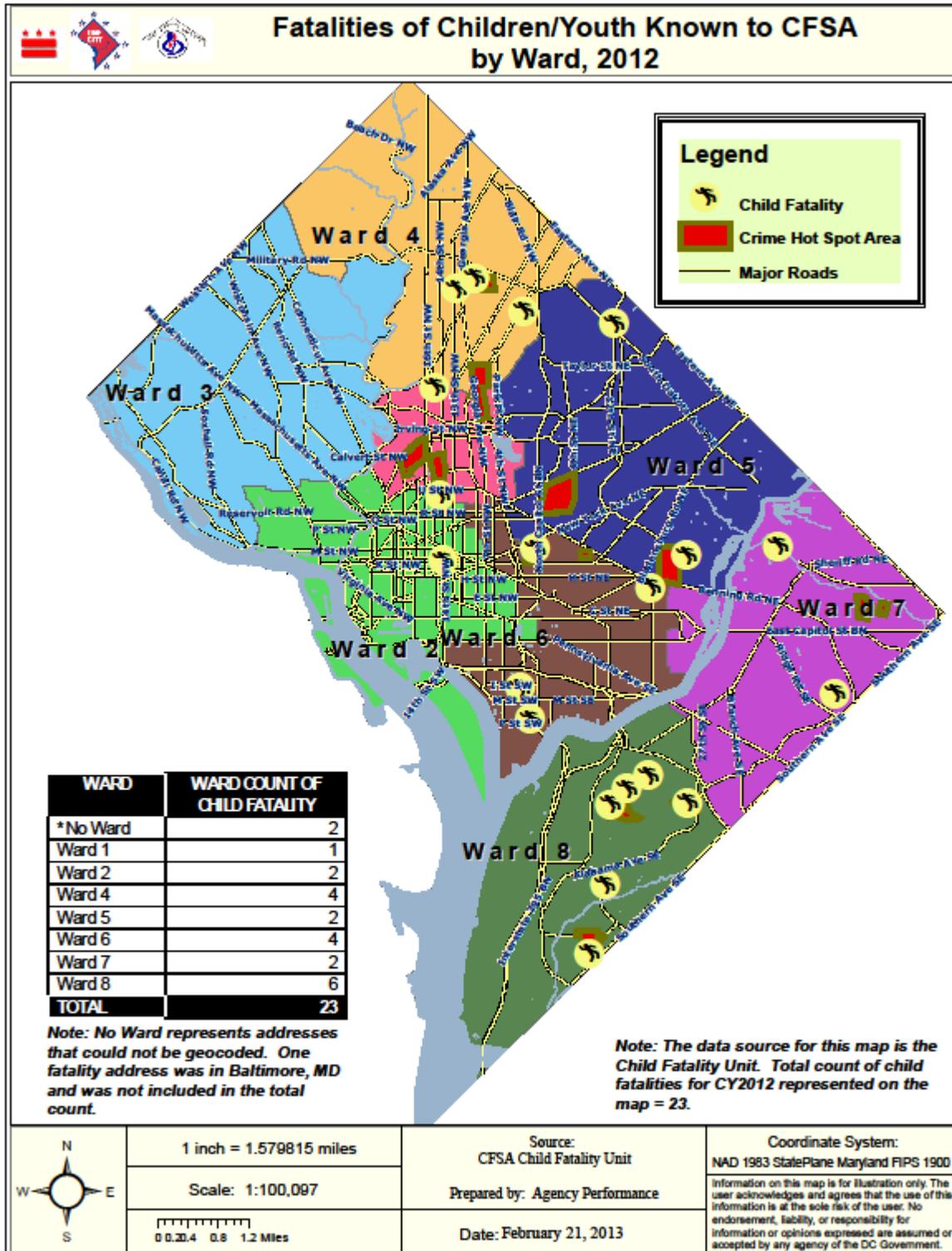
We had received numerous reports of neglect and abuse involving the decedent's only sibling, an older sister (born 2008) and had an open case for two months in 2010. We removed that child, now four years old, in 2011, when police arrested the mother during a drug raid on her home. The sister remains in care at the time of this writing. CFSA staff worked with the mother in 2012 to facilitate reunification with her child and to prepare her for her new baby, including providing her with a pack-and-play and assisting in its assembly. CFSA staff had also spoken to the mother about safe sleeping arrangements and had warned her about the dangers of bed sharing just three days before the child died. As indicated above, this child died while in the same bed as her father, who apparently rolled over onto her. The father was intoxicated at the time and was unaware that the child had been injured. The mother later reported that she did not let the child sleep in the pack-n-play that the Agency had provided as she was afraid the child could die from SIDS. As a result of the CPS investigation, both parents were substantiated for neglect.

### **Geographic Location of Fatalities**

Of the 24 children and youth with previous CFSA contact who died in 2012, most of the fatalities took place in Wards 5, 6, 7, and 8. This is consistent with historical trends.

The map which follows (Figure B) shows the locations of the fatalities for 2012.

Figure B.



## **Recommendations and Actions**

*The recommendations selected for inclusion are those that fit under one of the categories mentioned above: Improving case practice, correcting deficiencies, strengthening child protective performance, and identifying systemic factors that require citywide attention.*

### **Selected Recommendations from Child Fatality Review Unit Reports Following Critical Event Meetings (First-Level Review)**

The Critical Event Meeting is held within 24 hours of the Agency learning of the death of a known child, and is specifically intended to determine immediate next steps, if any, that must be taken by CFSA to protect or support the family, any surviving children in the home, or any staff that may be affected. It is not surprising therefore that the majority of the recommendations from these meetings are case-specific and address ensuring that the family is linked to services for grief counseling, or instruct the worker or investigator on the case to obtain specific information regarding the circumstances surrounding the child's death.

There were a few occasions in 2012 when the Critical Event meetings made more general recommendations for practice, as the following example demonstrates.

Under Strengthening Child Protective Performance:

*“Boppy” pillows.* There were two separate fatalities investigated this year where an infant died while or shortly after using a Boppy pillow. In neither case was there evidence that the pillow itself, or its use, directly contributed to the death of the child. However, participants expressed concern that the families seemed to be using the pillow for purposes other than those for which it is considered safe. The company's own website, for example, provides the following warning: “Never, ever allow baby to sleep on the Boppy pillow”<sup>16</sup>. CPS officials present at these meetings reported knowing of other fatalities which did not involve known children but where the family had been using a Boppy pillow prior to the child's death.

In none of these cases was there ever a direct link made between the use of the pillow and the child's death. However, the dual circumstances raised enough concern that a recommendation was made for CHSA to prepare a statement for social workers reminding them to notify parents of young children of the dangers of improper use of the pillows.

- CHSA will obtain information about the proper use of the Boppy pillow and distribute to case carrying social workers so that they can educate parents and caregivers about the proper use.
- The CHSA program manager will do further research on infant fatalities that involved Boppy pillows.

### **Selected Recommendations from the CFSA Internal Child Fatality Review Committee (Second-Level Review)**

Under Correcting Deficiencies:

The review of one of the medically fragile children who died this year raised concerns about the extent to

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<sup>16</sup> [www.boppy.com/product-instructions/](http://www.boppy.com/product-instructions/)

which staff in the agency responsible for the case were sufficiently attentive to the child's medical needs and fully understood the possible repercussions and consequences if the child (who was a teenager) failed to comply with his medication regimen. Although it was not stated as a recommendation during the review, CFSA officials decided to verify that all other children with severe medical issues who were assigned to that agency be reviewed by medical staff to ensure that their needs were understood by their foster parents, caregivers, and social workers. This step was undertaken primarily by nurse care managers in the Children's Health Services Administration (formerly the Office of Clinical Practice) and included those children with a nurse care manager or involvement with medical case managers from Health Services for Children with Special Needs (HSCSN). The review indicated that the social workers and caregivers for all of the remaining youth had an appropriate understanding of the medical needs of the children under their supervision.

This same review produced the following recommendation:

1. "It was recommended that the Nurse Care Managers be able to remain involved with the case until case closure. It was recommended that all medical staff be trained appropriately about the need to report medical neglect to the hotline, and that current training materials be reviewed to ensure that this area is properly covered."

**Response:** Upon further discussion it was learned that payment protocols prevent the Agency's nurse care managers from remaining involved with children post-reunification. However, there are options for nurses from other programs to become assigned to in-home cases upon request. CHSA continues to develop protocols to assist in triaging reunification cases so that the ones most in need of additional medical attention will be able to receive it.

A second recommendation, under Improving Case Practice, came from a different case:

2. "The strategic planning team should continue to explore the concept of allowing relatives to informally plan for children to prevent children from entering foster care."

Context: MPD's general practice, when a parent is being arrested, is to notify CFSA and request that the child or children be placed in foster care due to the lack of an available caregiver. MPD is not in the habit of allowing or facilitating parents to make placement decisions once an arrest is made. This has the unfortunate result of children being placed in foster care when the parent is absent or incarcerated for only a short time (sometimes only one night), even if relatives or neighbors are available and willing to care for the child on a short-term basis without government intervention.

**Response:** In 2012, CFSA launched the KinFirst initiative with the goal of dramatically reversing the District's low rate of placement with relatives. KinFirst speeds up identification of relatives and then devotes robust resources to engaging and supporting them. It coordinates the expertise of multiple interagency resources, including CFSA's Family Team Meeting (FTM) Unit, Diligent Search Unit (DSU), and Kinship Licensing Unit, all of which are housed within the new Entry Services Administration. By harnessing these varied resources at the earliest possible stages, KinFirst is able to divert some children from entering care and to keep others who must be placed with members of their extended family.

At the time of a child's removal from the home, or when it becomes evident that there is imminent risk of removal, CFSA policy requires the convening of a formal FTM. The investigative social workers are required to make formal referrals to DSU at the same time they make the FTM referral. The goal is to quickly identify and open communication with parents, grandparents, and other family members; to

solicit their attendance at the FTM; to assess their willingness and viability as potential placement resources for the child; and to keep them actively engaged throughout the life of the case.

At-Risk FTMs are offered for all cases assessed as intensive risk of a child's removal following the SDM™ assessment performed during an abuse or neglect investigation. CFSA encourages FTM participation from the youth or child (when age appropriate), birth parents or caregivers, adult members of the extended family, and any other person identified by the family as having a significant supportive connection to the child and family, as well as a child's assigned guardian ad litem. The purpose of this facilitated meeting is to identify and develop support networks to promote child and family well-being, and (if necessary) to make placement decisions that promote child safety and permanency.

If a child is removed from the family's home, the Kinship Licensing Unit quickly and temporarily licenses relatives' homes (within 5 hours in DC and within 48 hours in Maryland). This allows children in CFSA's custody to be placed immediately with family members who can keep them safe. In addition to securing greater potential for positive permanency outcomes, immediate placement with family caregivers reduces the trauma of a home removal for children. Support for the relatives comes from access to services that help kinship caregivers and their own families adjust to having their relative's child integrate into the household. Kinship Licensing staff helps caregivers access these services, and ensures that the services are tailored to meet the needs of all family members so that reunification can be expedited, or that other permanency options can be finalized with family.

### **Recommendations from the Citywide Child Fatality Review Committee**

A single recommendation from this committee from 2011 pertained to CFSA and falls under Improving Case Practice:

“Recommendation #5: The Child Fatality Review Committee recommends the Child and Family Services Agency (CFSA) should mandate annual domestic violence training for all staff social workers, contracted social workers, and paraprofessionals who provide direct services to children and their families who come into contact with the agency as a result of abuse and neglect. This will ensure that all direct service providers within the agency are trained to appropriately assess the family's needs and risk factors associated with domestic violence<sup>17</sup>.”

**Response:** The Child and Family Services Agency (CFSA) accepts the recommendation with the following modification: The Child Fatality Review Committee recommends the Child and Family Services Agency develop a phased approach and community partnership to providing domestic violence training for social workers and paraprofessionals who provide direct services to children and their families who come into contact with the agency as a result of abuse and neglect. This will ensure that child welfare direct service providers will develop skills necessary to assess the family's needs and risk factors associated with domestic violence and make appropriate referrals for domestic violence services in accordance with client's consent to services. Agency practitioners will be able to assess for and identify safety and risk factors associated with domestic violence and make appropriate referrals for services in accordance with clients consent to services. CFSA will identify community providers who will partner to share training resources and expertise. CFSA will identify opportunities within current training system and develop appropriate training curriculum to meet the training needs.

CFSA has begun to include domestic violence training for new direct service hires through pre-service training. In-service training will include “Domestic Violence and Traumatic Brain Injury” - the target population for this training is direct service practitioners and resource parents. CFSA sponsored 12

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<sup>17</sup> This recommendation stems from a 2010 fatality that is not covered in this report.

trainings on domestic violence in 2011. SAFE and the DC Coalition Against Domestic Violence co-sponsored/facilitated 10 of these 12 trainings. They were held on the following dates: February 3, April 28 and 29, June 13 and 27, July 18, 21, 27, 28, and December 2, 2011.”

Additionally, we note that trainings on this topic continue to be offered, including scheduled sessions on March 20 and June 13, 2013.

At the time this report was being prepared, the Citywide Child Fatality Committee was in the process of finalizing its recommendations for calendar year 2012. There were no recommendations from this committee specific to CFSA from the first and second quarters of the year. If any recommendations are produced subsequent to the publication of this report, they will be addressed in the 2013 Child Fatality Report

### **Recommendations from the Child Fatality Review Unit Based on Observed Trends and Issues Raised in 2012**

Under Identifying Systemic Issues that Require Citywide Attention:

1. Despite several years of attention to the issue, ***Bed sharing and unsafe sleeping arrangements continue to take lives of infants.*** Although CFSA staff routinely provide families with cribs and bassinets and speak to parents about safe sleeping, bed sharing and other practices continue to take the lives of young children in the District. It is CFSA’s position that this issue needs to be addressed more comprehensively by a number of agencies, not just CFSA.

In March 2013, the issue was raised to the Mayor’s Advisory Committee on Child Abuse and Neglect (MACCAN) as a priority focus to be addressed over the next year. This committee has requested additional data from CFSA and is reaching out to other District partners to develop a citywide response.

Under Improving Case Practice:

2. ***Staff remains unclear regarding their responsibilities towards siblings, non-committed children, and children of CFSA wards.*** In one of the fatalities this year, several different workers from different parts of the Agency were aware of the potential danger to a child, but did not take the initiative to bring all the professionals together to plan for the child’s safety. This issue has been discussed repeatedly in internal Child Fatality Reviews and other forums. The Agency’s position on which worker is ultimately responsible for such actions should be reiterated to avoid any further confusion.
3. ***There is a pattern of fatalities of youth suffering from obesity and obesity-related conditions.*** Three youth in the last three years have been in this category and in all three cases, the youth themselves sabotaged or rejected treatment that was put in place to help improve their lives and, ultimately, keep them alive. None of these youth were in supportive facilities at the time of their deaths; two were living with relatives who had previously enabled their destructive eating habits. All three had been provided extensive medical and psychological services and had been returned to their families by court order. CFSA needs to identify more comprehensive interventions to employ with youth such as these.
4. ***We continue to find situations where social workers are not familiar with a family’s history, even when the records are available electronically and when other social workers who have worked with the family in the past can be consulted.*** Failure to understand this information can

lead to an inaccurate assessment of a child's safety or of the family's service needs. Social workers should use all the resources available to them to understand the family's needs and history.

### **Conclusion**

In memory of every child and youth known to CFSA who died before reaching adulthood and to all those young people in need of protection in our city:

*All of us at CFSA continuously strive to improve our skills and abilities as investigators, social workers, managers, and administrators and to build a stronger and more effective safety net to protect the children, youth, and families of the District.*