Child Fatalities 2014-2015

Statistics, Observations, and Recommendations

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Purpose

The 11th annual *Child Fatality Report* (CFR) describes the trends, findings, and practice recommendations resulting from reviews of deaths of children known to the Child and Family Services Agency (CFSA) within four years of their death.[1] This current report addresses the 52 fatalities that meet the criteria and occurred during calendar years (CY) 2014 and 2015. The report further provides a mechanism for looking at information on fatalities and for considering changes needed in practice, policy, training, service array, or other factors to help reduce the number of child deaths in the future. CFSA uses aggregate data from fatalities to identify trends and patterns that may help to inform possible changes.

Notification of Child Fatalities

Immediate notification of a child fatality generally comes to CFSA through one of two sources: law enforcement officers or CFSA employees. One or both parties will notify the Child Protective Services (CPS) Hotline of any fatality involving a child or former child client. This prompts CPS to check the safety of other children in the home, if appropriate, and to assist the family in addressing any immediate needs.

CFSA also learns about District child fatalities through media sources and notifications from the Office of the Chief Medical Examiner (OCME), which is the sole authority in the District of Columbia to identify manner and cause of death. OCME notices may be received well after the deaths and may be about children or families who were involved with CFSA in the past but not at the time of the fatality.

Sources of Information

To prepare the *Annual CFR Report*, CFSA's Quality Assurance (QA) unit uses an internal database of basic information on the fatalities of children who had contact with CFSA. It includes the date and cause of death, circumstances surrounding the death, and pertinent demographics. QA also reconciles statistical data on fatalities.

In addition to analyzing all information gathered from OCME, QA reviews information from the District's citywide CFR Committee (CFRC) and the District's Metropolitan Police Department (MPD). QA further gathers information from interviews and from direct contact with social workers, service providers, attorneys, administrators, and others who had past involvement with the child or family. For children who die outside of the District or whose death is not reviewed by OCME, CFSA attempts to obtain information from a source within the other jurisdiction.

Approach to the Review and Report

The fatality review process assists CFSA in improving case practice, correcting deficiencies, strengthening child protective performance, and identifying systemic factors that require the attention of the agency and of District government. As noted above, the report further outlines the individual and aggregate findings of CFSA's internal fatality reviews (versus the citywide review process) while comparing these findings with what is known about child fatalities nationally. The *Annual CFR Report* also provides updates on key recommendations that have

[1] CFSA follows the guidelines that govern the citywide Child Fatality Review process, which can be found in DC Official Code §4-1371.05 (a) (2). Please note that throughout this document, the phrase "children known to CFSA" applies to the rule "within 4 years of death".

come out of the reviews. This report covers fatalities from two calendar years (2014 and 2015). All findings are based on currently available data.[2]

To provide clear comparisons with previous years, charts and tables showing yearly statistics are broken out. For the purposes of discussion and analysis, numbers from both years are considered together. This approach provides a larger, more legitimate sample from which to gather information that will reveal trends, and possibly result in new recommendations. For clarity, the phrase "this reporting period" includes both CYs 2014 and 2015; references to a single year's information will specify that year. Charts showing the demographics of the fatalities from individual years are included in the Appendices.

Child fatalities included in the internal review process must have had family contact with CFSA within the past four years.[3] The term "contact" includes either of the following circumstances:

- CFSA screened in the initial report for a family assessment or investigation.[4]
- CFSA opened an in-home or out-of-home case within the five-year time frame.[5]

Observations from the 2014 and 2015 Reviews

- **Number of known fatalities:** From 2008 through 2014, the number of deaths of children known to CFSA declined. The trend continued in 2014, where the smallest number of known fatalities was recorded (22) for the past eight years. For reasons not yet clear, the number increased in CY 2015 to the highest number since 2010 (30). Nevertheless, the combined number of child deaths for this reporting period (52) was still less than the total individual number of fatalities for the following years: 2004 (59), 2005 (53), 2006 (59), and 2008 (68) (see Table 1).

- **Abuse homicides involving children known to CFSA continue to be rare.**[6] One case was identified for 2014; there were none in 2015.

- **In each year in this review period, one child accidently killed another child playing with or handling a handgun.** Two children were killed by other children who had found unsecured weapons in the home. For one of these children, OCME declared the death to be a homicide due to the negligent way in which the gun was stored in the home. In addition, a third child who died during this period had injured himself while playing with an unsecured handgun years earlier.

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[2] While 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, the number of fatalities may not be complete due to notification of some fatalities months after a child's death.

[3] Although past annual reports have referenced four years, the practice has been to include families known to the agency within four years and 364 days. The current language is a clarification rather than a change.

[4] In September 2011, CFSA implemented a Differential Response model which supports a response to hotline reports with either a family assessment or an investigation depending on level of risk associated with the report. After determining that there are no safety concerns, CFSA's involvement with families through a family assessment is intended to be short-term, and family acceptance of services is voluntary.

[5] Under this protocol, CFSA does not review cases where the only contact within five years was a referral that was screened out by the Hotline, or a case that was open only for the purpose of payment of an adoption or guardianship subsidy. Families that CFSA refers to one of the five community-based Healthy Families/Thriving Communities Collaboratives or other community resources, but who were not involved with CFSA, are also not included.

[6] "Abuse Homicides" are defined as fatalities that occur at the hands of a parent, guardian, or caregiver. "Non-abuse homicides" are those fatalities which are caused by any person not in a caregiving capacity. "Non-homicide deaths" are deaths not caused by the actions of another person and include natural, accidental, suicide and undetermined.

- **Gunshot homicides remain the principal cause of death for known youth age 17 and older. In general, homicide continues to be the primary cause of death for older youth known to CFSA.** Of the 23 deaths of youth over age 17, 74 percent were the result of gun violence during this reporting period.

- **There were several fatalities connected to co-sleeping arrangements.** Co-sleeping or "bed-sharing" is defined as "the infant sleeping on the same surface with another person or animal."[7] This definition also includes situations where the child's sleeping place is made unsafe by blankets, pillows, toys, and other items. While the sleeping conditions may or may not have been identified as the actual cause of death, 8 of the 18 children (44 percent) under the age of one who died during this review period were found co-sleeping.

- **The number and percentage of fatalities that occurred while CFSA was working with or trying to engage the family increased during the reporting period.** Historically, the percentage of fatalities involving families who have a currently open case or investigation with CFSA has fluctuated between 15 and 26 percent. The percentage rose to 41 percent in 2014 and to 50 percent in 2015 based on CFSA's active involvement in more of the cases at the time of the fatalities.

Table 1: 12-Year Trends in Deaths of Known Children and Youth

Year	*2004*	*2005*	*2006*	*2007*	*2008*	*2009*	*2010*	*2011*	*2012*	*2013*	*2014*	*2015*
Deaths of Known Children	59	53	59	44	68	50	33	26	25	24	22	30
Non-Homicide Deaths	34	36	43	30	39	27	20	15	21	13	14	17
Non-Abuse Homicide	21	15	16	14	21	19	9	11	3	9	7	13
Abuse Homicide	4	2	0	0	8	4	4	0	1	2	1	0

Comparisons with National Data

Nationally, child death rates for all age groups have been declining for several years, reaching historic lows in 2013.[8] Similar decreases in child mortality are seen in CFSA's figures. Male children of all ages die at a higher rate than do females.[9] National figures also bear out the differences in death rates by age. For example, the national death rate for children under the age of one is 13 times that of children above the age of 15.

Continuing Trends

The following trends in the deaths of children known to CFSA have been noted in previous years and continued to be evident during CYs 2014 and 2015.

[7] Source: http://pediatrics.aappublications.org/content/134/2/e406
[8] Xu JQ, Murphy SL, Kochanek KD, Bastian BA. Deaths: Final data for 2013. National Vital Statistics Reports; Vol. 64 no. 2. Hyattsville, MD: National Center for Health Statistics. 2016.
[9] Child Trends Data Bank: Infant, Child and Teen Mortality. Downloaded May 27, 2016, from http://www.childtrends.org/wp-content/uploads/2012/11/63_Child_Mortality.pdf

- **The majority of known deaths involve males.**
  As indicated in Table 2, 33 (65 percent) of the fatalities over the past two years were males.

- **Just under half (48 percent) of the fatalities occurred on open cases or active CPS investigations or FAs.**

- **Abuse homicides are rare.**
  Fatalities that occur at the hands of a parent, legal guardian, or other caregiver are considered to be abuse homicides. Of the 52 known child fatalities in the two years covered in this report, one was determined to be an abuse homicide.

- **The oldest and the very young were most vulnerable.**
  Historically, most of the deaths of known children involve either the very young (under age one) or older youth (17 and older). Deaths by age group are indicated in Table 3.

- **Despite active efforts to educate clients about the dangers of co-sleeping (defined above), deaths that appear to be related to sleeping arrangements continue.**
  Co-sleeping was noted in two of the fatalities of infants under the age of one in 2014 (29 percent), and also identified as the cause of death for another (asphyxia due to overlay, i.e., an individual laying over the child while sleeping). Six fatalities associated with co-sleeping were observed in 2015, covering 60 percent of the fatalities involving children under the age of one. In 2011, no child known to CFSA died from co-sleeping; there were four such deaths (out of 13 infants, 31 percent) in 2012, and five (out of 8 infants, 63 percent) in 2013. While these numbers are concerning, this report includes the history of co-sleeping incidents to reflect its prevalence rather than indicating an actual increase in fatalities related to co-sleeping conditions.

  Of the six fatalities that had a co-sleeping component in 2015, three children were under the age of one. In all six cases, CFSA social workers had educated or counseled the parents about the dangers of co-sleeping. A nurse care manager was involved with one family in monitoring the child. Each of the family had a Pack 'n Play, which is recommended as part of the District of Columbia's Safe Sleep program.[10] The program collaborates with 30 community agencies as well as CFSA's contracted partners, the Healthy Families/Thriving Communities Collaboratives.

Demographics of Child Decedents Known to CFSA During 2014-2015

Overall Findings

- ***As in previous years, more than half of the children who died in 2014 and 2015 were males.***
  Following a continuous trend, a disproportionate number of children who died were males. They account for 66 percent of fatalities during the 12 years shown in Table 2.

[10] The District's Department of Health runs the Safe Sleep Program and provides families with a safety-approved Pack 'n Play, parent/caregiver education, referrals, and workshops. Parents and/or caregivers must participate in a safe sleep educational session 30 days prior to a child's delivery date in order to receive their Pack 'n Play.

Table 2: Percentages for Gender of Child Decedents Known to CFSA, 2004-2015												
Year	***2004***	***2005***	***2006***	***2007***	***2008***	***2009***	***2010***	***2011***	***2012***	***2013***	***2014***	***2015***
Male	63	72	71	59	66	72	58	73	58	67	68	63
Female	37	28	29	41	34	28	42	27	42	33	32	37

- ***More than half of the decedents known to CFSA in 2014 were youth age 17 and older.***
  Older youth continue to account for a large percentage of known fatalities and constituted a larger percentage in 2014 than at any other time over the last decade. The percentage dropped slightly in 2015 to just barely 50 percent. As Table 3 indicates, only in 2012 was the percentage of fatalities of known children over the age of 17 below 25 percent.

Table 3: Percentages for Age of Child Decedents Known to CFSA, 2004-2015												
Year	***2004***	***2005***	***2006***	***2007***	***2008***	***2009***	***2010***	***2011***	***2012***	***2013***	***2014***	***2015***
0-2 years	34	45	41	43	38	44	11	35	46	33	26	33
2-6 years	5	2	3	11	10	4	9	8	8	17	16	10
7-12 years	14	6	8	7	9	8	0	0	4	13	0	10
13-16 years	19	17	15	11	12	10	24	8	29	12	5	0
17 years and up	29	30	32	30	31	34	33	50	13	25	53	47

- ***Almost half of the families were actively involved with CFSA at the time of the child's death.***
  In the two years under review, 25 out of 52 of the known fatalities were children of families actively involved with CFSA at the time of the child's death. The ages of these children ranged from a few hours to 15 years. CFSA differentiates ongoing cases from active investigations and Family Assessments. Three of the 25 cases were active in the Family Assessment unit. Five children were residing in out-of-home placements. This included three children in hospitals or specialized medical placements.

Figure A: Six-Year Trend of Status of Children at Time of Death

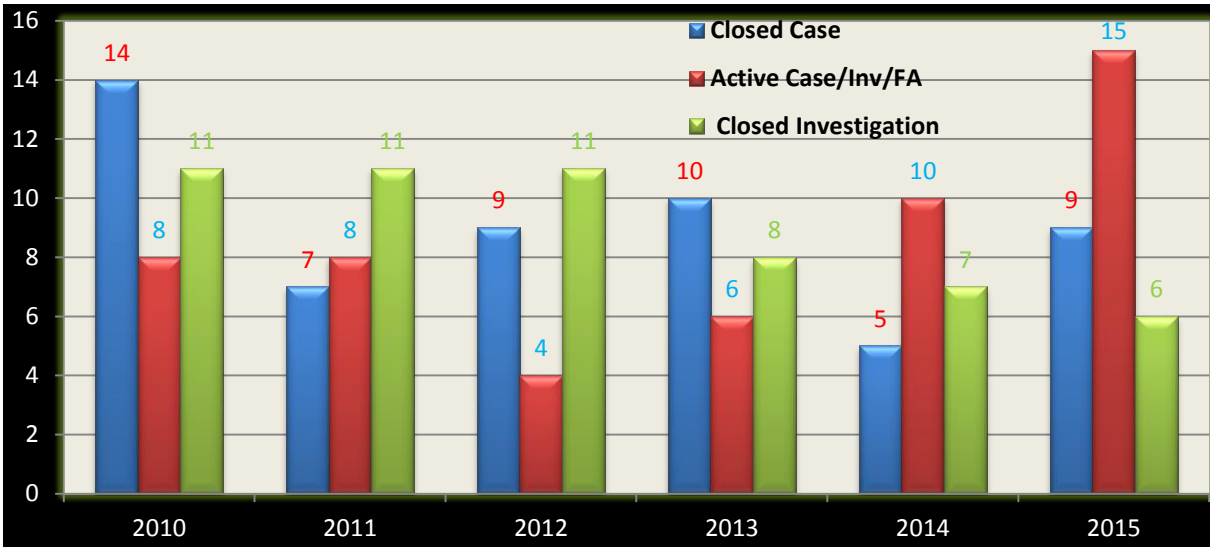


Figure A illustrates the breakdown of fatalities where CFSA was involved with the family at the time of the child's death. A closed case (blue) represents a closed in-home or out of home case. An active case (red) includes an open investigation, family assessment, or in- or out-of-home case at the time of the fatality. A closed investigation (green) represents investigations of the family prior to the fatality, but CFSA did not open a case.

Of the children included in the "active" category above, one older youth had already aged out of care, but the case remained open on her siblings (CY 2014). Another fatality in 2015 involved an infant who died a few hours after being born to a mother with an ongoing case. For that case, CPS had received a referral on the family but had not yet contacted them at the time of the child's death due to insufficient information being provided to the Hotline. Although these are categorized as being actively involved for the sake of consistency, there was no supervision or monitoring of the decedent at the time of the fatality.

- ***Continuing a trend, few children known to CFSA died from accidental deaths.*** During the past two years, five deaths (10 percent) have been determined to be accidental.

- ***In 2014, more than one third of the children known to CFSA who died were victims of non-abuse homicide, mostly gunshots.***
  In 2014 and 2015, 20 (39 percent) of the fatalities were victims of non-abuse homicide (killed by someone other than a parent or guardian).This is by far the most prevalent cause of death for known fatalities in either year. Non-abuse homicide statistics in previous years included 21 children (31 percent) in 2008 and 9 children (27 percent) in 2010 (see Table 8). All but two of these children were 17 years of age or older, and all but two were male. One is known to have been stabbed with a knife; in another case, an apparent result of domestic violence, the cause of death has not been made public.

Abuse Homicides

In 2014, one child previously known to CFSA died from abuse. The child's mother had a history with CFSA as a minor. Before the fatality, the mother had been the subject of a family

assessment which was called in due to her oldest child's unexcused absences from school. The family was provided additional beds to ensure safe sleep environment for the children. The FA had been closed for almost a year at the time of the fatality. At the time of this writing, the criminal case has not yet gone to trial.

No fatality in 2015 was due to abuse.

District child fatalities caused by maltreatment increased from 1.8 per 100,000 in 2012 (which was below the national average of 2.2) to 2.69 in 2013 and to 2.60 in 2014. The national rate was at 2.04 in 2013[11] and 2.13 in 2014.[12] 2015 data have not yet been published.

Analyses of Specific Categories of Child Decedents

This section takes a closer look at specific circumstances of deaths with regards to age, medical condition, or cause (when known). Table 4 provides a snapshot of the information on these children.

Age 17 and above

As noted earlier, there were 23 deaths (45 percent) in the reporting period for youth age 17 and above whose family had contact with CFSA within the five years preceding their deaths. Of those fatalities, 19 (74 percent) were the victims of non-abuse homicide. Two of the remaining three homicide victims were also teens, ages 15 and 16. Compared to the past 10 years, this is the highest percentage of decedents age 17 and above.

Based upon the case reviews, the following information helps to identify common factors related to the 23 youth:

- Involvement of the children's fathers could be cited for only two of the youth.
- Ten of the youth had previous involvement with the juvenile justice system, including one who sexually abused other children.
- Ten of the youth received mental health services as children; several spent time in psychiatric hospitals, therapeutic foster homes, or residential treatment centers.
- At least four were parents at the time of their deaths.[13]
- Four youth died of natural causes.
- Eight youth were reportedly doing well at the time of their deaths.
- The manners of death for two youth who died outside of the District are unknown at this writing.

[11] U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau, p. 56 (2013). Child Maltreatment 2013, available from http://www.acf.hhs.gov/programs/cb/research-data-technology/statistics-research/child-maltreatment.
[12] U.S. Department of Health & Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau, (2016). *Child maltreatment 2014*, available from http://www.acf.hhs.gov/programs/cb/research-data-technology/statistics-research/child-maltreatment, p.51.
[13] Information on parenting is not always provided for youth, especially young men.

Table 4: Manner of Death and Demographics for 52 Children who Died in 2014-2015								
Manner of death	*Natural Cause*	*Non-abuse Homicide*	*Abuse Homicide*	*Accident*	*Suicide*	*Undetermined*	*Pending*	*Total*
Age								
<24 months	9	0	0	3	0	5	0	17
2-6 years	1	0	1	1	0	0	3	6
7-12 years	0	0	0	1	1	1	0	3
13-16 years	0	3	0	0	0	0	0	3
17 + years	4	17	0	0	0	0	2	23
Total	**14**	**20**	**1**	**5**	**1**	**6**	**5**	**52**
Gender								
Male	6	18	1	1	1	3	3	33
Female	8	2	0	4	0	3	2	19
Total	14	20	1	5	1	6	5	52
Status with CFSA at the time of Death								
Manner of death	*Natural Cause*	*Non-abuse Homicide*	*Abuse Homicide*	*Accident*	*Suicide*	*Undetermined*	*Pending*	*Total*
Closed Case	3	9	1	0	0	1	1	15
Active Case	7	5	0	1	0	4	3	20
Closed Investigation/FA;	3	5	0	3	1	0	1	13
Active investigation/FA	1	1	0	1	0	1	0	4
Total	14	20	1	5	1	6	5	52
Placement Status								
Not Applicable	7	14	1	3	0	0	2	27
In-Home	3	4	0	2	1	6	2	18
Out-of-Home Placement	3	2	0	0	0	0	0	5
Other[14]	1	0	0	0	0	0	1	2
Total	14	20	1	5	1	6	5	52

Infant Fatalities

There were 17 fatalities of children under the age two. Just over half (53 percent) of these deaths have been determined to be from natural causes. The OCME has listed the cause of five others as "undetermined." The remaining three have been determined to be accidental with the manner being asphyxia due to overlay.

The families of 11 of the 17 infants had active cases with CFSA at the time of death. One was an investigation, two were FAs, and the other 14 were ongoing cases. One of the infants who died had been placed in foster care due to the birth parents' inability to provide for her significant medical needs.

One family receiving in-home services suffered the loss of two infants in separate incidents during this review period. The manner of death (i.e., how the death came about) for both fatalities has been officially classified as "undetermined," although the cause of one death was

[14] One decedent was a parent with a child in foster care, two were born and died in the hospital without being discharged home, and one was in abscondence.

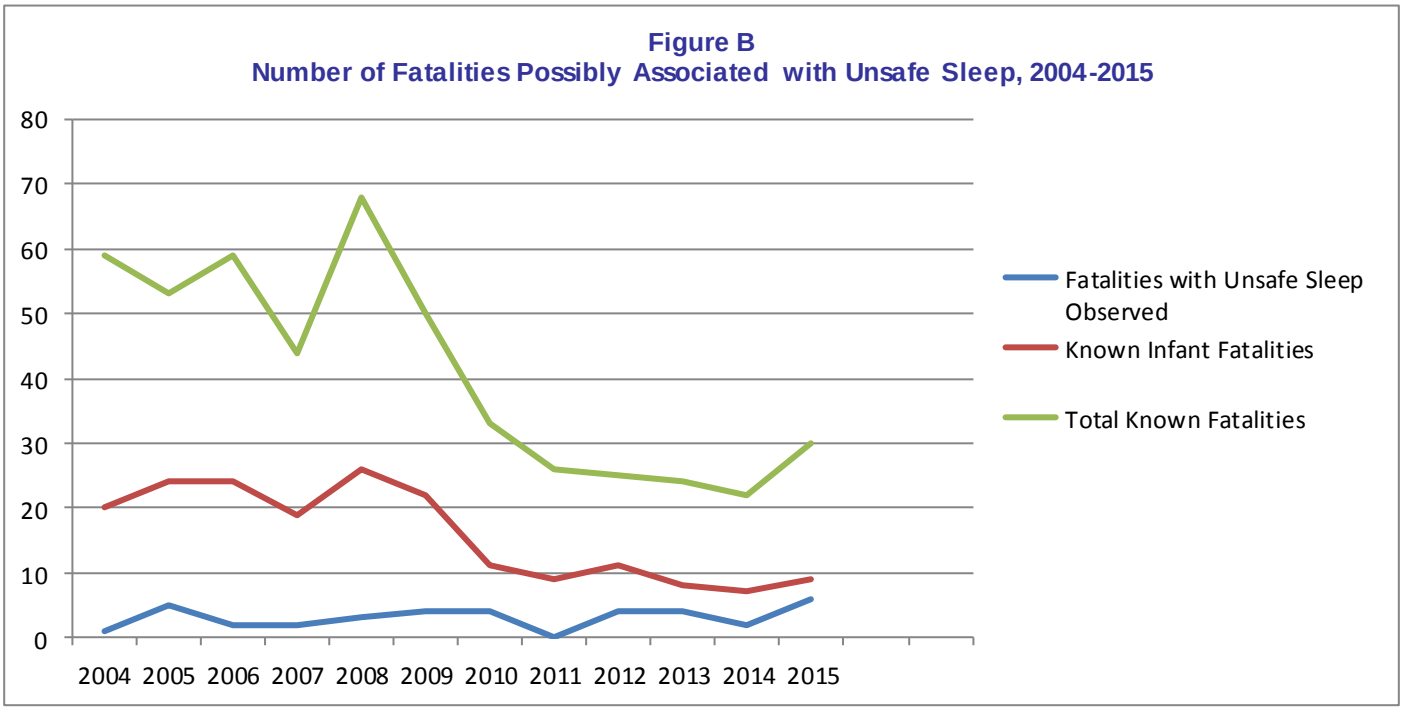
identified as acetaminophen toxicity and the other as Sudden Unexplained Death in Infancy or SUDI. The family was homeless for much of CFSA's involvement and moved repeatedly. The case remains open for monitoring of the surviving siblings as of this writing.

Fatalities Involving Questions about Sleeping Arrangements

The National Institute of Child Health and Human Development (NICHD),[15] in conjunction with other child and infant health organizations, encourages the creation of safe sleep environments for infants to reduce the risk of sleep-related child fatalities such as Sudden Unexplained Death of an Infant (SUDI) or Sudden Infant Death Syndrome (SIDS). Consistent with the District's Office of the Chief Medical Examiner (OCME), CFSA understands unsafe sleeping arrangements to include bed sharing (a sleeping arrangement in which the infant shares the same sleep surface with another person), sleep position, and sleep environment (including soft surfaces and choking hazards as well as temperature and exposure to smoke). NICHD encourages parents of young children to keep their sleep areas clear of pillows, blankets, and toys and to have these children sleep on their backs and not on an adult bed or couch with or without an adult. Although bed sharing is not considered child abuse or neglect in the District, CFSA staff routinely addresses sleeping arrangements with parents of young children. In addition to providing recommendations on safe sleeping arrangements, we assist with the provision of cribs, bassinets, and other equipment to keep children safe and to avoid the necessity of children sleeping in adult beds.

The number of fatalities where unsafe sleeping arrangements were observed has remained largely stable over the last 10 years. Even still, the number of fatalities of infants under 24 months, as well as those of all known children, has fluctuated, as Figure B below shows:

Figure B
Number of Fatalities Possibly Associated with Unsafe Sleep, 2004-2015



[15] National Institute of Child Health and Human Development, Safe Sleep Campaign, accessed at http://www.nichd.nih.gov/sts/about/environment/pages/look.aspx

Unsafe Sleep as a Contributing Factor to the Fatality

As mentioned above, CFSA is aware of eight deaths from this reporting period where bed sharing was known to occur or where other unsafe sleep practices were identified at the time of the child's death. As noted earlier, these situations could not always be directly linked to the cause of death.

Accidental Deaths

The deaths of five children known to CFSA were listed as accidental. Situations included traffic accidents, a drowning, one accidental shooting, and one bed-sharing situation.

Children, Youth, and Young Adults Diagnosed as Medically Fragile

Some children and youth involved with the child welfare system have serious, chronic medical conditions. In 2014, four children died from diagnosed chronic medical conditions. Two were in out-of-home placements, one was in a therapeutic foster home, and the other was in a residential medical care center. One child was at home with his parents, and the other was never discharged from the hospital after birth. The children were all males and ranged in age from one month to 19 years. All died from natural causes. One was a three-year-old diagnosed with Burkett Lymphoma (cancer of the lymphatic system) who received chemotherapy. A 19-year-old was diagnosed with Down syndrome, malnutrition, Amblyopia Esotropia OS[16], and cataract OS. The youth died after suffering cardiac arrest during a dental treatment. Another 19-year-old youth was diagnosed as intellectually disabled and with attention deficit hyperactivity disorder. This youth died after several episodes of bleeding from his tracheotomy site and lungs. As stated above, the manner of death was natural. All four children had been monitored for their physical, educational, and emotional well-being.

Near-Fatalities

Near fatalities are reported when abuse or neglect results in serious bodily injury as determined and reported by a medical or other qualified professional. CFSA received notification of two events initially categorized as near-fatalities in 2014. Both children eventually succumbed to their injuries and the fatalities were reviewed.

A third child was removed from his mother in 2014, after it was learned that he had been tied with duct tape and intentionally starved. His condition was life-threatening, but that child survived and is doing well in placement with relatives.

Deaths of Children Not Previously Known to CFSA

During this reporting period, the CFSA Hotline was notified of 17 child fatalities where the families had no prior contact with CFSA. The ages of all but one of these 17 children were in the birth-to-24 month age group. Three of these children died due to medical complications; two were the victims of abuse homicide, meaning they were killed by their parent or caregiver.

Co-sleeping was identified in the homes of six of these fatalities. These sleeping arrangements have been determined to have directly contributed to three of the infants' deaths.

It is noteworthy that the District of Columbia has seen improvements in the child mortality rate in recent years. In 2011, the rate was at a historic low of 7.4 for 1,000 live births. This rate increased slightly the following year, to 7.9 per 1,000 live births in 2012. The city's infant

[16] Amblyopia Esotropia OS is a medical condition where the eye (in this case, the left eye, i.e., OS or oculus sinister) is lazy and turned inward.

mortality rate decreased to 6.9 per 1,000 live births in 2013[17] but is still slightly higher than the national average of 6.14 per 1,000 live births.

Recommendations and Actions

The following recommendations outline areas for improving case practice, correcting deficiencies, strengthening child protective performance, and identifying systematic factors that require both internal and citywide attention. This section does not include case specific recommendations, i.e., situations where the committee recommended an interaction for a particular family or staff member.

From the CFSA Internal Child Fatality Review

1. During a review involving a closed case, there were concerns regarding documentation that a private agency would continue to monitor the family for 90 days after the case was closed in court. The agency did not, however, continue monitoring but rather closed the case on the date the case was closed in court.

***Recommendation*:** CFSA's Office of Contract and Monitoring should review the private agency contracts to determine if there is a process in place to notify CFSA when they end-date a client, and to determine if they have the ability to close a case.

Status: The private agencies are not required to notify CFSA when they end-date a client. However, contracts as of January 2014 state that when the goal is reunification, the provider shall continue to monitor the safety of the child to ensure the child is stable in the home after the court case closes for as long as is needed to achieve a case plan goal. The provider may also transition the families to one of the Collaboratives or other appropriate, community-based resources as appropriate.

2. During a discussion of a youth who had been receiving in-home services, concerns were voiced over whether the youth could have benefited from services provided by the Office of Youth Empowerment (OYE). It was not clear during the discussion whether the youth was also eligible for OYE services.

Recommendation: CFSA's Office of Planning, Policy, and Program Support (OPPPS) should clarify via the *Older Youth Services* policy whether non-committed youth can be referred for OYE services.

Status: Upon further review it was determined that the policy does not need to be clarified. The *Older Youth Services* policy outlines the services provided through OYE and those services are only applicable for youth in foster care. The policy is clear about the criteria for services through OYE.

3. In another review, there were concerns regarding a youth who absconded from an out–of-home placement and subsequently returned with a large amount of cash, expensive clothes, and musical instruments provided that were reportedly given to him by "his friends." Several participants saw these "gifts" as an indicator that the youth may have been sex trafficked.

[17]Department of Health and Human Services , Washington , DC , 2013 Infant Mortality rate for the District Of Columbia accessed at http://doh.dc.gov/sites/default/files/dc/sites/doh/publication/attachments/IMR%202013%20%28Final%20Report%2005%2007%202015%29.pdf

Recommendation: To ensure that staff has the information needed to recognize when a youth may have been sex trafficked and the skills to divert the youth's actions for safety and well-being, the Child Welfare Training Academy (CWTA) training on *Sex Trafficking* should be made mandatory for all case-carrying staff. It was recommended that training sessions be conducted in small groups.

Status: The CWTA training on sex trafficking has been mandatory for all case-carrying social workers, as well as congregate care providers since July 2013. The course is offered at least one time every month.

4. Two reviews in 2014 involved youth who were diagnosed with special needs and who experienced medical emergencies that required the appointment of a medical guardian. There were concerns that there was no policy or protocol to facilitate this type of appointment.

Recommendation: CFSA should discuss the appointment of medical guardians for youth over 18 years of age prior to a serious medical incident.

Status: DC Code allows for the appointment of a guardian to make certain decisions for incapacitated adults. The relevant definition (DC Code 21-2011(11, 11A)) states:
(11A) "Incapacitated individual for health-care decisions" means an adult individual who lacks sufficient mental capacity to:

(A) Appreciate the nature and implications of a health-care decision;

(B) Make a choice regarding the alternatives presented; or

(C) Communicate that choice in an unambiguous manner.

Appointments of guardians for adults take place through an intervention proceeding at the Probate Division of DC Superior Court.

In January, 2015, CFSA released Administrative Issuance 15-1, *Transition of Youth to the Developmental Disabilities Administration (DDA).* This issuance spells out the steps that workers are to take prior to a youth with developmental challenges reaching the age of 18 to ensure that they are able to receive DDS services, if applicable, and that other arrangements necessary to their care have been made. One of the areas specified in the AI is the instruction for the social worker to notify the Assistant Attorney General on the case to begin the process to appoint a guardian.

5. One of the reviewed decedents was no longer involved with CFSA and died in another jurisdiction. His friend called the CFSA Hotline for assistance to contact the decedent's mother. There were concerns that the family was not notified in a timely manner.

Recommendation: CFSA should explore developing a timely method or resource for notifying and reaching out to families when a youth dies. It was recommended that this should be someone other than the Diligent Search Unit (DSU) due to the specific responsibilities of DSU for placements and prioritizing use of DSU resources for a quick turnaround.

Response: If the ongoing social worker is still employed by CFSA, it is CFSA's position that this social worker will have more knowledge of a family and should therefore be the first to notify a family in a timely fashion based on the last documented information. If the social worker is unavailable, the appropriate supervisor will notify the family.

Recommendations from the Citywide Child Fatality Review Committee

During this reporting period, CFSA responded to the following recommendations from the citywide CFRC:

Recommendation: CFSA should provide training to staff that specifically addresses intervention strategies when intra-family violence is a presenting issue (i.e., arguing and fighting between parents and their teen children) in investigations and ongoing cases. This training could be a component of the domestic violence training the Agency provides to its direct service social work staff and contractors.

Status: CFSA accepted the recommendation with the following modification:

> *CFSA will train staff on a model of domestic violence specifically designed for child welfare. This model will be used in conjunction with trauma-based tools and assessments to prepare staff to assess and respond to interfamilial violence.*

CFSA provided training for staff on the ***Safe and Together*** model, a perpetrator-pattern-based, child-centered, survivor strengths approach to working in the area of domestic violence. This model provides a way for staff to assess how domestic violence (DV) impacts the children involved in addition to providing intervention strategies. CFSA anticipates that staff training in the model will result in better recognition of DV patterns and that this recognition will transfer to staff being more capable of addressing and mitigating patterns that are repeated in child-parent violence.

Recommendation: When CFSA is investigating a child fatality, the Agency shall not close its investigation until OCME has communicated the "cause and manner of death" or provided the Agency with a completed autopsy report. In such cases where the cause and manner of death is pending or the cause of death is undetermined or homicide, CFSA should communicate with OCME and MPD to evaluate the safety and risk to children remaining in the home prior to closing the CPS investigation.

Status: CFSA rejected the recommendation and offered the following alternative

> CFSA proposes the following alternative resolution for situations where OCME has not identified a manner of death for a child who has surviving minor siblings and where there are no other reasons (identifiable safety factors) justifying the opening of an ongoing case:
>
> 1. Prior to closing the investigation, CFSA will notify the detective (if any) handling the investigation of its intent to close the case and ask that a call be made to the CFSA Hotline in the event that MPD learns of information suggesting that the child died of abuse or neglect, or that any surviving minor children might be in danger.
> 2. Prior to closing the investigation, the CPS supervisor will notify CFSA's QSR program manager or designee that a fatality investigation is being closed without an identified manner of death. The supervisor should request that communication be maintained on the matter between QA and OCME. The QSR manager or designee will follow up at least monthly until the finding is returned.
> 3. CPS will clearly document its final safety and risk assessment in FACES.NET and will include a written narrative explaining why it has assessed that the investigation can be closed.
> 4. If the investigation is closed but a case is opened on the family, the responsibility for following up with OCME will rest with the ongoing social worker. CPS will

communicate this responsibility to the ongoing social worker as well as the assigned supervisor during the case transfer staffing.

Since implementing this practice in 2015, CFSA has requested and received final determinations on 26 investigations closed by CPS between 2014 and 2016 without a final determination from OCME. The majority of these had been closed based on an assessment that any surviving children were safe, although a few were transferred to ongoing services. In the one case where the finding suggested maltreatment on the part of the caregiver the surviving sibling had already been removed from the home and the family had an open case for services.

Recommendation: In cases involving the care and custody of children diagnosed as medically fragile, CFSA should implement integrated case planning to include the social worker and the medical team to ensure they are meeting the child's needs. Also, early intervention, including community papering, should be implemented when necessary.

Status: CFSA accepted the recommendation with the following modification:

> CFSA's In-Home Services utilizes the Consultation and Information Sharing Framework,[18] specifically to actively engage the assigned social worker and all other partners on cases. More specifically, in cases that involve children who have been diagnosed as medically fragile, the medical team is engaged and participates in team meetings along with the family and other key supports that the family has. This collaboration helps to ensure that everyone on the team has the needed information to be able to support the family. In addition to this teaming process, In-Home Services utilizes a combination of assessments to accurately determine the strengths and needs of the family. These assessments include the Caregiver Strengths and Barriers Assessment and the CAFAS/PECFAS.[19] Furthermore, there are several early intervention strategies and tools at CFSA's disposal to help ensure the success and the safety of the child and family. One such program is the Homebuilders program which provides intensive family preservation services for up to 6 weeks. The goal of this program is to help stabilize the family and prevent the need to remove the child from the home. CFSA also can utilize Community Papering, where CFSA brings a case to court and asks for legal oversight and connect the family to behavioral health services for depression or other mental health diagnosis when warranted. The purpose of this is to encourage a family to engage in services and to help prevent harm to the child. If a family is not able to follow a case plan that is being monitored by the courts, the child can be removed from the home for their safety.

The Health Services division of CFSA maintains a list of children who meet the definition of medically fragile and updates the list monthly.[20] All cases are subject to medical review and

[18] The Consultation and Information Sharing Framework occurs in a collaborative setting among multidisciplinary CFSA staff. The framework allows for open discussion among participants while also providing the structure and consistency to ensure productivity and effective decision-making.

[19] CFSA has incorporated use of the Child and Adolescent Functional Assessment Scale (CAFAS) and the Preschool and Early Childhood Functional Assessment Scale (PECFAS) to measure a child's functioning over the following eight domains: (1) school or work, (2) home, (3) community, (4) behavior toward others, (5) mood or emotions, (6) self-harming behaviors, (7) substance use [Note: PECFAS does not measure substance use], (8) thinking capabilities.

[20] Medically Fragile is defined as a chronic physical condition which results in a prolonged dependency on medical care for which daily skilled nursing intervention is medically necessary and is characterized by one or more of the following: (1) there is a life-threatening condition characterized by a reasonably frequent period of acute exacerbation, which requires frequent medical supervision, and/or physician consultation, and which in the absence of such supervision or consultation, would require hospitalization; (2) the individual requires frequent time-consuming

determination by the Healthy Horizons Supervisor or her designee. This process ensures that only those children who are defined as "medically fragile" will appear on the list.

Recommendation: CFSA should monitor cases referred to the Healthy Families/Thriving Communities (HFTC) Collaborative organizations for 30 days prior to closing the case to ensure that the family is stable, whether or not the Collaborative agency's services were utilized by the family. CFSA should document the efforts of the Collaborative organizations during this 30-day monitoring period.

Status: CFSA rejected the recommendation with the following explanation and response:

> A family can only be referred to a Collaborative if the final risk assessment rating for the family is determined to be low or moderate. "Family-Declined Services" indicates that the family was offered services for ongoing supports in the community but the family chose not to participate. Although CFSA will encourage the family to participate with Collaborative services, the Agency does not have authority to mandate the family to services in this circumstance. Additionally, a family's choice not to participate in services in these situations is not grounds for amending the risk assessment for opening a case, or for a new referral for abuse or neglect.
>
> The Agency is partnering with HFTC to receive data on family compliance, level of participation, and the impact of the services on the family. If there is a new concern or chronicity of a current concern that rises to the level of child abuse or neglect, the HFTC staff is aware to contact the Hotline to refer the family for CPS intervention. In those instances where the risk level is high or intensive, CPS staff refers the family to In-Home Services for service coordination and case management services. Partnership with the HFTC case is likely in these instances. CPS and In-Home Services can request community papering when the families' refusal of services compromises the safety of the child in the home.

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administration of specialized treatments, which are medically necessary; and (3) the individual is dependent on medical technology and/or assistive devices such that without the device or technology, a reasonable level of health could not be maintained.

APPENDICES

Appendix One - *Internal Child Fatality Review Process*

CFSA's process for responding to and understanding child fatalities outlined below.

Immediate First-Level Review

CFSA's Quality Assurance unit convenes a Child Fatality Critical Event Meeting within 24 hours of receiving notice of a recent child fatality. Meeting participants include representatives from relevant CFSA program areas (those who have had contact with the child or the child's family) as well as legal, administrative and investigation staff. The meeting focuses on the immediate needs of the family and particularly any surviving children while still exploring circumstances surrounding the child's death. Meeting participants assess the level of risk, if any, to other children in the home and recommend immediate next steps for the investigative social workers or other personnel, as appropriate.

As mentioned in the 2013 report, this immediate first level review continues to include the Consultation and Information Sharing Framework, a structure used in a number of administrations throughout CFSA to help participants employ critical thinking skills in addressing specific family situations. In addition to next steps and recommendations, the meetings now include discussions around the family constellation through the use of genograms, safety and risk statements, strengths and protective factors, complicating factors, and gray areas.

CPS Investigation of Fatalities

If there is reason to believe that a child fatality was the result of abuse or neglect, the circumstances around the death may be investigated by the CPS administration. Because medical findings may require more than 35 days, in many cases, the investigation is closed before the autopsy report is completed and CPS makes no findings regarding abuse or neglect. Frequently the role of the investigative social worker is to offer services to the family and to ensure that any surviving children in the home have their needs met.

Monthly Second-Level Review

QA prepares a written report for the monthly internal CFR meetings. These reviews include a multidisciplinary panel of representatives from CFSA (e.g., training, health services, program operations, policy, and legal) alongside external stakeholders (citywide CFRC, CSSP, and the community).

Each report is based on a comprehensive review of information about the decedent and his or her family. Sources of information include the CFSA investigative or case record; 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 OCME, the Metropolitan Police Department (MPD), and media coverage.

The internal CFR process also includes an examination of the child and family's involvement with the child welfare system, identification of issues surrounding the involvement and the death, and recommendations for immediate actions. Recommendations include long-term strategies for improving case practice, enhancing child protection, and minimizing preventable deaths.

Appendix 2 - Year-Specific Statistical Information

Table 5: Manner of Death and Demographics for 22 Children who Died in 2014								
Manner of death	***Natural Cause***	***Non-abuse Homicide***	***Abuse Homicide***	***Accident***	***Suicide***	***Undetermined***	***Pending***	***Total***
Age								
<24 months	5	0	0	1	0	1	0	7
2-6 years	1	0	1	1	0	0	0	3
7-12 years	0	0	0	0	0	0	0	0
13-16 years	0	1	0	0	0	0	0	1
17 + years	4	6	0	0	0	0	1	11
Total	10	7	1	2	0	1	1	22
Gender								
Male	5	6	1	0	0	1	1	14
Female	5	1	0	2	0	0	0	8
Total	10	7	1	2	0	1	1	22
Status with CFSA at the time of Death								
Manner of death	***Natural Cause***	***Non-abuse Homicide***	***Abuse Homicide***	***Accident***	***Suicide***	***Undetermined***	***Pending***	***Total***
Closed case	3	2	1	0	0	0	0	6
Active case	5	1	0	0	0	1	1	9
Closed investigation/ family assessment; no case opened	2	4	0	1	0	0	0	8
Active investigation/ family assessment	0	0	0	1	0	0	0	1
Total	10	7	1	2	0	1	1	22
Placement Status								
Not applicable: case closed/ investigation	6	5	1	1	0	0	0	13
In-home	1	2	0	1	0	1	0	5
Out-of-home placement	2	0	0	0	0	0	0	2
Other[21]	1	0	0	0	0	0	1	2
Total	10	7	1	2	0	1	1	22

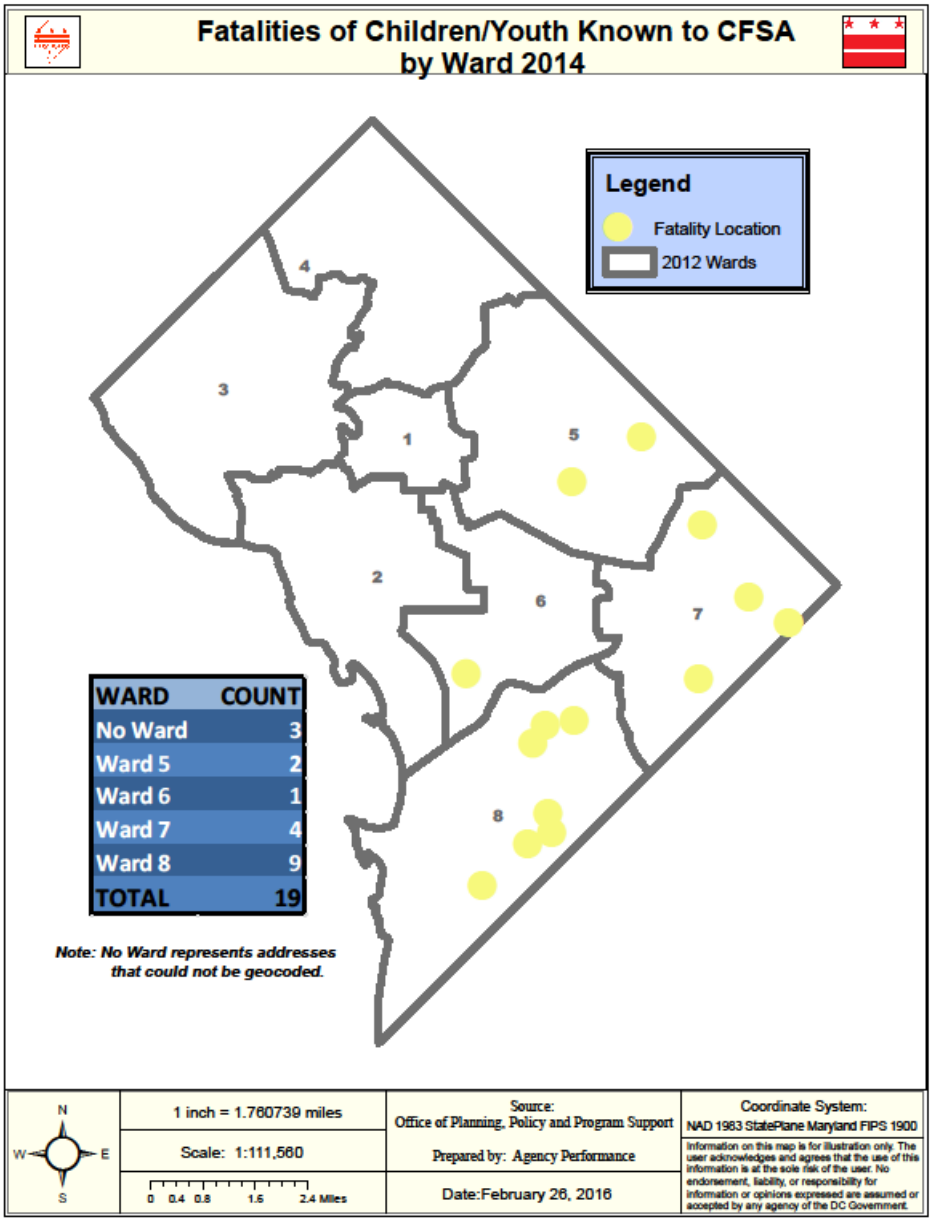
[21] One decedent was a parent with a child in foster care, and one was in abscondence.

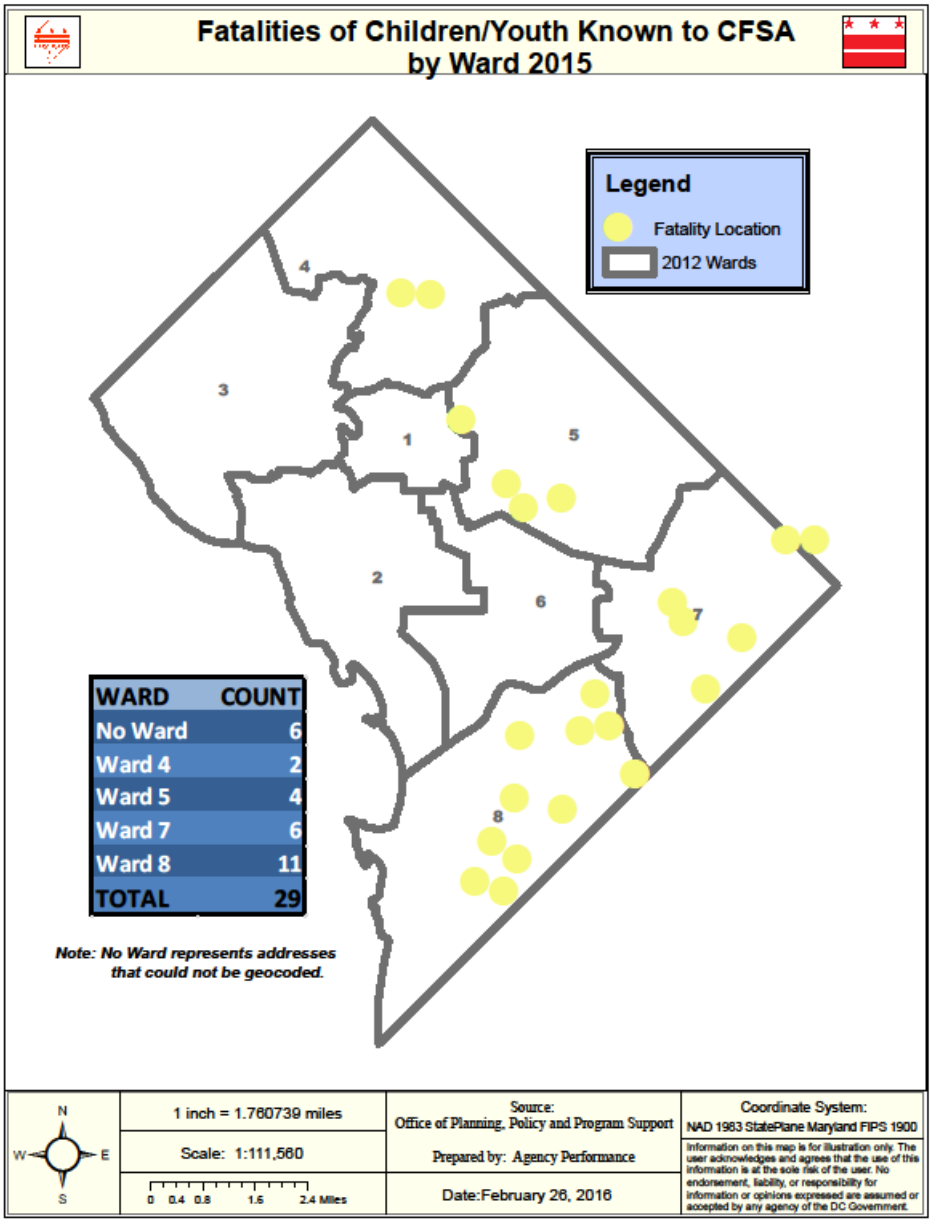
Table 6: Manner of Death and Demographics for 30 Children who Died in 2015								
Manner of death	*Natural Cause*	*Non-abuse Homicide*	*Abuse Homicide*	*Accident*	*Suicide*	*Undetermined*	*Pending*	*Total*
Age								
<24 months	4	0	0	2	0	4	0	10
2-6 years	0	0	0	0	0	0	3	3
7-12 years	0	0	0	1	1	1	0	3
13-16 years	0	2	0	0	0	0	0	2
17 + years	0	11	0	0	0	0	1	12
Total	4	13	0	3	1	5	4	30
Gender								
Male	1	12	0	1	1	2	2	19
Female	3	1	0	2	0	3	2	11
Total	4	13	0	3	1	5	4	30
Status with CFSA at the time of Death								
Manner of death	*Natural Cause*	*Non-abuse Homicide*	*Abuse Homicide*	*Accident*	*Suicide*	*Undetermined*	*Pending*	*Total*
Closed case	0	7	0	0	0	1	1	9
Active case	2	4	0	1	0	3	2	12
Closed investigation/ family assessment; no case Opened	1	1	0	2	1	0	1	6
Active investigation/ family assessment	1	1	0	0	0	1	0	3
Total	4	13	0	3	1	5	4	30
Placement Status								
Not applicable: case/ Investigation closed	1	9	0	2	1	0	2	15
In-home	2	2	0	1	0	5	2	12
Out-of-home placement	1	2[22]	0	0	0	0	0	3
Other	0	0	0	0	0	0	0	0
Total	4	13	0	3	1	5	4	30

[22] This includes one youth whose placement disrupted shortly before his death and was temporarily staying with family.

Appendix 3 - *Geographic Location of Fatalities*

The maps on the next two pages show the locations of 39 of the fatalities for 2014 and 2015. Of the 13 remaining fatalities, some did not occur within District boundaries and therefore are not reflected here. Additionally, there were some fatalities that could not be mapped as CFSA had only Ward location or street names, but no specific address.




Fatalities of Children/Youth Known to CFSA
by Ward 2015
Legend
Fatality Location
2012 Wards
4
3
1
5
2
6
7
8
WARD COUNT
No Ward 6
Ward 4 2
Ward 5 4
Ward 7 6
Ward 8 11
TOTAL 29
Note: No Ward represents addresses that could not be geocoded.
N
W
E
S
1 inch = 1.760739 miles
Scale: 1:111,560
0 0.4 0.8 1.6 2.4 Miles
Source:
Office of Planning, Policy and Program Support
Prepared by: Agency Performance
Date:February 26, 2016
Coordinate System:
NAD 1983 StatePlane Maryland FIPS 1900
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