POLICY TITLE:	*Child Fatality Review*		
	CHILD AND FAMILY SERVICES AGENCY		
Approved By:	**Date Approved:**	**Original Effective Date:**	**Last Revision:**
Brenda Donald	January 6, 2020	March 3, 2009	N/A

I. AUTHORITY	All applicable federal and District of Columbia laws, rules, and regulations, including DC Code §§ 4-1371.01 *et seq.)*, the LaShawn Modified Final Order (November 18, 1993), and the *LaShawn A. v. Bowser* Exit and Sustainability Plan (2019).
II. APPLICABILITY	Agency staff, contract agency staff and contracted personnel.
III. RATIONALE	A well-organized and intentional child fatality review process can identify risk factors contributing to child deaths and build capacity among human service systems and direct practitioners to help prevent them. The D.C. Child and Family Services Agency ("CFSA" or "Agency") Internal Child Fatality Review ("ICFR") is a coordinated Agency process that aims to understand the reasons behind the deaths of children who have intersected with the child welfare system. It is integrated into the processes of the District of Columbia ("District") Child Fatality Review committee. The goal is to reduce the number of preventable child deaths by employing continuous quality improvement methods to inform recommendations to improve Agency practice and system-wide coordination around child safety and well-being.
IV. POLICY	The ICFR committee shall review any death of a child currently known to or whose family has been known to the Agency within 5 years prior to the child's death. If the Agency holds a critical event staffing following a child death, then an ICFR committee meeting shall be held within 60 days of the critical event staffing (see CFSA's Critical Event policy). If the Agency does not hold a critical event staffing following a child death, the ICFR committee meeting shall be held within 180 days of notification of the fatality. The ICFR committee comprises Agency staff and foster care service contractors from all levels and disciplines, staff attorneys from the Office of the Attorney General, and external stakeholders. The ICFR entails a comprehensive review and analysis of the circumstances surrounding the death (if known) and the agency's involvement with the family, with particular focus on risk factors and the quality of Agency case practice. The committee makes recommendations on general system improvements, Agency practice, service delivery, policy and procedure, and training needs.

V. CONTENTS	**A.** Criteria for CFSA Internal Child Fatality Review **B.** Notifications of the Death of a Child **C.** Membership of the CFSA Internal Child Fatality Review Committee **D.** Internal Child Fatality Review Staff Requirements **E.** Internal Child Fatality Review Committee Requirements and Development of Recommendations **F.** Accountability and Practice Improvement
	Section A: Criteria for CFSA Internal Child Fatality Review 1. The staff of CFSA's Child Fatality Review Unit shall conduct a comprehensive review of any death, irrespective of cause, of any child who is known to the Agency at the time of death or whose family has been known to the Agency within 5 years prior to the child's date of death. 2. A child is to be considered "known to the Agency" if the child's family has, or has had, an Entry Services referral (even if it has been screened-out), an open in-home case, or an out-of-home case.
	Section B: Notifications of the Death of a Child 1. Any staff person who knows of the death of a child on the Agency's active caseload shall report it to CFSA's abuse and neglect hotline. 2. Any staff person who knows of the death of a child who has been known to the Agency within 5 years prior to the child's date of death shall inform CFSA's Child Fatality Review unit at cfsa.fatality@dc.gov.
	Section C: Membership of the CFSA Internal Child Fatality Review Committee 1. The CFSA Deputy Director for Planning, Policy, and Program Support ("OPPPS"), or his or her designee, shall convene and chair the meetings of the ICFR committee. 2. The following CFSA program areas are to be represented at meetings of the ICFR committee: a. Office of the Deputy Director for Entry Services b. Office of the Deputy Director for Program Operations c. Office of the Deputy Director for OPPPS d. Office of the Deputy Director for the Office of Well-Being e. Office of the General Counsel f. Agency Ombudsman g. Other internal stakeholders at the discretion of the ICFR chair 3. If the child's family had an open case at the time of the fatality, the supervisor and/or program manager assigned to the case will be invited to the meeting. 4. The following external stakeholders are to be invited to all meetings of the ICFR committee: a. Contracted child placing agencies (as appropriate) b. Deputy Attorney General for the Family Services Division

	c. *LaShawn* Court Monitor d. DC Office of the Chief Medical Examiner 5. At the discretion of the chair of the ICFR committee, and as appropriate for the child fatalities under review, other relevant external stakeholders may be invited to the meeting.
	Section D: Internal Child Fatality Review Staff Requirements 1. Upon receiving notification of a child fatality that meets the requirements for review under Section A, the fatality is assigned to a specialist from the Agency's Child Fatality Review unit to research case history and compose a report addressing the following questions: a. What were the parental, familial, environmental, and behavioral factors that contributed to the fatality? b. Did CFSA take every reasonable action and make every reasonable effort to ensure the safety of the child and other children in the household? c. What are the practice, training or policy issues in need of resolution? d. What systemic issues such as supervision, staffing, access to records, etc. need to be resolved? e. Following analysis of available information, what steps or actions would be done differently? f. What are the interagency issues to present to the District Child Fatality Review Committee? 2. Child fatality reports shall identify personal, environmental, and behavioral risk factors that may have contributed to the fatality; Agency practice, strengths, challenges, and trends in family function; and Agency practice and system-wide supports impacting the fatality. 3. Child fatality reports shall not include any personally identifiable information that would divulge the identities of the decedent or any family member. 4. All ICFR committee meeting participants shall receive the draft child fatality report 3 business days prior to the scheduled ICFR meeting through encrypted email. 5. The draft child fatality report shall be updated after the ICFR meeting to include any new information or recommended changes discussed at the meeting. 6. The child fatality report shall be finalized once all requested changes and updates have been made.

	Section E: Internal Child Fatality Review Committee Requirements and Development of Recommendations 1. Meeting participants shall sign a confidentiality agreement at the outset of the meeting and shall not use personally identifiable information during the meeting discussion when referencing the child or family that is subject to review. 2. During reviews, the ICFR committee shall examine the circumstances surrounding the death and identify risk factors that may have contributed to the death. 3. After reviewing the risk factors, the ICFR committee shall determine which, if any may have contributed to the fatality. For each fatality review, the ICFR committee may develop and document recommendations within or across two domains: a. the direct or indirect prevention of future child fatalities; or, b. general improvements to policy, program, services or resource availability. 4. Irrespective of domain, recommendations shall: a. Address an issue or concern identified during the review b. Identify the responsible Agency party to act on the recommendation c. Identify a reasonable timeframe for implementation, deliverables, and updates d. To the extent practicable, be consistent with established measurable benchmarks and progress indicators 5. The chair of the ICFR committee shall confirm formal recommendations with meeting participants prior to adjournment and shall be responsible for recording and tracking them. 6. All recommendations are subject to the review and approval of the Agency Director. Recommendations agreed upon by the majority of attendees at the meeting shall be forwarded to the Agency Director.
	Section F: Accountability and Practice Improvement 1. The ICFR committee meeting agenda shall include an update on current and ongoing recommendations from previous fatality reviews. 2. The chair of the ICFR committee shall submit a quarterly report to the Agency Director on progress toward the implementation of each recommendation. 3. The chair of the ICFR committee shall coordinate CFSA child fatality review activities with those of the District Child Fatality Review under the Office of the Chief Medical Examiner. This shall include the sharing of all relevant information, data, and case files of the deceased child and family, in accordance with D.C. Code §§ 4-1371.01 *et seq*.

	4. The program administrator or deputy director is responsible for reviewing the recommendations from the ICFR committee meeting. These recommendations may pertain to practice, training, system, or other issues that were identified during the review process. Within 2 weeks of receipt of the recommendations, the program administrator or deputy director shall indicate to the CFSA Child Fatality Review unit his/her plans to implement the recommendations in writing. 5. The ICFR committee shall monitor progress on the implementation of recommendations on a quarterly basis. 6. Recommendations and resulting Agency reforms shall be incorporated into the Annual Child Fatality Review Report, which shall include an overview of the cases reviewed during the calendar year and trends related to demographics, manner of death, family supports and services, and family's child welfare history. The report concludes with an overview of recommendations presented by the ICFR committee. The report shall be submitted to the District Child Fatality Review committee and posted on the CFSA website. 7. All finalized child fatality reports and Annual Child Fatality Reports shall be retained electronically. The hard copy shall be destroyed 4 years from the completion date of the report. 8. ICFR data collection records (participant lists, surveys, interview notes, etc.) shall be retained and destroyed 3 years from the completion of the final report. 9. Notwithstanding section (V)(F)(3)&(6) above, all records and information acquired or generated by or in the possession of the ICFR shall remain confidential and disclosure is subject to D.C. Code §§ 4-1302.03 and 4-1303.6. See also CFSA's policy on Confidentiality.