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Testimony Before the Council of the District of Columbia

Committee on the Judiciary and Public Safety

**Public Hearing:
Performance Oversight Hearing
OCME/Fatality Review Committees
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Good morning Chairperson Allen and members of the Committee on the Judiciary and Public Safety. My name is Stephanie McClellan and I am the Deputy Director of DC KinCare Alliance. I am pleased to testify today regarding the Child Fatality Review Committee. DC KinCare Alliance is a member of the Fair Budget Coalition and we support budget priorities and policies that alleviate poverty in the District of Columbia.

The mission of DC KinCare Alliance is to support the legal, financial, and related service needs of relative caregivers who step up to raise children in their extended families in times of crisis when the children's parents are not able to care for them due to mental health and substance use disorders, incarceration, death, abuse and neglect, and/or deportation. DC KinCare Alliance is the only organization in DC focused solely on serving relative caregivers raising DC's at-risk children. We rely on our Relative Caregiver Community Advisory Board, comprised of 18 relatives raising 23 at-risk DC children, to identify systemic issues with policies and practices affecting DC kinship families.

Through our work supporting relative caregivers, we come into contact with children and families involved with the DC Child and Family Services Agency (CFSA) and other government agencies serving DC children. We wanted to know how these agencies are doing their jobs to protect our most vulnerable children from the most extreme forms of abuse and neglect—child maltreatment fatalities and near fatalities. We have reviewed DC's Child Fatality Review Committee reports for the last several years and you may be surprised to know that there is no way to tell whether child maltreatment fatalities and near fatalities are going up or down each year. Actually, there is no way to tell how many children die each year in DC for any reason because there is no current reporting of that information—DC Health's most recent

vital records Mortality Report only provides information as of 2012,¹ and the DC OCME and CFRC only review a subset of deaths each year.

History of Establishment of the CFRC

In 1993, the Court in *LaShawn v. Dixon* ordered the creation of a Child Fatality Review Committee (“CFRC”) that would

[a]t the end of each District of Columbia Fiscal Year . . . issue a formal report reviewing all fatalities of members of the plaintiff class during the year and make recommendations concerning appropriate corrective action to be taken by the defendants to avert future fatalities[.] *LaShawn A. v. Dixon*, Modified Final Order, November 18, 1993, p. 6.

That order was later codified as Child Fatality Review Committee Establishment Act of 2001 (the “Act”) at D.C. Code § 4-1371.01 *et. seq.* The Act states that the purpose of the CFRC is, in part, to

[e]xamine past events and circumstances surrounding child deaths by reviewing the records and other pertinent documents of public and private agencies responsible for serving families and children, investigating deaths, or treating children **in an effort to reduce the number of preventable child fatalities and shall give special attention to child deaths that may have been caused by abuse, negligence, or other forms of maltreatment**[.]

D.C. Code § 4-1371.03(b)2 (emphasis added).

The CFRC reports, however, **do not** review all fatalities of children during a given year and **do not** give special attention to child deaths from maltreatment.

Failure to Review and Report on Child Deaths in a Given Year

The most obvious problem is that every year, the CFRC reviews child deaths that occurred over several preceding calendar years and does not break down its statistical analysis by year in which the deaths occurred, making it impossible to identify trends in the data. In its most recent report, which is the 2018 report issued in

¹ 2008-2012 Mortality Report, January 2016, p. 52, available at <https://dchealth.dc.gov/page/death-reports>.

December 2019,² the CFRC reviewed a subset of child deaths that occurred in 2018, 2017, 2016, 2015 and 2014.³

We wanted to know why CFRC was not reviewing all child deaths for the year the report addresses, and why there were so many deaths from prior years included in each year's reports. One way to find out would be to look at how quickly CFRC reviews child deaths after being notified of them. OCME's Annual Performance Reports represent that 100% of CFRC reviews are held within 6 months of notification of the death.⁴ However, CFRC defines "being notified of the death," as "when all of the records have been received by the staff and the staff is ready to present the case to the Committee. In other words, the clock starts when the case is placed on the Committee's agenda."⁵ That is a definition of the word "notification" that strains credulity and makes that performance measure meaningless. DC residents deserve better. This Committee should ask and demand the answers to these questions:

"What percentage of CFRC reviews are held within 6 months of when CFRC staff first learn of the death from any source?"

"What percentage of CFRC reviews are held within 6 months, 1 year, 2 years, or more than 2 years from the date of death of a child?"

"What supports does the CFRC need to be able to review and report on all deaths within 6 months of when staff learn of the death?"

² Based on the CFRC's normal practice, the 2019 report should have been issued in December 2020.

³ District of Columbia Child Fatality Review Committee 2018 Annual Report, December 31, 2019, p.15, available at <https://ocme.dc.gov/publication/2018-child-fatality-review-committee-cfrc-annual-report>.

⁴ Office of the Chief Medical Examiner FY 2020 Annual Performance Report, p.3, available at https://oca.dc.gov/sites/default/files/dc/sites/oca/publication/attachments/OCME_FY20PAR.pdf.

⁵ Adams, Rodney K., General Counsel, Office of the Chief Medical Examiner, "Re: 2021-FOIA-01737" electronic message to Spindel, Marla, Executive Director, DC KinCare Alliance, December 22, 2020.

Failure to Give Special Attention to Child Maltreatment Fatalities

The CFRC is divided into two teams: the Infant Mortality Review Team (“IMRT”), which reviews the deaths of children under the age of one year, and the Child Fatality Review Team (“CFRT”), which reviews the deaths of children over the age of one year. *See* D.C. Code § 4-1371.05(d). The teams each have separate sections in the Report.

In the IMRT section of the 2018 CFRC Report, thirty-three infant deaths were reviewed, of which four (12%) were classified as homicide.⁶ There is only one detail offered regarding these four homicides and that is that they were the result of fatal abuse.⁷ Three infant deaths (9%) were classified as accidental and no details are offered regarding how they died or whether neglect was a factor.⁸ Twenty-four infant deaths were classified as natural, where the infant has an underlying medical condition or was medically fragile but it is not disclosed whether medical neglect was a contributing factor. The CFRC Report also does not provide any of the following relevant information: (1) in what year the infants were killed;⁹ (2) their cause of death, e.g. gunshot, sharp or blunt force trauma; starvation, asphyxiation; (3) whether there had been a CPS hotline call(s), including whether there had been a call to the hotline from hospital staff when the infant was born and, if so, the reason for the call; (4) to whom the infant was discharged from the hospital; (5) what type and how many contacts CFSA had with the family of each infant and what type of follow-up was done, if any; (6) whether CFSA had an ongoing investigation or open case; (7) if there was no ongoing

⁶ This information is listed in a pie chart labeled “Cause of Death” although it is clear that what is meant is “Manner of Death.” District of Columbia Child Fatality Review Committee 2018 Annual Report, December 31, 2019, p.38, available at <https://ocme.dc.gov/publication/2018-child-fatality-review-committee-cfrc-annual-report>.

⁷ *Id.*

⁸ *Id.*

⁹ CFRC reviewed “a subset of fatalities that occurred in 2014, 2015, 2016, 2017 and 2018” in the Report. *Id.* at 15.

investigation or open case, what the last CFSA contact was and why CFSA involvement terminated; (8) whether the family had been referred to a Neighborhood Family Strengthening Collaborative or other community service provider and whether the family was engaging with that provider at the time of the death; (9) whether the infant had been placed in foster care, was in informal kinship care, or lived with one or more parents at the time of death; (10) whether the infant had siblings; (11) who the infant's primary caregiver was, and (12) who the perpetrator was and their relationship to the infant or family.

The IMRT section further states that ten infant deaths had unsafe sleep as a factor, although the report does not state to what extent unsafe sleep contributed to the death. Further, given that there were only three accidental deaths and eight where the manner of death could not be determined, there appear to be a significant number of infant deaths where it could not be determined whether the baby was purposefully smothered or suffocated accidentally.

In the CFRT section of the CFRC Report, thirty-eight child deaths were reviewed, eleven (29%) of which are classified as homicide and one (3%) of which is listed as accidental.¹⁰ Unlike the IMRT section, the deaths are broken down by cause of death. Eight of the homicides involved gunshot or stabbing to youth aged sixteen to twenty years. The other three homicides involved children aged one to three years and were the result of multiple blunt force trauma, positional asphyxia combined with blunt force trauma, and gunshot. Two of the deaths are noted as being the result of fatal abuse but the report does not disclose which two.¹¹ It is most likely, but not certain, that the deaths due to fatal abuse were the children aged one and three years who died of blunt force trauma and asphyxia, respectively, but the report does not include that information. The report briefly discusses a

¹⁰ *Id.* at p. 51.

¹¹ *Id.* at p. 56.

death due to children playing with a gun found in the home, presumably the three-year-old gunshot victim.¹² There is no discussion of the age of the shooter or of the child who died or whether child neglect played a role in the death. There is one accidental death of a six-year-old boy due to blunt force trauma from an automobile accident.¹³ The inference is that a pedestrian child was hit by a car, although that is not made clear. There is no discussion of whether child neglect, such as lack of supervision of the child at the time of the accident, was involved. Finally, two deaths were classified as suicides, but there is no information on what factors may have led to the suicides, whether the children were involved with child welfare or another child serving agency at the time of death, such as the Department of Behavioral Health.

The report does not disclose information that would be relevant to the purpose of reducing the number of child fatalities, such as: (1) in which year the children were killed;¹⁴ (2) whether there had been a CPS hotline call(s) within the last four years; (3) what type and how many contacts CFSA had with the family of each of deceased children and what type of follow-up was done, if any; (3) whether CFSA had an ongoing investigation or open case at the time of death; (4) if there was no ongoing investigation or open case, what the last CFSA contact was with the family and why CFSA involvement terminated; (5) whether the family had been referred to a Neighborhood Family Strengthening Collaborative or other community service provider and whether the family was engaging with that provider at the time of the death; (6) whether the child was in foster care, was in informal kinship care or lived with one or more parents at the time of death; (7) whether the child had siblings; (8) who the child's

¹² *Id.* at p. 57.

¹³ *Id.*

¹⁴ In 2018, the CFRT reviewed thirty-eight (38) cases involving children and youth whose deaths occurred in 2015, 2016, 2017 and 2018. *Id.* at 51.

primary caregiver was, and (8) who the perpetrator was and their relationship to the child or family.

Far from “special attention” being given to infant and child deaths due to child maltreatment, the report gives little to no attention to these deaths. Almost all the attention in the IMRT section is given to maternal health, premature birth, and safe sleeping practices. Almost all the attention in the CFRT section is given to youth gun violence. While these issues are important and should certainly be addressed, they should not be used as shields to hide deaths due to child maltreatment and the failures of those who had the opportunity and duty to prevent them. There is one section in the report entitled “Child Welfare and Juvenile Justice Deaths,” which is only two paragraphs long and has no information on whether CFSA or other agencies were involved with the child or family at the time of death and whether or to what extent the death could have been prevented.¹⁵ Notably, the IMRT delineates and quantifies maternal risks that transversed a majority of the infant mortality cases reviewed, including substance use, history of abuse or neglect, history of mental health, history of domestic violence and history of homelessness.¹⁶ It would be appropriate to identify these risk factors for the caregivers in all child deaths, not just infants.

Recommendations to Ensure Robust and Meaningful CFRC Reporting

In 2012, Congress amended the Child Abuse Prevention and Treatment Act (CAPTA) to require “that each state disclose the age and gender of each child killed or nearly killed by maltreatment, as well as the cause and circumstances that led to the harm and whether there had been any previous involvement by protective services relevant to the incident.”¹⁷ See 42 U.S.C. § 5106a (2017). Despite the requirement for public disclosure of fatalities and near

¹⁵ *Id.* at 52.

¹⁶ *Id.* at 39.

¹⁷ Huseman J., Palmer E., and Schroering H. ‘The Price of America’s Inability to Track Child Deaths from Abuse and Neglect? Sometimes, More Lives.’ *ProPublica* December 13, 2019 at p. 4.

fatalities by CAPTA, there is no law requiring any DC agency to track or report on near fatalities.¹⁸ In 2016, ProPublica and the Boston Globe requested records on child fatality and near fatality reporting by state due to child maltreatment from 2011 to 2015; the authors explained that the article did not include DC data because DC “did not respond to multiple requests to identify the relevant records.”¹⁹

In order for CFSA to fulfill its mission of “protecting child victims and those at risk of abuse or neglect”²⁰ and for the CFRC to fulfill its mission of reducing preventable child fatalities while giving special attention to deaths due to child maltreatment, significant changes must be made to the CFRC Reports.²¹ It is impossible to implement data driven policies when so much of the relevant data is not in an accessible format or is missing altogether. The following are recommendations that would shed light on actual numbers of child fatalities and near fatalities due to abuse and neglect in the District:

- 1) When reports for the preceding calendar year are not issued until December 31st of the following year, as a general matter, the CFRC must be required to review and report on ALL deaths in the preceding calendar year.
- 2) To the extent deaths from multiple years are included in the reports, CFRC should be required to provide statistical data broken down by year in which the death occurred.
- 3) DC law should require that the CFRC review near fatalities as well as fatalities. In particular the CFRC should work with District pediatric healthcare providers,

¹⁸ Federal and DC law define “near fatality” almost identically as a child in “serious or critical” medical condition “as certified by a physician.” 42 U.S.C. § 5106a(b)(4) (2017) and D.C. Code § 4-13-3.31(6).

¹⁹ Fung, H., Huseman, J. and Schroering H., ‘Nobody Knows How Many Kids Die From Maltreatment and Abuse in the U.S.’ *ProPublica*, December 13, 2019 at *Notes*, available at <https://projects.propublica.org/graphics/child-abuse>.

²⁰ <https://cfsa.dc.gov/page/about-cfsa> accessed April 23, 2020.

²¹ Huseman J., Palmer E., and Schroering H. ‘The Price of America’s Inability to Track Child Deaths from Abuse and Neglect? Sometimes, More Lives.’ *ProPublica* December 13, 2019, available at <https://www.propublica.org/article/the-price-of-americas-inability-to-track-child-deaths-from-abuse-and-neglect-sometimes-more-lives>.

Children's National Medical Center ("CNMC") in particular,²² to collect the data necessary to review and report on near fatalities.

- 4) CFRC annual reports must address whether each child fatality and near fatality reviewed was a result of child abuse or neglect and/or whether child abuse or neglect was a contributing factor. If the child or infant homicide was the result of abuse, the report must clearly state that. If the child or infant death was the result of neglect, the report must clearly state that. Neglect should include all child deaths when the caregiver's poor decisions or inattentiveness to caregiving is a causal factor, whether or not the caregiver is criminally charged. (*e.g.* infant drowning during unattended bathing or being asphyxiated by caregiver during unsafe co-sleeping.)

By accurately determining how many children die and experience a near death event due to infant and child maltreatment in DC each year, we give the DC Council the tools they need for oversight and holding agencies tasked to protect children accountable. Moreover, having accurate and complete information allows policy makers to make data driven decisions about what policies best serve DC children and at what level they need to be funded.

Thank you for the opportunity to testify today. I am happy to answer any questions.

²² Notably, representatives of CNMC are members of the CFRC.