

**Testimony Before the Council of the District of Columbia
Committee of the Whole**

**Public Hearing:
Budget Oversight Hearing
The Council of the District of Columbia
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Good morning Chairperson Mendelson and Members of the Committee of the Whole. My name is Stephanie McClellan, and I am the co-founder and Deputy Director of DC KinCare Alliance. Our mission is to support the legal, financial, and related service needs of relative caregivers who step up to raise DC 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 a member of the Fair Budget Coalition, and we support budget priorities and policies that alleviate poverty in the District of Columbia and ensure a just and equitable recovery.

I am pleased to testify today in support of funding for the Office of the Ombudsperson for Children. Once funded, this will be an essential protection for children in DC that: conforms to nationally recognized standards; mediates, investigates and advocates for DC children; and is not beholden to the agencies it oversees. We thank the DC Council for recognizing this need and for overriding the Mayor's veto of the Office of the Ombudsperson for Children Establishment Amendment Act of 2020. But the fight is not over. If there is to be a fully functioning Office of the Ombudsperson for Children at all, it will be up to the DC Council to make sure it has an appropriate budget to do its important work. This work would help ensure CFSA is responsive to its constituents by making available an independent moderator of conflicts, who can also assist with identifying and addressing systemic issues that may limit the agency's ability to meet its mission of protecting DC's abused and neglected children.

The timing for fully funding the Office could not be more critical. The LaShawn class action lawsuit closed on June 2, 2021 after 30 years, and the long-time Director of the Child and Family Services Agency (CFSA) retired on that same date. Accordingly, the agency is

embarking on a new chapter without court oversight or monitoring while at the same time without a permanent Director. Moreover, while the COVID-19 pandemic resulted in fewer reports of abuse or neglect to the agency, those reports alleged more severe abuse than before the pandemic. We still do not know the full impact of the pandemic on abused and neglected children for whom there were no reports but who may have suffered silently in their homes. CFSA must meet the challenges that will come with the end of the pandemic when children go back to school in person and family stability becomes more at risk with the end of the public health emergency and associated end to the eviction, debt collection and utility shut-off moratoria.

While CFSA contends that it can self-regulate and operate without oversight, unfortunately, our experiences have shown that is not the case. First, our clients have often reported and we have sometimes observed that agency staff are dishonest and disrespectful in their communications. Second, when we have tried to engage with the agency to rectify issues that kinship families face, we have not found CFSA to be responsive or interested in engaging in a productive way. Recently, we met with and provided recommendations to CFSA staff about how to make the Grandparent Caregiver Program (GCP) more accessible through legislative and policy change. Staff represented that they agreed with many of our recommendations and had even submitted proposed legislative language to the Council. We discovered later that the agency did not agree with our recommendations after all and that the Council had received no proposed legislative changes from the agency. Transparency and integrity is an area where the agency is seriously challenged. Because we have not been able to work productively with the agency, we have been forced to file multiple federal lawsuits challenging CFSA's unconstitutional and discriminatory practices that have hurt DC children and families (discussed under section 2 below). We are hopeful an Ombudsperson can help to

make the agency more responsive, respectful, and transparent with its constituents and community providers.

Some of the systemic issues that the Ombudsperson may be able to address are set forth below below.

1. DC's Kinship Navigator Program

Federal law defines kinship navigator programs as programs “to assist kinship caregivers in learning about, finding, and using programs and services to meet the needs of the children they are raising and their own needs, and to promote effective partnerships among public and private agencies to ensure kinship caregiver families are served.”¹ Federal law further requires kinship navigator programs, among other things, to be:

planned and operated in consultation with kinship caregivers and organizations representing them; establish information and referral systems that link (via toll-free access) kinship caregivers, kinship support group facilitators, and kinship service providers to . . . each other; provide outreach to kinship care families, including by establishing, distributing, and updating a kinship care website, or other relevant guides or outreach materials . . .²

Unfortunately, although CFSA has received more than \$400,000 in federal kinship navigator funding in FYs 2019 and 2020,³ it does none of these things. First, DC KinCare Alliance is the sole organization in DC serving only relative caregivers; however, neither we nor our clients have been consulted by CFSA regarding the establishment and operation of its Kinship Navigator Program. Second, CFSA has no kinship-navigator specific helpline, website, or resource guide. Last year, CFSA represented that its Kinship Navigator Program

¹ 42 U.S.C. § 627(a)(1).

² *Id.*

³ CFSA Oversight Responses FY 2019-2021, Question No. 82.e., available at <https://dccouncil.us/wp-content/uploads/2020/02/cfsa20.pdf>. There is also federal funding available for kinship navigator programs in FY 2021, as well as pandemic reimbursement of program expenses from April 4, 2020 through September 30, 2021, but we do not know if DC has already received or intends to receive these funds.

had a “helpline” number of 866-326-5461 or 866-FAM-KIN1.⁴ Yet, that telephone number is not answered “Kinship Navigator Program helpline” but rather “CFSA,” and the office that answers the phone is that of the Close Relative Caregiver Program. While CFSA also represented that it purchased “ a web-based directory to link kinship caregivers to resources, called “NOWPOW,”⁵ relative caregivers do not have access to it. It is only accessible by entering a dc.gov e-mail with a user ID and password.⁶ We understand CFSA uses NOWPOW to track referrals of community partner organizations with its Family First Success Centers, although our understanding is that many referrals are made directly—outside of the NOWPOW software. Further, the Success Centers are not tailored specifically to kinship families, but all families within each Center’s reach, which necessarily excludes relative caregivers of DC children who do not live in DC. The end result is that neither we nor our clients know what services or supports the CFSA Kinship Navigator Program provides, if any, or what the eligibility criteria is for obtaining them.

We have major concerns that DC’s kinship navigator program will not be able to meet the rigorous standards required by federal law to receive funding in future years, which include being approved by a national clearinghouse, case management, and data tracking of outcomes measures. Accordingly, there will continue to be no functioning navigator program run by DC even though there are federal dollars available to fund one. We hope the Ombudsperson can help ensure DC receives all available federal funding and has a robust and effective kinship navigator program.

⁴ CFSA Oversight Responses FY 2019-2021, Question No. 82.a., *available at* <https://dccouncil.us/wp-content/uploads/2020/02/cfsa20.pdf>.

⁵ CFSA Oversight Responses FY 2019-2021, Question Nos. 7 and 82.a., *available at* <https://dccouncil.us/wp-content/uploads/2020/02/cfsa20.pdf> .

⁶ <http://nowpow.cfsa.dc.gov/>. To be sure there was not an accessible kinship-specific website or webpage, a Google search was conducted on February 24, 2021 for the term “DC Kinship Navigator.” It did not identify CFSA’s Kinship Navigator Program. An additional search was conducted on CFSA’s website with the term “kinship navigator” in the search bar. Again, there was no result for CFSA’s Kinship Navigator Program.

2. Kinship Diversion (also known as Hidden Foster Care)

Another issue the new Ombudsperson will face is kinship diversion (also known as hidden foster care). This occurs when CFSA determines that there is abuse or neglect of a child and the child can not remain safely at home with their parents, even with the provision of services. But, rather than follow both federal and DC law requiring removal of the child to foster care—preferably with a relative who has received an expedited temporary kinship foster care license—CFSA diverts the child to live with the relative, without providing the legally required due process, services or supports, including foster care maintenance payments. DC KinCare Alliance has filed six federal lawsuits on behalf of DC kinship families who have been harmed by this illegal and discriminatory practice.⁷

In July 2020, CFSA issued a policy entitled “Diversion Process at Investigations,”⁸ which defines diversion and purports to record and track its numbers. On page 1 of the policy, CFSA defines diversion as: “Rather than placing the child in foster care, CFSA will partner with the child’s parent to plan for the child to be safely cared for by a relative or another identified caregiver.” The accompanying footnote explains that a diversion “identifies who will assume physical care of the child.” The policy further explains the diversion determination process as follows: “When a child and their family comes to the attention of CFSA through a hotline report of abuse and neglect, the investigative social worker must conduct an assessment to determine if: (1) the child(ren)/youth is in imminent danger, which

⁷ *K.H. et al. v. District of Columbia et al.*, 1:19-cv-03124 (D.C.D.C. filed Oct. 18, 2019); *S.K. et al. v. District of Columbia et al.*, 1:20-cv-00753 (D.C.D.C. filed March 17, 2020); *D.B. et al. v. District of Columbia et al.*, 1:21-cv-00670 (D.C.D.C. filed March 11, 2021); *T.J. et al. v. District of Columbia et al.*, 1:21-cv-00663 (D.C.D.C. March 11, 2021); *M.S. et al. v. District of Columbia et al.*, 1:21-cv-00671 (D.C.D.C. March 11, 2021) and *S.S. et al. v. District of Columbia et al.*, 1:21-cv-00512 (D.C.D.C. March 19, 2021).

⁸ CFSA Administrative Issuance 20-1, “Diversion Process at Investigations,” July 13, 2020, available at <https://cfsa.dc.gov/publication/ai-diversion-process-investigations>.

would result in a removal, and (2) if the child(ren)/youth can remain safe in the community with an identified caretaker.”

Accordingly, diversion as defined and practiced by CFSA involves the determination by CFSA that the parent cannot care for the child in his or her home because of abuse or neglect, ***and*** that the child must physically live somewhere other than the parent’s home to ensure the child’s safety. It is, therefore, a removal and placement of a child without the legally required filing of a neglect case and the concomitant due process and other protections that come along with it.

Regarding tracking diversion, the policy indicates that diversions are recorded and tracked by month. However, it does not require tracking of the most important information about diverted children -- ***their outcomes following a diversion***, such as: how long children stay in a diversion arrangement; whether they return home and when; what services they receive; whether they are subject to future abuse or neglect; and whether they are ultimately removed to foster care.

There are many reasons why diversion as practiced by CFSA is problematic. First, there are serious Constitutional⁹ and legal concerns when a decision to divert is made by a CPS social worker. This is because CFSA *may* discuss the plan for the child to live with the relative with the parent and relative and *may* obtain the consent of the parent to do so. However, in some cases, parental consent is not ever obtained. While CFSA references its Safety Plan Policy in its Diversion Policy, it is clear that it does not follow its requirements of having a written plan that a competent parent must execute, and that the plan be time limited

⁹ “The state is limiting one of the most precious substantive liberty rights recognized by the Constitution—that of parents to the care, custody, and control of their children—and the reciprocal right of children to live with their parents.” Josh Gupta-Kagan, *America’s Hidden Foster Care System*, Stan. L. Rev. 841 at 843 (2020), available at <https://review.law.stanford.edu/wp-content/uploads/sites/3/2020/04/Gupta-Kagan-72-Stan.-L.-Rev.-841.pdf>.

and last no longer than 30 days. In our experience working with more than 350 kinship families, we have seen diversions where there is no written plan, no parental consent, or parental consent but the parent does not have the mental capacity to consent. Parents of diverted children often grapple with serious and pervasive mental health or substance use issues, and the family is well-known to CFSA. Yet, CFSA involvement never stops the cycle of abuse; rather, the child is maintained in an unsafe home or diverted over and over again to live with different relatives. We have also seen diversion *after* the child previously had been removed to kinship foster care, reunified with the parent, and then the parental abuse or neglect started all over again.

From our first-hand observations of CFSA's diversion discussions with families and from the many accounts relayed to us by our clients, both the parent and the relative are coerced into agreeing to the diversion or safety plan for the child to live with the relative. The parent is coerced because they are told that if they do not agree, the child will go into foster care and it will be difficult to ever get the child back. In this situation, the parent is not in a position to freely consent to anything.¹⁰ CFSA has all the power and is effectively making the decision alone.

The caregiver is coerced because they are told that if they do not agree, the child will go into foster care with a stranger. The caregiver is never told that they would be the first choice for placement if the child were to be formally removed, nor is the caregiver told that they would receive a foster care payment to help care for the child. If the caregiver somehow knows to ask about kinship foster care, they are told that it is not available or that they may not qualify and that it could take a long time. They are not told that there is a fast track

¹⁰ *Id.* at 866.

licensing process for kin and that all non-safety related requirements can be waived under DC regulations.

The second reason CFSA's diversion policy and practice is problematic is because it fails to grant any legal rights or documentation to the person who is taking the child into their home. In this regard, the caregiver is rarely provided with any documents needed to care for the child, such as the child's birth certificate, social security card, Medicaid card, or vaccination records. These things are needed to apply for benefits, get medical care for the child, and enroll the child in school. Additionally, a diversion arrangement does not grant legal custody to the caregiver nor is it legally enforceable. Accordingly, the parent could come get the child at any time, or the caregiver could return the child to the parent even if the parent is still not safe.¹¹

The third and most important reason why CFSA's diversion policy and practice is troubling is that, by definition, the child is going to live informally with a relative *instead of* foster care. As such, it does not provide the due process and other legal protections required when separating children from their parents. Foster care provides an important check on the power of CFSA to remove a child from a parent because parents and the child are appointed lawyers to represent them and a judge determines if there is sufficient evidence to warrant removal. With diversion, there is no judicial oversight or other check on the power of the agency.¹² Foster care also furnishes services and supports that are not available through diversion. A parent will receive services to address the problem that led to the separation from their child and to assist with the goal of reunification.¹³ The licensed caregiver and the child will receive services like respite care and transportation as well as foster care

¹¹ *Id.* at 882.

¹² *Id.* at 875.

¹³ *Id.* at 878.

maintenance payments that have been shown to ameliorate the impact of poverty on this population.¹⁴

The purpose of foster care is permanency, either through reunification with a parent or guardianship or adoption with the caregiver. Diversion provides none of these pathways, as children are diverted multiple times or stay with relatives informally for months, years, or even until they become adults. While CFSA may follow up for a short period (typically, no more than a month), CFSA will close its investigation even if the plan is not working, and leave the caregiver to figure out how to care for the child long-term. If a caregiver tells CFSA that they can no longer care for the child because of all of the hurdles to do so, CFSA will threaten the caregiver with a neglect case. In other words, once CFSA closes its case, it will not get reinvolved to help stabilize the family unless a new allegation of abuse or neglect is called into the hotline, which is when the “safety plan” has already failed. The reason we find out about diversion is invariably because something has gone wrong. CFSA treats abused and neglected children like hot potatoes; they do not want to be responsible for vulnerable children in need of protection.

In 2001 and 2004, the DC Council acknowledged these problems with diversion, known at the time as “temporary third party placements,” when it revoked CFSA’s authority to engage in them from the Child Abuse and Neglect Act.¹⁵ This revocation was in response to changes in federal laws and requests from the *LaShawn* court monitor. CFSA has decided to flout the DC Council’s intent to eliminate these arrangements by calling them by another name -- diversions.

¹⁴ *Id.* at 880.

¹⁵ Child and Family Services Agency Establishment Amendment Act of 2000, Pub. L. 13-277 (Apr. 2001); Child in Need of Protection Amendment Act of 2004, Pub. L. 15-531 (Apr. 2005).

DC KinCare Alliance requested information from CFSA about its new diversion policy as of December 31, 2020. We wanted to know how many children had been diverted from July to December 2020. At first we were told that no children have been diverted. A month later, we were told that one child was diverted back in July of 2020. The truth is that DC KinCare Alliance knows of four other families who experienced diversion during that period. It is clear that CFSA has not been properly tracking diversions, although it is unclear why this is the case – whether the staff are not properly trained on how to track diversion or whether there is a data integrity problem.

The District of Columbia has a much lower rate of foster care placement with kinship caregivers than the national average of 32%.¹⁶ CFSA stated in its performance oversight responses that DC's rate is 28%,¹⁷ and it was in FY 2020, but DC's rate went down to 26% in the first quarter of FY 2021 and 25% in the second quarter of FY 2021.¹⁸ CFSA claims its low rate is because many DC families identify Maryland caregivers and Maryland cannot waive the non-safety related licensing requirements that DC can; but if that were true, Maryland would also have a low kinship placement rate. Maryland's kinship placement rate is 40%.¹⁹ The real reason DC continues to lag behind year after year is because of diversion.

The vast majority of families involved with CFSA are Black, live in Wards 7 and 8, are poor, and have lower levels of education. This results in a concerning power imbalance between the agency and the families they are tasked to serve. CFSA takes advantage of this

¹⁶ Children's Bureau, *Foster Care Statistics 2018*, available at <https://www.childwelfare.gov/pubPDFs/foster.pdf>.

¹⁷ CFSA Oversight Responses FY 2020-2021, Question No. 69.a., available at www.dccouncil.us/wp-content/uploads/2021/02/FY20-21-CFSA-Pre-Hearing-Responses_FINAL.pdf.

¹⁸ CFSA Data DashBoard at <https://cfsadashboard.dc.gov/page/placement-children-foster-care>.

¹⁹ <https://datacenter.kidscount.org/data/tables/6247-children-in-foster-care-by-placement-type#detailed/2/22/false/37,871,870,573,869,36,868,867,133,38/2622,2621,2623,2620,2625,2624,2626/12994,12995>.

power imbalance to deny kinship families much needed economic benefits to which they are entitled.

The Ombudsperson will have the opportunity to review and make recommendation to the Council about CFSA’s recent diversion policy and long time practices, which only serve to exacerbate existing inequalities—the very definition of systemic racism.

3. Child Fatalities and Near Fatalities

Another area the Ombudsperson for Children will need to tackle is determining how many children die or suffer from near fatalities²⁰ as a result of abuse or neglect in DC each year. Stuningly, we do not have answers to these critical questions because it is not anyone’s job to collect or make publicly available *any data* on near fatalities, and the data provided in public reports on fatalities is not provided in a way that would assist the DC Council to ensure all steps are being taking to prevent child maltreatment deaths. As a result, we cannot answer any of the following questions:

What is the number of DC children who die from maltreatment each year, and is that number going up or down?

What is the number of children who suffer a near fatality from maltreatment each year, and is that number going up or down?

Is CFSA doing its most important job of protecting DC children from death and near fatalities?

The Ombudsperson will be able to assist CFSA, the Child Fatality Review Committee, and this Council to ensure we know the answers to these important questions. Attached to this testimony is an information sheet on fatalities and near fatalities in calendar year 2020 with recommendations for how CFSA can better track and report data that can save children’s lives.

²⁰ Near Fataility is defined as “a child in serious or critical medical condition as a result of child abuse, neglect, or maltreatment, as certified by a physician.” DC Code § 4-1303.31(6).

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



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2020 Known Child Maltreatment¹ Fatalities

** Information Is from the Gerstein Affidavits Filed in the Criminal Cases*

Name: McKenzie Anderson

Date of Death: On or about February 1-3, 2020

Age: 11 months

Cause of Death: Blunt Force Trauma to the Head

Manner of Death: Homicide

Perpetrator: Mother

Prior DC Govt Agency Involvement: DHS Homeless Shelter; CFSA Involvement—Unknown

Risk Factors: Mother Mental Health Issues; Domestic Violence; Allegations of Substance Use (PCP and Ecstasy); Co-sleeping; Other young children in the home (diverted to live with grandmother)

Criminal Charges: First Degree Cruelty to Children and Felony Murder

Name: Gabriel Eason

Date of Death: April 1, 2020

Age: 2 years

Cause of Death: Blunt Force Trauma to Head and Abdomen (resulting in liver and kidney injury); there were 36 old and new rib fractures, as well as injury to the genitals and heart, among other injuries

Manner of Death: Homicide

Perpetrator: Mother (Ta'Jeanna Eason) and Her Husband (Antonio Turner)

Prior DC Govt Agency Involvement: CFSA and MPD involvement (as a result of mandated reporting by child care, although not all allegations were reported): starting May 22, 2019, daycare noticed injuries to G.E. (around when Mother started dating husband); first report made by daycare to CFSA on Oct 9, 2019 (this was the 5th injury since May 22); investigation by MPD commenced Oct 16, 2019; investigation closed as unfounded on Jan 16, 2020; Jan 28, 2020 GE taken to ER with severe laceration to forehead; Feb 2020 GE and 3-year-old brother LE did not attend daycare for most of the month; March 2020 GE and LE did not attend daycare the entire month

Risk Factors: Other children in the home (ages 11 and 3) were repeatedly physically abused and had injuries at the time of Gabriel's death; Pregnancy of Mother

Criminal Charges: First Degree Cruelty to Children and Felony Murder

¹ For purposes of this document, "maltreatment fatality" is defined as a child abuse or neglect fatality. According to the 2020 Child Fatalities Review Data Snapshot (<https://cfsa.dc.gov/publication/2020-child-fatalities-review-data-snapshot>), there was a neglect fatality of a seven-year-old male from a car accident outside of the jurisdiction where the mother was driving under the influence, but we do not have any other information on the family to provide detailed information here.

2020 Known Child Maltreatment Near Fatalities²

** Information Is from the Gerstein Affidavits Filed in the Criminal Cases*

Name: L.E. (Gabriel Eason's Brother)

Date of Near Fatality: April 1, 2020

Age: 3 years

Injuries: Old and new rib fractures; liver lacerations caused by blunt force trauma; bruising around ears and head; dark purple around right eye; scars to the head; red linear patterns on the chest and back consistent with being hit with a belt; evidence of pattern of abuse; attending physician compared the severity of trauma to be equivalent to sustaining injury from multiple vehicle car accident or falling from a 20-story building

Perpetrator: Mother (Ta'Jeanna Eason) and Her Husband (Antonio Turner)

Prior DC Govt Agency Involvement: Unknown

Risk Factors: Other children in the home (ages 11 and 2) were repeatedly physically abused; Pregnancy of Mother

Criminal Charges: First Degree Cruelty to Children

Name: S.C.

Date of Near Fatality: December 21, 2020

Age: 2 months

Injuries: Bilateral skull fractures; bleeding on both sides of the brain; extensive brain injury; multiple rib fractures at multiple stages of healing; right pupil blown

Perpetrator: Father (Donovan Gilchrist)

Prior DC Govt Agency Involvement: Unknown

Risk Factors: 3 other children in the home (were removed to foster care); Domestic Violence-Criminal Contempt

Criminal Charges: First Degree Cruelty to Children

Name: L.D.

Date of Near Fatality: December 22, 2020

Age: 2 years

Injuries: Broken jaw on left and right side; broken ribs on both sides; contusions to right kidney; liver injury, internal bleeding; admitted to CNMC as a trauma patient

Perpetrator: Mother's Paramour (Maurice Meniefield)

Prior DC Govt Agency Involvement: Unknown

Risk Factors: Allegations that Mother beats her 6 children on a regular basis; Domestic Violence

Criminal Charges: First Degree Cruelty to Children

² DC law defines "near fatality" as "a child in serious or critical medical condition as a result of child abuse, neglect, or maltreatment, as certified by a physician." DC Code § 4-1303.31(6).

2020 Unknown Child Maltreatment Fatalities and Near Fatalities

In general, we only know about 2020 child maltreatment fatalities or near fatalities to the extent they have been covered in the news. While various DC government agencies conduct reviews of child fatalities and publish reports summarizing their reviews, these reports often are released to the public years after the occurrence of a fatality, and none of the reports include information about near fatalities.

The DC Department of Health Vital Records does not report total child fatalities in a timely manner—the last report is from 2014. The OCME/Child Fatality Review Committee only reviews a subset of child fatalities, and the reporting combines data from multiple years, with the most recent report covering 2015-2018, so there is no way to determine trends from year to year.

CFSA's most recent internal child fatality report provides data for child deaths that occurred and were reviewed in 2019 with a new Appendix A that includes deaths reviewed in 2019 that occurred in 2015-2018. According to CFSA, its reports "include only those children whose families were known to CFSA within five years of the child's death." Accordingly, if a child fatality was caused by abuse or neglect, but the family was not previously known to CFSA, that death would presumably not be included in the report. CFSA's 2019 report also discusses the array of DC agency involvement in the lives of the families reviewed, but does not include a discussion of community provider involvement and to what extent there are service gaps that may have prevented the fatality.

In sum, advocates and policy-makers cannot determine from the available public reports the total number of child fatalities in DC in a given year. Further, by the time the reports regarding child fatalities are published, any benefit from the reports are lost because of the length of time between the death and issuance of the reports. Moreover, there is no public reporting whatsoever regarding child near fatalities, which are just as concerning as fatalities with respect to ensuring appropriate policies and practices are implemented to prevent future harm to children. As noted by the Commission to Eliminate Child Abuse and Neglect Fatalities, "***collecting data on life-threatening injuries from child abuse and neglect is important because the children who suffer from these injuries closely resemble children who die from abuse or neglect.*** Statistically, the two groups are almost identical in age, family risk factors (including high prevalence of domestic violence and substance abuse), and relationships between perpetrators and victims. ***What often differentiates a life-threatening injury from a fatality is simply the difference in medical care received and the timing of that medical care.***"³

³ Commission to Eliminate Child Abuse and Neglect Fatalities. (2016). *Within our reach: A national strategy to eliminate child abuse and neglect fatalities*. Washington, DC: Government Printing Office, available at <http://www.acf.hhs.gov/programs/cb/resource/cecanf-final-report>.

Recommendations to Improve CFSA's Child Fatality Public Reports

1. CFSA should continue to report on all child fatalities of families known to CFSA within 5 years of the death, but should also report on child *maltreatment* fatalities whether or not the family was known to CFSA prior to the fatality.
2. CFSA should report on all child near fatalities of families known to CFSA within the 5 years prior to the near fatality,⁴ as well as all child *maltreatment* near fatalities whether or not the family was known to CFSA prior to the near fatality.
*Note: These 16 jurisdictions report on near fatalities: AZ, CA, CO, KY, MA, MN, MT, NV, OH, OK, PA, RI, TX, WV, WI, and WY
3. CFSA should identify the relationship of the perpetrator to the child, e.g., parent, caregiver, paramour/boyfriend (whether or not in a caregiving role to the child), someone acting in loco parentis, or someone unknown to the family.
4. CFSA should coordinate with MPD to identify in its reports how many calls were made to MPD for abuse or neglect, or for a welfare check to the home, that were not also called into the CFSA hotline prior to the child fatality or near fatality.
5. CFSA should report on all calls to the hotline regarding any children in the family for the 12 months prior to a child fatality or near fatality, and identify who made the report as well as CFSA's response to each report, e.g. screened out, I&R (including what referrals or services were provided), investigation, substantiated, unsubstantiated, foster care, community papering, in-home case. If a family was referred to services, discuss what services were recommended and whether the family engaged in those services.
6. CFSA should report on whether there are services available through DC government agencies or in the community that could have been utilized by the family and recommendations for how to ensure families are connected to and engage in those services. Correspondingly, CFSA should identify service barriers or gaps (e.g., waiting lists, services not available in DC, lack of transportation to get to services, lack of phone or other communication method to obtain services, etc.) and whether additional or different services may have been helpful to prevent the fatality or near fatality.
7. CFSA should report on whether a child had been diverted to live informally with a relative within the 5 years prior to the fatality or near fatality, and where the child was living at the time of the fatality or near fatality (i.e., whether the child was still living with the relative or had returned home).

⁴ CFSA already maintains internal information and records about critical events per its Critical Events Policy and Critical Events Reporting Form, available at https://cfsa.dc.gov/sites/default/files/dc/sites/cfsa/publication/attachments/Critical_Event_Reporting_Form_%282019%29.pdf

8. CFSA should complete its review of each child fatality or near fatality within 3 months of the date of the death or near death incident.
9. CFSA should release public reports on child fatalities and near fatalities quarterly so that no death or near death is reported more than 6 months from the date of the occurrence.⁵

⁵ On March 25, 2021, CFSA issued a 2020 Child Fatalities Review Data Snapshot (<https://cfsa.dc.gov/publication/2020-child-fatalities-review-data-snapshot>), and stated that its Comprehensive 2020 Annual Child Fatality Report would be issued in July 2021. This indicates that CFSA could meet the timelines recommended here.