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Testimony Before the Council of the District of Columbia

Committee on Human Services

Public Hearing:
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Good morning Chairperson Nadeau and Members of the Committee on Human Services. My name is Marla Spindel and I am the Executive 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. We are the only organization in DC focused solely on serving relative caregivers raising DC's at-risk children. In the four years since our founding, we have helped over 500 relative caregivers raising more than 650 DC children. DC KinCare Alliance is a member of the Fair Budget Coalition, and we support a just and equitable recovery from the COVID-19 pandemic.

According to the Annie E. Casey Foundation's Kids Count Data Center, in 2019, 7,000 District children younger than age 18 were living in grandparent-led households and an additional 9,000 were living in households led by a relative caregiver. These relatives are primarily Black women who live in Wards 7 and 8. They often live at the economic margins of our society, even before they are called upon to raise a relative child. Many also report a significant disability.

The children who come into their care often have serious mental health or medical needs and suffer from trauma. These relative caregivers need financial help and stable housing to raise these children. However, the established systems are set up for traditional families, not kinship families, resulting in severe barriers to access benefits by relative caregivers.

Our work with relative caregivers, children, and families touched by the DC child welfare system has led us to advocate for various supports and services for this vulnerable and underserved population. Of particular significance to our work is ensuring that DC's FY

2023 Budget includes adequate funding for the Ombudsperson for Children, the grandparent and close relative caregiver subsidies, and child fatality reviews.

A. Funding for the Ombudsperson for Children

The independent Ombudsperson for Children will be a critical protection for DC's most vulnerable children. This is because, as legislated, it will: conform to nationally recognized standards; mediate, investigate, and advocate for DC children; and not be beholden to the agencies it oversees. We thank the DC Council for recognizing this need and enacting 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 and that it is fully funded each year. Unfortunately, the Mayor has defunded the moneys allocated to the Office for FY 2022, and has not included any funding for the Office in her FY 2023 Budget. We implore the Council to prevent the Mayor from effectively eliminating the Office, and to move swiftly together to identify and reallocate funds to ensure the Office can operate as intended.

Appropriate funding will ensure the Council is able to employ a well-qualified individual to implement the essential functions of the position. We look forward to an independent Ombudsperson who will ensure CFSA is responsive to its constituents through mediating conflicts, and who will assist with identifying and addressing systemic issues that limit the agency's ability to meet its mission of protecting DC's abused and neglected children and stabilizing families. Although CFSA is transitioning from court oversight in the *Lashawn v. Bowser* class action lawsuit, that does not mean that systemic issues have been addressed. Indeed, we regularly see concerning issues with CFSA's operations, treatment of

families, and interference with parent's and children's Constitutional rights.[1] We discuss some of these systemic issues below.

B. DC's Grandparent and Close Relative Caregiver Programs

As this Council knows, the Grandparent Caregiver Program (GCP) had a two-year waiting list that was only eliminated about a year ago. This waiting list was not necessitated by budget limitations and should never have occurred in the first place. There was more than enough money available to fully fund the GCP in FYs 2019 and 2020. Indeed, DC repurposed over $2 million of CFSA's budget to pay for Metropolitan Police Department overtime costs last summer; less than half of that amount would have eliminated the GCP waiting list. Only after years of advocacy by stakeholders did CFSA finally allocate money to end the waiting list. To ensure there are no waiting lists in the future, we ask that the Council allocate sufficient funds to cover both programs' costs in FY 2023, which would include an additional amount to address the new law expansion of the programs to include caregivers with parents in the home who have a disability, godparents, and those living in other jurisdictions.[2] We are troubled that the Mayor reduced funding in CFSA's FY 2023 Budget for the GCP, and we strongly urge the Council to ensure the program is appropriately funded.

Meanwhile, both the GCP and the CRCP have been fraught with regular operational errors and missteps for years. There is much work to be done to ensure timely processing of GCP and CRCP applications so that relative caregivers receive the funds they need for these children promptly. CFSA reports that the average length of time it takes from submitting a

[1] DC KinCare Alliance has filed 6 federal lawsuits challenging CFSA's illegal and unconstitutional practices. *See 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 at 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).

[2] The Grandparent and Close Relative Caregivers Program Amendment Act of 2021, Bill B24-0462.

complete subsidy application to the issuance of an EBT card is 30 days.[3] DC KinCare Alliance has assisted many clients with submitting applications for the GCP and CRCP subsidies in FY 2021 and in FY 2022 to date. We have never had a client receive their EBT card that quickly. In our experience, the application process takes approximately three months. First, we assist clients with submitting an application via e-mail. Along with the application, clients must submit a vast array of supporting documents showing identification, income, residence, relationship, that the child lives with them, and that they have applied for TANF. They also must complete a form requesting a Child Protection Registry (CPR) check and, in recent months, a new form authorizing FBI and local District background checks.

Often, it is difficult to get acknowledgment that CFSA has everything it needs and that the application is complete. For example, when we submit an application on behalf of a client, we request that CFSA acknowledge receipt and let us know if the application is complete. We often do not receive any response to this email for weeks, if at all. Further, if a client uses an older CPR form, from 2020 instead of 2021, it will be rejected, even though the information provided is the same. The client may not be notified of that for weeks. CFSA also will often tell clients that they need additional documentation, such as school records, when that is not required. Finally, CFSA has mixed up a client's application on a number of occasions, and has even revealed confidential applicant information to another applicant.

The next hurdle is the client getting fingerprinted. We used to be able to call and schedule a fingerprinting appointment. Often, no appointments would be available for several weeks, but at least we could schedule one. During the first year and a half of the COVID pandemic, CFSA waived the fingerprinting requirement and conducted its background checks

[3] Child and Family Services Agency FY21 Pre-Hearing Performance Oversight Hearing Follow-up Responses to "Written Response Requested Questions from the DC Council Committee on Human Services, p.10 (February 15, 2022).

virtually. In October 2021, the fingerprinting requirement was reinstituted, but we are not able to call to make an appointment. Rather, the client must wait for someone from CFSA to contact them and set it up. As a result, a number of weeks typically elapse before fingerprinting is scheduled and can be conducted.

Even after the fingerprinting is complete, it takes time for CFSA to complete the background checks and receive the EBT card in from its vendor. Getting EBT cards in a timely manner is a problem that CFSA has experienced regularly for many years, and that problem alone often results in weeks or more of delay. Once the cards come in, the client must then make an appointment to go in to CFSA to sign their subsidy agreement and retrieve the EBT card. We have advocated for years for CFSA to permit recipients to sign the subsidy agreement electronically, as well as to mail or electronically provide recipients with the EBT cards, as is done by the Department of Human Services for TANF and SNAP. Unfortunately, CFSA has refused to consider recommendations to make the process more streamlined and accessible to its constituents. A forensic review of the application process should be undertaken to identify and address systemic issues and ensure barriers to access are eliminated.

C. Child Fatalities and Near Fatalities

Another area where we have significant concerns is with respect to children who die or suffer from near fatalities as a result of abuse or neglect in DC.[4] CFSA's annual Internal Child Fatality Report (ICFR) does not provide data regarding child near fatalities and its data regarding maltreatment child fatalities is deeply flawed and does not provide the public with the information needed to make meaningful change.

[4] Near Fatality 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).

CFSA continues to report that none of the child fatalities it reviewed in 2018, 2019 or 2020 that occurred in CY 2018 were due to abuse or neglect,[5] yet we know that two-year-old Aceyson "Ace" Ahmad was beaten to death on April 17, 2018, that one-year-old Carter Sanders was beaten to death on May 16, 2018, and that six-month old Brooklynn Hill Davis was scalded to death on September 5, 2018.[6] Were all three of these babies really not known to CFSA at or prior to their deaths?

CFSA reports that four of the child fatalities that it reviewed in 2019 and 2020 that occurred in CY 2019 were the result of abuse or neglect, and that three of the child fatalities that it reviewed in 2020 that occurred in CY 2020 were the result of abuse or neglect. [7] CFSA compares these numbers in the conclusion of its 2020 ICFR[8]—the implication being that abuse and neglect homicide numbers are going down, but we will not know that for several more years as neither the review of 2019 nor 2020 child fatalities is likely complete. Typically, CFSA reviews child fatalities that occur in any given calendar year over that year and the two following it for a total of three years.[9] One thing we do know from available data is that child fatalities due to homicide for very young children five years old and younger is going up -- from four homicides reported in 2018[10] to five in 2019.[11]

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[5] *Child and Family Services Agency Internal Child Fatality Report Statistics Observations and Recommendations 2020* at p. 31 available at https://cfsa.dc.gov/sites/default/files/dc/sites/cfsa/publication/attachments/2020%20CFR%20Annual%20Report%20vF%20-%2010.26.21.pdf.

[6] *Baskin, Morgan, To Escape Court Oversight DC's Child Welfare System is Cutting Corners, Washington City Paper,* April 11,2019, https://washingtoncitypaper.com/article/180828/to-escape-court-oversight-dcs-child-welfare-system-is-cutting-corners/.

[7] *Child and Family Services Agency Internal Child Fatality Report Statistics Observations and Recommendations 2020* at p. 31 available at https://cfsa.dc.gov/sites/default/files/dc/sites/cfsa/publication/attachments/2020%20CFR%20Annual%20Report%20vF%20-%2010.26.21.pdf.

[8] *Id.* at p. 28.

[9] *Id.* at p. 31.

[10] *Office of the Chief Medical Examiner 2018 Annual Report* at p. 44 available at https://ocme.dc.gov/sites/default/files/dc/sites/ocme/OCME_2018_Annual%20Report.pdf.

[11] *Office of the Chief Medical Examiner 2019 Annual Report* at p. 34 available at https://ocme.dc.gov/sites/default/files/dc/sites/ocme/agency_content/OCME_2019_web.pdf.

Of the three abuse and neglect homicides that CFSA has reviewed thus far for CY 2020, two were widely reported in the media. They were the brutal beating deaths of eleven month old Mackenzie Anderson and two year old Gabriel Eason. Both deaths seemed eminently preventable but we do not know what CFSA's involvement with these two babies was before they died. Could CFSA have prevented their deaths? If so, what lessons has CFSA learned from any mistakes made in their cases? These are the kinds of questions that CFSA's 2020 ICFR should be designed to answer, yet none of them are.

We know that of the 40 total child fatalities in 2020 that CFSA has reviewed and reported on thus far, 38 of them or 95% had hotline calls screened out within 5 years of the child's death.[12] What that means is that those hotline calls were not investigated. Of the 38 who had hotline calls screened out, 16 or 40% had 4 or more hotline calls that were never investigated. Given the incredibly high percentage of calls that were not investigated regarding children who later died, one would think that there would be some red flags about this issue and perhaps a recommendation that CFSA review its hotline calls to assess the reasons why calls were screened out and whether it was appropriate to do so. However, there is no recommendation in the 2020 ICFR that touches on this issue.

We also know that 33 of the 40 children or 83% had investigations opened within 5 years prior to their death.[13] Of the 33 who had investigations opened, 10 or 25% had 4 or more investigations. Given the high number of investigations that ultimately did not prevent these children's deaths, CFSA needs to take a hard look at how investigations are resolved,

[12] *Child and Family Services Agency Internal Child Fatality Report Statistics Observations and Recommendations 2020* at p. 19 available at https://cfsa.dc.gov/sites/default/files/dc/sites/cfsa/publication/attachments/2020%20CFR%20Annual%20Report%20vF%20-%2010.26.21.pdf.

[13] *Id.*

especially repeat investigations. There is no recommendation in the 2020 ICFR that touches on how investigations are resolved.

Additionally, 23 or 58% of families had one or two in-home or permanency cases opened within 5 years of the child's death.[14] Given the number of in-home cases that did not successfully prevent the death of a child, CFSA should look at how it is closing cases and whether it is following best practices for safe closure.

Further, 9 or 22% of families had an open case or open investigation at the time the child died.[15] This raises the question of how this could happen while CFSA was involved with the family and what could have been done to prevent the deaths. But there is no specific information provided in the report about this or recommendations to enhance future practice. For instance, did Gabriel Eason have an open in-home case at the time of his death? Were there multiple reports of the abuse that Mackenzie Anderson suffered that were screened out or for which there was an open investigation at the time of her death?

These are not new questions and this is not a new oversight issue. In 2017, I wrote a white paper titled *In Memory of Baby Trinity Jabore* about the starvation death of Trinity on Christmas Day 2016.[16] She was only seven weeks old. That case revealed how CFSA repeatedly missed opportunities to prevent Trinity's death, but it appears that CFSA did not learn from that case and nothing has really changed. The public and this Committee should know what opportunities CFSA had to intervene in all child deaths that were caused by abuse and neglect so that improvements can been made to do better in the future.

[14] *Id.*
[15] *Id.* at 12.
[16] Spindel, Marla, *In Memory of Baby Trinity Jabore: Ensuring Better Outcomes for D.C.'s Children and Families*, July 21, 2017, available at https://www.dckincare.org/wp-content/uploads/2019/12/trinity_jabore_paper.pdf .

As a final note, we request that funding we made available to ensure that CSFA is able to provide the public with the information needed to prevent child abuse and neglect fatalities and near fatalities. We also request that funding be made available for better coordination between CFSA and the DC Child Fatality Review Committee (CFRC) to ensure it can comply with its mission as set forth in the Child Fatality Review Committee Establishment Act of 2001 (the "Act") at D.C. Code § 4-1371.01 *et. seq.* 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. Indeed, a review of the CFRC's most recent report, its 2020 Annual Report, has no discussion of the abuse deaths of McKenzie Anderson or Gabriel Eason, both of whom died in early 2020.[17] Rather, the Report provides information on infant mortalities, mostly related to congenital factors or unsafe sleep, and teen mortalities, mostly from gun violence. We further understand that the 2021 CFRC Report will not include their deaths, as they were not reviewed in 2021. Accordingly, by the time we receive a CFRC report with recommendations regarding the deaths of McKenzie Anderson and Gabriel Eason, at least three years will have elapsed since their deaths. Recommendations related to maltreatment deaths from three years ago may not even

[17] Child Fatality Review Committee 2020 Annual Report (December 2021), *available at* https://ocme.dc.gov/sites/default/files/dc/sites/ocme/publication/attachments/CFRC%202020%20Annual%20Report-FINAL%20WEBv2.pdf.

be relevant to maltreatment deaths in 2023 and, even if they are, we will be too late to prevent similar causes of death during that three year period.

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Thank you for your consideration of these important matters. Our children are the leaders of tomorrow. We must safeguard and protect them, lift them out of poverty, and provide them with opportunities to grow and thrive in safe and stable homes.