



Critical Work of the Child Fatality Review Committee Should Build on Recent Reforms

July 21, 2017

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A Report by the Office of the District of Columbia Auditor
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Why ODCA Did This Audit

ODCA conducted this audit to analyze data about child fatalities and identify trends, (2) evaluate the extent to which recommendations of the Child Fatality Review Committee (CFRC) address the trends, and (3) assess the response of D.C. government agencies to selected recommendations of the CFRC.

What ODCA Recommends

The CFRC should continue efforts to draft focused recommendations based on case findings, using the SMART (specific, measurable, action-oriented, relevant, and time-based) model as a guideline and continue to improve programs and services for children and their families through public education and policy change.

To ensure that CFRC recommendations receive a thorough review by policymakers, the Council should hold a public hearing on each CFRC annual report (as required by law), and the City Administrator should ensure that agencies incorporate CFRC recommendations into their annual performance plans (also required by law).

The Office of the Chief Medical Examiner (OCME) should allocate an additional staff position to help the CFRC fulfill its duty to review all child deaths. In addition, OCME should publish the CFRC's annual report by September 30 of the following year.

The Council should amend the statute on CFRC membership, by exempting CFRC community members from Council confirmation or placing time limits on confirmation; reducing the number of community members; and directing the Public Charter School Board to appoint a representative to the CFRC.

For more information contact Diane Shinn at Diane.Shinn@dc.gov or 202-727-3600.

What ODCA Found

The District's child death rate decreased by 39 percent from 2008 to 2015, reflecting a sharp drop in the 5-19 age groups, though there has been a troubling increase between 2013-2015. Infant mortality, which accounts for a majority of child deaths, dropped by 30 percent from 2008 to 2014.

The child death rate remained 69 percent higher than the national average (2015 data) and the infant death rate exceeded the national average by 27 percent (2014 data). Sharp racial and geographic disparities in child mortality persist, placing African-American children and children in Wards 5, 7, and 8 at particular risk. Child fatalities in D.C. disproportionately affect boys and young men, particularly African-American males.

The CFRC's recommendations addressed a broad range of problems reflected in the child fatality data, such as premature birth and inadequate maternal nutrition, and the risk factors and systemic problems identified in CFRC case reviews, such as chronic truancy and domestic violence.

Although agencies often agreed with the recommendations, some responses appeared pro-forma rather than reflecting a commitment to change policies or procedures. Three of the six sample recommendations analyzed had been implemented, but in two of those cases the outcome did not seem directly related to the CFRC's work.

The CFRC has taken steps to build capacity, using grants to fund training, equipment purchases, a web portal that allows members to review cases prior to meetings, and a CFRC outreach position. The CFRC has also undertaken a broader range of activities, including outreach to educate community members about important child safety topics, such as safe sleep.

A major concern is that the number of child fatalities analyzed in CFRC annual reports has dropped sharply, from 122 in 2010 to 35 in 2015. This decrease partly reflects budget and staff cuts, and must be reversed for the CFRC to fulfill its duty to review all child deaths in D.C.

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Background

The Child Fatality Review Committee (CFRC) is an interagency, multidisciplinary body that strives “to reduce the number of preventable child fatalities in the District of Columbia through identifying, evaluating, and improving programs and systems responsible for protecting and serving children and their families.”¹ Originally established by Mayor’s Order in 1992, the CFRC’s purpose, composition, and duties were formally defined in D.C. law by the “Child Fatality Review Committee Establishment Act of 2001” (“Act”), effective October 3, 2001.²

The Act assigns the following six duties to the CFRC:

1. Identify and characterize the scope and nature of child deaths in the jurisdiction, particularly those that are violent, accidental, unexpected, or unexplained.
2. Examine the circumstances surrounding child deaths by reviewing records and other relevant documents of public and private agencies that serve children and families, treat children, or investigate deaths, in order to reduce the number of child fatalities.
3. Develop and revise, as necessary, operating rules and procedures for the review of child deaths.
4. Recommend systemic improvements to public and private systems serving children and families.
5. Recommend components for prevention and education programs.
6. Recommend training to improve the investigation of child deaths.

The CFRC’s role in reviewing child deaths is also governed by a Modified Final Order, issued in U.S. District Court on November 18, 1993, that resulted from a class-action lawsuit (*LaShawn A. v. Dixon*, now known as *LaShawn A. v. Bowser*³) claiming statutory and constitutional violations by the D.C. government’s child welfare system. To end the Court’s ongoing oversight of the District’s child welfare system under *LaShawn*, the D.C. government must meet all terms of an Implementation and Exit Plan approved by the court, which includes a requirement for the CFRC to review the deaths of children in the child welfare system and to recommend corrective actions to avert future fatalities.

¹ District of Columbia Child Fatality Review Committee, “2015 Annual Report,” presented to Mayor Muriel Bowser, the D.C. Council, and the residents of the District of Columbia (December 2016).

² The “Child Fatality Review Committee Establishment Act of 2001” was enacted as Title XLVI of D.C. Law 14-28, the “Fiscal Year 2002 Budget Support Act of 2001,” effective October 3, 2001. The Act, which has been amended several times, is codified at D.C. Code § 4-1371.01 *et seq.*

³ 762 F.Supp. 959 (D.D.C. 1991).

The Act provides that the CFRC shall be comprised of at least one representative from each of 13 D.C. government agencies; at least one representative from each of five federal, judicial, and other categories; and eight community representatives.⁴ The agencies and sectors that must be represented on the CFRC are shown in Figure 1.

Figure 1: Composition of the CFRC

D.C. Government Agencies	Federal, Judicial, and Other Sectors	Community
<ul style="list-style-type: none"> • Department of Human Services • Department of Health • Office of the Chief Medical Examiner • Child and Family Services Agency • Metropolitan Police Department • Department of Fire and Emergency Medical Services • D.C. Public Schools • D.C. Housing Authority • Office of the Attorney General • Department of Behavioral Health • Department of Health Care Finance • Department of Youth Rehabilitation Services • Office of the State Superintendent of Education 	<ul style="list-style-type: none"> • D.C. Superior Court • Office of the U.S. Attorney for the District of Columbia • District of Columbia hospitals where children are born or treated • College or university schools of social work • Mayor’s Committee on Child Abuse and Neglect 	<p>Eight community representatives</p>

Source: D.C. Official Code § 4-1371.04

The Act requires the CFRC to compile an “Annual Report of Findings and Recommendations” which must be made available to the Mayor, the Council of the District of Columbia (D.C. Council), and the public, and presented to the D.C. Council at a public hearing. Agencies under the authority of the Mayor must respond in writing within 30 days to any recommendations addressed to them by the CFRC. In addition, CFRC policy recommendations to an agency must be incorporated into the agency’s annual performance plans and reports required by the Government Managers Accountability Act of 1995, as amended.⁵

The Act defines a “child” as an individual who is 18 years of age or younger, or an individual up to the age of 21 who is a committed ward of the child welfare, intellectual and developmental disabilities, or juvenile systems of the District of Columbia.⁶ The Act directs the CFRC to review the deaths of

⁴ Community members may not be employees of the D.C. government.

⁵ D.C. Code § 4-1371.09.

⁶ D.C. Code § 4-1371.02.

children who were residents of the District of Columbia and of such children who, or whose families were known to the District's juvenile justice or intellectual or developmental disabilities systems at any point within two years of the child's death, or known to the District's child welfare system at any point within four years of the child's death. The CFRC also may review the deaths of non-resident children if the death is determined to be accidental or unexpected, and occurred within the District.

The CFRC encompasses two separate review teams: an Infant Mortality Review Team, which reviews the deaths of children under the age of one, and a Child Fatality Review Team, which reviews the deaths of children who are age one or older.⁷ CFRC meetings are closed to the public and the body is subject to strict confidentiality rules.⁸

The CFRC membership selects the CFRC co-chairs,⁹ who are currently the District's Chief Medical Examiner, Dr. Roger Mitchell, and Assistant U.S. Attorney Cynthia Wright. The CFRC is housed within the Office of the Chief Medical Examiner (OCME) for administrative purposes.¹⁰

In 2016, the final report of the Commission to Eliminate Child Abuse and Neglect Fatalities (an expert panel appointed by the President and Congress) underscored the importance of child fatality review bodies, stating that:

Identifying children and families most at risk of a maltreatment fatality is key to knowing when and how to intervene. Therefore, we recommend that states undertake a retrospective review of child abuse and neglect fatalities to help them identify family and systemic circumstances that led to child maltreatment deaths in the past five years. States will then use this information to identify children at highest risk now, and they will develop a fatality prevention plan to prevent similar deaths both now and in the future.¹¹

The purview of the District's CFRC goes beyond child maltreatment deaths to include all child deaths, giving the CFRC an important role in D.C. government efforts to prevent these tragedies. Experts have noted that child death review panels can promote collaboration among child welfare professionals and government agencies, identify gaps in community

⁷ D.C. Code § 4-1371.05.

⁸ D.C. Code § 4-1371.08.

⁹ D.C. Code § 4-1371.04.

¹⁰ By Mayor's Order 2001-119, dated August 9, 2001, Mayor Anthony Williams assigned the OCME the duty of providing facilities and other administrative support to the CFRC.

¹¹ Commission to Eliminate Child Abuse and Neglect Fatalities, *Within Our Reach: A National Strategy to Eliminate Child Abuse and Neglect Fatalities*, Final Report, 2016, p. 13.

services, strengthen government policies and procedures, and catalyze initiatives to protect children.

Because the CFRC's work is so critically important, the Office of the District of Columbia Auditor (ODCA) initiated a review of the CFRC's activities, findings, and recommendations. The CFRC's work provides a perspective on the problems facing the most vulnerable children in the District of Columbia. This review is intended to support and strengthen the D.C. government's efforts to help and protect those children and their families.

Objectives, Scope, and Methodology

Objectives

Pursuant to D.C. Code § 1-204.55(b),¹² ODCA reviewed the activities of the CFRC, with a particular focus on its findings and recommendations to reduce the number of child fatalities. The objectives of the evaluation were to:

1. Analyze the available data about child fatalities to identify trends in the number of deaths, as well as their manner, cause, and other circumstances.
2. Evaluate the extent to which CFRC recommendations address the trends in child fatalities and their underlying causes.
3. Assess how D.C. government agencies have responded to select recommendations made by the CFRC.

Scope

This evaluation involved a review of the CFRC's activities, findings, and recommendations from 2011 through the present. To focus the analysis of D.C. government agencies' responses to CFRC recommendations, ODCA selected six recommendations (listed in Figure 2 on the next page) for closer examination.

ODCA based its selection of the six recommendations on several factors, including the agency that received the recommendation, the specificity of the recommendation, and the issues underlying the recommendation. In particular, a relatively large number of CFRC recommendations are directed to the Department of Health (DOH) and the Child and Family Services Agency (CFSA), respectively,¹³ and four of the recommendations ODCA chose for further study are directed at those agencies. In addition, the prenatal and neonatal care issues highlighted in the three DOH recommendations ODCA chose to study are important factors pertaining to infant mortality.

¹² D.C. Code § 1-204.55(b) provides, in part, that, "The District of Columbia Auditor shall each year conduct a thorough audit of the accounts and operations of the government of the District in accordance with such principles and procedures and under such rules and regulations as he may prescribe."

¹³ From 2011 to 2014, DOH, and CFSA were each the subject of six CFRC recommendations, more than any other agency, and represented 24 percent of all recommendations CFRC issued during this period. CFRC recommendations can be directed at more than one agency.

Figure 2: CFRC Recommendations Selected for Detailed Examination

Target of Recommendation	Recommendation and Year Issued
DOH	<ol style="list-style-type: none"> 1. DOH should devise an agenda to improve the nutrition of mothers before and during pregnancy to reduce the risk factors associated with obesity and pregnancy outcomes. The following practices are recommended: nutrition counseling should be offered to women as part of pre-conception counseling; nutrition counseling should be offered at 1st prenatal visit and at subsequent visits; and prenatal clinics should provide pamphlets and brochures depicting appropriate food choices to control weight gain before and during pregnancy.(2013) 2. DOH should convene a group of obstetricians and gynecologists to assess and evaluate best practices to address pre-conceptual counseling and discuss best practices to address pregnancy risk factors such as incompetent cervix. (2013) 3. DOH, in collaboration with the D.C. Hospital Association, should promote cardiology screening in newborns prior to the discharge following delivery. (2013)
CFSA	<ol style="list-style-type: none"> 4. CFSA should provide training to staff that specifically addresses intervention strategies when intra-family violence is a presenting issue (arguing and fighting between parents and their teen children) in investigations and ongoing cases. The training could be a component of the domestic violence training the agency provides to its direct service social work staff and contractors. (2013)
Child Fatality Review Committee	<ol style="list-style-type: none"> 5. With inclusion of maternal interviews in the fatality review process, Child Fatality Review Committee members will gain a better understanding of the circumstances surrounding the infant’s death, as well as the family’s access, utilization, and barriers to service. (2014) 6. In an effort to reduce infant mortality, the Infant Review Mortality Team will review cases where the infant was determined to be non-viable at birth yet resuscitated by the medical team. (2014)

Source: District of Columbia Child Fatality Review Committee, *2013 Annual Report* (December 2014), pp.28-29, and *2014 Annual Report* (December 2015), p. 21.

Note: Recommendation #4, as written by the CFRC, refers to “inter-family violence,” which would mean violence *between* families. Nevertheless, the clear intent of the recommendation is to address the problem of violence *within* families, or “intra-family violence.” See District of Columbia Child Fatality Review Committee, *2013 Annual Report* (December 2014), pp.29, 33-34. Therefore, Figure 2 uses the phrase “intra-family violence” to convey this intent.

Although this review is not focused on the CFRC’s management and operations, ODCA gained an understanding of the group’s internal processes by reviewing its analyses, findings, and recommendations. The following sections of this report include ODCA’s observations, findings, and recommendations about CFRC management and operations in an effort to strengthen its capacity to protect vulnerable children and families and reduce child fatalities.

Methodology

This review is based on a wide range of research, data collection, and analysis. The research and analysis combines information about child fatalities in the District of Columbia and the work of the District's CFRC with national data and information about child fatality teams around the nation.

First, ODCA reviewed the literature on child fatality review bodies throughout the nation, examining issues such as the membership, structure, scope, procedures, and outcomes of these bodies in order to provide context on the District's CFRC. ODCA also examined studies of child maltreatment conducted by national associations and expert groups such as the Commission to Eliminate Child Abuse and Neglect Fatalities and the American Academy of Pediatrics.

Second, ODCA analyzed the data on child fatalities in the District of Columbia compiled by the CFRC, DOH, and U.S. Centers for Disease Control and Prevention (CDC). Although ODCA originally intended to rely on CFRC data to analyze trends in child deaths in the District of Columbia, these data had limitations that required ODCA to rely on DOH and CDC data. The CFRC's annual reports review child deaths from several previous years, which complicates the trend analysis. For example, the CFRC's 2015 annual report reviewed cases of children who died in 2012, 2013, and 2014. In addition, the number of cases reviewed by the CFRC has dropped sharply in recent years, from 122 in 2010 to 35 in 2015, a trend that is discussed more fully later in this report. Because each annual report covers cases from several years and the number of cases reviewed has dropped, the annual reports cannot provide a clear picture of trends in child fatalities even though they contain valuable insights.

Third, ODCA interviewed 11 CFRC members and three CFRC staff members in order to understand better the CFRC's goals, objectives, procedures, and outcomes, and to gain insights on the CFRC's strengths and weaknesses. The interviews included both CFRC co-chairs—the Chief Medical Examiner, Dr. Roger Mitchell, and Assistant U.S. Attorney Cynthia Wright—as well as a broad array of other CFRC members representing D.C. government agencies, the judicial sector, non-governmental organizations, and the community. In addition, ODCA staff interviewed managers from D.C.'s Office of Victim Services and Justice Grants, which has awarded grants to the CFRC to improve its efficiency and effectiveness, as well as several agency officials involved in implementing CFRC recommendations.

Finally, ODCA reviewed the discussion, findings, and recommendations presented in the CFRC's annual reports in order to understand better the trends in child fatalities, their causes, and the CFRC's proposals to prevent these tragedies. The interviews with CFRC members and staff, mentioned above, provided additional insight about the development of the findings

and recommendations contained in the CFRC's annual reports. An ODCA staff member also attended two Child Fatality Review Team meetings and one Infant Fatality Review Team meeting to gain a better understanding of the CFRC's operations and case review process, and reviewed meeting minutes from both teams.

The ODCA project team included four graduate students in public policy and public administration from The George Washington University who were involved in all aspects of the project under the supervision of ODCA staff. The report was drafted, reviewed, and approved in accordance with the standards outlined in ODCA's Policy and Procedure Manual.

Audit Results

ODCA’s findings from its review of child fatalities in the District of Columbia and the work of the Child Fatality Review Committee are described in four following sections:

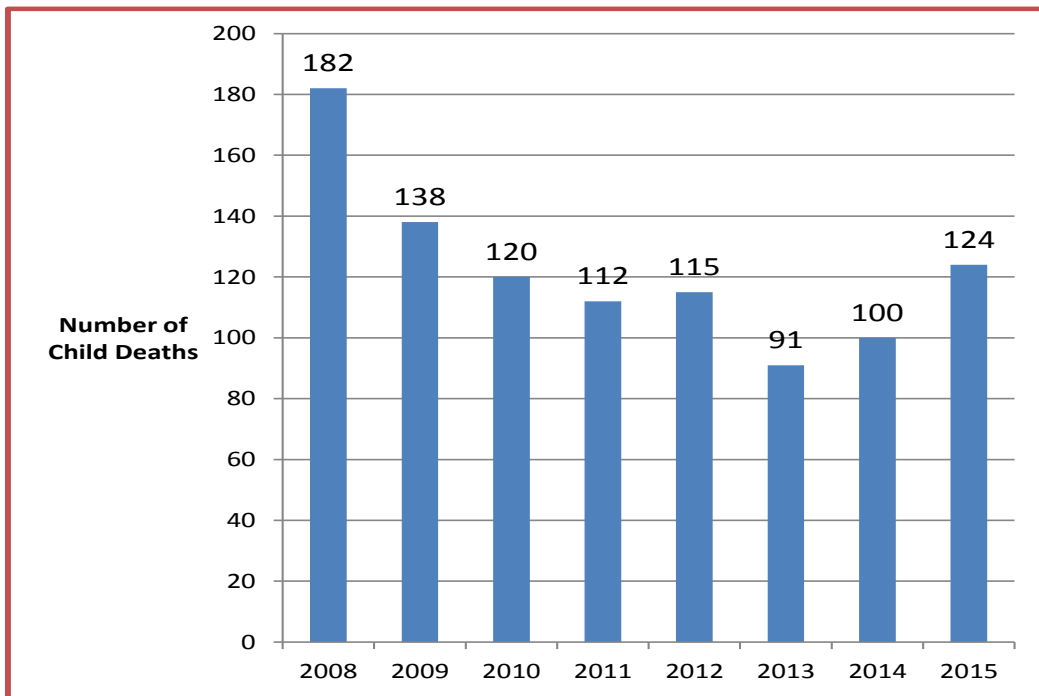
- I. Trends in Child Fatalities in the District of Columbia.
- II. CFRC Recommendations.
- III. Agency Responses to CFRC Recommendations.
- IV. Additional Observations on the CFRC’s Operations.

I. Trends in Child Fatalities in the District of Columbia

Child deaths in the District of Columbia decreased significantly from 2008 to 2015, falling faster than overall deaths. Moreover, the drop in the death rate among 5- to 14-year-olds, and among 15- to 19-year-olds, was particularly sharp.

Data provided by the CDC show that deaths among children and youth (birth to age 19) in the District of Columbia decreased by 32 percent from 182 in 2008 to 124 in 2015.

Figure 3: Deaths Among Children, Youth (Birth-Age 19) in D.C., 2008-2015



Source: Centers for Disease Control and Prevention

Because the number of children and youth in the District of Columbia grew from 2008 to 2015, the child death rate declined even more sharply (39 percent), from 145.8 deaths per 100,000 children and youth in 2008 to 88.7 deaths per 100,000 children and youth in 2015. By contrast, total deaths in the District of Columbia from 2008 to 2015 fell much more slowly than deaths among children and youth. The number of deaths among all residents dropped by 5 percent, from 5,140 to 4,871, during this period (compared to 32 percent among children and youth), and the overall death rate per 100,000 residents dropped by 18 percent, from 885.8 to 724.6 (compared to 39 percent among children and youth).

Particularly encouraging is a sharp decrease in deaths among 5- to 14-year-olds, and 15- to 19-year-olds in the District of Columbia. CDC's public data on deaths among D.C. 5- to 14-year-olds is limited, because the agency suppresses small data values in order to prevent revealing information that may identify individuals. Nevertheless, DOH reported that deaths among 5- to 14-year-olds decreased 56 percent from 18 in 2008 to eight in 2012, and that the death rate per 100,000 5- to 14-year-olds simultaneously fell by 53 percent, from 31.5 to 14.7.

Deaths among 15- to 19-year-olds in the District of Columbia have also fallen sharply. CDC data show that the total number of deaths in this age category decreased by 53 percent, from 45 in 2008 to 21 in 2015. At the same time, the death rate per 100,000 15- to 19-year-olds fell by 49 percent), from 111.1 to 56.6, due to a drop in the number of youth in this age group. It must be emphasized that there is more annual variation in the number of deaths for narrower age groups. Although the overall trend in deaths among children and youth is downward, there is still a lot of fluctuation.¹⁴

Despite the recent progress, the child death rate in the District of Columbia (88.7 deaths per 100,000) in 2015 exceeded the child death rate for the United States (52.4 deaths per 100,000), meaning that the District's child death rate is 69 percent higher than the national average. The national rate provides a benchmark for further reductions in the child death rate that could be achieved in the District of Columbia.

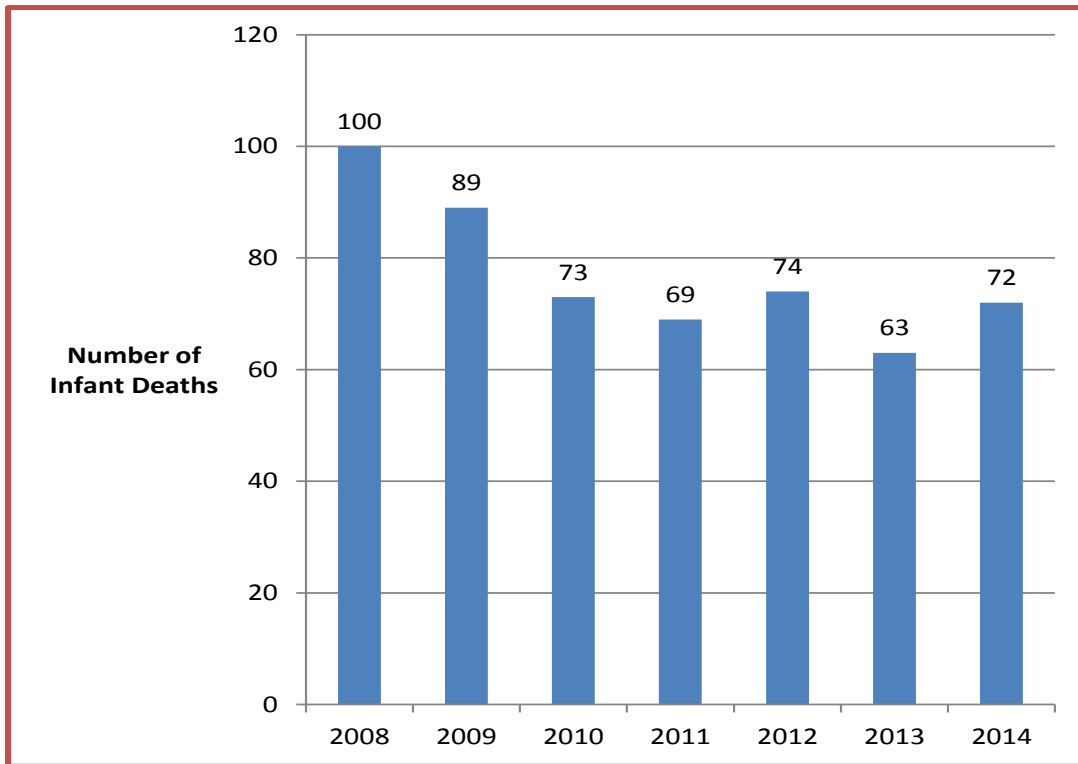
Infant mortality rates in the District of Columbia have dropped significantly.

Infant mortality (deaths to children before their first birthday) is a major component of child mortality because infants are highly vulnerable due to their small size and dependency. In the District of Columbia, infants accounted for 82 of 124 child deaths, or 66 percent, in 2015, while the comparative figure for the U.S. in 2015 was 55 percent.

¹⁴ For example, deaths among 15- to 19-year-olds in the District of Columbia dropped from 33 in 2011 to 24 in 2012 and 11 in 2013, but then increased to 15 in 2014 and 21 in 2015. Although the overall trend is downward, there are significant annual fluctuations.

The District of Columbia has made progress on infant mortality in recent years. In its *Infant Mortality Report: 2014*, DOH stated that the number of infant deaths decreased from 100 in 2008 to 72 in 2014, a 28 percent drop. During that same period, the infant mortality rate (defined as the number of infant deaths per 1,000 live births) decreased from 10.9 to 7.6, a 30 percent drop. Figure 4 shows the number of infant deaths reported by DOH for each year between 2008 and 2014.

Figure 4: Infant Deaths in the District of Columbia, 2008-2014



Source: D.C. Department of Health, *Infant Mortality Report: 2014*, March 31, 2016, p. 2

DOH also pointed out in the *Infant Mortality Report: 2014* the District's infant mortality rate has been consistently lower than that of Baltimore, Detroit, or Richmond, cities that DOH describes as having a size and population mix similar to D.C. As noted earlier, the District's infant mortality rate for 2014 was 7.6 per 1,000 live births, compared to 10.4 in Baltimore, 10.6 in Detroit, and 12.3 in Richmond. Still, ODCA notes that some similarly-sized cities have reported lower infant mortality rates than the District. For example, Boston recorded a rate of 6.3 infant deaths per 1,000 live births in 2014 (recent Census Bureau estimates, based on American Community Survey data from 2011 to 2015, show that Boston's population of 650,281 is very close to D.C.'s population of 647,484).

Despite the District's progress on infant mortality, its infant mortality rate for 2014 (7.6) remained higher than the national rate (6.0) the same year,

meaning that the District's infant death rate is 27 percent higher than the national average. The national rate provides a benchmark for further reductions in the child death rate that could be achieved in the District of Columbia.

The District has been closing the gap between its infant mortality rate and the national rate. In 2008 the disparity between the District's rate (10.9) and the national rate (6.6) was more than double what it was in 2014.

Infant deaths in the District of Columbia are primarily natural deaths and are strongly associated with certain risk factors such as inadequate prenatal care, prematurity, and low birthweight.

Not only do infant deaths comprise a large percentage of child deaths, but they are highly concentrated in a number of key categories. First, most infant deaths in the District of Columbia are "natural deaths," meaning that a disease alone causes the death. Second, infant deaths in the District of Columbia are strongly associated with a number of health risk factors described below, such as inadequate prenatal care, prematurity, and low birthweight.

As noted earlier, 72 infants died in the District of Columbia in 2014. The five leading causes of infant death reported by DOH for 2014, which accounted for 52 of 72 infant deaths, or 75 percent, in D.C. that year, were all natural causes:

1. Congenital malformations, deformations, and chromosomal abnormalities, 16 deaths.
2. Maternal complications of pregnancy, 11 deaths.
3. Disorders related to short gestation and low birthweight, 9 deaths.
4. Complications of placenta, cord, and membranes, 8 deaths.
5. Other symptoms, signs, and abnormal clinical and laboratory findings, 8 deaths.

The CFRC's annual reports have reported similar data about the predominance of natural deaths among infants and the most common causes of natural deaths among infants. Among the 21 infant deaths reviewed by the CFRC in its 2015 annual report, 17 (81 percent) were natural deaths.¹⁵ The most common cause of death reflected in the 21 cases was complications of prematurity (8 deaths). The four non-natural infant deaths reviewed by the CFRC in 2015 included two accidental deaths and two cases of sudden unexpected infant death.

¹⁵ The 21 cases reviewed in 2015 were those of infants who died in 2012, 2013, and 2014.

Deaths of infants in D.C. also reflect a number of demographic and health risk factors. Understanding these risk factors may help policymakers identify ways to attack the problem of infant mortality.

DOH reported that infant deaths in the District of Columbia in 2014 were clustered as follows:

- Two-thirds of infant deaths (48) occurred in the neonatal period, defined as the first 28 days of life.
- Almost three-quarters of infant deaths (53) occurred to low birthweight infants, defined as birthweight under 2,500 grams or 5 pounds, 8 ounces.
- Almost three-quarters of infant deaths (52) occurred to premature infants, defined as births that occurred prior to 37 weeks of gestation.

There is significant overlap among these risk categories. For example, the 53 deaths in 2014 to low-birthweight infants occurred mostly in the neonatal period (41 of the 53 deaths among low birthweight infants). Similarly, almost all premature infants who died in 2014 (50 of the 52 deaths of premature infants) had low birthweights.

Late entry into prenatal care, defined as starting prenatal care in the third trimester of pregnancy, or no entry into prenatal care, is an important factor that underlies the risk categories outlined above. DOH's *Infant Mortality Report: 2014* states that:

Early, high-quality prenatal care (PNC) is one of the cornerstones of a safe motherhood program, which begins before conception, continues with appropriate PNC and protection from pregnancy complications, and maximizes healthy outcomes for infants and mothers. Women who receive late (third trimester of pregnancy) or no PNC do not receive timely preventive care or education and are at risk for having undetected complications of pregnancy that can result in severe maternal morbidity and sometimes death.

While 58 percent of D.C. mothers who gave birth in 2014 began prenatal care in the first trimester of pregnancy, 22 percent began care late, had no record of prenatal care, or were documented not to have received any prenatal care, according to DOH. More specifically, CFRC data indicate that inadequate prenatal care—including entry into prenatal care after the first trimester as well as missed prenatal care visits—was associated with 47 percent of premature infant death cases it reviewed in 2013 and 37 percent of premature infant deaths it reviewed in 2014. (the CFRC did not include comparable data in its 2015 report).

Among infant deaths that do not result from natural causes, unsafe sleep environments are a major factor. In 2014, the CFRC reviewed six infant deaths “attributed to Sudden Unexplained Infant Death (SUID) associated with unsafe sleeping conditions.” These cases included infants put to sleep in the following ways: on adult mattresses; on excessive soft bedding; on air mattresses; in cluttered cribs or bassinets; or with adults or other children. As noted earlier, the CFRC reviewed two cases of SUID in 2015.

Through the case analysis performed by its Infant Mortality Review Team, the CFRC’s 2015 annual report identified additional health, social and environmental, and behavioral risks associated with infant deaths in the District of Columbia, which are summarized in Figure 5.

Figure 5: Other Health, Social and Environmental, and Behavioral Risk Factors Associated with Infant Deaths in D.C. (Number of Cases Reviewed in the CFRC’s 2015 Annual Report)

Health Factors	Social/Environmental Factors	Behavioral Factors
<ul style="list-style-type: none"> • Chorioamnionitis infection (nine cases) • Obesity (eight cases) • Premature rupture of membranes (four cases reviewed in 2015 report) 	<ul style="list-style-type: none"> • Sexually transmitted diseases (10 cases) • Illicit drug use (nine cases) • Cigarette smoking (three cases) 	<ul style="list-style-type: none"> • Mental health disorders (eight cases) which co-occurred with substance abuse in seven cases • Child welfare intervention (six cases)

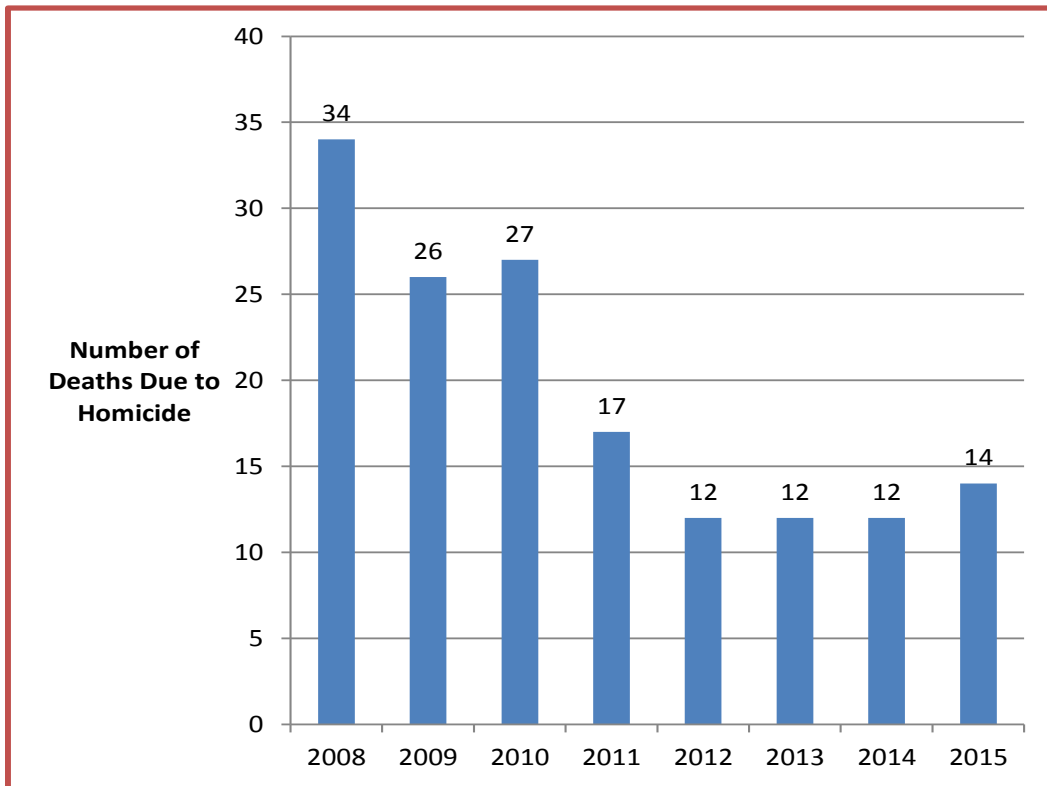
Source: Office of the Chief Medical Examiner, Child Fatality Review Committee, 2015 Annual Report, pp. 13-15

Note: Chorioamnionitis is an infection of the amniotic fluid and membranes that can lead to serious illness and death in newborn infants.

Homicides, which have been the leading cause of death among 15- to 19-year-olds in the District of Columbia, have decreased significantly among children and youth.

Child homicides in the District of Columbia have decreased sharply in recent years. According to data provided by the CDC, the number of deaths of D.C. children and youth from birth to age 19 due to “assault-homicide” fell from 34 in 2008 to 14 in 2015. Figure 6 (see next page) shows the number of homicides of children and youth in each year from 2008 to 2015. Homicide rates cannot be calculated for all of the years because the CDC reports death rates as “unreliable” when the number falls below 20.

Figure 6: Homicides Among Children and Youth (Birth-Age 19) in D.C., 2008-2015

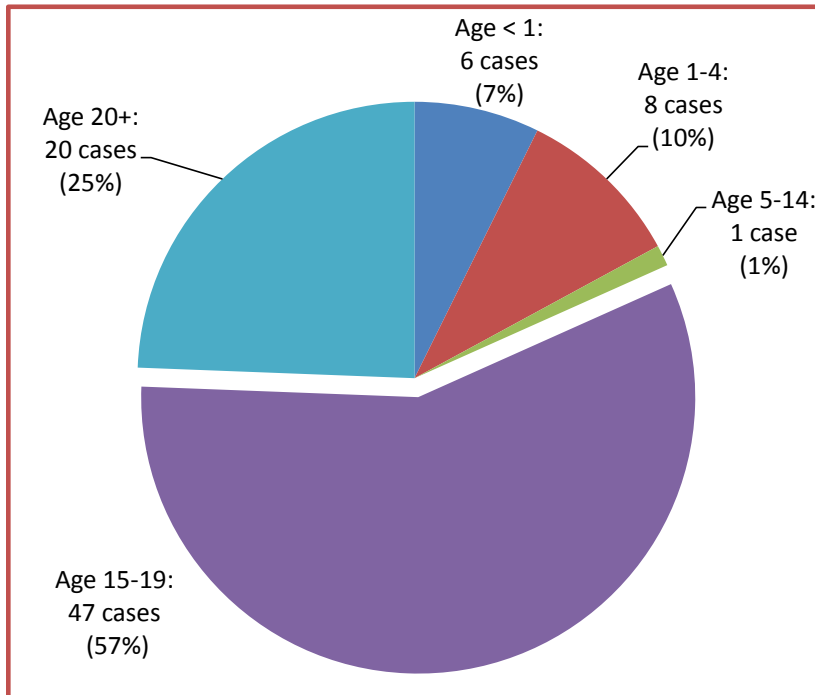


Source: Centers for Disease Control and Prevention

Homicide has been the leading cause of death among 15- to 19-year-olds in the District of Columbia and homicides of children and youth have been concentrated in this age group. According to CDC data, the number of homicides of 15- to 19-year-olds in D.C. also fell sharply, from 26 in 2008 to 11 in 2015. In fact, the CDC did not report the number of homicide deaths for D.C. 15- to 19-year-olds from 2012 to 2014 due to its policy of suppressing small data values in order to shield information that could identify individuals.

The majority of child and youth homicide cases reviewed by the CFRC from 2011 to 2015 involved 15- to 19-year-old victims (47 of 82 cases, or 57 percent). As shown in Figure 7 (see next page), most of the other homicide victims in cases reviewed by the CFRC during this period were 20 years of age or older (comprising 25 percent of victims). Homicide deaths of children from birth to age 14 were much less common.

Figure 7: Number of Homicide Cases Reviewed by the CFRC, 2011-2015, By Age of the Victim



Source: CFRC Annual Reports, 2011 to 2015

Child homicides in the District of Columbia are primarily due to gun violence among youth, and the victims are predominantly African-American.

The case reviews performed by the CFRC’s Child Fatality Review Team provide further detail about child homicide cases in the District of Columbia. The CFRC categorizes child homicide cases in the following manner:

- Fatal child abuse and neglect, defined as “homicides that occur at the hands of a parent, legal custodian or person responsible for the child’s care at the time of the fatal incident.”
- Youth violence, defined as “cases involving juvenile victims” that “may be random, associated with criminal activity, arguments, or retaliation.”
- Other homicides, defined as “homicides that are the result of an act of violence by a perpetrator who is not the parent/caretaker of the child.”

Among the child homicide cases reviewed by the CFRC from 2011 to 2015, 79 percent (65 of 82 cases) were cases of youth violence, and the other 21 percent (17 of 82 cases) stemmed from child abuse and neglect. There were no cases of “other homicides” reported during this period.

Gunshot wounds were the cause of death in 76 percent (62 of 82) of child homicide cases reviewed by the CFRC from 2011 to 2015. Gunshot wounds were involved in most youth violence cases. For example, 25 of 26 youth violence homicides were caused by gunshot wounds in 2011.

Almost all (98 percent, or 78 of 82) of the victims of child homicide in the cases reviewed by the CFRC from 2011 to 2015 were African-American. There were also two white victims and two Hispanic victims.

CFRC analyses have also identified a clustering of risk factors among youth homicide victims. In 10 youth homicide cases (victims who were 15 years of age or older) reviewed by the CFRC in 2014, the following risk factors were identified:

- Child welfare involvement, eight cases.
- juvenile justice involvement, six cases.
- Domestic violence (witnessed in the family or directly involving the youths), five cases.
- Truancy, four cases.

With regard to youth homicide, the CFRC stated in its 2015 annual report that, “Children and youth residing in neighborhoods with few economic opportunities, as well as children and youth of families experiencing economic instability are at risk. Truant youth, and those with frequent child welfare or juvenile justice contacts, are also at greater risk. This indicates an opportunity for the collaboration of child welfare and juvenile justice agencies to proactively collaborate and address the needs of this high-risk population of children and youth.”

Sharp racial and geographic disparities in child mortality rates persist in the District of Columbia. African-American children, as well as children in Wards 5, 7, and 8, suffer the highest rates of mortality.

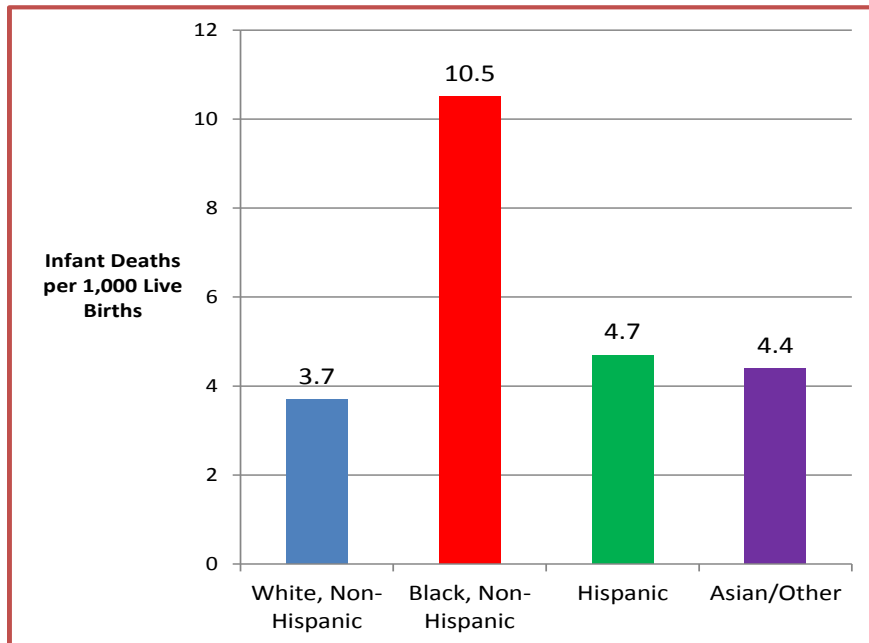
Racial and geographic differences in child mortality remain stark in the District of Columbia, reflecting disparities in income, access to health care, and other factors affecting maternal and child health and well-being. African-American children, as well as children in Wards 5, 7, and 8 (all of which are predominantly African-American wards) suffer the highest rates of mortality.¹⁶

Infant mortality data reported by DOH highlight these sharp racial and geographic disparities. In 2014, the infant mortality rate for non-Hispanic blacks (10.5 deaths per 1,000 live births) was almost three times the rate

¹⁶ Wards 5, 7, and 8 also have the lowest median incomes in the District of Columbia. See D.C. Office of Planning, “Key Demographic Indicators: District of Columbia and the United States,” p. 3.

for non-Hispanic whites (3.7 deaths per 1,000 live births). Reflecting this disparity, deaths to African-American infants comprised 69 percent of all infant deaths in the District of Columbia in 2014 (50 of 72 deaths). Infant mortality rates for Hispanics (of any race) and Asian-Others were slightly higher (4.7 and 4.4 deaths per 1,000 live births, respectively) than for whites the same year. Figure 8 shows infant mortality rates by race and ethnicity for the District of Columbia in 2014.

Figure 8: Infant Mortality Rates in D.C. by Race or Ethnicity, 2014

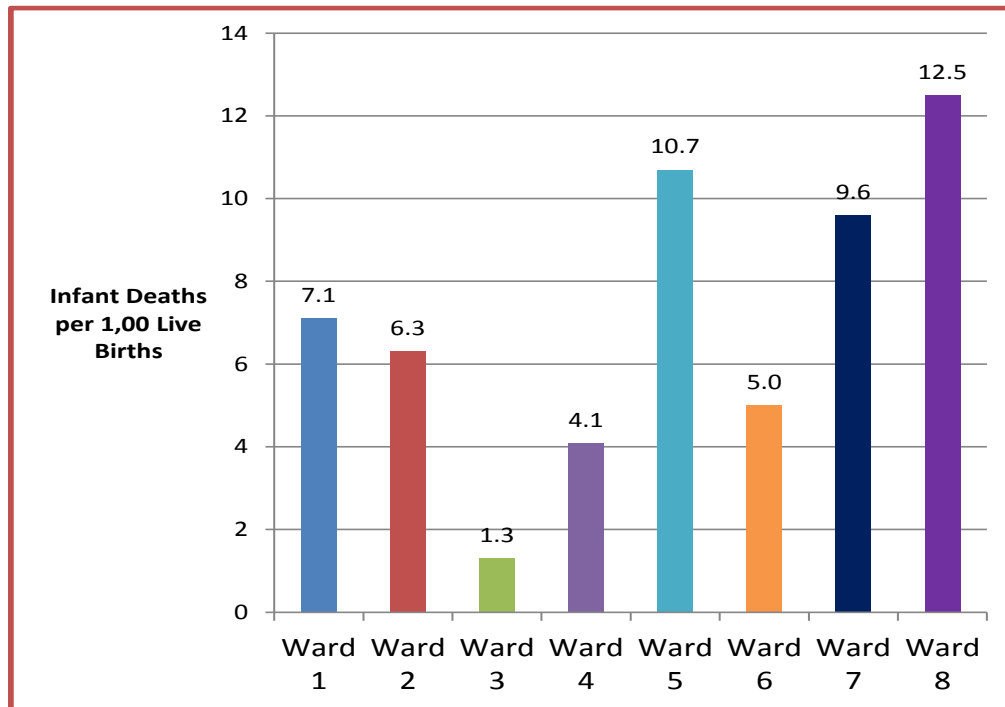


Source: Department of Health, *Infant Mortality Report: 2014* (March 31, 2016), p. 5

Ward 8 had the highest infant mortality rate in 2014 (12.5 deaths per 1,000 live births), whereas Ward 3 had the lowest rate (1.3 deaths per 1,000 live births). The two wards are at opposite ends of the spectrum economically: Ward 8 has the District’s highest poverty rate and its lowest median household income, while Ward 3 has the District’s lowest poverty rate and its highest median household income.¹⁷ Figure 9 (see next page) shows the infant mortality rate by ward for the District of Columbia in 2014.

¹⁷ In an analysis of U.S. Census Bureau data from 2011 to 2015, the D.C. Office of Planning’s State Data Center reported that the poverty rate in Ward 8 averaged 37.7 percent, almost four times the 9.4 percent rate in Ward 3. At the same time, median household income in Ward 3 averaged \$112,873, almost four times the \$30,910 median household income in Ward 8. See Office of Planning, State Data Center, “Key Demographic Indicators, District of Columbia and the United States: American Community Survey 5-year Estimates 2011-2015.”

Figure 9: Infant Mortality Rates in D.C. by Ward, 2014



Source: Department of Health, *Infant Mortality Report: 2014* (March 31, 2016), p. 19

The racial and geographic disparities in infant mortality mirror inequities in access to health care and health care outcomes, such as low birthweight and prematurity, which place infants at risk. In 2014, the percentage of low birthweight infants (12.8 percent) was highest among African-American mothers, more than double the rate among white mothers (6.2 percent) and higher than the rate for both Asian/Pacific Islander mothers (7.3 percent) and Hispanic mothers (7.7 percent). Similarly, premature births were more frequent among African-American mothers (11.7 percent of births) in 2014 than for white mothers (6.9 percent), Asian/Pacific Islander mothers (8.0 percent), or Hispanic mothers (8.3 percent). African-American mothers who gave birth in 2014 were also the least likely (57 percent) to have begun prenatal care in the first trimester, compared to 68 percent of Hispanic mothers and 83 percent of white mothers.¹⁸ Furthermore, mothers in Wards 5, 7, and 8 who gave birth in 2014 were the least likely to start prenatal care in the first trimester and the most likely to deliver their infants prematurely.

Demographic data on child mortality for other age groups are more limited than they are for infants, but racial disparities also characterize overall child mortality in the District of Columbia. CDC data indicate that there were 124 deaths to children and youth from birth to the age of 19 in

¹⁸ These data are derived from D.C. Department of Health, *Infant Mortality Report: 2014*, which did not include data on entry into prenatal care among Asian/Pacific Islander mothers.

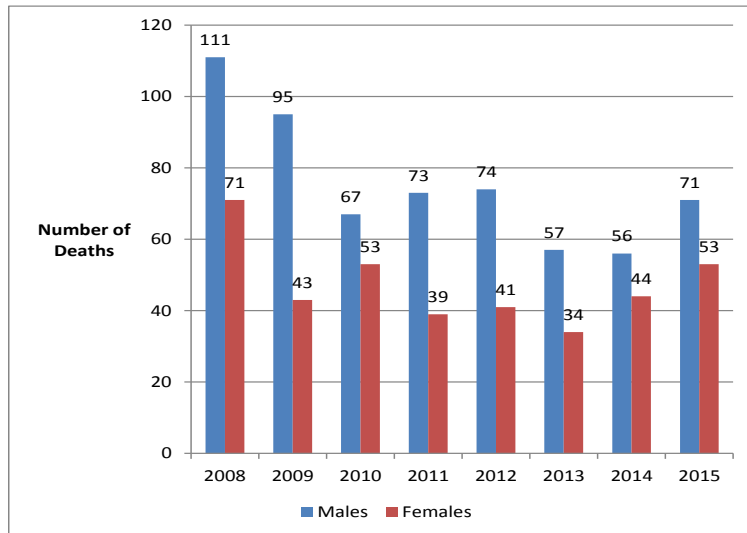
the District of Columbia in 2015. Of that number, 101 were African-American and 23 were white. The death rates that year (deaths per 100,000 children and youth) were 121.3 for African-American children and youth and 46.2 for white children and youth in D.C. Unlike the DOH data presented earlier, these CDC data do not separate Hispanic children and youth into a separate category; rather, Hispanic children can be of any race.

CFRC data show similar racial and geographic disparities in child deaths. In 2015, 74 percent of the cases reviewed by the CFRC involved deaths of African-American children and youth, even though non-Hispanic black children comprise only 57 percent of the child population in the District of Columbia. In its 2014 annual report, the CFRC also noted that, “Child fatalities significantly impact the eastern wards of the District of Columbia.”¹⁹ (Wards 5, 7, and 8 are all on the eastern side of the District).

Child fatalities in the District of Columbia disproportionately affect boys and young men.

In each year from 2008 to 2015, the number of male children and youth (birth to age 19) exceeded the number of female children and youth who died in the District of Columbia, according to CDC data. In 2015, for example, 71 male children and youth died (a rate of 102.5 deaths per 100,000) and 53 female children and youth died (a rate of 75.2 deaths per 100,000) in the District of Columbia. Figure 10 shows the number of child fatalities by sex in the District of Columbia from 2008 through 2015.

Figure 10: Fatalities of Children and Youth in D.C. by Sex, 2008 to 2015



Source: Centers for Disease Control and Prevention

¹⁹ Office of the Chief Medical Examiner, Child Fatality Review Committee, *2014 Annual Report*, p. 5.

In turn, the higher child fatality rates among males in D.C. largely reflect higher fatality rates for African-American children and youth. As noted above, the CDC data show that in 2015 there were 71 deaths among male children and youth in D.C., compared to 53 deaths among female children and youth, a difference of 18 deaths. At the same time, there were 58 deaths among African-American male children and youth in D.C., compared to 43 deaths among African-American female children and youth, a difference of 15 deaths.

Homicides of children and youth also are concentrated among African-American males. For example, among the six homicide deaths reviewed by the CFRC in 2015, four of the victims were African-American males, one was a African-American female and one was a white male. Similarly, among the 13 homicide deaths reviewed by the CFRC in 2014, nine of the victims were African-American males, two were African-American females, one was a white male, and one was a Hispanic male.

II. CFRC Recommendations

The recommendations issued by the CFRC from 2011 to 2014 address a broad range of program, practice, and management issues that reflect the issues and trends highlighted in the CFRC's annual reports.

The CFRC's case reviews, conducted at monthly meetings of its two review teams (the Child Fatality Review Team and the Infant Mortality Review Team), provide the starting point for drafting recommendations. The CFRC staff learns about child deaths from a variety of sources, including DOH's Vital Records Division and the OCME, and then gathers information about the case. The result of this research is a case summary that describes the circumstances of the death, interactions the child or family had with D.C. government and other agencies (including private organizations), the child's family situation, and his or her health history. The case summary provides the basis for the CFRC's discussion at monthly meetings of the Child Fatality Review Team or the Infant Mortality Review Team.

During the case discussions, the CFRC members try to identify risk factors affecting the child or family and discuss what was done, as well as what could have been done to mitigate those risks. Agency representatives can provide additional information about steps their agency did or did not take, and other individuals who knew the child, such as a teacher or social worker, may be invited to attend and contribute to the discussion. The goal is not to assign blame for the particular case, but rather to identify ways that agencies can prevent these tragedies in the future.

At the end of a case discussion, members may propose, debate, refine, and approve recommendations. Within the past year, the CFRC has engaged in an effort (discussed below in more detail), to strengthen its recommendations by first discussing findings from the case review, which would then serve as the basis for recommendations. As part of the reform effort, the CFRC has also sought to translate findings into recommendations only when the proposed solutions are compelling.

The proposed recommendations are then referred to a recommendations subcommittee, which reviews a statement of need, a description of the beneficiary population, the implication of a recommendation, and the agencies involved before determining if a recommendation should be issued formally by the CFRC.²⁰ If a recommendation is approved by the subcommittee, it is sent to the relevant agency director or directors, who have 30 days to respond to the recommendation in writing.²¹ Agency heads can disagree with a recommendation or modify it, but they must

²⁰ CFRC members can volunteer to participate in the work of the recommendations subcommittee; there is no fixed membership. The subcommittee meets quarterly and is led by the CFRC co-chair, Dr. Roger Mitchell.

²¹ Some recommendations are not approved by the subcommittee. In some cases, recommendations are tabled for additional information gathering and discussion.

justify those decisions. All of the CFRC's recommendations issued during a year are published in the CFRC's annual report.

To assess whether the CFRC's recommendations address the issues and trends highlighted in the CFRC annual reports, ODCA first sought to classify the 25 recommendations included in the CFRC's reports from 2011 to 2014 (there were no recommendations in the 2015 report). ODCA drew on research by Emily Douglas and Jennifer Cunningham of Bridgewater State College, who created an 11-part typology for child fatality review recommendations, based on their analysis of more than 300 recommendations issued by child fatality review teams in 29 states.²² Nevertheless, ODCA modified the framework created by Douglas and Cunningham because:

1. It did not fully or adequately reflect the purpose of some recommendations issued by the CFRC.
2. It focused solely on deaths due to child maltreatment, instead of the full range of child deaths reviewed by the CFRC.

ODCA's modification of the Douglas and Cunningham framework resulted in 15 categories that were used to classify the CFRC's recommendations from 2011 to 2014.²³

ODCA then analyzed the language of each recommendation to code the recommendations into as many of the 15 categories as seemed applicable, based on the judgment of the project team. Figure 11 (see next page) shows the 15 categories and the number of recommendations that fell into each category. Each recommendation can be assigned to multiple categories.

²² Emily Douglas and Jennifer Cunningham, "Recommendations from Child Fatality Review Teams: Results of a U.S. Nationwide Exploratory Study Concerning Maltreatment Fatalities and Social Service Delivery," *Child Abuse Review*, Vol. 17, pp. 331-351, 2008.

²³ Specifically, ODCA removed the "criminal responsibility," "home visiting," and "miscellaneous" categories from the Douglas and Cunningham framework, while adding categories for "policies and procedures," "agency collaboration," "oversight and monitoring," "maternal health," "child health," "youth development," and "education."

Figure 11: Subject Areas of CFRC Recommendations, 2011-2014

Subject of Recommendation	Number and Percentage of Recommendations (25 Recommendations Total)
Child health	9 (36%)
Agency collaboration	8 (32%)
Maternal health	8 (32%)
Training for professionals	8 (32%)
Youth development	8 (32%)
Child welfare	7 (28%)
Policies and procedures	7 (28%)
Public education and outreach	7 (28%)
Risk factors/assessment	7 (28%)
Agency communication	5 (20%)
Oversight and monitoring	5 (20%)
Child death investigations	3 (12%)
Education	3 (12%)
Child death review teams	2 (8%)
Mandated reporting	1 (4%)

Source: ODCA analysis of CFRC annual reports

Notably, the CFRC recommendations from 2011 to 2014 covered a broad range of program, practice, and management issues, as reflected by the narrow spread in the number of recommendations per category shown in Figure 11. Child health, the subject of nine of the 25 recommendations issued from 2011 to 2014 (36 percent), was closely followed by agency collaboration, maternal health, training for professionals, and youth development (each the subject of eight recommendations, or 32 percent), and by child welfare, policies and procedures, public education and outreach, and risk factors/assessment (each the subject of seven recommendations, or 28 percent). Reflecting the importance of maternal and child health, as well as the child welfare system to the protection of vulnerable children and families, the Department of Health and the Child and Family Services Agency were the most frequent subjects of CFRC recommendations (six each) from 2011 to 2014.

The issues addressed by the CFRC in its recommendations seem to reflect its statutory mission to recommend systemic improvements to public and private programs serving families and children, components for prevention and education programs, and training to improve the investigation of child deaths.²⁴ As noted above, the recommendations cover program areas (such as child health, child welfare, and education), as well as issues pertaining to systemic change and professional practice (such as agency collaboration, training for professionals, and policies and

²⁴ D.C. Code § 4-1371.03.

procedures). The internal, operational focus of the CFRC's recommendations on training, policies, and procedures, and oversight and monitoring is complemented by the external focus of recommendations that address public education and outreach.

More importantly, the CFRC recommendations address risk factors, conditions, and trends that are highlighted in the CFRC's annual reports. As noted earlier, the bulk of child deaths in D.C., as well as the nation, are those of infants. Reflecting this pattern, 60 percent of child deaths reviewed by the CFRC in 2015 (21 of 35 deaths) were infants. The recommendations to improve child health (targeted in nine recommendations from 2011 to 2014) and maternal health (targeted in eight recommendations from 2011 to 2014) often reflect efforts to reduce infant mortality, as reflected in the 2013 recommendations to improve maternal and child health highlighted below (each of these recommendations is among those selected by ODCA for case studies of agency implementation). In particular, the first recommendation listed below is designed to address risk factors such as obesity and inadequate prenatal care that are associated with infant death.

- DOH should devise an agenda to improve the nutrition of mothers before and during pregnancy to reduce the risk factors associated with obesity and pregnancy outcome. The following practices are recommended: nutrition counseling should be offered to women as part of pre-conception counseling; nutrition counseling should occur at the first prenatal visit and at subsequent visits; and prenatal clinics should provide pamphlets and brochures depicting appropriate food choices to control weight gain before and during pregnancy.
- DOH should convene a group of obstetricians and gynecologists to assess and evaluate best practices to address pre-conceptual counseling, and discuss best practices to address pregnancy risk factors such as incompetent cervix.
- DOH, in collaboration with the D.C. Hospital Association, should promote cardiology screening in newborns prior to the discharge following delivery.

The CFRC recommendations pertaining to youth development (targeted in eight recommendations from 2011 to 2014) and education (targeted in three recommendations from 2011 to 2014) represent efforts to address the deaths of 15- to 19-year-olds in the District of Columbia, which result primarily from homicides. For example, in 2015 the CFRC reviewed only five deaths of 15- to 19-year-olds, but three of these deaths resulted from homicide. Even though the following recommendations do not directly address the direct causes of youth homicides (such as gun violence), they exemplify the CFRC's efforts to reduce youth deaths from homicide (as well as other causes such as accidents) by keeping youth engaged in activities that will help them become self-sufficient, responsible adults.

- All youth committed to the Department of Youth Rehabilitation Services (DYRS) must receive and participate in educational programs which address their specific academic levels to prepare the youth for his/her eventual return to the community. (2011 recommendation)
- DYRS should outline and comply with established aftercare protocols to ensure discharge plans for committed youth are developed prior to their discharge from treatment and adult correction facilities, implemented and tracked for compliance. This may require the development of protocols and training for direct service staff and supervisors. (2012 recommendation)
- The Deputy Mayors for Health and Human Services, Public Safety, and Education should design and implement a multi-agency, multi-disciplinary triage process to address the needs of youth who have multiple interactions with government services as a result of high-risk activity. (2013 recommendation)

Finally, the CFRC recommendations have attempted to address the needs of children and youth in the District's child welfare system (seven recommendations from 2011 to 2014 addressed child welfare issues). Almost half (15 of 35, or 43 percent) of the child deaths reviewed by the CFRC in its 2015 annual report concerned children and youth who were known to the Child and Family Services Agency within four years of their death. CFRC recommendations intended to protect children and youth in the child welfare system, or to prevent them from entering the child welfare system, include the following:

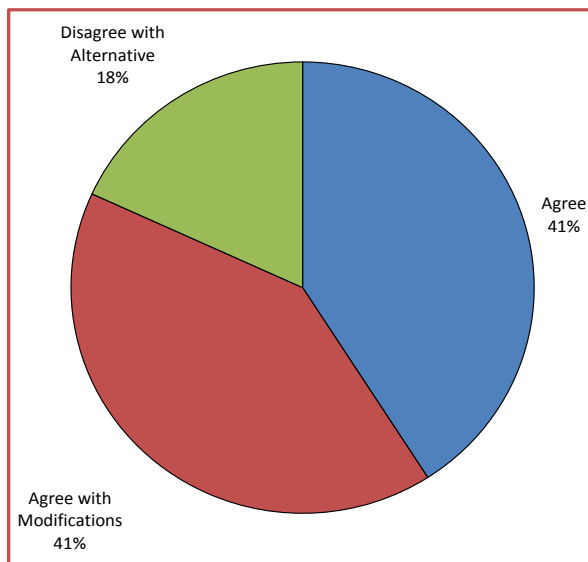
- The Child and Family Services Agency (CFSA) should mandate annual domestic violence training for all staff social workers, contracted social workers, and paraprofessionals who provide direct services to children and their families who come into contact with the agency as a result of abuse and neglect. This will ensure that all direct service providers within the agency will be trained to appropriately assess the family's needs and risk factors associated with domestic violence. (2011 recommendation)
- The Metropolitan Police Department (MPD) should provide information regarding domestic violence and child abuse to parents involved in domestic disputes. The information should contain information for parents on how to recognize perpetrators of domestic violence and early stages of child abuse in toddler and young children. (2012 recommendation)
- CFSA should monitor cases referred to the Health Families/Thriving Communities 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. (2014 recommendation)

Still, the question remains as to whether the CFRC recommendations address the issues and problems identified in a clear, compelling, and realistic manner that will lead to effective implementation and the ultimate goal of better outcomes for vulnerable children and youth. This issue will be addressed in the next section.

Even though agencies usually agreed with CFRC recommendations or agreed with modifications between 2011 and 2014, agency agreement often seemed pro-forma rather than reflecting a genuine commitment to change policies or procedures.

ODCA reviewed agencies' official responses to 22 recommendations issued by the CFRC to other agencies in the 2011 to 2014 annual reports (as noted earlier, there were no recommendations included in the CFRC's 2015 report).²⁵ As shown in Figure 12, agencies stated that they agreed with nine of the 22 recommendations (41 percent), agreed with modifications to another nine recommendations (41 percent), and disagreed with four recommendations while proposing alternatives (18 percent).

Figure 12: D.C. Government Agency Official Responses to 22 CFRC Recommendations Issued from 2011-2014



Source: CFRC Annual Reports from 2011 to 2014

²⁵ Although the CFRC issued 25 recommendations in its 2011 to 2014 annual reports, two of the recommendations issued in 2013 concerned the CFRC's internal practices and a third recommendation issued in 2013 was not addressed to a specific agency. Therefore, there were only 22 recommendations issued to other agencies contained in the CFRC annual reports from 2011 to 2014.

Even when agencies agreed with CFRC recommendations, the tone and substance of the responses varied considerably. In some cases, agencies described specific policy changes that were directly related to the CFRC recommendations, while in other cases agencies mostly outlined policies and procedures that were already in place or subject to routine modifications. In the latter group of cases, the agency's agreement often seemed to be perfunctory or pro-forma, rather than reflecting a genuine commitment to change policies or procedures. Several interviewees cited a pattern in which agency officials would respond by saying, "We're already doing that," or, in the words of another interviewee, "Thanks, but no thanks."

The Department of Behavioral Health (DBH) was notable for responding in very specific language to a 2012 CFRC recommendation that DBH should identify and disseminate information about community-based mental health providers that help children and youth struggling with gender identity. Specifically, DBH stated that it had already hired a social marketing coordinator to increase community-based education about mental health and pledged to:

1. Make available by September 2014 a community mental health resource guide listing DBH providers who have experience serving youths who are lesbian, gay, bisexual, transgender, or questioning (LGBTQ), while also providing information and resources to community-based organizations that serve this population.
2. Include a focus on the mental health needs of LGBTQ youths in social marketing and community education efforts on an ongoing basis.

By contrast, MPD agreed with a 2012 recommendation to "provide information regarding domestic violence and child abuse to parents involved in domestic disputes" but the bulk of its response described procedures in place through a departmental order dated November 18, 2010. MPD also noted that it had published a brochure titled, "The Effect of Domestic Violence on Children in the Home," with resource information and guidance about the signs of child abuse, but it was not clear how the brochure was being used or when it was published.

Other CFRC recommendations did not gain acceptance because they did not sufficiently describe how agency practices should change or if system failures resulted from flawed policies or implementation. CFSA disagreed with a 2012 CFRC recommendation to "develop and implement a protocol to address issues related to poor living conditions in publicly funded housing (e.g. mold, poor air quality) that may present health risks to the home's residents," arguing that existing investigative procedures are designed to identify a full range of risks to child health and safety.

By not sufficiently defining the problem with CFSA investigative procedures or practices, the CFRC was unable to point the way toward a solution. Although CFSA characterized its response as “disagreed with explanation for alternative recommendation,” the agency’s response did not include any policy changes and instead represented a statement of current policy.

Finally, a recommendation issued in 2014 had poor implementation prospects because it was very general and was not addressed to a particular agency or agencies. As one of three “prevention focused recommendations” issued in 2014, the CFRC called for “improvements in educational and vocational opportunities for government agencies serving at-risk youth,” noting that, “Many older youth who succumb to homicide were truant and failed to re-engage with education or vocational programs during/following involvement with government programs.” Although the underlying concern is important, having emerged from the CFRC’s review of youth violence homicides, the CFRC did not propose any ways to increase educational and vocational opportunities for at-risk youth or identify steps that particular agencies should take.

The CFRC members whom we interviewed acknowledged shortcomings in the CFRC’s recommendation process but added that the body was taking steps to strengthen its recommendations. Members stated that the CFRC’s recommendations had often been too general to affect agency operations while failing to set time frames and identify who was responsible for implementation. At the same time, members noted that the CFRC was now seeking to develop its recommendations more directly from case review findings and to generate a smaller number of focused, well-reasoned recommendations, rather than a larger number of scattered and more general recommendations, building on a training in July 2016 led by Theresa Covington of the National Center for the Review and Prevention of Child Deaths.

The CFRC’s efforts to make its recommendation-writing process more focused and deliberative seem well-founded. Guidelines on developing effective recommendations for child death review teams, which were prepared by Stephen Wirtz of the California Department of Public Health and based on a review of more than 1,000 recommendations prepared by 75 review teams (state and local), emphasize similar steps.²⁶ These guidelines point out that effective recommendations require not only a diagnosis of the problem, a review of promising practices for addressing the problem, identification of responsible parties, and time frames for implementation, but also an understanding of existing local efforts, resources, capacity, and political will. In other words, effective recommendations to prevent child fatalities require an understanding of institutions as well as policies, procedures, and leading practices. A more

²⁶ This work is described in Children’s Safety Network, “Child Death Review Findings: A Road Map for MCH Injury and Violence Prevention,” available at www.ChildrensSafetyNetwork.org.

deliberative approach is more likely to account for all of those key elements.

The Institute of Internal Auditors (IIA), a professional association of 185,000 members who work to improve organizational operations, offers guidelines for effective recommendations that seem broadly applicable to the CFRC. The IIA contends that recommendations should adhere to the “SMART” model, with SMART standing for Specific, Measurable, Action-Oriented, Relevant, and Time-Based. These guidelines address some of the shortcomings of CFRC recommendations that were discussed earlier, such as being overly vague or failing to set time frames for implementation, and could be used to evaluate future recommendations.

Recommendation

1. The CFRC should continue its effort to draft more focused recommendations that are based on case findings, using the SMART model as a guideline for improving the quality of the recommendations.

III. Agency Responses to CFRC Recommendations

A review of six CFRC recommendations issued in 2013 and 2014 indicates an impact that is modest at best and often unclear. Three of the six recommendations had been implemented, but in two of the three cases the outcome did not seem directly related to the CFRC's recommendation.

CFRC members interviewed by ODCA also shared concerns about agency follow-through on the CFRC's recommendations even as they acknowledged that the recommendations could be better-crafted. Several members stated that they would like to know more about agency implementation (or the lack thereof), noting that the CFRC does not track the status of recommendations after it receives the formal agency response. "The follow-up is sort of missing," one interviewee stated. At least two other members stated that they could not cite major impacts from the CFRC's work.

The CFRC does not have enforcement powers. Agencies receiving recommendations from the CFRC must respond to the recommendation in writing within 30 days but are not obligated to implement the recommendations. Still, the CFRC establishment act includes the following provisions designed to spotlight the CFRC's recommendations and ensure that agencies take them seriously:

1. A requirement that the CFRC's annual report be presented to the D.C. Council at a public hearing.²⁷
2. A requirement that agencies incorporate CFRC recommendations into the annual performance plans and reports required by required by the Government Managers Accountability Act of 1995.²⁸

As noted earlier, ODCA selected six CFRC recommendations from 2013 and 2014 for more in-depth analysis of whether and how agencies implemented the recommendations. This analysis was part of an effort to go beyond the agencies' written responses to the CFRC to see if the recommendations affected agency policies and practices.

ODCA assessed implementation of the six recommendations and their impact on agency policy and practice by interviewing CFRC members, agency officials, and outside experts with knowledge of the issues, and by documenting any changes in policy and practice.

²⁷ D.C. Code § 4-1371.09(f).

²⁸ D.C. Code § 4-1371.09(l).

ODCA found that:

- One recommendation concerning the CFRC’s internal practices had been implemented.
- Two recommendations had been implemented, but the CFRC’s effect on the outcome is not demonstrated.
- Two recommendations had been partially implemented, but the CFRC’s effect on the outcome is not demonstrated.
- One recommendation had not been implemented.

The six recommendations examined by ODCA are shown in Figure 13 along with the status of each recommendation. Although the CFRC’s recommendations seem to have had a modest impact, at best, on agency policies and practices, the impacts of a given recommendation are complicated to trace over time. Numerous individuals and organizations advocate for policy change in fields such as health care or public safety, and public officials consider a wide range of data, analyses, findings, and recommendations in making policy decisions,²⁹ making it difficult to isolate the impact of any single input into the policy process.

In a study of child fatality review teams, Emily Douglas and Sean McCarthy of Bridgewater State University noted that, “The overwhelming purpose of CFRTs is to prevent future fatalities. Yet, the mechanisms for doing so are not immediately evident, at least not in statute.”³⁰ It is notable that the lone recommendation in Figure 13 that has been implemented (recommendation #6) was a discrete, relatively straightforward policy change under the CFRC’s direct control.

Figure 13: Impact of Six CFRC Recommendations on Agency Policy or Practice

Recommendation and Year of Issuance	ODCA Assessment of Agency Response
<p>1. DOH should devise an agenda to improve the nutrition of mothers before and during pregnancy to reduce the risk factors associated with obesity and pregnancy outcomes. The following practices are recommended: nutrition counseling should be offered to women as part of pre-conception counseling; nutrition counseling should be offered at first prenatal visit and at subsequent visits; and prenatal clinics should provide pamphlets and brochures</p>	<p><u>Partially Implemented but CFRC Role Is Not Demonstrated.</u> DOH pledged to address obesity in pregnant women and help women achieve optimum health prior to pregnancy through a public-private partnership to reduce infant mortality known as “Stronger Together.” This initiative, announced by the Gray administration in 2014, was not continued by the Bowser administration, but DOH stated that it had a seven-part perinatal health strategy in place, covering issues such as reproductive health,</p>

²⁹ For example, 21 people appearing as individuals and representatives of organizations testified before the D.C. Council’s Committee on Health and Human Services in February 2015 on Bill 21-6, the “Healthy Hearts of Babies Act of 2015.”

³⁰ Emily Douglas and Sean McCarthy, “Child Fatality Review Teams: A Content Analysis of Social Policy,” *Child Welfare*, Vol. 90, No. 3 (May-June 2011), p. 104.

Recommendation and Year of Issuance	ODCA Assessment of Agency Response
<p>depicting appropriate food choices to control weight gain before and during pregnancy. (2013)</p>	<p>prenatal care, and neonatal care.</p>
<p>2. DOH should convene a group of obstetricians and gynecologists to assess and evaluate best practices to address pre-conceptual counseling and discuss best practices to address pregnancy risk factors such as incompetent cervix. (2013)</p>	<p><u>Implemented but CFRC Role Is Not Demonstrated.</u> DOH pledged to address pre-conceptual counseling and best practices to address pregnancy risk factors through a Technical Advisory Group to the “Stronger Together” initiative that would include obstetricians and gynecologists. Although the Stronger Together initiative was not pursued by the Bowser administration (see discussion above), DOH officials participate in a perinatal collaborative led by the Department of Health Care Finance which convenes obstetricians, gynecologists, other health-care practitioners, and government officials to discuss best practices, risk factors, and linkages to care.</p>
<p>3. DOH, in collaboration with the D.C. Hospital Association, should promote cardiology screening in newborns prior to the discharge following delivery. (2013)</p>	<p><u>Implemented but CFRC Role Is Not Demonstrated.</u> DOH agreed with this recommendation but did not elaborate on implementation plans. In 2015, the D.C. Council approved and Mayor Bowser signed legislation (D.C. Law 21-20, the “Healthy Hearts of Babies Act of 2015,” effective September 17, 2015) mandating that DOH oversee requirements for hospitals and maternity centers to perform congenital heart defect screening on every newborn prior to discharge. Still, the CFRC recommendation does not appear to have affected this outcome. The council’s Committee on Health’s report on the legislation did not mention the CFRC’s recommendation in explaining the rationale for the bill, and national groups such as the American Academy of Pediatrics appear to have played a key role. Experts interviewed by ODCA indicated that the cardiology screenings are taking place.</p>
<p>4. The Child and Family Services Agency should provide training to staff that specifically address intervention strategies when intra-family violence is a presenting issue (arguing and fighting between parents and their teen children) in investigations and ongoing cases. The training could be a component of the domestic violence</p>	<p><u>Partially Implemented but CFRC Role Is Not Demonstrated.</u> CFSA stated that it was already implementing a new model to address domestic violence, known as “Safe and Together,” and would begin training staff in this model in FY 2015 and 2016. Safe and Together emphasizes intimate partner violence, rather than the parent-teen interactions cited in the CFRC</p>

Recommendation and Year of Issuance	ODCA Assessment of Agency Response
training the agency provides to its direct service social work staff and contractors. (2013)	recommendation. CFSA also stated that it would implement a trauma screening tool, the “Child Disorders Stress Checklist,” on December 1, 2014. CFSA stated that it had provided the Safe and Together training to 210 workers and 10 supervisors as of April 2017, and that the agency’s training office would finish completing a “train the trainers” process by the end of FY 2017. CFSA also stated that the trauma screening tool had been implemented, a point that was echoed in interviews with CFRC members.
5. With inclusion of maternal interviews in the fatality review process, Child Fatality Review Committee members will gain a better understanding of the circumstances surrounding the infant’s death, as well as the family’s access, utilization, and barriers to service. (2014)	<u>Not Implemented.</u> CFRC stated that it would work with OCME, its parent agency, to implement maternal interviews. As of May 2017, the maternal interviews had not been implemented and were planned to begin at the start of FY 2018. The CFRC had worked to develop, in partnership with other agencies, a procedure for post-interview social service referrals for mothers who discuss the pain of their child’s death and may still be in a state of crisis. The CFRC has developed position descriptions for the employees who will conduct the maternal interviews; these positions will be funded by DOH.
6. In an effort to reduce infant mortality, the Infant Review Mortality Team will review cases where the infant was determined to be non-viable at birth yet resuscitated by the medical team. (2014)	<u>Implemented Due to CFRC Recommendation.</u> The CFRC has been reviewing non-viable births, including a cluster review conducted in October 2016.

Source: ODCA analysis based on interviews and document review

ODCA also identified a separate CFRC recommendation (not part of the six case study recommendations discussed above) that had a direct impact on agency policy. Based on a case review indicating that children did not know what to do in the event of a fire at home, the CFRC recommended in November 2011 that the Office of the State Superintendent of Education (OSSE) and the Department of Fire and Emergency Medical Services (FEMS) “collaborate to disseminate information about fire safety and prevention to children and youth attending District of Columbia Public and Charter Schools.” After failing to receive a response from the agencies, the CFRC renewed the recommendation in March 2013.³¹ OSSE and FEMS responded by publishing a fire safety program overview in OSSE’s

³¹ This recommendation also was cited in Child Fatality Review Committee, “2012 Annual Report,” p. 27.

quarterly newsletter, with FEMS fire safety contact information. FEMS also offered schools the following fire safety classroom presentations: “Safety Smart about Fire” for children in kindergarten through grade 3 and “Safety Smart Science (Understanding Fire)” for students in grades 4 through 8. The FEMS Internet site now includes a page on fire safety activities for children, and teachers, administrators, parents, and other community members can request fire safety presentations (including those tailored for children) online.

Although the fire safety recommendation discussed above affected the practices of OSSE and FEMS, this example reflects not only the potential of the CFRC process but also the missed opportunities that can result from poor management and bureaucratic neglect. If the CFRC had not followed up on the initial recommendation, there might have been no corrective action in this case.

CFRC recommendations might have a greater likelihood of affecting agency policies and procedures if officials used the two statutory levers discussed earlier in this section. ODCA could not find any evidence that the D.C. Council had held a public hearing to receive and review the CFRC’s annual report since 2008,³² although one interviewee stated that the CFRC’s work might have been discussed in annual agency performance hearings held by the council. ODCA notes that the council’s annual performance hearings, which review the accomplishments of each agency prior to hearings on the Mayor’s annual budget request, provide a useful forum to review the status of CFRC recommendation directed to agencies as varied as the DOH, DHCF, CFSA, DYRS, MPD, FEMS, D.C. Public Schools (DCPS), and OSSE. At the same time, reviewing CFRC recommendations during D.C. Council performance hearings should help focus the attention of deputy mayors and agency directors on the recommendations.

ODCA’s tests of whether three CFRC recommendations (one directed to CFSA, one directed to DOH, and one jointly directed to OSSE and FEMS) were incorporated into agency performance plans and reports found no evidence that the recommendations were reflected in those documents in the three years following the recommendation. CFSA’s FY 2016 performance plans and reports included an initiative concerning the “Safe and Together” training to prevent domestic violence, which was cited in CFSA’s response to the CFRC’s 2013 recommendation that CFSA training should address intrafamily violence (discussed under recommendation #4 in Table 12). Nevertheless, CFSA had planned to implement Safe and Together prior to the CFRC recommendation, so CFSA’s inclusion of the initiative in its FY 2016 performance plans and reports does not seem directly responsive to the CFRC.

³² The D.C. Council’s Committee on Public Safety and the Judiciary and Committee on Human Services held a joint public hearing on the CFRC’s recommendations on February 7, 2008.

Recommendations

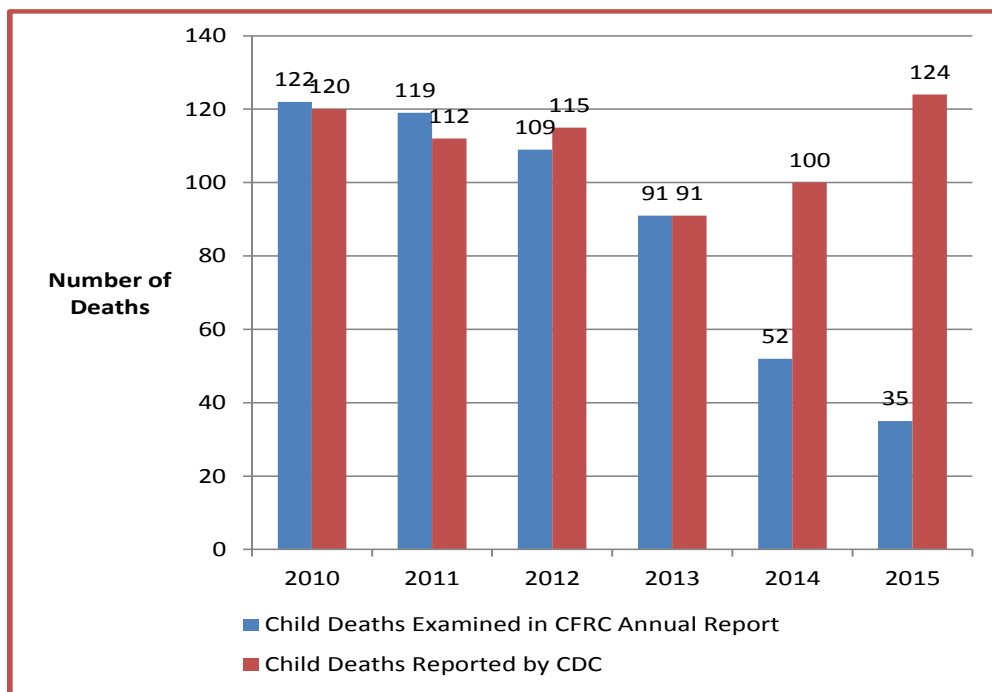
- 2.** The D.C. Council should hold a public hearing on each CFRC annual report, as required by law.
- 3.** The City Administrator should ensure that agencies incorporate CFRC recommendations into annual performance plans and reports, as required by law.

IV. Additional Observations on the CFRC's Operations

The number of child fatalities analyzed in CFRC annual reports has dropped sharply, from 122 in 2010 to 35 in 2015.

The number of child deaths analyzed in the CFRC's annual reports has dropped sharply, from 122 in 2010 to 35 in 2015 (a decline of 71 percent). Because the number of child deaths in the District of Columbia was relatively steady during this time period (rising slightly from 120 deaths in 2010 to 124 deaths in 2015, according to the CDC), this means that the CFRC's annual reports were less comprehensive and informative. As noted earlier, the CFRC has a statutory mandate to review the deaths of *all* children in the District of Columbia. Figure 14 shows the number of cases examined in the CFRC's annual reports and compares it to the number of child deaths in the District of Columbia each year, as reported by the CDC.

Figure 14: Number of Child Deaths Examined in CFRC Annual Reports Compared to the Number of Child Deaths in D.C., 2010-2015



Sources: Office of the Chief Medical Examiner, Child Fatality Review Committee, annual reports from 2010 to 2015, and Centers for Disease Control and Prevention.

As shown in Figure 14, the number of child deaths examined by the CFRC in its annual reports closely tracked the number of child deaths in the District of Columbia through 2013, but then diverged sharply. By 2015, the number of child deaths reviewed by the CFRC in its annual report (35) was only 28 percent of the total number of child deaths reported by the CDC (124).

Although the number of cases examined by the CFRC and the number of child deaths in the District of Columbia should roughly correspond, the relationship will never be exact because it takes time for the CFRC to learn about each death and prepare the necessary information for case review.³³ Moreover, the CDC data shown in Figure 14 show the number of deaths of children and youth from birth to age 19, which departs slightly from the CFRC's mandate to review the deaths of children from birth to age 18 who were D.C. residents, as well as the deaths of some young people over the age of 18 who were involved with the District's disability, juvenile justice, or child welfare systems.³⁴

Even if one takes account of the caveats mentioned above, the divergence between the number of cases reported on by the CFRC and the number of child deaths in the District of Columbia is troubling. If the CFRC continues to review only a fraction of the child deaths that occur each year, it will have difficulty in identifying systemic problems and recommending timely corrective actions. As noted earlier, the CFRC's 2015 report reviewed child deaths from 2012, 2013, and 2014, meaning that there is often a lag of several years between a death and case review. Two CFRC members interviewed by ODCA stated that when such lags occur, agency representatives can say that issues and problems identified in case review are not relevant to current practice.

CFRC officials offered two explanations for the drop in the number of cases reviewed annually: (1) budget and staffing cuts that limited the CFRC's ability to conduct statistical reviews on the child deaths that were not subject to individual review by the panel, and (2) more intensive review of complex cases that absorbed more staff time.

As part of the budget cuts needed to keep the District's budget in balance in the aftermath of the 2007 to 2009 recession, which reduced revenues and increased social welfare expenditures, the CFRC suffered a 64 percent budget reduction from FY 2009 to FY 2011 (from \$815,000 to \$292,000) and lost five of its eight full-time equivalent staff allotment. The CFRC's FY 2017 budget of \$594,000, which supports five FTEs, is still 27 percent lower than the FY 2009 budget. Individuals interviewed by ODCA stated that these budget cuts made it difficult for the CFRC to maintain the same level of case review.

³³ Because of these time lags, the 35 cases covered in the CFRC's 2015 annual report involve deaths that occurred in 2012, 2013, and 2014. See Child Fatality Review Committee, "2015 Annual Report," p. 6.

³⁴ The CFRC's authorizing statute defines "child" as an individual who is 18 years of age or younger, or up to 21 years of age if the individual is a committed ward of the District's child welfare, intellectual or developmental disability, or juvenile justice systems. In addition to examining the deaths of children who were D.C. residents, the CFRC must examine the deaths of young people (regardless of residence) if they, or their families were known to the District's disability or juvenile justice systems at any point during the two years prior to the death, or if they or their families were known to the District's child welfare system at any point during the four years prior to the death.

OCME has used a number of strategies to secure additional resources for the CFRC and thereby soften the impact of budget cuts. In addition to using a grant from the Office of Victims Services and Justice Grants to hire a CFRC outreach specialist, as discussed earlier,³⁵ the CFRC has employed Capital City Fellows (recent master's degree graduates who rotate through positions at different agencies) as well as participants in the Office of Risk Management's Return to Work program (injured workers who are returning to work). If the OCME could allot an additional position to the CFRC through the OCME's annual budget, or by drawing on external resources such as the Capital City Fellows or Return to Work programs, the additional staff member could help the CFRC increase the annual number of death reviews.

Although the CFRC is mandated to review all child deaths, it can choose from several different approaches to examine specific cases, thereby bringing appropriate levels of expertise to bear that reflect the circumstances and complexity of the case. Specifically, the CFRC's authorizing statute allows the panel to conduct:

- Multidisciplinary/multi-agency reviews of individual fatalities.
- Multidisciplinary/multi-agency reviews of clusters of fatalities identified by a special category or characteristic.
- Statistical reviews of fatalities.
- Any combination of the three previously-stated approaches.³⁶

By law, the CFRC must conduct an individual fatality review by a multi-disciplinary, multi-agency team for:

- Children known to the juvenile justice system.
- Children known to the intellectual or developmental disabilities systems.
- Children from families that had been reported for child abuse or neglect.
- Children under the jurisdiction of D.C. Superior Court.
- Children who were wards of the District of Columbia for any other reason.
- OCME cases.³⁷

A majority of cases reviewed by the Child Fatality Review Team, which provides multi-agency, multi-disciplinary review, since 2014 have fallen into the statutory categories described above.³⁸ The cases that did not fall

³⁵ OVSJG grant funding is included in the CFRC's FY 2017 budget of \$594,000 and five FTEs.

³⁶ D.C. Code § 4-1371.05(c).

³⁷ D.C. Code § 4-1371.05(e).

³⁸ The discussion in this paragraph focuses on cases reviewed by the Child Fatality Review Team, but not cases reviewed by the Infant Mortality Review Team (IMRT), because the IMRT cases mostly involve natural deaths and are less likely to fall into the six categories that require a multi-disciplinary, multi-agency review.

into those categories involved other major public safety and health issues such as homicides and the care of medically-fragile children.

Other cases, including many natural death cases, could be subject to a statistical review, defined as “a review of the relevant data factors identified for routine data collection” (the least intensive type of review),³⁹ if OCME were able to allocate an additional staff position to the CFRC. Another way to increase the pace of case review is for the CFRC to perform more cluster reviews, which bundle cases “that share common characteristics and trends that may indicate a prevailing community problem or risk factor for specific types of fatalities,” and subject them to a multi-disciplinary, multi-agency review.

Recommendation

4. OCME should seek to identify an additional staff position for the CFRC to conduct statistical reviews and help the CFRC fulfill its mission to review all child deaths in the District of Columbia.

The CFRC has published its annual reports on a more timely basis in recent years, but has fallen short of goals to publish the reports by September 30 of each year.

The CFRC has published its annual report on a timelier basis in recent years, as shown in Figure 15. The CFRC’s 2010 annual report was published almost two-and-a-half years later than the end of the period it covered, but the CFRC has since improved its performance, producing the 2013, 2014, and 2015 reports before the end of the next year.

Figure 15: Publication Date of CFRC Annual Reports, 2010-2015

Year	Date of Publication
2010	May 2013
2011	May 2013
2012	March 2014
2013	December 2014
2014	December 2015
2015	December 2016

Source: Child Fatality Review Committee, Annual Reports for 2010 to 2015

Nevertheless, the CFRC failed to meet a goal, set in its FY 2015 performance plan, to publish the 2014 annual report by September 30, 2015. OCME’s FY 2016 performance plan included an initiative to “publish” fatality review reports, issued by the CFRC and a developmental disability fatality review board also administered by OCME, “in a timely manner,” but

³⁹ See Title 28, Section 5101.1(c) of the *D.C. Municipal Regulations*.

did not define the meaning of “timely.” OCME’s FY 2016 performance report noted that the CFRC’s 2015 annual report was completed by September 30, 2016, and “thus in compliance with initiative requirements,” but the report was not published (the outcome specified in the performance plan) until December 2016. OCME’s FY 2017 performance plan does not include any goals or initiatives pertaining to timely publication of the CFRC’s report.⁴⁰

Because the timely publication and dissemination of findings and recommendations about child protection should help reduce dangers to children, ODCA recommends that OCME and the CFRC should reinstate and achieve the goal of publishing the CFRC annual reports by September 30 each year.

Recommendation

5. OCME should include in its annual performance plans the goal of publishing the CFRC’s annual report by September 30 of the following year.

The CFRC has taken steps to build its capacity in recent years, drawing on grants provided by the Office of Victim Services and Justice Grants, as well as internal initiatives.

The CFRC has taken important steps to build its capacity to review cases, develop strong recommendations, and engage with the community during the past three years. In particular, grants from the Office of Victim Services and Justice Grants (OVSJG) have helped the CFRC upgrade its technology, training, and communications so that it can perform its duties more efficiently and effectively.

OVSJG’s mission is to “develop, fund, and coordinate programs that improve public safety; enhance the administration of justice; and create systems of care for crime victims, youth, and their families in the District.” In accordance with that mission, OVSJG made the following grants to the CFRC:

- OVSJG Grant No. 2016-OCME-002, entitled, “Child Fatality Review Board Support,” which provided \$100,000 in fiscal year 2016 (October 1, 2015, to September 30, 2016).
- OVSJG Grant No. 2017-OCME-002, entitled “Fatality Prevention: Stakeholder Communication and Community Engagement,”

⁴⁰ OCME’s FY 2017 grant application to the Office of Victim Services and Justice Grants includes a September 30, 2017, target date for “completion” of the CFRC’s 2016 annual report. Nevertheless, ODCA notes that this goal retreats from the OCME’s FY 2015 performance goal of publishing the report by September 30, making the report publicly available.

which provided \$119,091 in fiscal year 2017 (October 1, 2016 to September 30, 2017).

The FY 2016 grant was intended to further three goals:

- Hiring an outreach specialist for the CFRC.
- Engaging a consultant to train CFRC members on interpreting findings and developing an annual report.
- Contracting for the development of a web portal to transfer information efficiently for the review of child death cases.

To achieve these goals, the grant budget included \$77,358.58 to pay for the salary and fringe benefits of an outreach specialist for three-quarters of the fiscal year, \$14,850 for web portal services, \$6,020 for expert consultant services, and \$1,771.42 for office supplies.

Because of delays in hiring the outreach specialist, in July 2016 OCME and OVSJG agreed on a grant modification to reallocate unused funds. Although the grant had been designed to cover the salary and fringe benefits of the outreach specialist for three-quarters of the fiscal year, the specialist did not begin work until April 18, 2016, with less than half of the year remaining. Therefore, the two agencies agreed to reallocate \$40,725.57 in salary and fringe benefit funds to support equipment purchases (\$38,148.57) and supply purchases (\$2,577).

In addition, OCME and OVSJG agreed to reallocate \$2,830 of unneeded consultant funds to employee travel. In justifying the reprogramming, OCME noted that:

- Equipment purchases, including a high-speed scanner and a copier/printer exclusively for the CFRC's use, would make case review more efficient and effective by helping staff manage the large flow of case records and prepare materials for meetings.
- Supply purchases would enhance community outreach by allowing the CFRC to produce bound volumes of its annual report, and by providing the outreach specialist with items such as an easel and flipchart.
- Travel funding would be used to cover the registration fees, transportation, lodging, and other costs, for staff members to attend conferences and thereby receive training directly related to child fatality review.

As envisioned in the OVSJG grant, the CFRC provided expert trainings to members in FY 2016. The trainings included:

1. “Enhancing the Recommendation Process” by Theresa Covington, executive director of the National Center for the Review and Prevention of Child Deaths, on July 25, 2016.
2. “SIDS and Sleep-Related Infant Deaths”⁴¹ by Dr. Rachel Moon on July 28, 2016.
3. “Creating a Hospital Based Safe Sleep Education and Awareness Program” by Dr. Michael Goodstein on July 28, 2016.

The web portal was also implemented during FY 2016, although the CFRC sometimes failed to meet the goal of uploading case summaries to the portal three days before scheduled fatality review meetings, for reasons ranging from staff absence to unavailability of the portal when uploading was attempted. Some CFRC members also experienced difficulties gaining access to the portal because of firewalls, but members also stated that technical problems that impeded access were resolved. Moreover, the web portal is used only for meetings of the Child Fatality Review Team, but not the Infant Mortality Review Team, because some of the IMRT participants are not CFRC members.

The FY 2017 OVSJG grant of \$119,091 devotes most of its funding (\$94,878) to continue paying for the salary and fringe benefits of the CFRC outreach specialist. The rest of the funding includes \$14,850 for continued operation of the web portal, \$3,300 for staff travel to meetings and conferences, \$3,050 for training by expert consultants, and \$3,013 for supplies.

This funding is intended to help the CFRC reach the following goals and objectives stated in the FY 2017 OVSJG grant include:

- Completing the CFRC Annual Report for 2016 by September 30, 2017.
- Increasing communication with the public about CFRC’s mission, focus, and recommendation process.
- Using the web portal to make case summaries available three days before a fatality review meeting 90 percent of the time.
- Providing members with technical assistance or workshops on topics of interest.

CFRC members and staff interviewed by ODCA stated that the initiatives funded by OVSJG had improved the effectiveness and efficiency of the CFRC. In particular, members and staff noted that the web portal had been beneficial, despite the initial difficulties described earlier. There was broad agreement that the portal enabled members to spend more time analyzing the cases rather than reading them for the first time at

⁴¹ “SIDS” stands for Sudden Infant Death Syndrome.

meetings, which was the prior practice. One CFRC member stated that the web portal “really changed the way we do business,” while another member described it as a “real time-saver.”

The trainings offered to CFRC members during the summer of 2016 were also described as beneficial, although some members were not able to participate. Each training session earned the highest score in a four-tier rating system from more than 80 percent of participants. In particular, members noted that training provided by Theresa Covington of the National Center for the Review and Prevention of Child Deaths had prompted efforts by the CFRC to tighten the focus of its recommendations and to ground them in specific findings from case review.

The CFRC’s efforts to build internal capacity through technology and training are complemented by its initiative to share information and findings with the community. Although the CFRC’s outreach efforts were stymied during FY 2016 due to the delayed hiring of the outreach specialist, the OVS grant for FY 2017 envisions that the outreach specialist will establish relationships between the OCME, CFRC, and residents, including a “listening tour” with community organizations; obtain community perspectives on child fatalities through a survey given at community meetings; present the survey results to CFRC members by September 30, 2017; and formalize a communication process between the CFRC and the community.

The CFRC’s outreach specialist has been involved in a wide range of communication and outreach efforts since he was hired in April 2016, including:

- Making a presentation on youth violence at the School Without Walls in an event also attended by Office of the U.S. Attorney and Federal Bureau of Investigation officials.
- Discussing opiates and heroin awareness at the Mickey Leland House.
- Attending the Hillcrest community’s “What’s Going on with Heroin” event to raise awareness about the public health risks of heroin.
- Attending the “Building Bridges of Trust” program, which brought together local law enforcement professionals and community members to talk about police-community relations, at Shiloh Baptist Church.
- Meeting with National Institutes of Health officials to collaborate on a safe sleep media campaign and a fall 2017 conference.
- Meeting with officials from the National Child Traumatic Stress Network about trauma-informed care.
- Helping to plan the Office of the U.S. Attorney’s annual youth summit.

- Visiting the Malcom X Opportunity Center once a week to meet community members.
- Attending a meeting of Mayor Bowser’s “Safer, Stronger” outreach team and shadowing outreach workers in the community.

The CFRC leadership and staff received positive reviews for helping improve the CFRC’s operations and work products.

The capacity-building efforts funded through the OVSJG grants described in the prior section reflect efforts by the CFRC leadership and staff, who were credited with facilitating a variety of other reform initiatives in interviews conducted by ODCA. In particular, interviewees cited the leadership provided by Dr. Roger Mitchell since he became Chief Medical Examiner and CFRC co-chair in 2014 as an important factor in improving the CFRC’s operations.

CFRC members commended Dr. Mitchell for his high level of engagement in CFRC proceedings, keeping case discussions focused, and for reinforcing a constructive tone that promotes productive case discussions. One member characterized the more constructive tone as a “culture shift.” In addition, members praised the CFRC leadership for scheduling presentations by agency representatives and outside experts to inform the group about available resources and current issues in child protection, such as restorative justice.

More generally, CFRC members noted that in the past several years, the CFRC leadership had placed more emphasis on regular attendance, helping to ensure that the group would attain the quorum needed for it to conduct official business. Members also credited the CFRC staff with providing detailed case summaries that serve as the basis for the group’s discussions, and stated that the quality of the summaries had improved.

Although CFRC members interviewed by ODCA expressed optimism about the direction of the CFRC, a range of significant concerns persist. While recognizing improvement in the tone and candor of case discussions, several CFRC members stated that defensive or territorial behavior remains an impediment to productive deliberations. As noted in the previous sections of this report, many CFRC members believe that the organization must continue to improve the quality of its recommendations and promote agency implementation. Sustained efforts are needed for the CFRC to translate improvements in organizational capacity, management, and operations into tangible improvements in the lives of children and their families.

The CFRC membership reflects the multi-agency, multi-disciplinary structure prescribed by law, but there have been a significant number of vacancies.

As noted in the background section of this report, the CFRC’s authorizing legislation prescribes that the panel shall be comprised of at least one representative from each of 13 designated D.C. government agencies; at least one representative from five federal, judicial, and other categories; and eight community representatives.⁴² The CFRC’s membership as of November 15, 2016, is shown in Figure 16 (see next page), along with positions that were vacant. As of that date:

- Eight of the 13 D.C. government agencies that are included in the CFRC had active members.⁴³
- Four of the five of the federal, judicial, and other sectors had active members on the CFRC.⁴⁴
- One of the eight community positions was filled by an active member.

The CFRC’s membership reflects the statutory intent to include a broad range of disciplines from both the public and private sectors. As shown in Figure 16, the membership as of November 15, 2016, encompassed human services agencies (such as the CFSA and the Department of Human Services), health care agencies (DOH and Department of Health Care Finance), public safety agencies (MPD and fEMS), federal and judicial agencies (Office of the United States Attorney for the District of Columbia and D.C. Superior Court), and private-sector organizations (Children’s National Health System and Howard University School of Social Work). CFRC members interviewed by ODCA cited the panel’s interdisciplinary structure as a key strength, not only because it brings a wide range of expertise to the discussion of child fatality cases, but it also helps members learn about programs offered by other agencies and make appropriate referrals of vulnerable children and their families, thereby reinforcing the CFRC’s mission of prevention.

At the same time, vacancies left several gaps in the CFRC’s interdisciplinary structure, most notably the vacant community positions described above (the D.C. Council approved two nominations of community representatives on November 15, 2016, and they joined the CFRC after being confirmed, reducing the number of vacant community positions to five). In addition, as of November 15, 2016, the education sector (D.C. Public Schools and Office of the State Superintendent of

⁴² D.C. Code § 4-1371.04.

⁴³ The Fire and Emergency Medical Services Department and the Office of the Attorney General each had two active members at this time.

⁴⁴ D.C. Superior Court had six active members at this time: two Superior Court judges, two officials from the Family Court Social Services Division, and two officials from the Center for the Study of Social Policy who were D.C. Superior Court appointees.

Education) was not represented on the CFRC because ppointments from both agencies were in process at that point.

Figure 16: CFRC Membership as of November 15, 2016

D.C. Government Agencies	Federal, Judicial, and Other Sectors	Community
<ul style="list-style-type: none"> • Dr. Roger Mitchell, OCME (CFRC co-chair) • Sakina Beth Thompson, Department of Human Services • Christian Greene, CFSA • Dr. Torey Mack, DOH • Colleen Sonosky, Department of Health Care Finance • Assistant Chief Robert Alder, MPD • Aleazor Taylor and Tony Falwell, FEMS • Erin Cullen and Tamar Meekins, Office of the Attorney General <p>Notes: Nominations to fill vacant slots for the DYRS, the D.C. Public Schools, and the Office of the State Superintendent of Education were pending at this point; slots reserved for the Department of Behavioral Health and the D.C. Housing Authority were vacant; no nominations were pending at this point.</p>	<ul style="list-style-type: none"> • Cynthia Wright, Office of the United States Attorney (CFRC co-chair) • Judge Hiram Puig-Lugo, D.C. Superior Court • Judge Carol Dalton, D.C. Superior Court • Lawrence Weaver and Terri Odom, D.C. Superior Court Family Court Social Services Division • Judith Meltzer and Rachel Paletta, Center for the Study of Social Policy (appointed by D.C. Superior Court) • Dr. Eric Rosenthal, Children’s National Health System • Jacqueline Smith, Howard University School of Social Work <p>Note: A nomination to fill a vacant slot reserved for the Mayor’s Committee on Child Abuse and Neglect was pending at this point.</p>	<ul style="list-style-type: none"> • Jelani Freeman <p>Note: Although seven community positions were vacant at this point, two nominations (Claudia Booker and Marie Cohen) were approved by the D.C. Council on November 15, 2016, and they began serving shortly thereafter.</p>

Source: Mayor’s Office of Talent and Appointments.

The vacancies on the CFRC and the associated gaps in agency and sector representation reflects frequent turnover in some positons. A review of the D.C. Register, the D.C. government’s official legal bulletin, from March 2016 through February 2017 showed that 13 new members were appointed during that period. Among the 13 new appointees, 11 were D.C. government representatives from eight different agencies, and two were community members. Among five appointments to the CFRC announced in Mayor’s Order 2017-19, dated January 18, 2017, three were to fill vacant seats.

In the most notable example of turnover for a single agency, Sergeant Robert Parker was appointed to represent MPD on the CFRC on August 8, 2014, but was then replaced by Commander Robert Alder on August 31, 2016. Commander Alder was then replaced by Commander Leslie Parsons on January 18, 2017. In addition, Sergeant Keith Batton was named as another MPD representative on January 18, 2017, filling a vacant seat.

Although some turnover is inevitable as individuals change jobs or leave their organizations, the level of turnover may impede the effectiveness of the CFRC because the work is very complex and may involve a significant learning curve. Moreover, membership instability may make it more difficult for the CFRC to fulfill its duty to identify patterns in child fatalities over time.

A diverse but stable agency membership also yields indirect but important benefits through informal relationship building. As noted earlier, a number of CFRC members interviewed by ODCA stated that they benefited from getting to know colleagues from other agencies whom they could contact about problems facing children and their families in their daily work. For example, one member described contacting CFRC colleagues to cut through “red tape” with CFSA and Children’s Hospital. To build and maintain a cohesive interdisciplinary body that can work on child protection in both formal and informal ways, the Mayor’s Office of Talent and Appointments could encourage agency directors to view a CFRC appointment as a commitment of at least two years, whenever possible.

The problem of vacant positions has also been particularly salient for the eight community members, who serve three-year terms. Several individuals interviewed by ODCA noted that the community members can serve an important role, because they are not appointed to represent particular organizations and therefore may have more latitude to express their views, as well as different perspectives than government appointees. As noted earlier, seven of the eight community positions were vacant as of November 15, 2016, although Claudia Booker and Marie Cohen were confirmed by the D.C. Council as community representatives the same day and their appointments were officially promulgated by Mayor’s Order 2016-188, dated December 2, 2016. A search of the council’s legislative database found that only one other community member besides Ms. Booker and Ms. Cohen had been nominated in the past three years.⁴⁵

CFRC members who were interviewed by ODCA offered some reasons why it may be difficult to maintain eight community members on the panel. Not only does effective service on the CFRC require a major time

⁴⁵ Claudia Booker and Marie Cohen were nominated in September 2016, and Sandra Williams was nominated in July 2014.

commitment as well as the ability to attend meetings during the day, but the work is also difficult and requires relevant experience.

Community members are also the only CFRC appointees who must be confirmed by the D.C. Council,⁴⁶ a process which often delays their appointments by several months. Because CFRC members serve only in an advisory capacity, rather than making policy decisions, adjudicating cases, or issuing regulations, the council could change the law to eliminate the confirmation process for CFRC community members so they can begin serving immediately upon appointment, similar to the current practice for several advisory panels.⁴⁷ Another option would be for the D.C. Council to create a statutory limit on the confirmation period, after which the nominations would automatically be approved. Current practice also provides precedent for such a step: the D.C. Official Code lists more than 40 boards or commissions with a time limit on the council's confirmation process. If the council does not act within the statutory time frame, the nomination is deemed approved.⁴⁸

ODCA reviewed the legislative history of 18 nominations of community members to the CFRC since 2009; one of these nominations appeared to be duplicative because the individual had already been nominated to the CFRC earlier in the same year.⁴⁹ Among the other 17 nominations, 10 were approved by the D.C. Council, four were not voted on, and three were withdrawn (the record does not state why nominations were withdrawn or not voted on).

The confirmation process for CFRC community members appears to be inefficient because almost half (seven of 17) of the nominations made since 2009 did not receive a vote and because there are sometimes significant delays between a nomination and final vote. Almost eight months elapsed between the nomination of Tara Taylor (P.R. 18-768) on March 10, 2010, and her unanimous confirmation by the council on November 9, 2010, while more than six months elapsed between the nomination of Jelani Freeman (P.R. 20-445) on September 18, 2013, and his unanimous confirmation by the D.C. Council on April 8, 2014.

⁴⁶ D.C. Code § 4-1371.04(c).

⁴⁷ There is precedent for this approach, as the D.C. Council does not confirm appointees to several commissions, such as the Commission on Latino Community Development and the Commission on Aging, that serve advisory roles.

⁴⁸ See D.C. Official Code §1-523.01(f). Boards and commissions with nominees who are subject to time limits on D.C. Council confirmation include the Apprenticeship Council, the Board of Dentistry, and the Child Support Guideline Commission.

⁴⁹ P.R. 18-1000, a 2010 nomination of Tara Taylor to serve as a CFRC community member, appeared to be duplicative because Ms. Taylor had already been nominated earlier in 2010 by P.R. 18-768.

Recommendation

6. The D.C. Council should exempt community members of the CFRC from the confirmation process or place a limit on the confirmation review period, after which nominees would be deemed confirmed. The D.C. Council should revise the law to require a minimum of four community representatives on the CFRC.

The CFRC membership, as prescribed by statute, omits the public charter schools.

During this study ODCA learned that the Public Charter School Board is not required by law to appoint a representative to the CFRC and that public charter schools do not participate in the child fatality review process. By contrast, the Mayor is required by law to appoint a representative of the DCPS to the CFRC.

The omission of public charter schools from the CFRC's statutory membership is significant, because public charter schools enrolled almost as many students in the fall of 2016 (41,505) as DCPS did (48,556).⁵⁰ The CFRC has identified truancy as a significant risk factor, making it important for officials to track the status of truant students regardless of what type of school they attend. In addition, the ability of students to switch from DCPS to public charter schools, and vice versa, reinforces the importance of coordination between DCPS and the charter schools. In the tragic case of the Jacks family, where four girls were found dead at home in 2008, all of the girls had stopped attending their charter schools almost a year before their deaths were discovered. One CFRC member interviewed by ODCA stated that when a child dies, it is often difficult for the CFRC to find out if the child was attending school, a point that underscores the need for participation both by DCPS and charter schools.

Recommendation

7. The D.C. Council should amend the Child Fatality Review Committee Establishment Act of 2001 to require the Public Charter School Board to appoint a representative to the CFRC.

⁵⁰ There were 47,892 students at traditional DCPS schools, 533 students at DCPS alternative schools, and 131 students at DCPS special education schools. In addition, there were 40,350 students at traditional charter schools, 904 students at alternative charter schools, and 251 students at special education charter schools. See Office of the State Superintendent of Education, "Schedules of Student Enrollment and Independent Accountant's Examination Reports Thereon for the School Year Period Ended October 5, 2015," pp. 11-16.

The CFRC has undertaken a broader range of activities that could help fulfill its statutory duty to recommend systemic improvements in public and private services for children and their families.

Although child fatality case reviews represent the core activity of the CFRC and the basis for recommending systemic improvements in public and private services for children and their families, there are other ways that child death review teams can promote advances in child protection. National research on child death review teams by academics and professional associations has noted the work of the teams to address major causes of child fatalities, such as suicide, pool safety, safe sleeping, and safe surrender of abandoned infants.⁵¹ Child death review teams have promoted public education campaigns to reduce toddler drowning in buckets, promote the use of child-proof medicine containers, encourage fencing of pools to prevent children from drowning, and urge people to install home smoke detectors.⁵²

The following are examples of public education campaigns, policy changes, and program initiatives that have been cited in the research literature as resulting from the work of state child fatality review teams:

- An awareness campaign on shaken baby syndrome, providing educational videos to doctors' offices and social services agencies in Virginia.
- A publicity campaign to highlight the dangers of bed sharing between adults and infants, which included letters to all 3,500 child health care providers in the state in Massachusetts.
- Enactment of stronger laws governing motor vehicle restraints for children in Georgia.
- Enactment of a law requiring helmet use by all-terrain vehicle operators and passengers under the age of 18 in Tennessee.
- Systemwide improvements the child welfare system, including funding increases, training requirements, and interagency protocols, in Nevada.⁵³

The CFRC has already begun placing greater emphasis on community outreach and public education by using OVSJG grant funding to hire an outreach specialist in April 2016, as discussed earlier in this report. As stated in the CFRC's FY 2017 grant application to the OVSJG, "The Outreach Program Specialist will also take the lead in outreach and

⁵¹ See Michael Durfee, Juan Parra, and Randell Alexander, "Child Fatality Review Teams," *Pediatric Clinics of North America*, Vol. 56 (2009), p. 381.

⁵² See Neil Hochstadt, "Child Death Review Teams: A Vital Component of Child Protection," *Child Welfare*, Vol. 85 (2006), p. 664.

⁵³ These examples are based on Neil Hochstadt, "Child Death Review Teams: A Vital Component of Child Protection," *Child Welfare*, Vol. 85 (2006), p. 665, and American Academy of Pediatrics, "Policy Statement – Child Fatality Review," *Pediatrics*, Vol. 126, No. 3 (September 2010), p. 593.

engagement with the community by providing information on the role and function of the CFRC, promoting the 2015 CFRC Annual Report, and sharing the recommendations from the Annual Report and obtaining feedback from the community ... through ‘listening tours.’”⁵⁴

In addition, the CFRC is planning an initiative to engage both the public and private sectors in a campaign to educate the public on safe sleep practices and the dangers of bed sharing between adults and children. The campaign would include a conference in the fall of 2017 to share information and generate publicity. One of the strategies CFRC members have discussed is to focus on male caregivers who are not knowledgeable about safe sleep. As noted earlier, unsafe sleep conditions have been a significant factor in the deaths of infants and young children. In 2014, the CFRC reviewed six infant deaths that involved unsafe sleep environments. The planned campaign on safe sleep reflects an effort to promote larger-scale behavioral change intended to protect children by addressing a problem that has been a factor in multiple cases reviewed by the CFRC.

Another way for the CFRC to promote systemic change would be to publish special reports on major topics related to child fatalities, in order to highlight the problems and possible solutions for policymakers and the general public. Although the CFRC has published special reports on subjects such as youth homicide, youth homicides in the Washington Highlands neighborhood, safe sleep, and fatal abuse deaths, it has not issued any of these special studies for at least the past five years.

Recommendation

- 8.** The CFRC should continue its efforts to promote systematic improvements in public and private systems serving children and their families through public education and policy change.

⁵⁴ Office of the Chief Medical Examiner, “FY 2017 Consolidated Request for Applications (RFA) – Fatality Review Unit Project,” pp. 17-18.

Evaluation Results Summary

Finding	Recommendation
Child deaths in the District of Columbia decreased significantly from 2008 to 2015, falling faster than overall deaths. Moreover, the drop in the death rate among 5- to 14-year-olds , and among 15- to 19-year-olds, was particularly sharp.	No recommendation was made.
Infant mortality rates in the District of Columbia have dropped significantly.	No recommendation was made.
Infant deaths in the District of Columbia are primarily natural deaths and are strongly associated with certain risk factors such as inadequate prenatal care, prematurity, and low birthweight.	No recommendation was made.
Homicides, which have been the leading cause of death among 15- to 19-year-olds in the District of Columbia, have decreased significantly among children and youth.	No recommendation was made.
Child homicides in the District of Columbia are primarily due to gun violence among youth, and the victims are primarily African-American.	No recommendation was made.
Sharp racial and geographic disparities in child mortality rates persist in the District of Columbia. African-American children, as well as children in Wards 5, 7, and 8, suffer the highest rates of mortality.	No recommendation was made.
Child fatalities in the District of Columbia disproportionately affect boys and young men.	No recommendation was made.
The recommendations issued by the CFRC from 2011 to 2014 address a broad range of the program, practice, and management issues that reflect the issues and trends highlighted in the CFRC's annual reports	No recommendation was made.
Even though agencies usually agreed with CFRC recommendations or agreed with modifications between 2011 and 2014, agency agreement often seemed pro-forma rather than reflecting a genuine commitment to change policies or procedures.	1. The CFRC should continue its effort to draft more focused recommendations that are based on case findings, using the SMART model as a guideline for improving the quality of the recommendations.

Finding	Recommendation
A review of six CFRC recommendations issued in 2013 and 2014 indicates an impact that is modest at best and often unclear. Three of the six recommendations had been implemented, but in two of the three cases the outcome did not seem directly related to the CFRC's recommendation.	2. The D.C. Council should hold a public hearing on each CFRC annual report, as required by law. 3. The City Administrator should ensure that agencies incorporate CFRC recommendations into annual performance plans and reports, as required by law.
The number of child fatalities analyzed in CFRC annual reports has dropped sharply, from 122 in 2010 to 35 in 2015.	4. OCME should seek to identify an additional staff position for the CFRC to conduct statistical reviews and help the CFRC fulfill its mission to review all child deaths in the District of Columbia.
The CFRC has published its annual reports on a more timely basis in recent years, but has fallen short of goals to publish the reports by September 30 of each year.	5. OCME should include in its annual performance plans the goal of publishing the CFRC's annual report by September 30 of the following year.
The CFRC has taken steps to build its capacity in recent years, drawing on grants provided by the Office of Victim Services and Justice Grants, as well as internal initiatives.	No recommendation was made.
The CFRC leadership and staff received positive reviews for helping to improve the CFRC's operations and work products.	No recommendation was made.
The CFRC membership reflects the multi-agency, multi-disciplinary structure prescribed by law, but there have been a significant number of vacancies.	6. The Council should exempt community members of the CFRC from the confirmation process or place a limit on the confirmation review period, after which nominees would be deemed confirmed.
The CFRC membership, as prescribed by statute, omits the public charter schools.	7. The D.C. Council should revise the law to require a minimum of four community representatives on the CFRC.
The CFRC has undertaken a broader range of activities that could help fulfill its statutory duty to recommend systemic improvements in public and private services for children and their families.	8. The CFRC should continue its efforts to promote systematic improvements in public and private systems serving children and their families through public education and policy change.

Conclusion

This year marks the 25th anniversary of the CFRC, which grew out of a national movement that began in 1978, when Los Angeles County established the first child death review team. Other California counties followed suit, as did states, including Oregon, South Carolina, and Missouri. In 1996 the federal Child Abuse Prevention and Treatment Act required each state to have a citizen review panel that would review child maltreatment deaths, and by 2016 there were more than 1,350 state and local child death review teams operating in all 50 states and the District, according to the National Center for Fatality Review and Prevention. The CFRC is one of the child death review teams with the most ambitious mandate: to review *all* child deaths in the jurisdiction.

The CFRC stands at a critical juncture. As this report notes, the child death rate in the District of Columbia dropped 39 percent from 2008 to 2015, reflecting particularly sharp declines in deaths among 5- to 14-year-olds and 15- to 19-year-olds. Even with this progress, the child death rate in the District is 69 percent higher than the national average, and mortality rates for certain subgroups, such as African-American children and children living in Wards 5, 7, and 8, exceed the District's own average.

The CFRC can play a major role in the effort to reduce child fatalities and promote child welfare more broadly. As described in this report, in recent years the CFRC has enhanced its human, managerial, technological, and analytic capacity to identify the family and systemic conditions that contribute to child deaths and devise ways to prevent those deaths. By implementing changes ranging from a web portal for sharing case information to a community outreach initiative and a stronger training program, the CFRC has positioned itself to be a stronger voice for vulnerable children and their families. Individuals interviewed for this project noted that the conditions that lead to child deaths also cause harm to a wide range of children, likening the fatality cases that are examined to a “canary in a coal mine” in terms of potential harm to children.

Many of the CFRC's reform initiatives are at an early stage. The effort to draft stronger, more focused recommendations that will gain acceptance from executive branch agencies is underway but has not yet demonstrated results. To be effective, the CFRC must reverse the decline in the number of child fatality cases reviewed for its annual reports. The task ahead is to translate the reform efforts into better outcomes for children and, most importantly, the prevention of child fatalities. Accomplishing the mission of the CFRC requires both action and oversight from the Mayor, Council, agency directors, and other senior officials.

Agency Comments

On June 15, 2017, we sent a draft of this report to the Office of the Chief Medical Examiner (OCME) and the Office of the City Administrator (OCA). OCME and OCA both responded on June 30, 2017; their comments are included below in their entirety, followed by ODCA's response.



GOVERNMENT OF THE DISTRICT OF COLUMBIA
OFFICE OF THE CHIEF MEDICAL EXAMINER
401 E Street, S.W.
Washington, DC 20024

202-698-9000 (Main)

202-698-9101 (Fax)

June 30, 2017

Kathleen Patterson
District of Columbia Auditor
717 14th Street, N.W., Suite 900
Washington, DC 20005

Dear Mrs. Patterson,

Thank you for providing us with the opportunity to review the draft report entitled **Child Fatality Review Committee Can Build on Recent Reforms** (Report). We are excited that the efforts of the Office of the Chief Medical Examiner (OCME) and the Child Fatality Review Committee (CFRC) have been recognized. Both the OCME and the CFRC have been working diligently to reduce preventable deaths of infants, children and youth within the District of Columbia.

We are particularly impressed that you highlighted the numerous times that the CFRC identified child fatality trends similar to the Department of Health and U.S. Centers for Disease Control. Importantly, you noted that the CFRC data went beyond those trends and also highlighted comprehensive health, social, environmental and behavioral risk factors. This comprehensive approach to case review is in support of the CFRC's efforts over the last two years to restructure the recommendation process to garner more robust outcomes for children and families. As the restructuring efforts continue, the CFRC staff will evaluate the Report's recommendation categories for adoption with an immediate focus on utilizing the SMART approach to the CFRC's recommendation process.

It is because of the continued level of engagement and participation of the CFRC membership comprised of District agencies, federal and community partners that we have been able to make excellent strides forward in this critically important work. We commend the members' initiative and welcome their continued contributions in protecting the District's most vulnerable children and families. We also thank you for your agency's commitment to the service of our District families and communities.

Sincerely,



Roger A. Mitchell, Jr., MD FASCP
Chief Medical Examiner

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Office of the City Administrator



June 30, 2017

Kathleen Patterson, District of Columbia Auditor
Office of the District of Columbia Auditor
717 14th Street, NW, Suite 900
Washington, DC 20005

Re: Office of the District of Columbia Auditor's draft audit report entitled "Child Fatality Review Committee Can Build on Recent Reforms"

Dear Ms. Patterson:

Thank you for the opportunity to review and provide comments on the Office of the District of Columbia Auditor's draft audit report entitled "Child Fatality Review Committee Can Build on Recent Reforms", dated June 15, 2017.

In that report, your office recommended that the City Administrator should ensure that agencies incorporate Child Fatality Review Committee (CFRC) recommendations into annual performance plans and reports, as required by law. This recommendation was based on your office's review of the CFRC's activities, findings, and recommendations from 2011 through the present.


The Office of the City Administrator agrees with this recommendation. OCA will work with agencies to ensure that relevant recommendations of the CFRC are included in the agencies' performance plans.

It should be noted, however, that when a CFRC recommendation is made during a fiscal year, it would be unnecessary to include the recommendation in the agency's performance plan if the recommendation is implemented by the agency within that same fiscal year (and therefore before the time frame of the agency's subsequent performance plan). In addition, OCA might not ensure inclusion of a recommendation in an agency's annual performance plan if the agency disagrees with the CFRC recommendation.



Thank you again for providing the opportunity to review and comment on the draft report. If you have any questions, please do not hesitate to contact me, or have your staff contact Jennifer Reed, Chief Performance Officer, at 202- 478-9206.

Sincerely,



Rashad M. Young
City Administrator

cc: Jason Juffras, Audit Supervisor, Office of the District of Columbia Auditor

ODCA Response to Agency Comments

ODCA appreciates the written comments on the draft report provided by OCME and OCA.

While OCME did not directly address each recommendation directed to the agency, we are pleased that the office indicated that it would bring “an immediate focus on utilizing the SMART approach to the CFRC’s recommendation process.” We look forward to providing updates on the implementation of that and other ODCA recommendations through our compliance reporting process.

There appears to be a misunderstanding on the part of OCA with regard to the requirement that CFRC recommendations be made a part of the performance plans of agencies to which the recommendations were directed. Not only does the law⁵⁵ require an agency director to respond in writing to the CFRC within 30 days of the publication of a recommendation, the statute explicitly states that “the policy recommendations to a particular agency...shall be incorporated into the annual performance plans and reports” that are required by the Government Managers Accountability Act.

The OCA letter suggests that a recommendation may be omitted from a performance plan if the agency disagrees with the CFRC recommendation, but the law does not provide discretion to ignore recommendations. If there is a disagreement, the rationale presumably could be included in the performance plan text, but ignoring the recommendations of the CFRC is not permitted by the statute.

⁵⁵ D.C. Code § 4-1371.09(l)