GOVERNMENT OF THE DISTRICT OF COLUMBIA
Child and Family Services Agency

OFFICE OF THE DIRECTOR

May 2, 2023

Marie K. Cohen
Child Welfare Monitor
marie@childwelfaremonitor.org

Ms. Cohen,

I am sending you this letter on behalf of the Child and Family Services Agency (CFSA) Director Robert L. Matthews, in response to your letter dated April 19, 2023, regarding concerns you raised about our initial response to your March 14, 2023, request for documentation and/or information regarding a child fatality or near fatality. Specifically, you questioned the level of redaction that we made to the documents that we have produced thus far, and you expressed that you believe that our response is in violation of DC Code §§ 4-1303.31 - 4-1303.32. We do not agree. In your letter, you also requested that CFSA provide the complete information that you requested by April 29th and information on all the near-fatalities from 2017 to the present.

As a result of your letter, we are requesting that you destroy and/or return any records that you have received thus far. In addition, we have done an additional review of any potential responsive information and apologize for the delay in resending the responsive information to you. As I previously advised, the information is voluminous and took time to review, re-review and complete redactions. Unfortunately, you will not be able to receive all of the documents at one time and we will continue to produce them electronically on a rolling basis as I also advised.

Please find accompanying this letter, Batch #1 of the information responsive to your request. Information was withheld and redacted in Batch #1 pursuant to DC Code §§ 4-1303.32(A); (E); and (G). We are also withholding any information regarding the death of a child that was not determined to be the "result of child abuse, neglect, or maltreatment, as certified by a physician, or the Chief Medical Examiner" pursuant to DC Code §§ 4-1303.31 - 4-1303.32. For purposes of your request, accidental deaths are not considered child fatalities as defined by DC Code § 4-1303.31(2)(A). Additionally, we do not intend to provide any information where the cause of death is unknown to CFSA. In your letter, you referenced 26 deaths in 2018 and seven in 2017 where the "manner was undetermined". For those deaths, the cause of death is unknown to CFSA. We do intend to provide information where we know that the Chief Medical Examiner could not rule out child abuse, neglect, or maltreatment as contributing to the cause of death pursuant to DC Code § 4-1303.31(2)(B).

Regarding your request for near-fatalities from 2017 to the present, CFSA only recently started tracking near-fatalities as of October 2022 and does not generate or publish reports on near fatalities. As such, CFSA does not have any information responsive to that portion of your request. If you have any questions, please contact me at nicola.grey@dc.gov or (202) 442-4238.

Best regards,

Nicola N. Grey
Deputy General Counsel

GOVERNMENT OF THE DISTRICT OF COLUMBIA

Child and Family Services Agency
200 I Street, SE
Washington, DC 20003

CONFIDENTIAL

[redacted]

February 17, 2019 – February 6, 2020

Child Fatality Case Review

March 12, 2020

[redacted]

Fatality Notification/Circumstances

On February 6, 2020, a Metropolitan Police [redacted] officer contacted the Child and Family Services Agency (CFSA) Hotline regarding [redacted] (age 11 months). It was reported that the mother, [redacted] presented to Children's National Medical Center (CNMC) with the infant and provided three different stories. According to the mother, the child fell on Monday; on Tuesday, the child was unable to walk or hold her head up. She further indicated that she put the child in the tub on Wednesday, walked away (length of time not documented), and found the child face down in the tub when she returned. She performed cardiopulmonary resuscitation (CPR) on the infant; when water came up, [redacted] thought the child was okay. The child was pronounced deceased at 2:42 pm. Local news outlet NBC Washington reported that the cause of death was blunt force trauma to the head. According to MPD, the manner of death was homicide.

Methodology

This case is applicable for review because the family was involved with CFSA within the five years prior to the fatality. In preparing this report, the Child Fatality Review Specialist reviewed available FACES.net information and spoke to two Family Assessment (FA) social workers, a CFSA investigator, an FA supervisor, three CPS social workers, an OAG, a diligent search investigator, a CFSA nurse supervisor, the Department of Youth Rehabilitation Services (DYRS) program manager care coordinator and a CPS supervisor. An attempt was made to contact an additional CPS social worker, another FA supervisor and an In-home social worker.

Family Composition at Time of Fatality

Mother: [redacted] **DOB:** [redacted] **Age:** 27
Father: [redacted] **DOB:** [redacted] **Age:** 24

Children	Date of Birth	Age	Father
[redacted]			
[redacted] (decedent)	[redacted]	11 months	[redacted]
Other Family Members			
[redacted]			

Information about Decedent

[redacted] was an 11-month-old African American female. Her last known physical was on May 2, 2019. Documentation from October 2019 states that [redacted] was scheduled for a doctor's

appointment on October 11, 2019; however, it is not known if [redacted] was seen on that date. It was also documented in October 2019 that [redacted] was overdue for several immunizations. A CPS social worker was present at CNMC while an MPD detective examined [redacted] body and took forensic pictures. It was documented that there was bump on the left side of her head, an injury on her forehead, and an abrasion on her right hand which may have been a burn. She also had several abrasions and bruises on her upper extremities including scratches. The medical examiner determined that there was *livor mortis* (discoloration of the skin due to the pooling of blood following death) at the bottom of [redacted], which suggests that her feet were in a suspended position after her death. Her funeral was held on [redacted].

Information about Primary Caregiver

[redacted] is a 27-year-old African American woman and the mother of four children [redacted] is the father of [redacted] three other children, including the decedent.

[redacted]. [redacted] was a teenage mother, having her first child when she was 16 years old. The maternal grandmother has cared for [redacted] since 2010. It is not verified if she obtained legal custody of him.

[redacted] has a criminal history starting in 2010 when she was arrested for assault of the maternal grandmother. She had four domestic violence (DV) cases where she was the defendant. [redacted]

During the May 2018 FA, it was documented that [redacted]. In November 2019, the family was displaced from their apartment due to a fire. [redacted]

She had community support (CSW and a housing liaison). [redacted]

[redacted] She engaged in two face-to-face community support sessions with her assigned CSW and engaged with the housing liaison. It was reported that the mother stopped answering their calls on December 2, 2019.

Information about Secondary Caregiver

[redacted] is a 24-year-old African American man and the father of three children: [redacted] (the decedent). [redacted] He was very active in the lives of his children. While he reportedly resided with the paternal great grandmother, he saw his children practically every day. He assumed care of the children for several months while [redacted]. At the time of the fatality, [redacted]

Summary of Agency Involvement

Since 2016, there were eight referrals made to the CFSA Hotline. [redacted] was the alleged maltreater in six referrals and [redacted] was the alleged maltreater in seven referrals. The referrals were made within five years of the fatality, as shown in the following table. A voluntary case was opened on July 5, 2016 and closed on October 5, 2016.

Date of Report	Referral Number	Allegation	Alleged Maltreater	Disposition
1. January 20, 2016	[redacted]	No specific allegation of abuse or neglect	[redacted]	Screen Out
2.March 15, 2016	[redacted]	Exposure to domestic violence in the home	[redacted]	Unfounded
			[redacted]	Unfounded
3.May 28, 2016	[redacted]	Exposure to domestic violence in the home	[redacted]	FA converted to CPS-I Referral [redacted]
4.June 1, 2016	[redacted]	Exposure to domestic violence in the home	[redacted]	Unfounded; voluntary case [redacted] opened 7/5/16; closed 10/5/16
5.April 17, 2017	[redacted]	Exposure to domestic violence in the home	[redacted]	Unfounded
6.May 25, 2018	[redacted]	Inadequate supervision	[redacted]	FA 5/25/18 -7/24/18

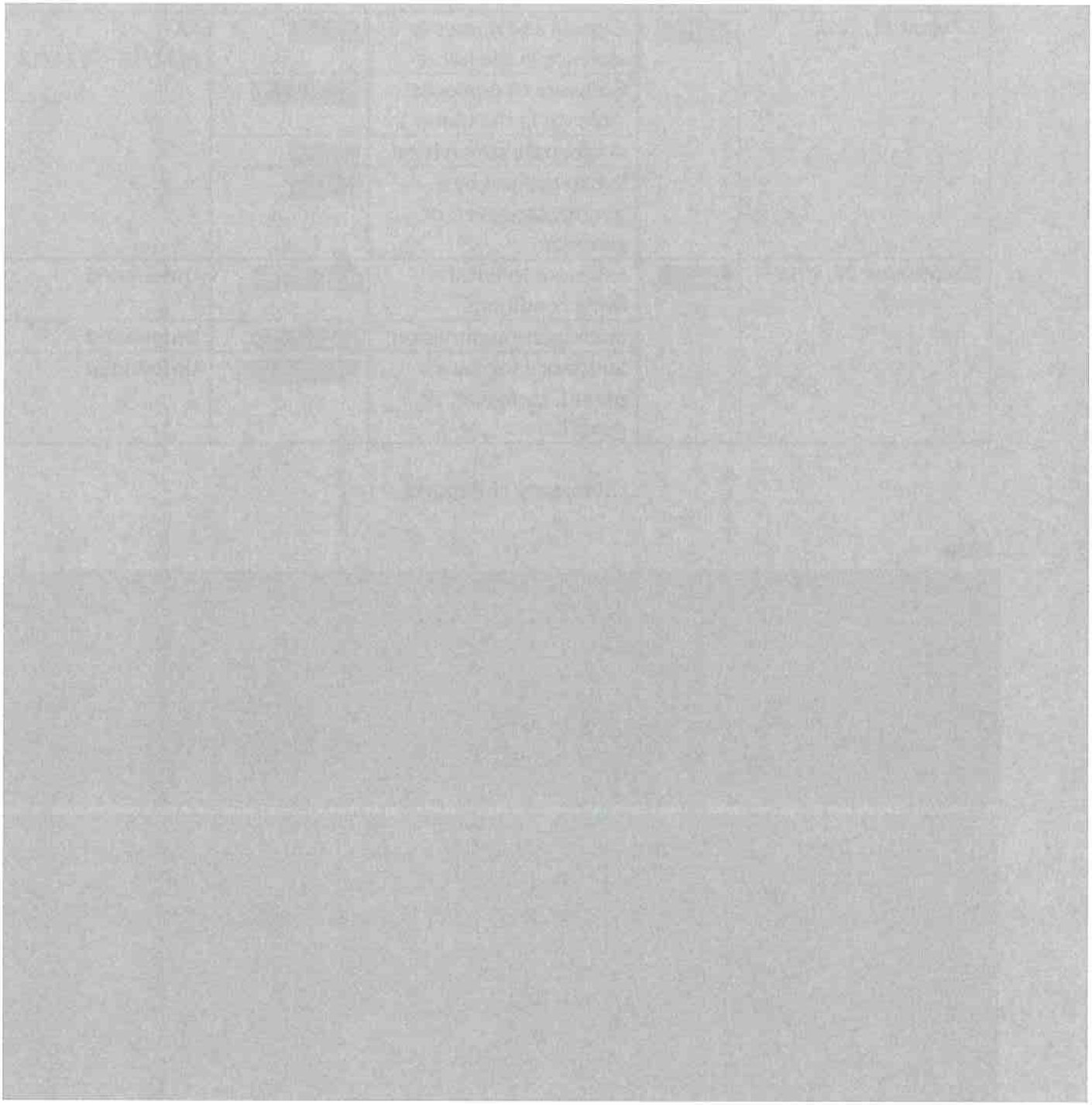
7.August 11, 2018	[redacted]	Exposure to domestic violence in the home	[redacted]	FA 8/11/18 - 9/24/18
		Exposure to domestic violence in the home	[redacted]	
		Inadequate supervision	[redacted]	
		Substance use by a parent, caregiver, or guardian	[redacted]	
8.September 28, 2019	[redacted]	Exposure to unsafe living conditions	[redacted]	Unfounded
		Inadequate supervision	[redacted]	Unfounded
		Substance use by a parent, caregiver, or guardian	[redacted]	Unfounded

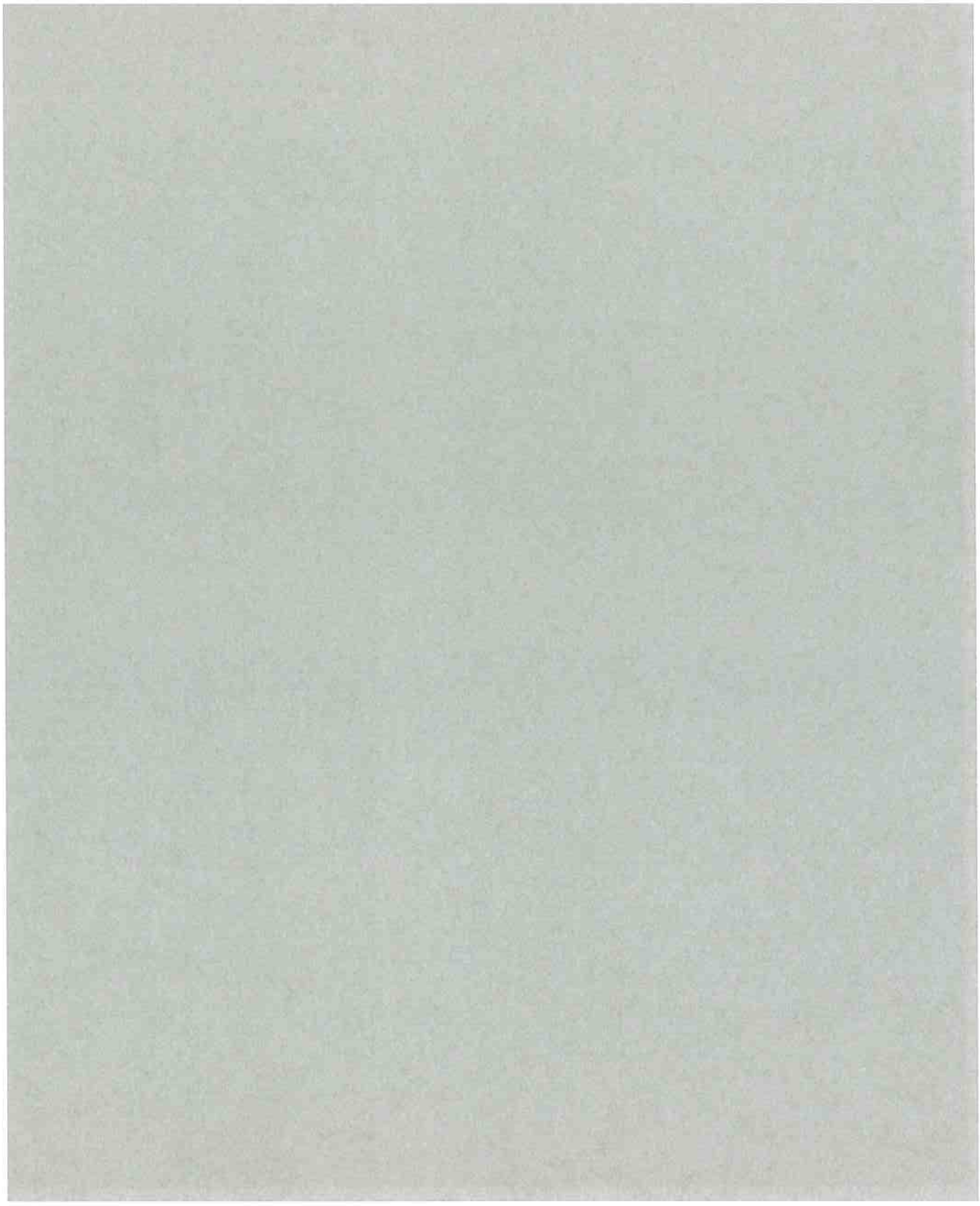
Summary of Reports

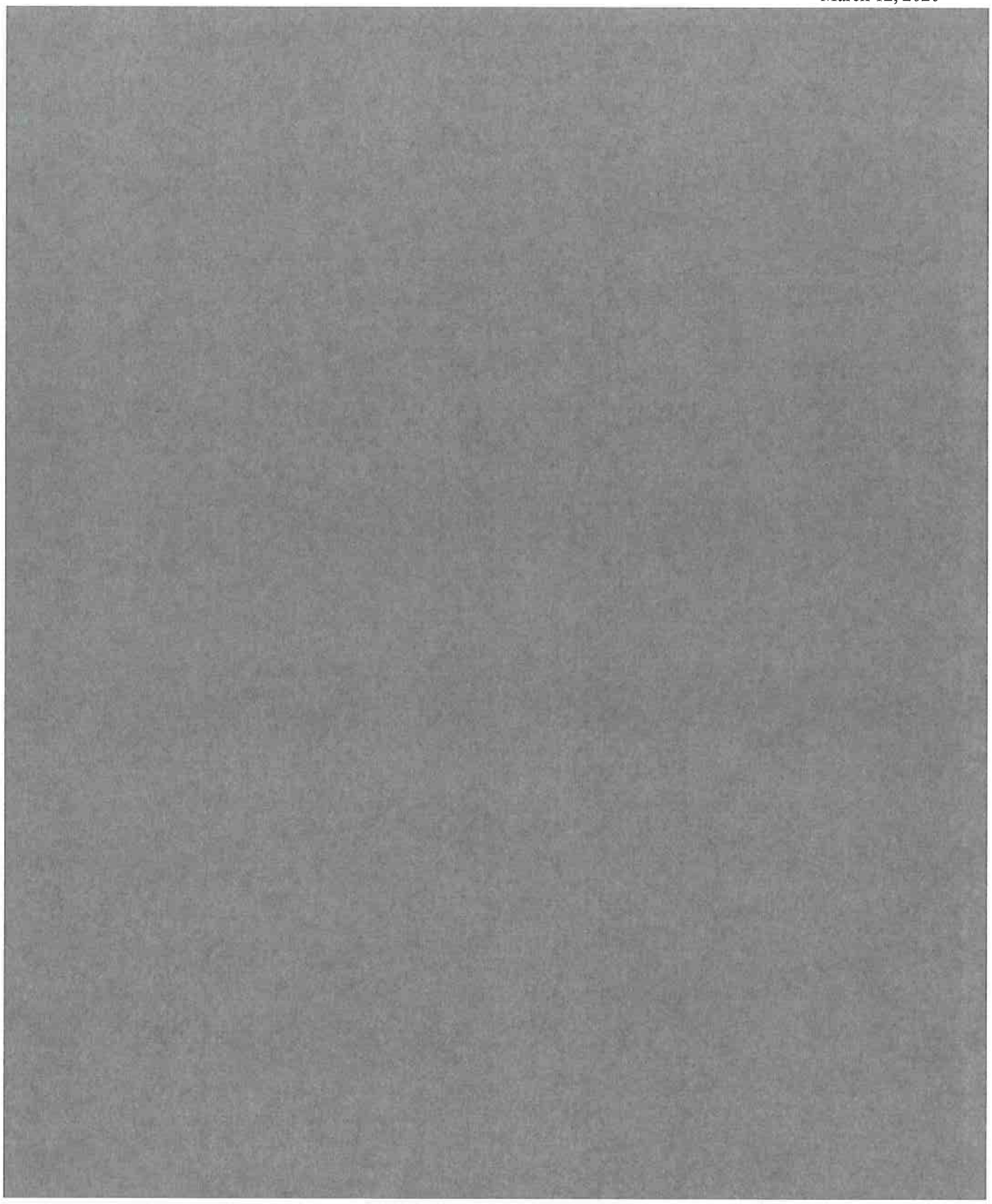
2016

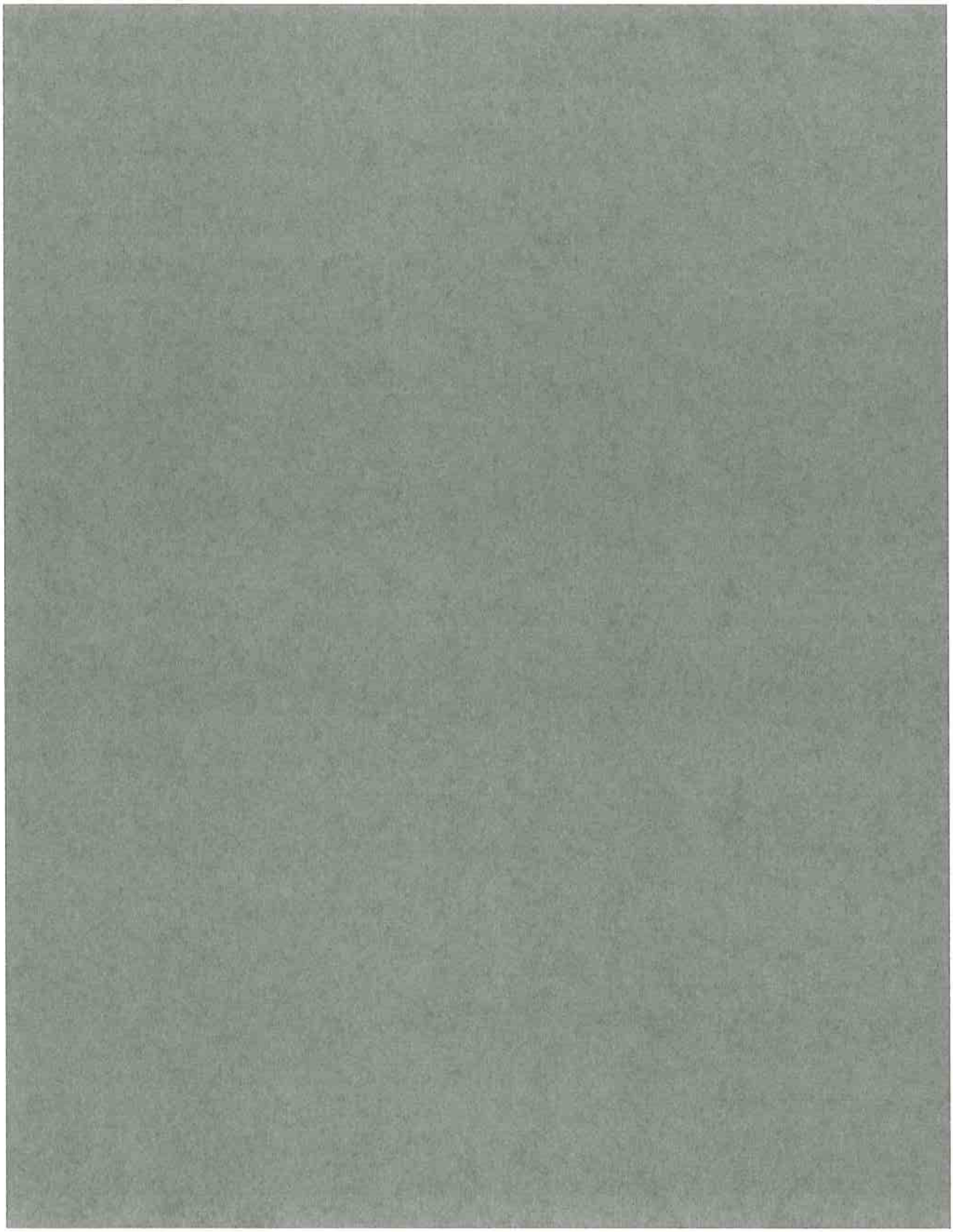
[redacted]

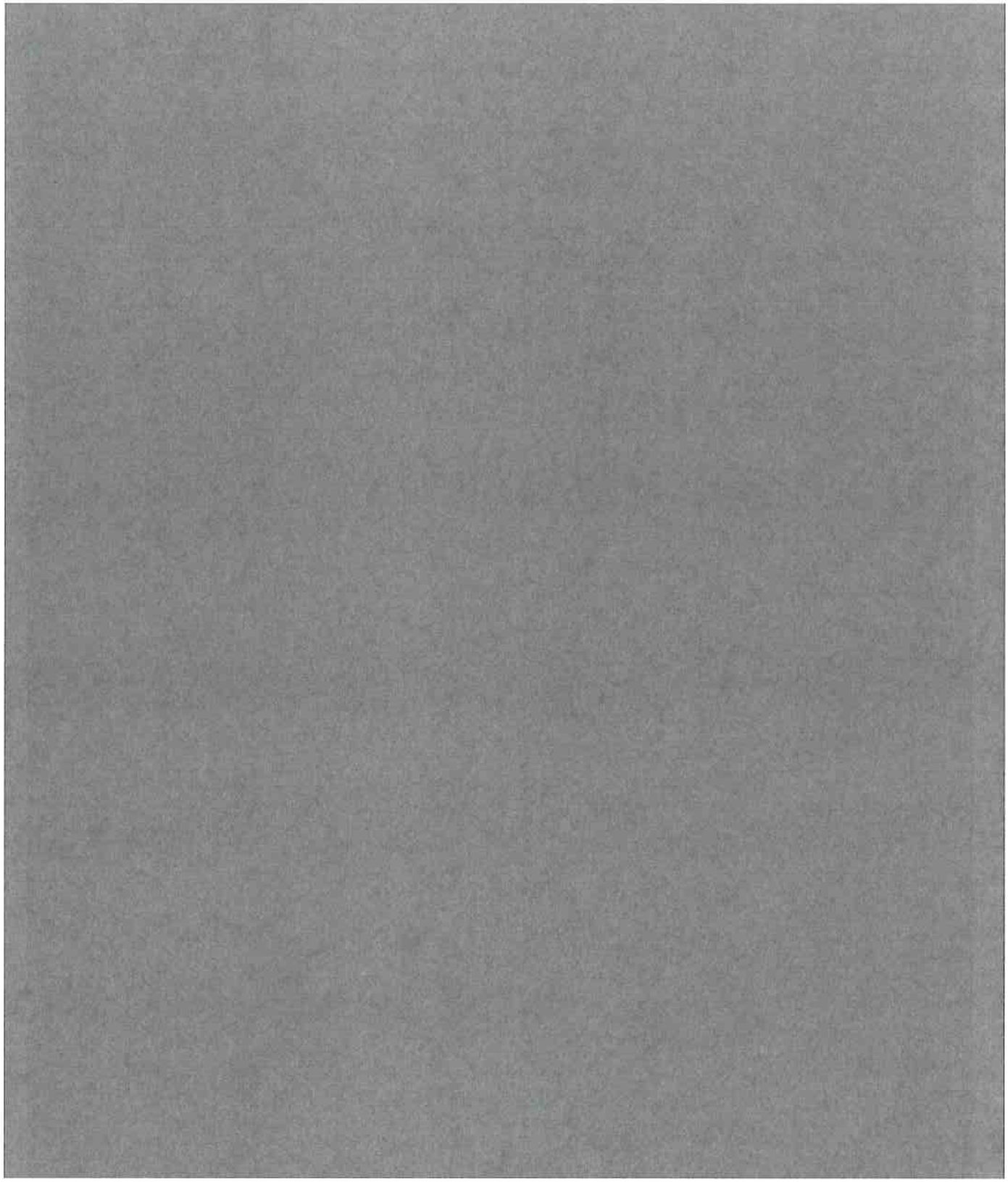
[redacted]

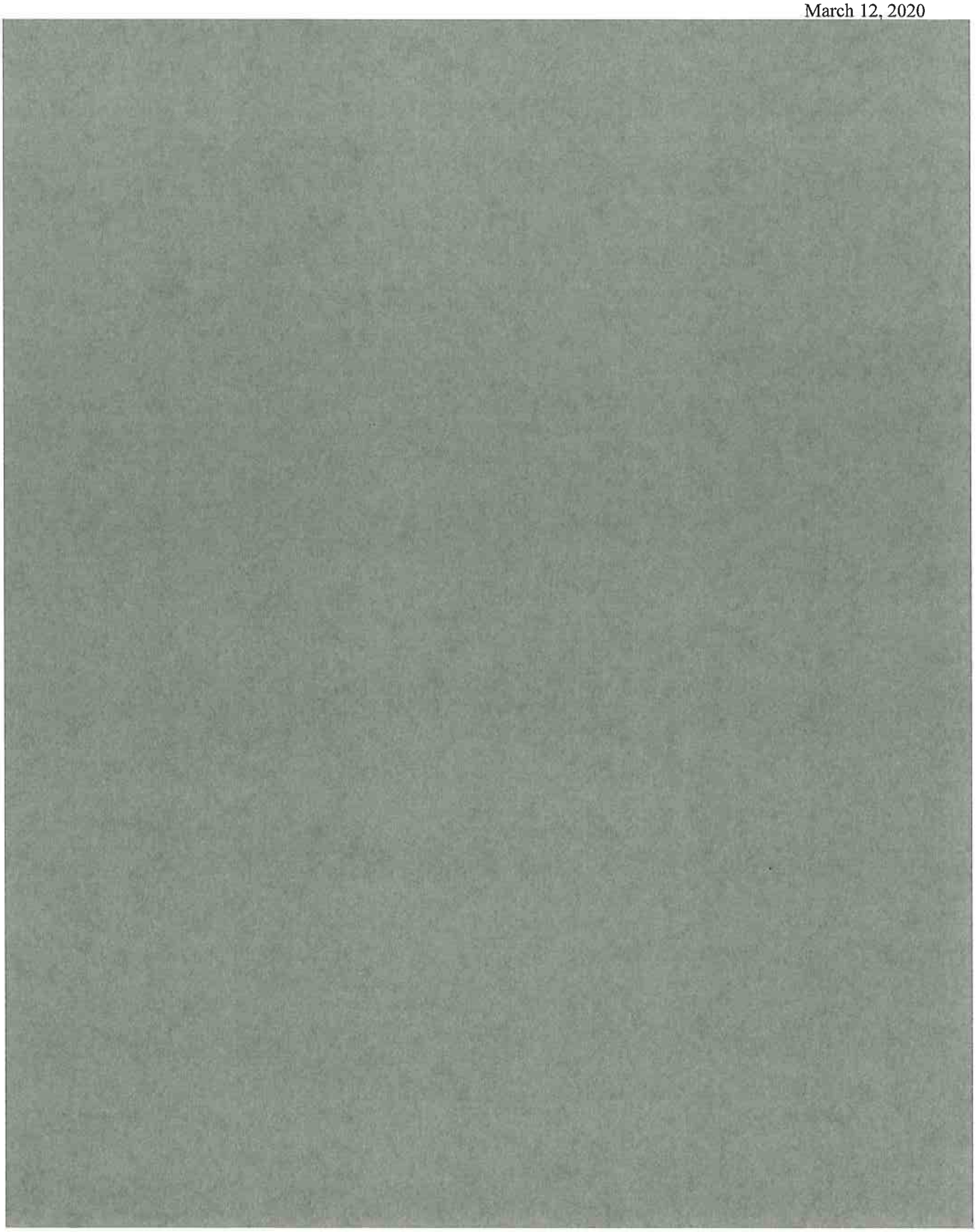


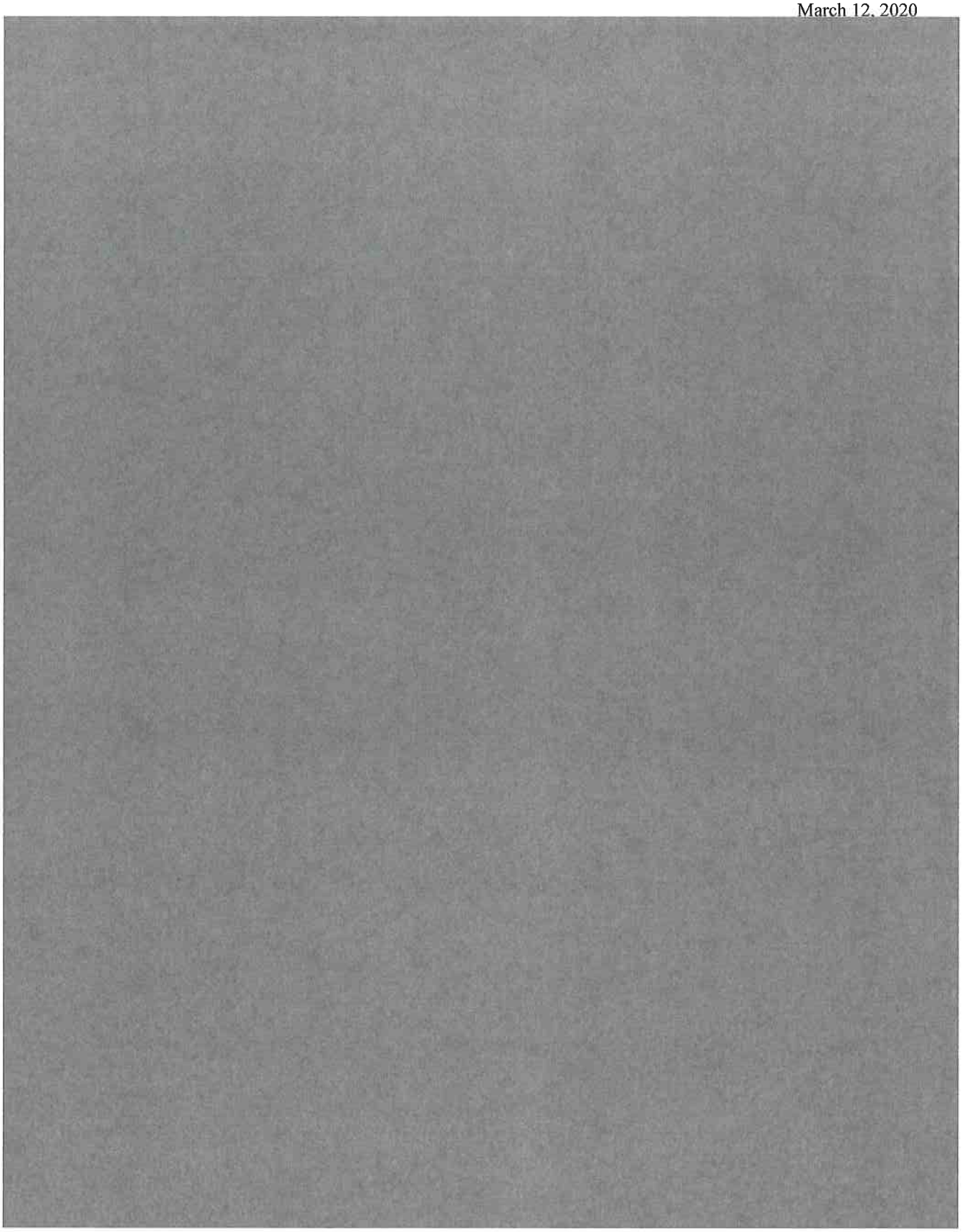












[redacted]

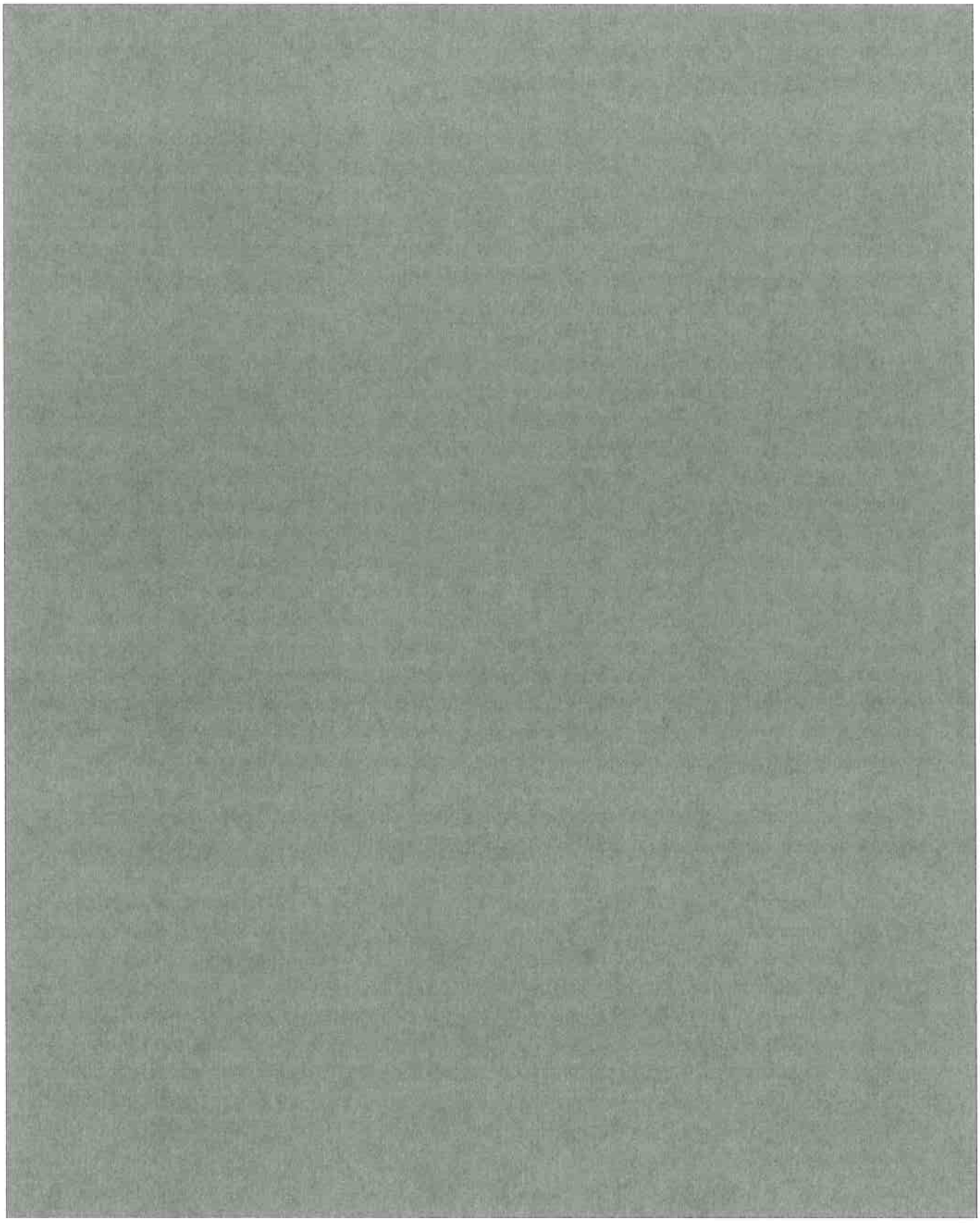
2019

[redacted]

[redacted]

On October 2, 2019, the CPS social worker completed a home visit and delivered & set up a Pack 'N Play with cribette for [redacted]. The CPS social worker educated [redacted] and [redacted] regarding safe sleep. The CPS social worker observed [redacted] and she was dressed in a pink onesie, pink pants, and a clean diaper. Her hair was freshly done, and she appeared well-groomed and well-nourished. The CPS social worker did not observe any marks or bruises or signs of maltreatment on [redacted].

Also on October 2, 2019, the CPS social worker obtained [redacted], and [redacted] On October 3, 2019, the CPS social worker obtained medical information from Unity Health Care that [redacted] were on May 2, 2019. Both girls had appointments scheduled for October 11, 2019. [redacted] was not in their system. On October 7, 2019, the CPS social worker confirmed that [redacted] was on February 22, 2019. Also on October 7, 2019, the CPS social worker submitted a [redacted] The outcome of the referral was not documented.



Post-Fatality Activities

On February 6, 2020, the CPS social worker was present at CNMC when an MPD detective examined [redacted] body and took forensic pictures.

The CPS social worker spoke to an MPD [redacted] detective who was at the Quality Inn viewing videos of the mother and children. The detective reported that a white car, believed to be driven by [redacted], had responded to the Quality Inn around 2:14 p.m. to pick up [redacted]. [redacted] was completely covered up and laying over [redacted] shoulder. An unnamed resident reportedly saw [redacted] in a baby walker with an injury to her head, and her head kept falling to the side. Reportedly, the witness asked [redacted] what happened to [redacted] and [redacted] stated that the child hit her head at the maternal grandmother's home.

The CPS social worker completed an initial assessment of [redacted] at the MPD's [redacted] District precinct. [redacted] refused to provide the name of the person who was caring for her children. [redacted] denied hurting [redacted]. She stated that [redacted] fell off the bed in the hotel room on Monday (February 3, 2020) and [redacted] had not been herself since then. On Tuesday (February 4, 2020), [redacted] noticed a "mushy bump" on [redacted] head. On Wednesday (February 5, 2020), [redacted] was not able to hold her head up and had difficulty standing up. [redacted] admitted to the detectives that, on the evening of February 5, 2020, she left [redacted] in the bathtub (length of time not documented) and when she returned, [redacted] was bent over at the waist in the water. Reportedly, [redacted] was "gasping for air," so [redacted] did chest compressions and foam came out of [redacted] mouth. [redacted] fed [redacted] [redacted] (time not specified) and put them to bed. [redacted] woke up around 10:00 a.m. and found [redacted] cold and unresponsive. Initially, [redacted] reported that a friend dropped her off at CNMC, but when she was confronted with the video evidence, she admitted that [redacted] had dropped her off. She had not wanted to admit it because he was banned from the shelter. When [redacted] was asked why it took her a long time to seek medical attention for [redacted], she replied that she was scared and did not know what to do.

On February 6, 2020, a corporal from the Charles County Sheriff Department confirmed that [redacted] (age 10) was with maternal grandmother [redacted] and he appeared to be in good health.

Also on February 6, 2020, the CPS social worker accompanied an MPD Homicide detective to [redacted] home to assess [redacted] and [redacted] No marks, bruises, or scars were observed on either child. The CPS social worker interviewed [redacted] and reported that [redacted] had been at her home since February 3, 2020, and that Maurice brought [redacted] to her home on February 6, 2020. [redacted] last saw [redacted] on February 3, 2020, around 3:00 pm and she seemed fine. She further stated that [redacted] resided in her home and he was off work last night and stayed home. The CPS social worker assisted [redacted] in completing a safety plan for [redacted] [redacted]. The safety plan indicated that [redacted] could not have unsupervised contact with [redacted] [redacted] pending the investigation. The plan was signed by [redacted], and the CPS social worker.

[redacted] paternal grandmother, resides in Waldorf, Maryland, and she obtained temporary legal custody of [redacted] (date not documented). She is scheduled to return to court on March 30, 2020.

[redacted] was interviewed by MPD Homicide and he was very detailed when he recounted his activities on Monday, February 3, 2020. When he was questioned about his activities the following days, he could not remember anything. Consequently, [redacted] was taken off the safety plan.

The CPS social worker devised a new safety plan indicating that [redacted] and Maurice could not have unsupervised visits with [redacted] and [redacted] signed it. Since [redacted] is the guardian, she will decide who the designee would be to supervise the parents' visits with the children. [redacted] has continued to attend her school in Washington, DC. [redacted] works in Washington, DC, so she is able to transport [redacted] to and from school.

[redacted]

On February 20,2020, the Family Team Meeting (FTM) facilitator spoke to [redacted] maternal uncle. [redacted] relayed that he spoke to [redacted] and she did not want to have a family meeting. Consequently, the FTM referral would be closed since Tyra did not want to participate.

Summary of Risk Factors

Child Factors	Parental Factors	Environmental Factors
• [redacted] was overdue for several immunizations	• [redacted] was a teenage parent • Parents have multiple allegations of DV • [redacted] • [redacted]	• Family resided in Ward 5 at the time of the fatality • [redacted] • [redacted]

Family Strengths

- There was familial support; i.e., maternal grandmother, paternal great grandmother, paternal great grandmother, etc.
- The father was employed at the time of fatality and very active in his children's lives.

Findings

Agency

- CFSA provided three Pack 'N Plays to the family and the FA and CPS social workers educated the parents about safe sleep.
- The CPS social worker in [redacted] the February 2020 investigation verified that [redacted] was being cared for by the maternal grandmother.

[redacted]

[redacted]

- During the October 2019 investigation, it was documented that [redacted] was overdue for DTap, Hib, IPV and Pneumo Conj 13 immunizations; however, it was not documented if that information was relayed to [redacted]

System

[redacted]

GOVERNMENT OF THE DISTRICT OF COLUMBIA

Child and Family Services Agency
200 I Street, SE
Washington, DC 20003

CONFIDENTIAL

[redacted]

December 28, 2015 – March 15, 2019

Child Fatality Case Review

May 9, 2019

Fatality Notification/Circumstances

On March 15, 2019, the Child and Family Services Agency's (CFSA) Hotline received a call from a Metropolitan Police Department (MPD) [redacted] The caller stated that the child, [redacted] (age 3), was not feeling well. Reportedly, she was given water but was unable to hold the water down; subsequently, she fell unconscious. [redacted] was transported to United Medical Center (UMC) where she was pronounced deceased. The manner of death is homicide.

Methodology

This case is applicable for review because the family had involvement with CFSA within 5 years prior to the fatality. In preparing this report, the Case Practice Specialist reviewed available FACES.net documentation. The Case Practice Specialist also spoke to a CPS program manager, two ongoing social workers, a CPS Hotline worker, a CPS supervisor, a kinship supervisory social worker, a resource development specialist, a non-recovery specialist, the OWB administrator, a CPS supervisor, a CPS social worker, a Family Assessment (FA) social worker, a health services program specialist, an Assistant Attorney General, a CPS nurse, and a CPS administrator. Attempts were made to speak to a CPS social worker and a CPS program manager.

Family Composition at Time of Fatality

Mother: [redacted] DOB: [redacted] Age: 43

Father: [redacted] DOB: [redacted] Age: 28

Children	Date of Birth	Age	Father
[redacted]			
[redacted] (decedent)	[redacted]	3	[redacted]
Other Family Members			
[redacted]			

Kinship Placement Composition at Time of Fatality

Kin Provider: [redacted] DOB: [redacted] Age: 24

Children	Date of Birth	Age	Mother	Father
[redacted]				
Others Present in the Home [redacted]				

Information about Decedent

[redacted] also known as [redacted] was a 3-year-old African-American female. She was removed from her mother [redacted] home after she ingested phencyclidine (PCP) on December 29, 2017. [redacted] was discharged from the hospital the following day and placed in foster care. She had gastronomical issues: she was on a gluten-free diet and did not eat dairy. [redacted] began attending the early childhood education program at Martha's Table on April 30, 2018. She was meeting all age-appropriate developmental milestones. She spoke in complete sentences and followed directions well. Her last physical examination was completed on February 13, 2018 and her last dental examination was completed on August 20, 2018.

Information about Decedent's Mother

[redacted]. is a 43-year-old African-American woman and the mother of seven children (4 adults and 3 minors). [redacted]

Information about Decedent's Father

[redacted] is a 28-year-old African-American male. [redacted] and was unable to care for [redacted]. or plan for her care. He was not active in the last 15 months of [redacted] life.

Information about the Decedent's Caregiver

[redacted] is a 24-year-old African American female. She is the eldest sister of [redacted] She has a 4-year-old daughter in her care, [redacted] father and is he is very active in her life. [redacted] Initially, [redacted] was identified as a backup provider for [redacted] (maternal uncle) and his wife [redacted] both of whom resided in Maryland. When [redacted] withdrew from the process, [redacted] was placed with [redacted] as her primary caregiver on January 23, 2018. [redacted] obtained an emergency kinship license on February 13, 2018 and was fully licensed on June 29, 2018. [redacted] completed the Child Protection Registry (CPR) clearance on December 20, 2017 and she was not listed on the registry. She completed the DC local police and FBI clearances on January 2, 2018 and no criminal record was found. The CPR clearance is to be updated on a yearly basis and the local and FBI clearances are updated every two years. [redacted] had failed to provide an updated CPR clearance which was due in December 2018. Her brother [redacted] (age 22) was her backup provider and he also resided in the home.

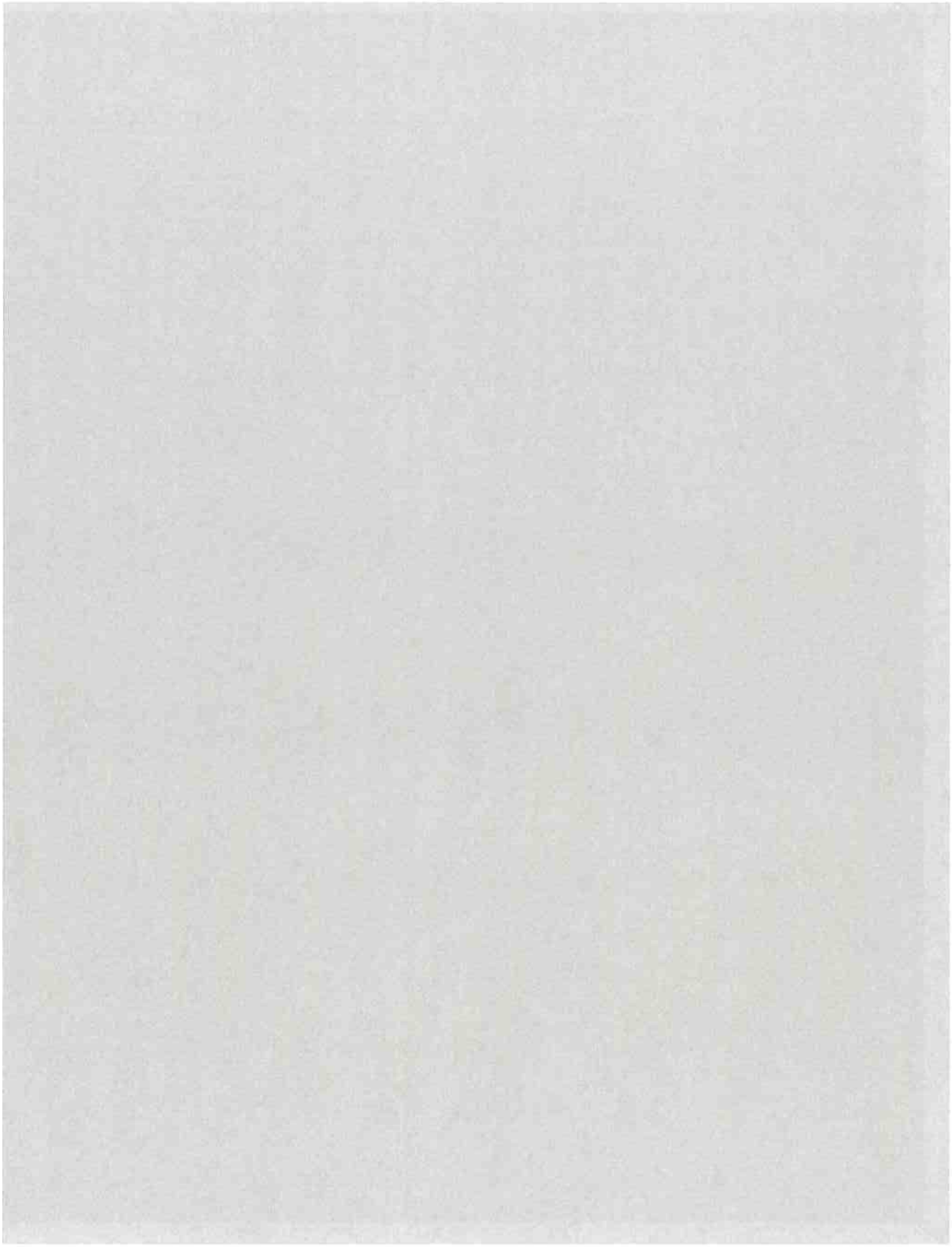
Summary of Agency Involvement – Decedent's Birth Parents

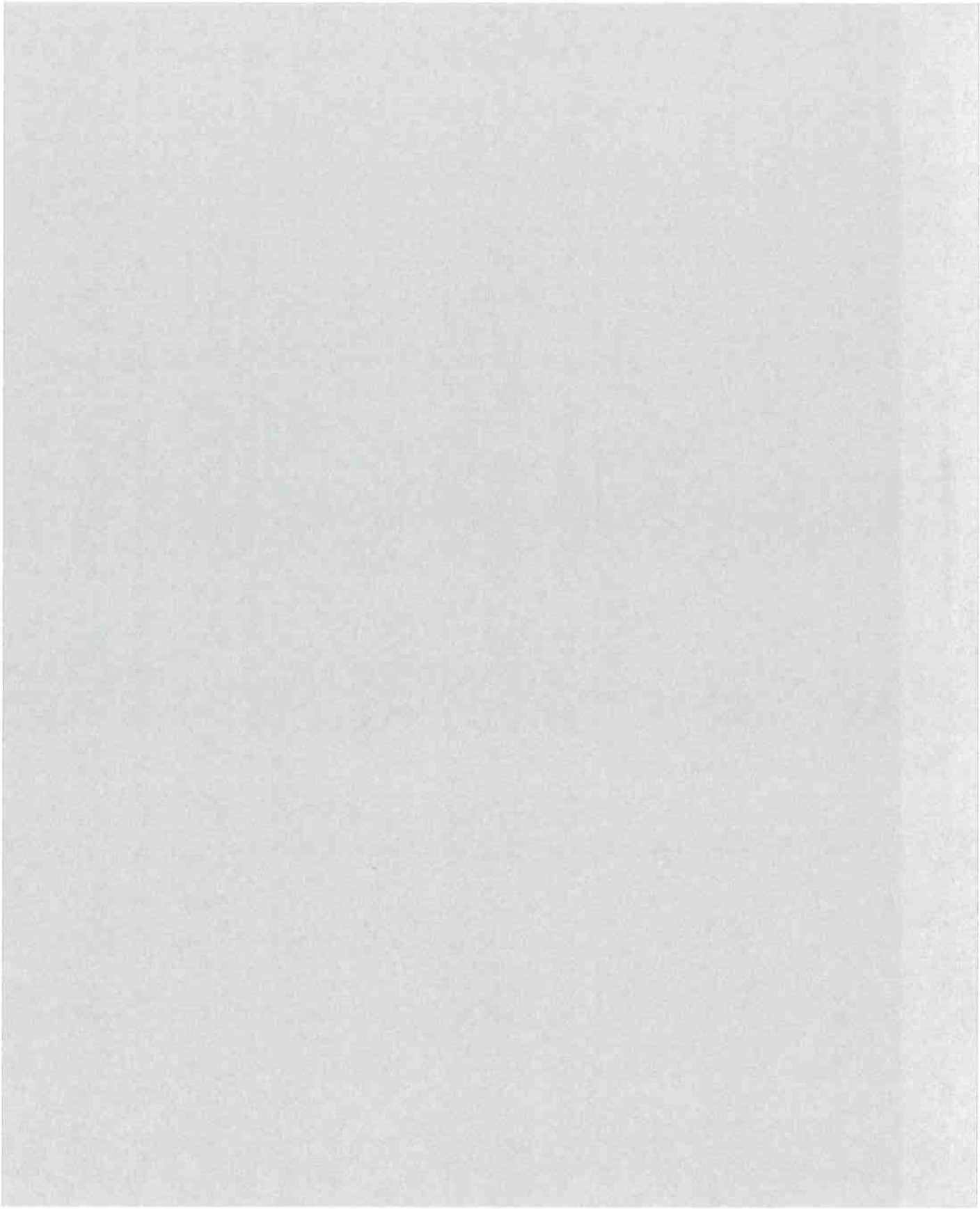
[redacted]

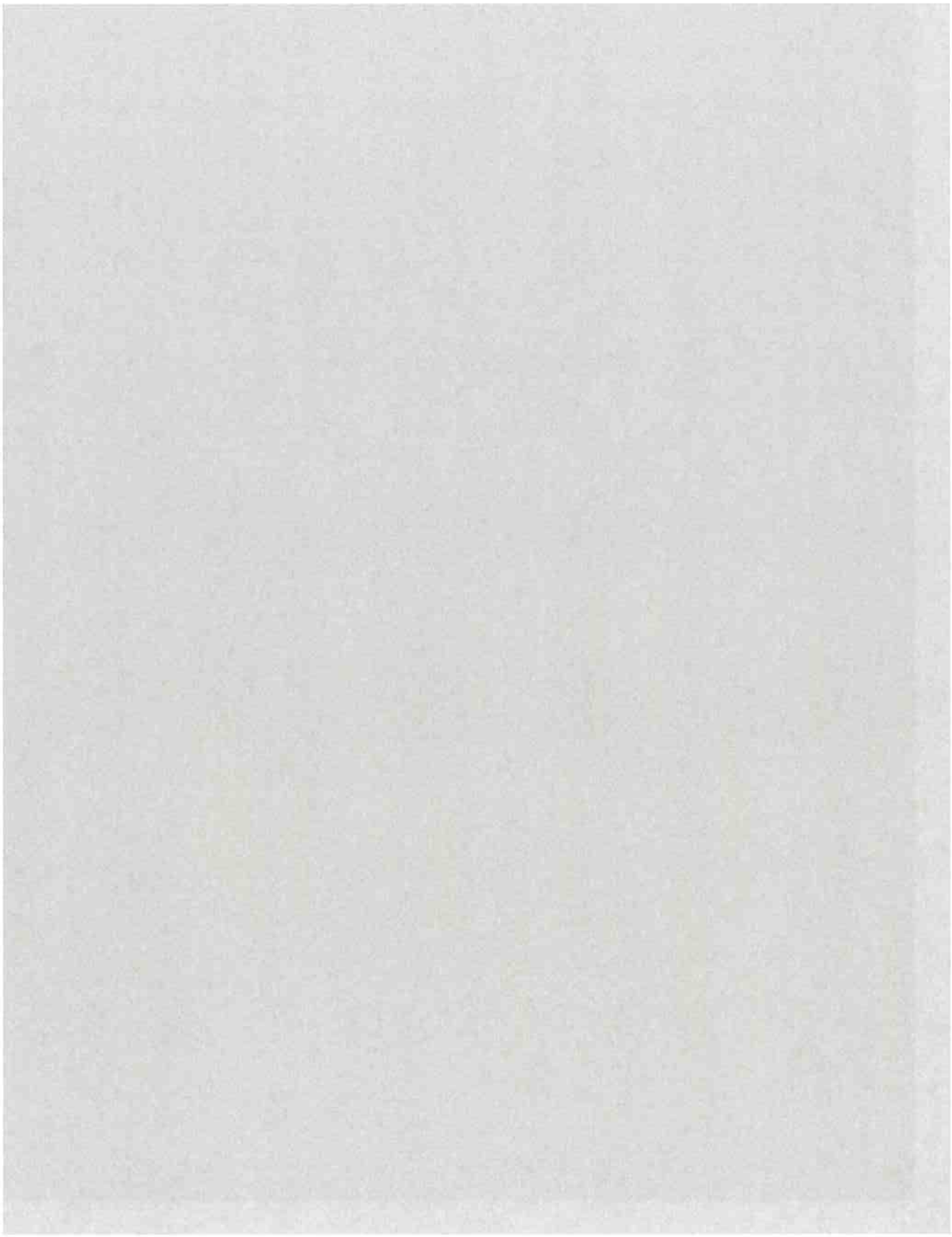
Date of Reports	Referral Number	Allegation	Alleged Maltreater	Disposition
1. February 28, 2014	[redacted]	Substance abuse (impacts parenting)	[redacted]	Substantiated
		Positive toxicology of a newborn	[redacted]	Substantiated
		Controlled substance in the system of a child	[redacted]	Unfounded
		Exposure to illegal drug-related activity in the home	[redacted]	Unfounded
2. March 21, 2014	[redacted]	Controlled substance in the system of a child	[redacted]	Linked to open investigation
3. June 25, 2014	[redacted]	Unable caregiver	[redacted]	Substantiated
4. December 31, 2014	[redacted]	Inadequate food/nutrition	[redacted]	RED Team Screen Out
		Unable caregiver	[redacted]	
5. June 3, 2016	[redacted]	Physical abuse	[redacted]	Unfounded
		Physical Abuse	[redacted]	Unfounded
		Physical Abuse	[redacted]	Unfounded
6. June 16, 2016	[redacted]	Inadequate supervision	[redacted]	Substantiated
7. January 26, 2017	[redacted]	Educational neglect	[redacted]	Screen Out

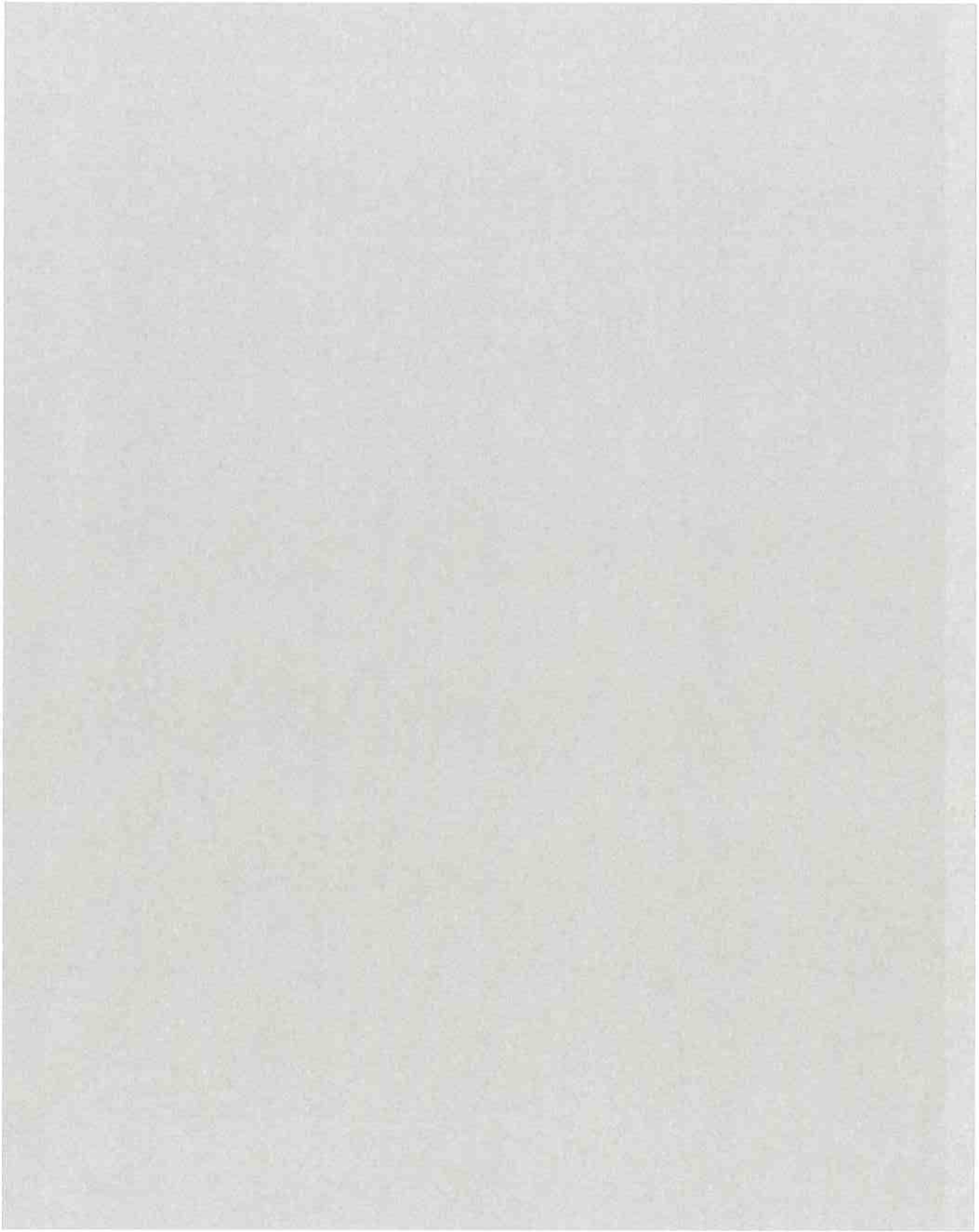
8. October 16, 2017	[redacted]	Neglect	[redacted]	Screen Out
9. October 17, 2017	[redacted]	FA - Substance use by a parent, caregiver or guardian		FA converted to CPS – I Referral [redacted]
		FA - Exposure to domestic violence in the home		
		FA - Educational neglect		
		FA - Physical abuse		
10. October 19, 2017	[redacted]	Exposure to domestic violence in the home		Unfounded
		Substance use by a parent, caregiver or guardian		Inconclusive
		Educational neglect		Unfounded
		Inadequate supervision		Substantiated
		Exposure to unsafe living conditions		Substantiated
11. November 9, 2017	[redacted]	Inadequate food/nutrition		Unfounded
		Exposure to unsafe living conditions		Unfounded
		Inadequate supervision		Unfounded
		Substance use, by a parent, caregiver or guardian		Unfounded
12. December 29, 2017	[redacted]	Substance use by a parent, caregiver or guardian		Substantiated
		Controlled substance in the system of a child		Substantiated

[redacted]









[redacted]

Due to her death, [redacted] neglect case was closed in DC Superior Court on April 9, 2019.

Summary of Agency Involvement – Decedent's Kinship Caregiver

There have been three referrals made to the CFSA Hotline on [redacted] since 2015, all within 5 years of the fatality, as shown in the following table.

Date of Reports	Referral Number	Allegation	Alleged Maltreater	Disposition
1. August 10, 2015	[redacted]	Exposure to unsafe living conditions	[redacted]	RED Team Screen Out
		Inadequate supervision	[redacted]	
13. August 18, 2015	[redacted]	Exposure to unsafe living conditions	[redacted]	RED Team Screen Out
		Exposure to unsafe living conditions	[redacted]	
14. October 23, 2017	[redacted]	Physical abuse	[redacted]	Screened Out
15. March 15, 2019	[redacted]	Suspicious child death – suspicious death of a child due to abuse or neglect	Unknown maltreator	Pending

[redacted]

[redacted]

Child Fatality

On March 15, 2019, a Metropolitan Police Department (MPD) [redacted] detective notified the CFSA Hotline that [redacted] was transported to UMC via ambulance. When [redacted] arrived at the ER, she was actively receiving cardiopulmonary resuscitation (CPR) and was intubated. It was reported that there was a little stiffening of her lower extremities, her pupils were fixed and dilated, her stomach was distended, and there were no visible external signs of trauma. She was pronounced deceased at 3:30 p.m.

The CPS social worker conducted separate joint interviews of [redacted] and her paramour, [redacted] with the MPD Homicide Detective at UMC. They each relayed their accounts of the day leading to [redacted] death, both indicating that [redacted] left the home in the morning to go to work and [redacted] and [redacted] were the only two in the home. [redacted] stated that [redacted] "looked uncomfortable" so she decided not to send her to school and [redacted] disclosed that he was unable to take [redacted] to school because he did not have the code. The significance of the code was not explained or documented. According to [redacted], when [redacted] woke up, [redacted] asked if she was hungry and [redacted] replied negatively. [redacted] gave her some fruit, but she did not eat it. [redacted] gave [redacted] some water and ginger ale and she threw up multiple times. She told [redacted] to give [redacted] Motrin because he reported she felt warm. When [redacted] returned home, she saw [redacted] in the chair "dozing out" and instructed [redacted] to go to the neighbor's home to have someone call 911. According to [redacted] when [redacted] woke up, she did not want any food. He tried to feed her some fruit, but she only nibbled on it. She later drank a 16-ounce bottle of water then threw it all up. He also gave her some ginger ale and also threw it up. Reportedly, [redacted] informed [redacted] that they need to take [redacted] to the hospital ([redacted] response was not documented). He tried several times to pat her on her back to help remove the spit up from her throat, but denied doing it with force. At one point, he went to the neighbor's home to get them to call 911. The emergency response person told him how to administer CPR, but stated he was confused and did not know how to do it. He did not recall whether or not [redacted] was conscious when he called 911, but she had been sitting up.

On March 16, 2019, the CPS social worker received an email from the MPD Homicide Detective. The email indicated that the Deputy Medical Examiner conducted the forensic autopsy and it

revealed the following tissue associated hemorrhaging and injury findings: contusions to the forehead and abdomen, lacerated liver, and blood in the abdominal cavity. In addition, her right lung was smaller and deflated in size compared to her left lung, which was indicative to the possibility of a viral infection. A skeletal examination was conducted and there were no fractures found to the skull, hyoid bone, trachea or larynx.

On April 26, 2019, the CPS social worker spoke to the MPD Homicide Detective and was informed that [redacted] case had been upgraded and ruled a homicide. Reportedly, it was discovered that there was an injury to [redacted] liver prior to her going unconscious and healing cells were found on the liver. The medical examiner concluded that the injuries were sustained prior to her passing and the injury was inflicted within 4-24 hours of her passing. According to the MPD Homicide Detective, this put [redacted] and [redacted] in the window/timeframe of the injury being inflicted. The detective completed a second interview of [redacted] on April 30, 2019 at the MPD 1st District [redacted] was informed that [redacted] suffered a laceration to her liver, there were signs of healing cells attached to the liver which indicated that the liver was injured before CPR was administered and soft tissue injuries were found on her body and head. The medical examiner indicated that the inflicted injury occurred between 6:00 a.m. and 2:30 p.m. [redacted] had no emotional response. It was documented that she evaded questions or did not give full responses and maintained that she had no idea how [redacted] could have sustained the injuries [redacted] did not implicate [redacted] nor did she exonerate him from inflicting the injuries. She maintained that there was no physical discipline administered to [redacted] by herself or [redacted] within 24 hours of her death. [redacted] indicated that she would be willing to take a polygraph.

Also on April 30, 2019, the CPS social worker completed a safety plan with [redacted] indicating since it was not known who could have injured [redacted]; it was unsafe for [redacted] to remain in her care at that time. [redacted] agreed to allow [redacted] to stay with her father throughout the duration of the investigation (MPD and CFSA). If [redacted] was found in [redacted] care unsupervised, CPS would remove [redacted] from her care. Once the autopsy findings were forwarded, the CPS social worker would engage [redacted] about the next steps. [redacted] walked out of the conference room prior to completing and signing the safety plan. A copy of the safety plan was forwarded to [redacted]

Themes

[redacted]

Family Strengths

- There were several maternal family members and friends that supported [redacted] and assisted in caring for the children.
- Through [redacted] her children did well in school.
- [redacted]

Case Practice Strengths

- [redacted]. The CPS social worker spoke to the people Ebony identified as resources and assessed their homes before the children were transported to the respective homes.
- [redacted]
- [redacted]
- 4+ staffings were held when appropriate.
- The ongoing social workers made attempts to engage the birth fathers.
- The case did not close until after the collaborative made contact with Ebony in June 2016.

[redacted]

[redacted]

System Matters Strengths

- None identified

[redacted]

GOVERNMENT OF THE DISTRICT OF COLUMBIA

Child and Family Services Agency
200 I Street, SE
Washington, DC 20003

CONFIDENTIAL

November 3, 2018 - December 3, 2021

Child Fatality Case Review

January 13, 2022

Fatality Notification/Circumstances

At 3:24am on December 3, 2021, a [redacted] Metropolitan Police Department (MPD) officer contacted the CFSA Hotline from the United Medical Center (UMC) to report the 1:18am death of [redacted] a 3-year-old African American male. Per the MPD investigation, two officers had responded to a 12:38am 911 call from the child's home. When officers arrived, they observed the unresponsive child and took turns performing CPR until EMS arrived. Per the reporting officer, the decedent's 28-year-old [redacted] mother, [redacted] stated that [redacted] climbed into bed with her around midnight. [redacted] woke up about 12:30am and noticed [redacted] not moving under the bedsheet. When she pulled the sheet back and lifted [redacted] body, his head fell limp, at which point [redacted] called 911. The reporting officer added that [redacted] was coherent and alert in the officers' presence. Also in the home was [redacted] older brother, 5-year-old [redacted] in good health with no visible signs of child maltreatment. [redacted] went with a family member to the maternal grandmother's home while EMS transported [redacted] and [redacted] to UMC with the officers following. Additional documentation indicated the home was cluttered with miscellaneous items stacked against the wall, and cigarette butts scattered throughout the apartment floor as well as on the windowsill of the boys' bedroom. There was a dead rodent in the kitchen, gnats around the refrigerator, a stopped-up toilet, and [redacted] bed was reportedly structurally unsound.

The reporting officer expressed concern overhearing [redacted] sharing details of the evening with a UMC nurse; [redacted] did not share these details with the officers. According to the reporting officer, [redacted] told the UMC nurse that [redacted] and [redacted] had been rough housing in their room when [redacted] bit [redacted] hand. In response, [redacted] pushed [redacted], who hit his head against the wall. The reporting officer acknowledged observing a knot on the back of [redacted] head. Both boys reportedly ran into [redacted] room to tell her what happened. [redacted] feared that [redacted] might have suffered a concussion and kept him awake until he grew tired and climbed into her bed. The officer also reported that a family member had contacted [redacted] 30-year-old birth father, [redacted] who was also at the hospital. Officers had not yet interviewed [redacted] due to his agitated state which included accusatory remarks regarding [redacted] parenting. Per a December 21, 2021 interview with one of the officers during the course of the MPD investigation, the officer indicated that [redacted] death was likely related to bed sharing and not considered an abuse homicide. Cause and manner of death were pending as of the writing of this report.

Methodology

This case is applicable for review because the family was involved with CFSA within 5 years of [redacted] death. In preparing this report, the reviewer attended the critical event meeting, examined available FACES.NET information, [redacted] for the decedent's deceased sister [redacted] and interviewed the CPS investigative social worker, the assigned In-Home and Permanency social workers, the kinship licensing specialist, and one

of the investigative police officers who was also part of the police presence during [redacted] investigation.

Family Composition at Time of Fatality

Mother: [redacted] **DOB:** [redacted] **Age:** 28
Father: [redacted] **DOB:** [redacted] **Age:** 30

Children	Date of Birth	Age	Father
[redacted]			
[redacted] (*decedent*)	[redacted]	3	[redacted]
[redacted]			
Other Relatives and Family Supports			
[redacted]			

Information about Decedent

[redacted] was a 3-year-old African American male. [redacted] father, [redacted] was intermittently involved with his son who reportedly stayed with [redacted] after the death of [redacted] younger sister [redacted] on June 23, 2021. Per reports during the June 2021 investigation of [redacted] death, [redacted] was safe and free from marks, bruises, or any other signs of maltreatment. During interviews, [redacted] was smiling and engaging appropriately with his father. He was reported to be developmentally on target. There is no information regarding prenatal care and no documentation regarding any specialized service needs.

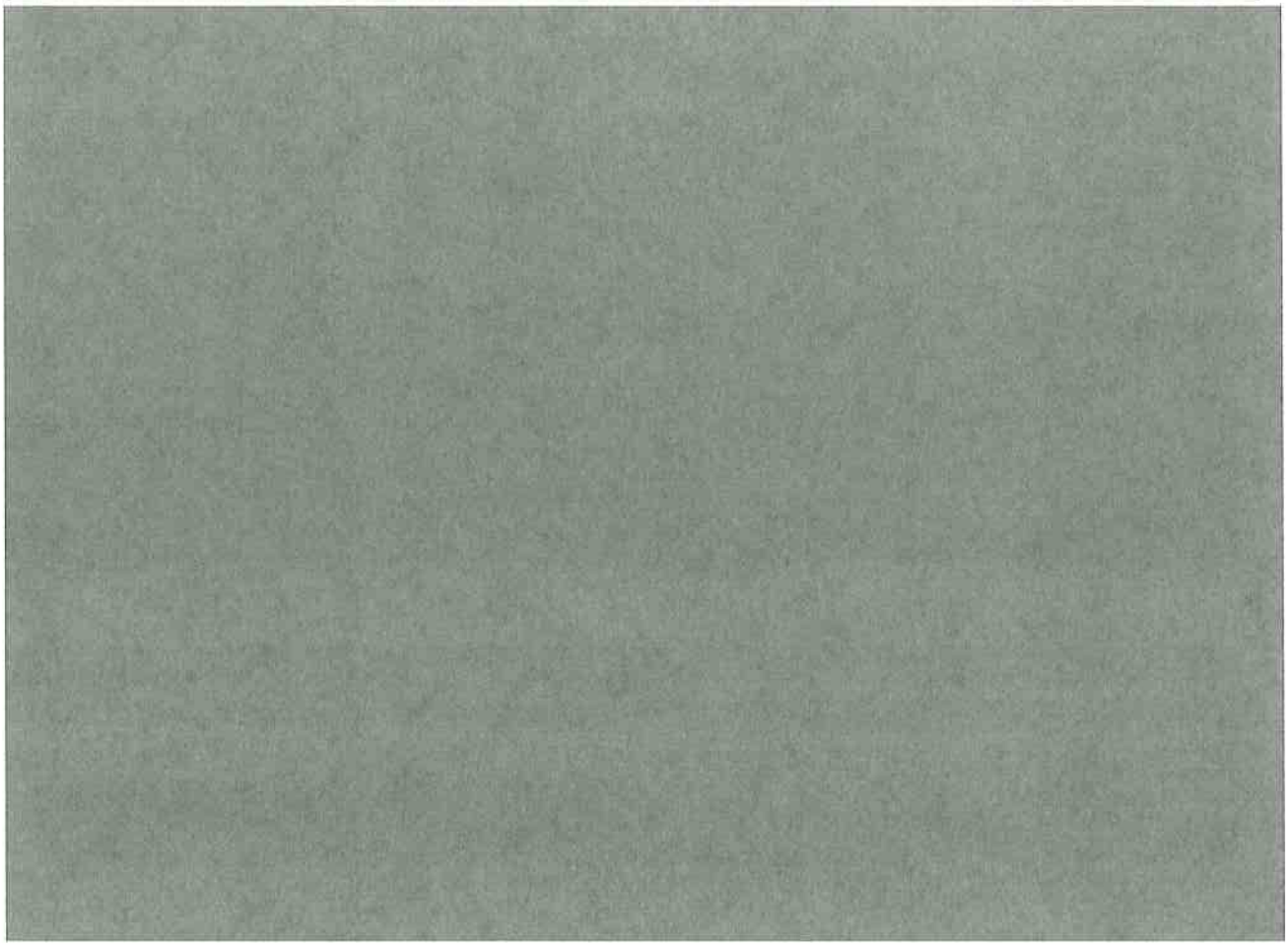
Information about Primary Caregiver

The decedent's primary caregiver was his mother, 28-year-old African American [redacted] t was the fourth of [redacted] six pregnancies and the third of her four live births. [redacted] is the eldest of seven siblings. [redacted]

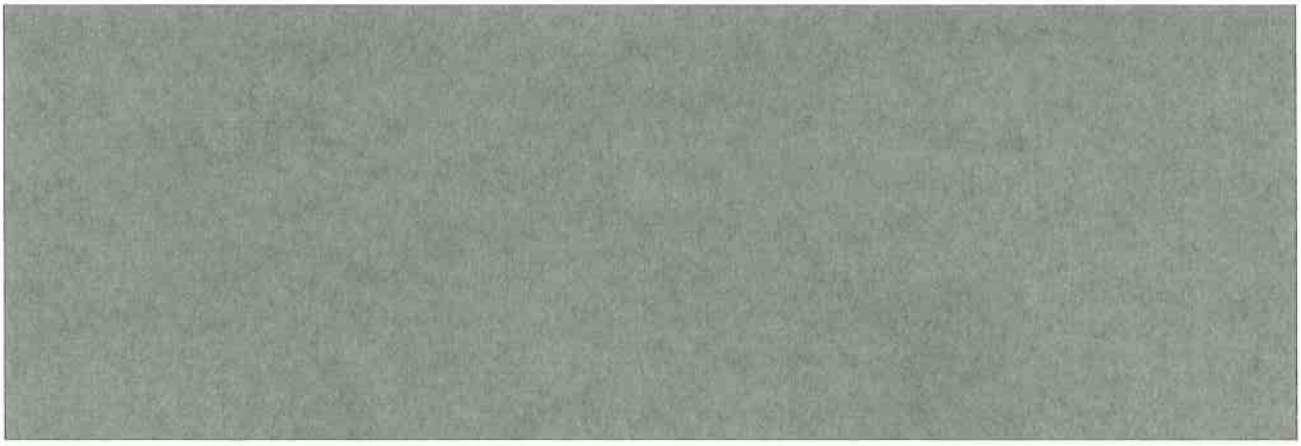
[redacted]

[redacted]

[redacted]



[redacted]



[redacted]

[redacted]

Information about the Birth Father

[redacted] birth father is 30-year-old [redacted] He is the African American father of three children: the decedent [redacted], [redacted]

[redacted]

Summary of Agency Involvement

[redacted] Of the 15 total referrals that included [redacted] as a parent, 12 occurred within 5 years of the fatality. The summary of reports below includes five of the referrals, [redacted] Prior to [redacted] death, the most recent investigation closed on October 6, 2021.

(*For previous referrals within the 5-year window for fatality reviews,* [redacted].)

Summary of Reports

	Date	Referral Number	Allegation(s)	Disposition	Alleged Maltreater(s)
1	June 23, 2021	[redacted]	Suspicious Death	Unfounded	[redacted]
			Neglect – Inadequate Supervision	Substantiated In-Home Case [redacted] Open: 7/21/2021	
2	June 25, 2021		Neglect – Substance Use	[redacted]	[redacted]

3	September 3, 2021	[redacted]	Neglect – Inadequate Food / Nutrition	Unfounded	[redacted]
			Neglect – Substance Use	Unfounded	
4	October 7, 2021		Educational Neglect	Screen Out (Hotline)	[redacted]
5	October 26, 2021		Educational Neglect	Screen Out (Hotline)	[redacted]

June 23, 2021 & June 25, 2021

On June 23, 2021, an MPD [redacted] police officer contacted the CFSA Hotline after responding to a 911 call around 6:30am for [redacted] 11-month-old daughter [redacted] who was unconscious. Per the Hotline report, [redacted] gave [redacted] a bottle then ran across the street to get a cigarette. In so doing, [redacted] had left 4-year-old [redacted] alone for an unknown length of time. When [redacted] returned home, she found [redacted] unconscious and foaming at the mouth. [redacted] began to administer CPR until the arrival of the medics who transported the infant to UMC. UMC physicians pronounced [redacted] time of death as 9:05am. The whereabouts of [redacted] other children, 10-year-old [redacted] 2-year-old [redacted], were unknown. The Hotline worker screened in the call for an immediate response.

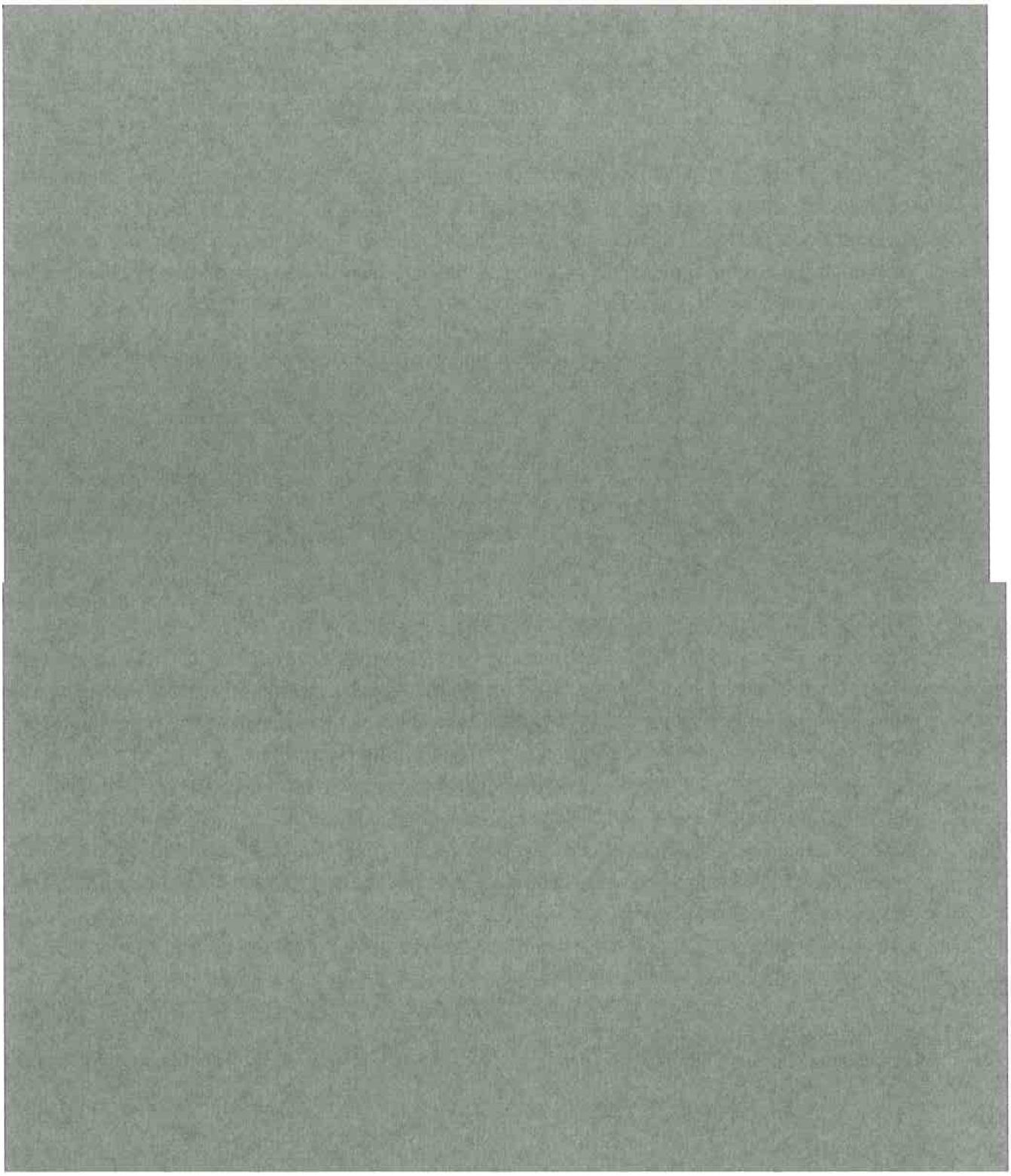
On June 25, 2021, the CFSA Hotline received an anonymous call regarding the open investigation of [redacted] death. The caller indicated that CFSA should take a closer look at the circumstances because [redacted] provided different stories to different people. The caller further expressed suspicion that prior to [redacted] death, the baby had been healthy and "... perfectly fine and then all of a sudden the baby is dead." [redacted]

Between June 23, 2021 and July 28, 2021, the investigative social worker conducted home visits and interviewed [redacted] father [redacted], other paternal and maternal family members, all minor children outside the presence of a caregiver (except for 2-year-old [redacted] due to this age), a neighbor who is also [redacted] best friend, the officers present at the home after the 911 call, and UMC physicians. Initial observations of [redacted] in the UMC emergency room indicated no visible signs of maltreatment as a cause of death. [redacted]

Regarding the circumstances of [redacted] 911 call, she described bed-sharing with [redacted] At around 6:00am, [redacted] lay [redacted] on her stomach with her head to one side and her bottle propped in her mouth. [redacted] stated that approximately 40 minutes went by between getting the cigarette and smoking it in the bathroom. When she saw [redacted] lifeless, she had to run to her neighbor to borrow a cell phone. The two women returned to [redacted] apartment and began performing CPR with the 911 dispatcher guiding them. Additional details are provided in [redacted] Case activities are listed below.

On July 21, 2021, CPS substantiated the allegation of neglect (inadequate supervision) and opened In-Home case [redacted]. The allegations of neglect (substance use by a parent) and suspicious death of a child were unfounded. The investigation closed on July 28, 2021.

[redacted]



Summary of Case Activities

	Case Number	Case Type	Date Opened	Date Closed
1	[redacted]	In-Home	July 21, 2021	December 3, 2021

- On July 21, 2021, an In-Home case was opened due to a substantiation for neglect (inadequate supervision) against [redacted]
- Between July 28 and August 11, 2021, the assigned social worker with the In-Home Administration was unable to assess the family despite repeated attempts to make unannounced visits to the home at various hours of the day and evening, in addition to leaving voicemail messages on [redacted] phone.

[redacted]

- [redacted] By September 10, 2021, the children were reportedly back with [redacted], but the assigned social worker was unable to make contact or assess the children due to [redacted] being unresponsive to telephone or text, or not being at home despite scheduled visits to locations where she was reportedly staying, e.g., [redacted] address of record, or with the children's great maternal grandfather.
- On September 23, 2021, the social worker was able to have a brief face-to-face interview with [redacted], who complained, "My daughter is dead, why do you keep showing up?" [redacted] declined mental health and Collaborative services. The social worker was able only to observe the children, who were sleeping. However, the social worker documented that the children appeared healthy with no additional concerns.
- Between September 30th and November 30th, the social worker made 13 documented unsuccessful attempts to make face-to-face contact the family, including visits to the children's school. [redacted]

[redacted]

[redacted]

Post-Fatality Activities

- A Permanency case was opened on December 3, 2021 as a result of [redacted] death, [redacted] lack of engagement with the agency during the open In-Home case, and the children's school attendance concerns. [redacted] were removed from [redacted] care on December 3, 2021 and placed with maternal aunt [redacted]. The permanency goal for [redacted] and [redacted] is reunification.
- During the investigation interviews December 3, 2021, [redacted] offered additional details regarding the death of her son [redacted]. Per [redacted] report, [redacted] and [redacted] began arguing over a teddy bear owned by their deceased sister, [redacted]. [redacted] pushed [redacted] such that he hit his head on the wall between their bunk beds and their dresser. When the boys went to bed, [redacted] was in bed with [redacted] who stated she may have also fallen asleep until she received a text from a friend at 12:31am stating that he was at her front door. After receiving the text, [redacted] realized that [redacted] was no longer positioned and leveled to her but was instead under her." During the interview, [redacted] then "pointed to below her chest." She nudged [redacted] but he didn't move, so she dialed 911. The operator instructed [redacted] to lay [redacted] on a flat surface and perform CPR. However, [redacted] reported that she was frightened due to having to perform CPR on [redacted] so recently. She ultimately performed the CPR and breathed in his mouth twice and provided 30 chest compressions until the arrival of the officers and EMS.
- In response to the allegations, [redacted] reported playing football with [redacted] in their bedroom when they got into a fight. He stated [redacted] bit his hand and drew blood, so he hit [redacted] with a closed fist to the chest. [redacted] told their mother that [redacted] had hit him but [redacted] clarified that [redacted] hit first. [redacted] then demonstrated how [redacted] then hit [redacted] with a closed fist on his thigh and told both brothers to go to bed. [redacted] stated that he had not observed [redacted] fall or hit his head, nor had he witnessed [redacted] use excessive force on Artist. Per the report, [redacted]
- Between December 3rd and December 9th, appropriate staff completed the following tasks:
  - Completion of emergency kinship licensing for [redacted].
  - [redacted]

- Attendance at the initial placement hearing where [redacted] waived probable cause and the court ordered supervised visitation, parenting classes, [redacted]
- Completion of [redacted]' forensic interview on December 8, 2021.
- Submission of the referral and attendance at the Removal FTM on December 9, including the following next steps outlined in the service plan:
  - Identification of back-up persons to assist [redacted], including [redacted] (maternal grandmother), [redacted] (maternal grandfather), [redacted] (maternal aunt), [redacted] (maternal aunt).
  - Completion of kinship licensing paperwork for [redacted].
  - [redacted]
  - Follow-up by the assigned ongoing social worker to assess fathers [redacted] and [redacted] and, if needed, submission of referrals with appropriate services.
  - Assignment of a PEER (parent engagement, education, and resource) specialist for [redacted]

- Between December 10th and December 21st, the following case activities occurred:
  - Supervised visitation of the children with [redacted] and with [redacted]. The social worker was unable to reach [redacted] father, [redacted]
  - [redacted]
  - Introduction between the PEER specialist and [redacted], plus a mailing of CFSA's *Birth Parents Information and Resource Guide* and a copy of the *Effective Black Parenting* booklet to [redacted]
  - Scheduling and completion of a Four Plus (4+) staffing on December 13th to (1) discuss any parental barriers impacting the safety and well-being of the children, (2) conduct a clinical analysis of the family's level of functioning (past and present), (3) discuss any needed services (unspecified), and (4) review FACES history, past court involvement, and any past cases.
  - Follow-up by the investigative social worker with the assigned Permanency Administration social worker, in addition to re-attempting engagement of both [redacted] and [redacted], contacting schools to assist with enrollment, and closing the investigation as the Permanency Administration team takes over.
  - [redacted]
- Between December 22nd and December 28th, the following ongoing Permanency and final CPS case management activities occurred:
  - Scheduled and completed placement stabilization meeting on December 22.

[redacted]

- Assessments for safety and risk for the children.
- Attempted contact with [redacted] father, [redacted]
- Interview with [redacted] housing case manager who reported that [redacted] has been unresponsive.

[redacted]

On January 6, 2022, CFSA substantiated [redacted] both for the suspicious death of a child and for neglect related to unsafe living conditions. The allegation of a suspicious death due to abuse or neglect was unfounded. The allegation of neglect due to a lack of supervision was inconclusive. The fatality investigation was closed on January 6, 2022.

Summary of Risk Factors

Child Factors	• Reported rough-housing with sibling • Bed-sharing
Parental Factors	• Prior substantiation for lack of supervision against the mother [redacted]
Environmental Factors	• Unstable bed in mother's room • Unsafe living conditions in the physical home environment

Family Strengths

- Both maternal and paternal family support, including kinship placement options

[redacted]

Findings

Agency

The In-Home Administration social worker consistently made efforts at all hours of the day and night to make face-to-face contact in order to engage Tysheka.

[redacted] all the children went to stay with [redacted] the In-Home social worker successfully engaged with [redacted] to help with school enrollment.

The kinship licensing specialist liaised with a church to sponsor [redacted] and ensure toys and family gifts for the children's Christmas holiday.

[redacted]

System

Summary of System Agency Involvement

- DC Department of Behavioral Health (Community Connections)
- DC Department of Corrections
- DC Department of Youth Rehabilitation Services
- DC Public Schools

As a system, CFSA, DBH, and DCPS might consider developing an "alert protocol" when dramatic changes in academic performance are concurrent with new diagnoses. DCPS might first consult with DBH but if the child is involved with CFSA, then consulting with CFSA might also reveal challenges or even trauma the child is facing in the home life or foster care [redacted]

[redacted]

GOVERNMENT OF THE DISTRICT OF COLUMBIA

Child and Family Services Agency
200 I Street, SE
Washington, DC 20003

CONFIDENTIAL

[redacted]

August 4, 2015 – May 2, 2019

Child Fatality Case Review

June 13, 2019

Fatality Notification/Circumstances

On May 2, 2019, a social worker from [redacted] contacted the Child and Family Services Agency (CFSA) Hotline regarding [redacted] a three-year-old African-American female. According to the child's birth mother, [redacted] was jumping up and down on the bed when she developed shortness of breath. She then vomited and appeared to lose consciousness. The parents contacted 911. Emergency medical services (EMS) arrived and began cardiopulmonary resuscitation (CPR) while transporting the child to the hospital. The attending physician noted that the child arrived at the hospital in full cardiac arrest. She had no documented medical history of heart trouble and no apparent signs of trauma or bruising. Despite efforts to resuscitate the child, hospital staff declared the child deceased at 3:25 am. The preliminary autopsy report (as of June 1, 2019) indicated the child to have had fentanyl in her system. Though not yet formally confirmed, CFSA anticipates that the manner of death will be homicide.

Methodology

This case is applicable for review because the family had involvement with CFSA within 5 years of the fatality date. In preparing this report, the child fatality reviewer attended the critical event meeting, interviewed the investigative social worker, and researched available FACES.net information.

Family Composition at Time of Fatality

Mother: [redacted] DOB: [redacted] Age: 43

Father: [redacted] DOB: [redacted] Age: 40

Children	Date of Birth	Age	Father
[redacted]			
[redacted] (decedent)	[redacted]	3	[redacted]

Other Relatives

[redacted]

Information about Decedent

Three-year-old [redacted] was a pre-kindergartener at a local elementary school. Due to her age, school attendance was not compulsory. Attendance records indicated 41 unexcused absences. At the time of her death, [redacted] had updated medical records.

Information about Decedent's Mother

[redacted] is a 43-year-old African American who is one of eight children born to the maternal grandmother, [redacted]

Like her mother, [redacted] has eight children, including the decedent and a five-month-old son who died in 2001 from sudden infant death syndrome. At the time, police removed [redacted], who were released to the maternal grandparents. Both children returned to their parents four months later.

[redacted] In addition, there is an admitted history of alcohol, phencyclidine (PCP), heroin and suboxone use. While suboxone is a prescription drug used for counteracting heroin addiction and withdrawal, [redacted] admitted procuring suboxone off the street. Her CPS history includes substantiations for educational neglect, substance abuse, positive toxicology, and inadequate supervision. Several cases were opened and closed, including Family Assessment referrals that were closed, due to the family declining services. During past investigative interviews, [redacted] reported that her support system includes her two adult daughters, the maternal grandmother, and two of the children's fathers, [redacted] the decedent's father, [redacted]

Information about Decedent's Father

[redacted] is a 40-year-old African-American father of the decedent, [redacted], and her younger sister [redacted] There is no additional information on the father's education, employment, past CPS history, and other children.

Summary of Agency Involvement

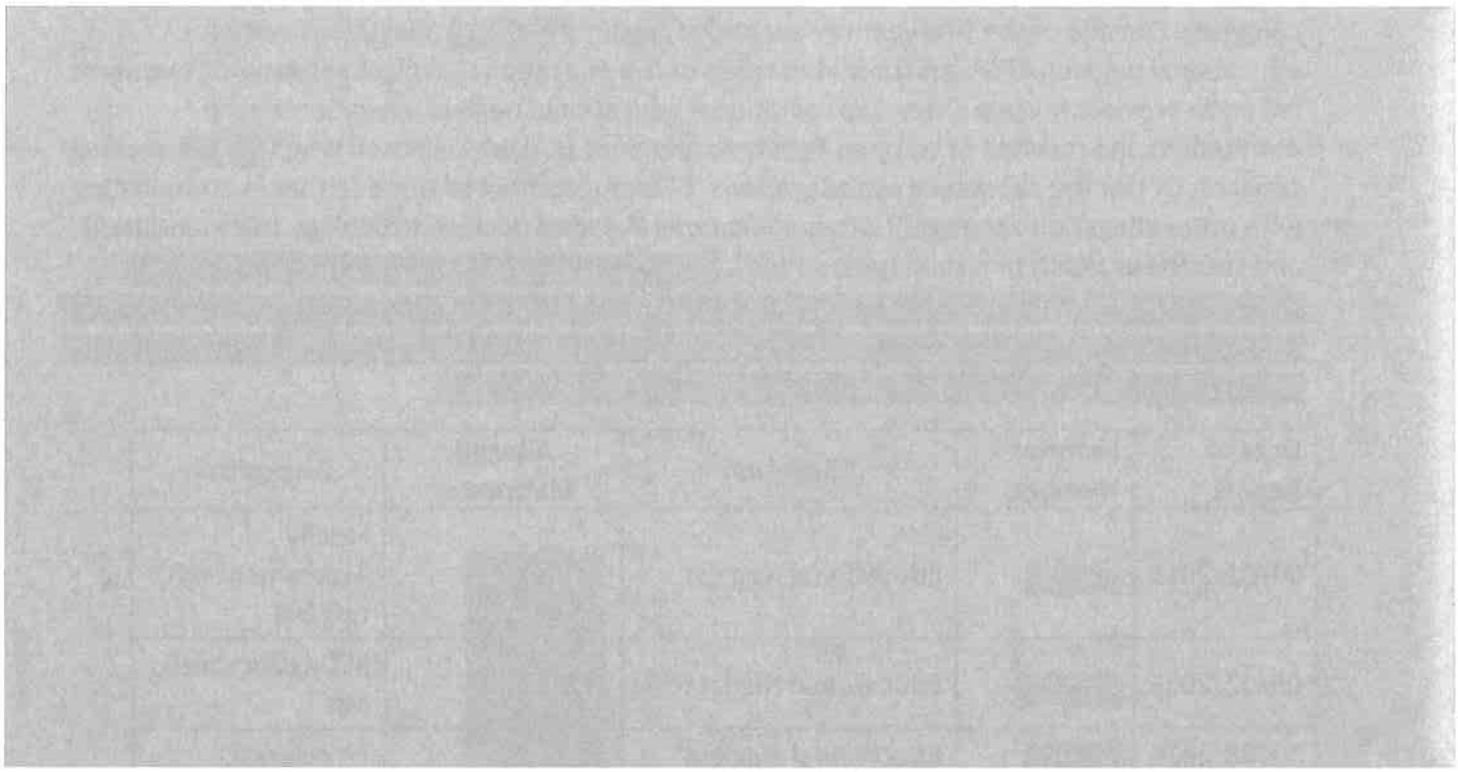
[redacted] Twenty of the referrals included [redacted] as the

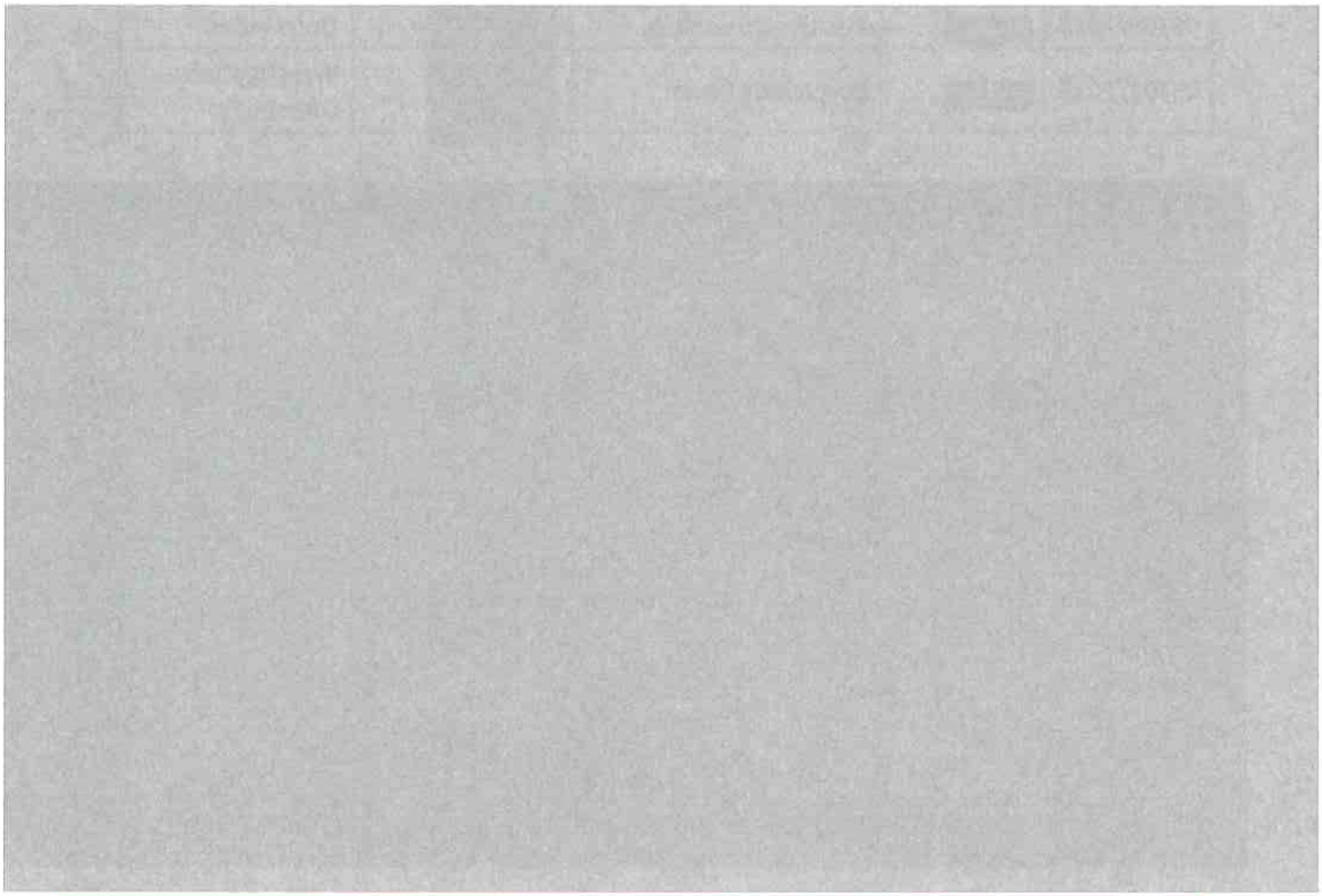
caregiver. Outside of the five-year review period, eight of [redacted] allegations were for educational neglect. CFSA substantiated three of the educational neglect allegations; two were linked to previously open cases. Two additional educational neglect allegations were unfounded; one resulted in an open Family Assessment (FA) which closed when [redacted] declined services. Of the five substance use allegations, CFSA substantiated three (either in combination with other allegations or alone). Other allegations included positive toxicology (substantiated) and suspicious death of a child (unfounded). [redacted]

Date of Report	Referral Number	Allegation	Alleged Maltreator	Disposition
04/02/2015	[redacted]	Educational Neglect	[redacted]	Family Assessment (FA) referral
03/02/2016	[redacted]	Educational Neglect		RED team screen out
12/28/2016	[redacted]	Educational Neglect		FA referral
08/09/2018	[redacted]	Positive Toxicology		Unfounded
05/02/2019	[redacted]	Suspicious Death		Investigation Ongoing

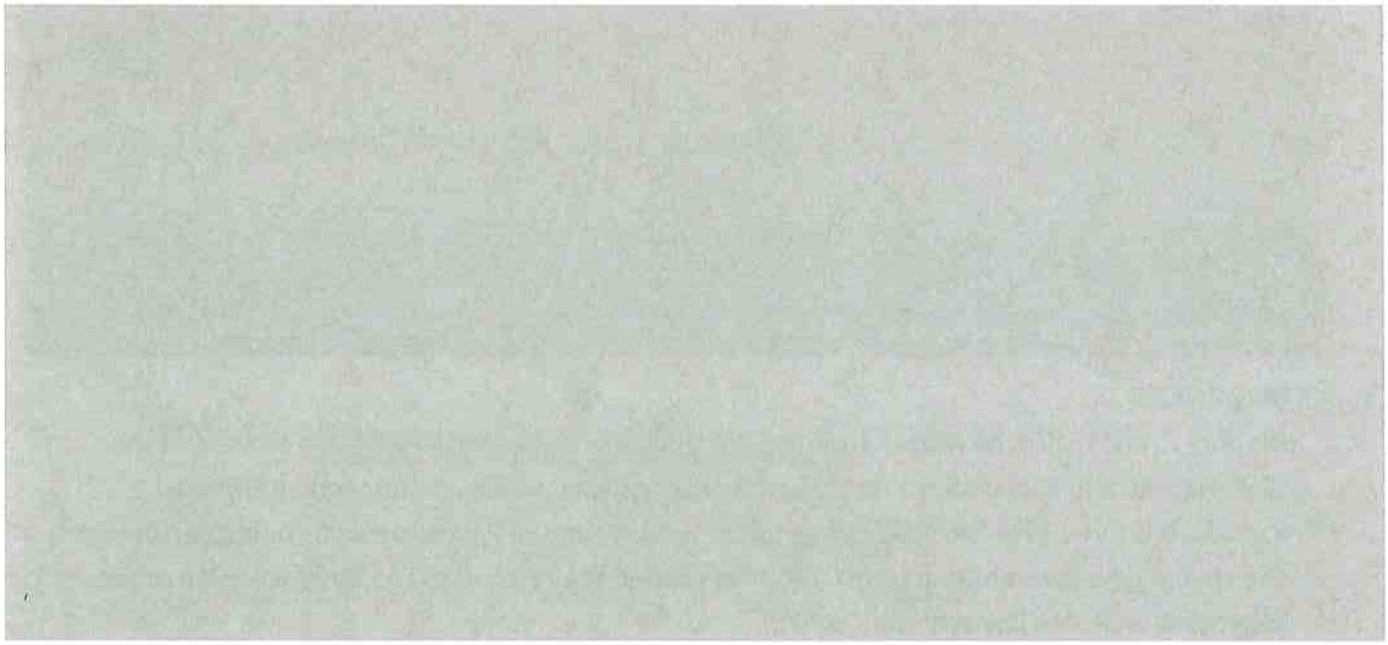
[redacted]

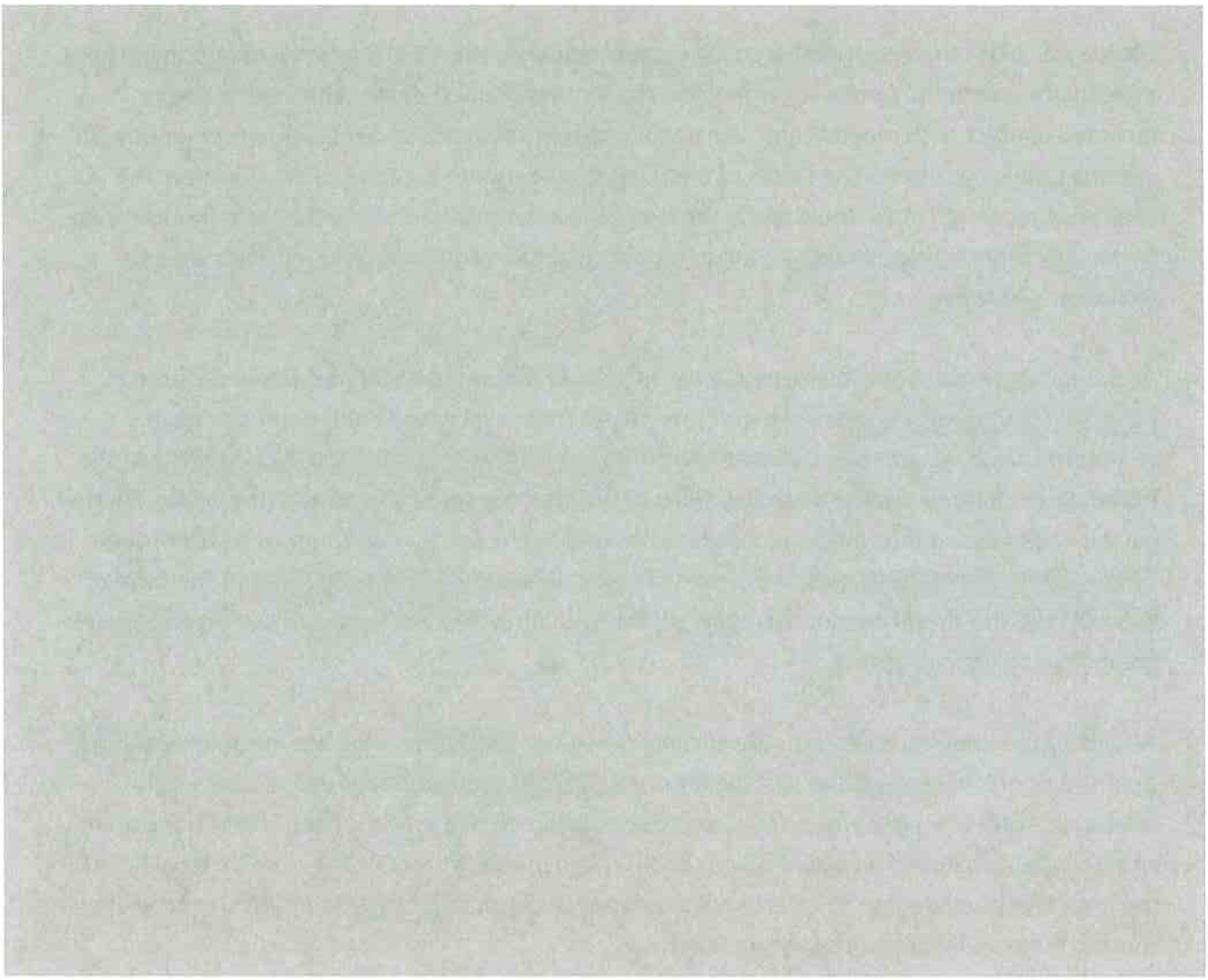
[redacted]





[redacted]





[redacted]

May 2, 2019

On May 2, 2019, a social worker from [redacted] contacted the CFSA Hotline and spoke with a Hotline supervisory social worker to report that EMS had transported three-year-old [redacted] to the hospital and CPR was currently being performed. The child died a few moments later. CFSA forwarded the referral to the Youth Division of the Metropolitan Police Department (MPD).

On May 2, 2019, the investigative social worker met with the MPD detective to conduct a joint investigation with the family regarding the child's unexplained death. The investigation included contact with medical and social work staff at the hospital along with interviews with various family members. The cause of death was pending the outcome of an autopsy. The attending physician indicated that no urine or blood samples were collected and therefore no toxicology reports were available; those reports would be conducted during the medical examiner's autopsy.

At the family home, both the investigative social worker and the MPD detective observed [redacted] asleep and then alert. The social worker and detective each conducted separate and private interviews of [redacted] in the home. Both children denied any allegations of physical abuse, sexual abuse, or neglect. Neither child had significant information to disclose related to the cause or manner of death of their sibling. [redacted] was in the care of his adult sister, [redacted] at the time of the incident and therefore not assessed. All three children were released to the care of their respective biological fathers.

As part of the joint investigation, the social worker and MPD detective also interviewed [redacted]. at the home. In response to the allegations, [redacted] indicated that use of prescription suboxone. However, she was unable to provide evidence of a prescription. The social worker and detective observed a cigarette with an odor consistent with PCP. The detective collected the cigarette as evidence. In reference to manner of death, [redacted] had difficulty providing a specific timeline leading up to the incident.

During an interview with [redacted] birth father, [redacted] he disclosed that he and [redacted] snorted heroin in powder form throughout the day in question. He was unable to provide an exact timeline and had a significant gap of their whereabouts for several hours.

Based on the joint assessment, there were several safety and risk concerns related to current drug use by [redacted] and the birth father, [redacted] Resultantly, CFSA provided both birth parents with written notice of removal, which occurred on May 3, 2019. CFSA also informed the parents by telephone that an initial court date was scheduled for May 6, 2019.

The investigative social worker continues to collaborate with the assigned police detective. The social worker also requested an At-Risk family team meeting to ensure the siblings remain in the care of their respective fathers and adult sister. This investigation is still open.

Themes

- Three of [redacted] four referrals included educational neglect concerns.
- [redacted]
- Previous child fatality for this birth mother [redacted] DOB: [redacted], deceased at 5 months)
- Substance abuse – [redacted] (alcohol, PCP, heroin, and suboxone)
- Exposure of children to domestic violence.

Strengths of the Family

- [redacted]
- The family had stable housing.
- There was a strong family support system for [redacted] - her two adult daughters, the maternal grandmother, and two of the children's fathers, [redacted] and the decedent's father, [redacted]

Case Practice - Strengths and Areas for Improvement

Strength:

- CFSA screened-in the second referral for educational neglect and submitted an FA referral.

[redacted]