

# **NATIONAL RESOURCE CENTER FOR CHILD PROTECTIVE SERVICES**

## **Technical Assistance Report**



Prepared for Child and Family Services Agency  
Washington, D. C.  
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Onsite Days: March 24 and April 20, 2006

Please indicate which responses were employed in this T/TA:

- Technical Assistance
- Training
- Phone Consultation
- Referral to another NRC
- Referral to Other Organization
- Review of Policy and Materials
- Publications Provided
- Secondary Research
- Other

### Situation and Technical Assistance Request

The Child and Family Services Agency (CFSA), Washington D.C. requested assistance in reviewing and making recommendations regarding the current process for child fatality review. The process is composed of an internal CFSA review and an external city-wide review. The internal process involves gathering case information, holding a review with CFSA staff and external stakeholders and preparing reports on the child fatalities. The information gathered during the internal review is provided to the external City-Wide Fatality Review Committee (CFRC).

System improvement was the basis of the request for technical assistance. There was concern that the current process for the internal CFSA review was time consuming, created an atmosphere that was not always conducive to system improvement and did not consistently produce clear outcomes. There was also concern about the coordination between the CFSA committee and the CFRC. CFSA requested research about the child fatality process in other states, a paper review of the requirements for the D.C. child fatality review process, interviews with key people involved in both the internal and external reviews and on-site observation of both fatality review committees was requested by the CFSA staff.

### Site Visit

#### *Preparation*

A review of the following materials was conducted:

- D.C. Code concerning Child Fatality Review Establishment Act of 2001
- CFSA Child Fatalities Statistics, Analyses and Recommendations, June 2005

- Center for the Study of Social Policy Memorandum August 2003 concerning agreements made in accordance with the Implementation Plan
- CFSA Internal Review reports of individual child deaths
- CFSA organizational chart

Research Materials Reviewed:

- Child Fatality Review Reports
  - Missouri
  - Los Angeles
  - Michigan
  - Hampton, Virginia
  - Colorado
- A Program Manual for Child Death Review. Ed. Theresa Covington, Valodi Foster, Sara Rich. The National Center for Child Death Review, 2005

Copies of these materials were sent electronically to staff within the CFSA.

*Telephone Consultation*

Interviews were conducted by phone with participants in the D.C. fatality review process:

- CFSA Quality Improvement Administrator
- CFSA Assistant General Counsel
- CFSA Regional Administrator
- City Wide Fatality Coordinator

There were similar issues identified by each person interviewed. The common concerns about the internal CFSA fatality review were:

- Despite efforts to focus on systems issues, the review frequently focused on the actions of individual staff. This created, at times, an atmosphere of defensiveness and stressful interactions;
- The case reviews had too much emphasis on CFSA case activities from years in the past and did not show a direct correlation to the child fatality; and
- The reviews did not have a clear association with system improvements.

### *On-site*

Two on-site visits were made. On March 24, 2006, the CFSA internal review committee was observed and meetings were held with members of Quality Improvement section of the Office of Organizational Development and Practice Improvement and the Planning Specialist from the Office of Planning, Policy and Program Support. Issues of concern about the review process were discussed as well as possible causes, barriers and solutions.

On April 20<sup>th</sup> the CFRC was observed. Meetings were conducted with a staff member from the Center for the Study of Social Policy (court monitor) and the Deputy Director for Organizational Development and Practice Improvement. The court monitor did not see any significant restrictions within the D.C. Implementation Plan to prevent changes in the current child fatality review process and the Deputy Director expressed commitment to addressing any barriers to enhancing the current process.

### **Next Steps**

A written set of recommendations based on the on-site reviews and the interviews with members of both the internal CFSA committee and the CFRC committee will be provided to the CFSA. The recommendations will include:

- Limit detailed child death information to case activities within the two years before the child's death;
- Prepare fatality case review information along with a system analysis. Present the analysis to the committee for discussion. Limit the focus on individual staff activities;
- Involve key administrative staff in the internal review process by having a predictable CFSA internal fatality review schedule;
- Set a timeframe for dissemination of recommendations resulting from the internal review and align the recommendations with ongoing Quality Improvement initiatives; and
- Facilitate change in the review process by holding focus groups on the specific topics involving members of the internal and city-wide review committees.

### *Additional NRCCPS Consultation*

Following the recommendations, additional consultation can be provided at the request of CFSA to facilitate the focus groups, to review new protocols and provide additional information from other states or child fatality review teams.