CHILD FATALITIES IN VIRGINIA

WHAT ARE CHILD FATALITY INVESTIGATIONS AND REVIEWS?

CHILD FATALITY INVESTIGATIONS are utilized in a variety of ways to collect information about the case either to determine cause/manner of death, the need for criminal proceedings, or signs of abuse/neglect.

CHILD FATALITY REVIEW (CFR) consists of a multidisciplinary analysis of the death of a child and provides an opportunity for states and localities to identify trends and underlying risk factors associate with the deaths of children in their area. Well-functioning CFR teams examine a community and systems-level approach to understanding health disparity trends and common threads between child deaths that could lead to prevention efforts. Child fatality review teams provide an opportunity for continuous quality improvement in agency response to child deaths and the improvement of service delivery to children and families prior to a potential fatality.

CHILD FATALITY INVESTIGATIONS IN VIRGINIA

THE OFFICE OF THE CHIEF MEDICAL EXAMINER (OCME) investigates and determined cause and manner of death for the following cases:

- any death from trauma, injury, violence, or poisoning attributable to accident, suicide, or homicide;
- sudden deaths to person in apparent good health or deaths unattended by a physician;
- deaths of persons in jail, prison, or another correctional institution, or in police custody;
- deaths of persons receiving services in a state hospital or training center operated by the Department of Behavioral Health and Developmental Services;
- the sudden deaths of any infant; and
- any other suspicious, unusual, or unnatural death.

CHILD PROTECTIVE SERVICES (CPS) through local Departments of Social Services (LDSS) investigates all child deaths that are suspicious of abuse and/or neglect. The investigation ends with a disposition of either founded or unfounded for abuse and/or neglect.

LAW ENFORCEMENT investigates child fatalities to determine if criminal proceedings are necessary.

CHILD FATALITY REVIEWS IN VIRGINIA

STATE CHILD FATALITY REVIEW TEAM, run through the OCME, selects cases based on trends data and conducts reviews on a topical basis.

THE OFFICE OF THE CHILDREN'S OMBUDSMAN (OCO) receives notification of child fatalities from VDSS that meet the following criteria:

- have a current open DSS referral/case at the time of the fatality
- a valid or invalid CPS report within the last year
- children who died in foster care of unnatural causes
- children who died in a trial home placement,
- or those with a foster care case, for the child or siblings, that was closed within the last two years

REGIONAL CHILD FATALITY REVIEW TEAMS, run through Virginia DSS, review child fatalities that have been investigated by CPS in their region that meet the OCO criteria.

THE SUDDEN DEATH IN THE YOUNG PROJECT, funded by the Centers for Disease Prevention and Control (CDC) and run through the OCME, investigates child fatalities for:

- children and youth ages 0-19 years old whose cause of death was undetermined or not fully understood
- occurred in the Western Tidewater region or the Central region including the cities of Hampton, Newport News, Norfolk, Virginia Beach, Chesapeake, Suffolk, Portsmouth, and the counties of Accomack, Northampton, and York

CHILD FATALITY DATA SURVEILLANCE PROJECTS IN VIRGINIA

VIRGINIA VIOLENT DEATH REPORTING SYSTEM, created in 2003 as part of the CDC's National Violent Death Reporting System and maintained by the OCME. The VVDRS holds information surrounding deaths due to violence such as suicide, homicide, unintentional firearm discharge, deaths due to terrorism, legal interventions, and deaths of an undetermined manner. Reports are published on specific types of death or special populations.

INFANT AND CHILD MORTALITY SURVEILLANCE, created in 2015 and maintained by the OCME. This database contains data on child deaths, ages 0-17, and is utilized to inform child fatality discussions and enhance legislative action. A new database, in partnership with the National Child Fatality Data Coordinating Center, began development in 2023 to build on the Sudden Death in the Young Case Registry. The new system is projected to be completed by the end of 2025 or early 2026.

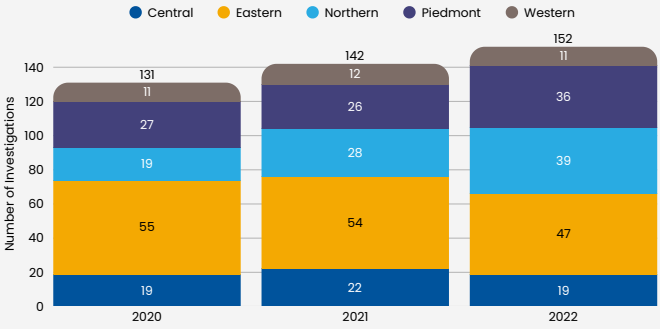
OUR YOUNGEST ARE THE MOST VULNERABLE

Children 0-6 years old accounted for 52% of total child fatalities investigated by the OCME in 2022. Sudden unexpected infant deaths (SUID) under one year of age represented 24.7% of all child deaths.

Children 0-6 years old accounted for 87% of child fatalities founded to be as a result of abuse or neglect by local DSS in State Fiscal Year 2023. 76% of all child maltreatment fatalities were children under the age of three which is above the national average of 66%.

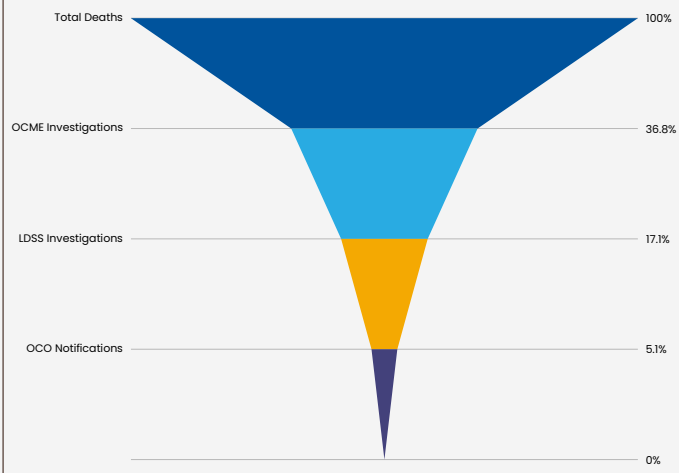
INCREASING CHILD DEATHS INVESTIGATED FOR MALTREATMENT

The National Child Abuse and Neglect Data System reported children died from abuse and neglect at an estimated rate of 2.73 per 100,000 children in 2023. This is a 9.6% increase compared to 2019. In State Fiscal Year 2021, Virginia experienced the highest rate of child maltreatment deaths in the past decade, 3.2 per 100,000 children. The following shows the investigations for abuse and neglect (ages 0-17) conducted in the calendar years of 2020 - 2022 by Virginia DSS region.



LACK OF INVESTIGATION/REVIEW

The Virginia Department of Health recorded **1001 total child deaths** (0-17 years old) in State Fiscal Year 2023. The **Office of the Chief Medical Examiner investigated 368** of these deaths to determine cause/manner. **Child Protective Services investigated 171** with only 38 founded to be due to abuse and neglect. The **Office of the Children's Ombudsman received 51 notifications**. Due to the limited scope of the state fatality review team and the structure of the regional child fatality teams aligning with the OCO notification criteria, **less than 15% of child fatalities investigated by the OCME, and approximately 5% of total child deaths would reach a review team.**



Virginia Fiscal Year 2023 Comparison of Total Child Fatalities (ages 0-17), OCME Investigations, Local DSS Investigations (LDSS), and OCO Notifications.

Further information can be found in the full Child Fatality Investigation and Review in Virginia report at fact.virginia.gov

Family & Children's Trust Fund