Child Fatality Investigation & Review in Virginia

Executive Summary

Family & Children's Trust Fund OF VIRGINIA

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Executive Summary

Child deaths overall, and specifically those due to maltreatment, have been increasing both nationally and in Virginia for the last several years. Nationally, between 2021 and 2022, there was a 3.3% increase in all-cause infant mortality. Child fatalities due to abuse and neglect increased 9.6% from 2019 to 2023. In State Fiscal Year 2021, Virginia experienced the highest rate of child maltreatment deaths in the past decade. Our youngest children continue to be the most vulnerable to child maltreatment deaths. Nationally, 66.9% of these deaths involved a child younger than three years old. Virginia's rate is above the national average with 76% of child maltreatment deaths in SFY 2023 involving a child under three years old.

There is a high level of difficulty in determining cause of child deaths that are not a result of medical conditions. Lack of consideration for the role child maltreatment may play in these deaths can leave additional children at risk, while inappropriately labeling deaths as maltreatment can lead to criminal consequences for grieving parents. Comprehensive investigation and review of these deaths can lead to more accurate classification and better prevention strategies. It is important to note that this report is focused on immediate and post-incident responses to children dying. However, the Child Abuse and Neglect Advisory Committee recognizes the critical protective impact addressing macro level factors, such as poverty and access to healthcare and childcare have on child and family stability. While those factors are foundational to health and safety outcomes for all individuals, families and communities, they are complex and beyond the scope of this report.

The purpose of this report is fourfold:

- provide a central reference document outlining the current efforts for child fatality investigations and review in Virginia,
- to highlight available data on these cases,
- to identify where gaps in data exist and,
- to provide points for consideration on ways to improve child fatality investigation and review processes to increase effective prevention strategies and protect our most vulnerable Virginians.

Child Fatality Investigations. In Virginia, independent child fatality investigations are conducted by law enforcement, the medical examiner, and child protective services. Law enforcement focuses on gathering information to determine if a criminal investigation is warranted. The Office of the Chief Medical Examiner (OCME) utilizes medicolegal death investigations to determine the individual's cause and manner of death (accident, homicide, natural, suicide, or undetermined). When determining manner of death, "undetermined" deaths are a result of uncertainty of one manner of death over another. This determination is limited to the medical cause and is not on its own a full explanation of circumstances of the death. Child Protective Services (CPS) programs within local Departments of Social Services investigate all child deaths suspected of child abuse and/or neglect to determine if a child's caregiver's actions are responsible for the death.

A protocol was developed in 2023 by the Department of Criminal Justice Services, in collaboration with law enforcement and CPS investigators, that emphasizes a uniform and collaborative response consistent across disciplines. The foundational principles of the protocol

include utilizing a multi-disciplinary approach to the investigation and that all unexplained deaths of children should be investigated as suspicious until proven otherwise. There is currently no mandate to utilize this protocol and localities across the Commonwealth have different approaches to their investigations that often are siloed within each agency.

Child Fatality Reviews. Responding to and the prevention of child fatalities is a community wide responsibility. No one agency or organization can tackle the complexities of child death and maltreatment. A collaborative, multidisciplinary approach is necessary to ensure all contributing factors are thoroughly considered when investigating and reviewing the death of a child. Child Fatality Review 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 associated with the deaths of children in their area. This information can then be utilized to produce recommendations for support of protective factors for children and families, adjust policies and procedures, and prevent further child deaths.

State level reviews of child fatalities are conducted by the Office of the Chief Medical Examiner (OCME) for certain types of death indicated by trends. Reviews of certain child maltreatment deaths are conducted by the Office of the Children's Ombudsman (OCO) and regionally through the Virginia Department of Social Services (VDSS). The regional VDSS teams changed their review criteria in 2024 to match the OCO notification requirements to include: children who have a current open DSS referral/case at the time of the fatality; a valid or invalid CPS report within the last year; who died in foster care of unnatural causes; 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.

Certain localities in Virginia are also a participant in the Centers for Disease Control and Prevention Sudden Death in the Young Project (SDY) which focuses on children and youth ages 0-19 years old whose cause of death was undetermined or not fully understood. Two review teams look at the fatalities: the SDY Child Fatality Review Team which focuses on systemic and socioeconomic factors contributing to the child's death, and a clinical review team that identifies medical risk factors.

Due to the limited scope for each team, many child deaths are going unreviewed under the current system. The most robust review of child fatalities in Virginia occurs through the SDY Project which is limited to certain Central and Eastern localities of the Commonwealth. Outside of the SDY Project, the VDSS regional review teams see the widest variety of cases but are still limited to those where abuse and/or neglect was suspected to have caused the fatality.

Data. Without public notification of child fatalities in Virginia, we are left to rely on published trends data which is often published years later thus making timely prevention efforts difficult. Even the data that is available is often incomparable due to differing data collection methods. Data from VDSS is captured by fiscal year while data from VDH and the OCME are published by calendar year. Regional data between agencies is incomparable due to health districts not matching social services regions. The comparisons published in this report are the first of their kind to achieve a public understanding of how many children are dying in Virginia and how that compares to the number of deaths that are being investigated and reviewed.

From 2020-2022, deaths for Virginian children 0-6 years old have been increasing, as well as the number of these deaths that have been investigated by CPS for maltreatment. Prior

to the change in the regional review teams criteria, approximately 24% of child deaths ages 0-6 years old never reached a child fatality review team in 2022 unless covered under the SDY project areas of selected for topical review by the state team.

In SFY 2023, the Virginia Department of Health recorded 1001 total child deaths. The OCME investigated 368 of these deaths and CPS investigated 171 with only 38 founded to be due to abuse or neglect. The OCO received 51 notifications of death in the same period. With the new structure, approximately 70% of cases investigated by CPS would not reach a review team. Less than 15% of child fatalities investigated by the OCME would reach one of these review teams.

Areas for Consideration. The following areas for consideration are summarized and offered to facilitate updates to the current child fatality investigation and review systems that will improve outcomes for all children and families.

- Increase inter-agency communication.
- Increase the number and scope of child death reviews.
- Increase education and support of professionals.
- Collect comprehensive and robust data.
- Conduct evaluations to improve prevention efforts.

Bottom Line Up Front: Child deaths are increasing at an alarming rate and Virginia's current lack of adequate coordination between state and local partners, low number and limited scope of case reviews, lack of accurate and transparent data, and lack of training and support for professionals does not provide an opportunity for effective identification and prevention strategies.