Child Fatality Investigation & Review in Virginia

The Family and Children's Trust Fund of Virginia

Prepared by Taylor Hohle, Senior Research Associate
and Nicole Poulin, Executive Director
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Acronyms Used in this Report

ALICE	Asset Limited, Income Constrained, Employed
CAN	Child Abuse and Neglect
CAPTA	Child Abuse Prevention & Treatment Act
CDC	Centers for Disease Control and Prevention
CFR	Child Fatality Review
CFRP	National Center for Fatality Review and Prevention
CFRT	Child Fatality Review Team
CJA	Children's Justice Act
CPS	Child Protective Services
CRP	Citizen Review Panel
CY	Calendar Year
DCJS	Department of Criminal Justice Services
FACT	Family and Children's Trust Fund
FIMRT	Fetal Infant Mortality Review Team
HRSA	Health Resources and Services Administration
LDSS	Local Departments of Social Services
MAT	Medicated assisted treatment
MDI	Medicolegal Death Investigator
MDT	Multidisciplinary Teams
OCME	Office of the Chief Medical Examiner
OCO	Office of the Children's Ombudsman
OFHS	Office of Family Health Services
PCC	Pathways to Coordinated Care
SDY	Sudden Death in the Young
SEI	Substance Exposed Infants
SFY	State Fiscal Year
SIDS	Sudden Infant Death Syndrome
SUID	Sudden Unexpected Infant Death
VDH	Virginia Department of Health
VDRS	Violent Death Reporting System
VDSS	Virginia Department of Social Services

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.

Overview of FACT and CAN Committee

The Family and Children's Trust Fund of Virginia (FACT) is a statewide public-private partnership focused on the prevention of family violence across the lifespan. FACT brings together state and local partners on issues related to child abuse and neglect, domestic violence, sexual assault, and elder abuse and neglect to increase coordination and effectiveness of efforts to strengthen families and protect children. FACT also supports community programs and initiatives through funding, awareness, and the promotion of evidence-informed and promising practices.

As part of that charge, FACT oversees Virginia's Child Abuse and Neglect Advisory Committee, which serves as one of the Citizen Review Panels required under the federal Child Abuse Prevention and Treatment Act. Comprised of a diverse group of health and human service representatives, the committee closely examines child abuse and neglect policies and processes and makes recommendations to improve prevention and response efforts.

For more information, visit www.fact.virginia.gov

History and Context

In 2022, the Child Abuse and Neglect Advisory Committee requested more information on Virginia's regional child death review teams. The interest of the committee led to an informational webinar in September 2023 on child fatality review processes in Virginia.[1] Around this time, multiple changes were occurring to these processes. These changes and the panel discussion prompted the creation of this report to provide a detailed document on the various agencies and processes involved in child fatality reviews.

It soon became apparent that this was an incredibly complex and complicated issue. Obtaining data that was comparable from different agencies, identifying all the key components and players, having discussions with various partners to understand their roles and challenges, and compiling national best practices were necessary to provide the best possible report. Nearly every layer explored revealed additional information that required further research and discussion. What started as a reference document on child fatality review teams developed over two years into a deep dive into the intricacies and challenges Virginia faces in its response to child deaths at both the investigation and review stages and ultimately the barriers in the prevention of these deaths.

In tandem with the development of this report, the CAN Advisory Committee has developed a workgroup to conduct a multidisciplinary review of selected cases that were investigated by VDSS across all five regions of the state in State Fiscal Year 2023. In addition to reviewing cases, the workgroup has provided support and overview in the development of this report. Child fatalities due to maltreatment continue to be a top priority for the CAN Advisory Committee and work will continue to examine the issue and provide recommendations for consideration to improve these systems.

[1] https://www.fact.virginia.gov/webinar-recordings/

Current State of the Problem

Child deaths overall and deaths due to maltreatment have been steadily increasing the last several years.[2] The most recent data available from the Centers for Disease Control and Prevention (CDC) found a 3.3% increase in all-cause infant mortality between 2021 and 2022, which marks the second consecutive increase following a steady decline since 1995.[3] The U.S. has an infant mortality rate over 50% higher compared to 32 other countries such as Spain and Japan. The National Child Abuse and Neglect Data System (NCANDS) reported children died from abuse and neglect at an estimated rate of 2.73 per 100,000 children nationally in 2023. This is a 9.6% increase compared to the recorded number of child maltreatment fatalities in 2019. While NCANDS is the best source for federal level child maltreatment data, the data submitted is voluntary for state child protective agencies and varying definitions of maltreatment among states mean the numbers are likely an undercount.[4] Approximately half of states report fatality information only for children who had a previous CPS case.

During State Fiscal Year (SFY) 2021, Virginia experienced the highest rate of child maltreatment deaths in the past decade at 3.2 child maltreatment deaths per 100,000 children. Although the total number of deaths of children increased between 2021 to 2023, the number of those deaths that were investigated remained the same. The rate of investigated deaths determined to be caused by maltreatment in 2023 fell to 2.0 per 100,000.

Our youngest children continue to be the most vulnerable to child abuse and neglect death. Children under the age of 1 have 3.3 times the fatality rate compared to 1-year-old children and account for almost half of all child fatalities due to abuse and neglect. Due to limited exposure to the outside world and mandated reporters in the first year of life, these children may not come to the awareness of child protective services until fatality occurs.[5] Children younger than 3 years old account for 66.9% of national maltreatment fatalities in Federal Fiscal Year 2023. In SFY 2023, 76% of child deaths in Virginia from abuse and neglect were under the age of 3 years old, putting Virginia above the national average.

Outside of abuse and neglect, young children are still at higher risk. In Virginia, 82.7% of undetermined deaths of all children, investigated by the medical examiner's office, were under the age of one. Approximately 25% of all medical examiner investigated child deaths were infants under the age of one certified as Sudden Unexpected Infant Death (SUID). Systemic investigations and reviews of these deaths provide an opportunity to identify potential risk factors and areas for prevention of further child deaths.

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[2] https://www.acf.hhs.gov/sites/default/files/documents/cb/cm2023.pdf

[3] Gruppuso PA, Oster EF, Adashi EY. Infant Mortality in the US—Sounding the Alarm. *JAMA Pediatr.* 2025;179(6):592–593. doi:10.1001/jamapediatrics.2025.0369

[4] https://www.casey.org/fatality-data-consistency/

[5] Commission to Eliminate Child Abuse and Neglect Fatalities. (2016). Within our reach: A national strategy to eliminate child abuse and neglect fatalities. Washington, DC: Government Printing Office.

Child Death Investigations and Sudden Unexplained Infant Deaths

There is a high level of difficulty in determining causes 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. Investigators need an appropriately high level of understanding of the dynamics of abuse and neglect and the appropriate tools, collaboration, and knowledge to determine root causes and areas for prevention.

Sudden Infant Death Syndrome (SIDS), previously called various names such as crib death or cot-death, was named in 1963 during a medical conference in Seattle. In 1969, at the second conference the term SIDS was defined as "the sudden death of any infant or young child, which is unexpected by history and in which a thorough postmortem examination fails to demonstrate a cause of death." [6] While various causes such as allergies and infection were examined as potential connections, many of the deaths varied with no true cause determined.

In 1994, the Back to Sleep campaign was created to encourage parents to place babies on their backs to sleep to reduce SIDS risk. Death rates dramatically dropped; however, they remained relatively stagnate until 2020 when rates started increasing. This increase does not appear to be a reversal in sleep trends.[7] Additional risk factors for SIDS have been identified such as prenatal and postnatal tobacco and opioid exposure, low birth weight, and late or no prenatal care.[8] Recent research has shown lack of vaccination in children is also a significant factor associated with SIDS and could even explain a peak in SIDS deaths in the 1980s when Bordetella vaccination rates dipped.[9] These findings call for additional research outside of unsafe sleep in the identification of SIDS. Sudden Unexpected Infant Death (SUID) is now used to include fatalities due to SIDS, unknown cause, and accidental suffocation and strangulation in bed. In 2022, the combined national SUID rate per 100,000 live births was 100.9 with SIDS accounting for 41.7 and accidental suffocation and strangulation in bed at 28.4. [10]

Lack of oxygen was briefly considered to be the underlying cause of SIDS; however, in the 1990s several deaths previously assigned medical causes were determined to be due to intentional suffocations. Unless there is additional evidence from scene investigation and history, an autopsy alone cannot differentiate accidental suffocation of an infant from intentional suffocation. Another autopsy review found that 40% of infants included in the national study who died without an obvious cause before two days old had evidence of cocaine

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[6] Bergman AB, Beckwith JB, Ray CG, editors. Sudden infant death syndrome: proceedings of the Second International Conference on Causes of Sudden Death in Infants; 1969; Seattle, WA. Seattle (WA): University of Washington Press; 1970. 248 p.

[7] Ding G, Peng A, Chen Y, Vinturache A, Zhang Y. Nonsupine sleep position among US infants. *JAMA Netw Open*. 2024;7(12):e2450277. doi:10.1001/jamanetworkopen.2024.50277

[8] https://www.thename.org/assets/docs/AAP%20Identifying%20child%20abuse%20fatalities%20during%20infancy%202019%20e20192076.full%20%281%29.pdf

[9] Müller-Nordhorn J, Hakimhashemi A, Keil T. Vaccination Coverage and Sudden Infant Death Syndrome. *JAMA Pediatr.* Published online May 19, 2025. doi:10.1001/jamapediatrics.2025.1032

[10] https://www.cdc.gov/sudden-infant-death/data-research/data/sids-deaths-by-cause.html#toc

exposure.[11] These discoveries created a push towards comprehensive medicolegal death investigations.

Due to the traumatizing impact of infant death and the difficulty in determining cause of death, the Centers for Disease Control and Prevention (CDC) developed investigation guidelines for SUID cases[12] and created the SUID Investigation Reporting Form[13] in 2007. The guidelines provide standardized information on scene evaluation, documentation of both the body and the scene, and the gathering of infant and caregiver history. Because of the high likelihood of the infant being moved after death (ex. picked up by a caregiver to attempt resuscitation), the guidelines discuss the importance of not only scene photograph but scene re-enactment with a doll to record the infant's position when found dead

Investigation resources for children over the age of one are more uncommon. In 2014, the Sudden Unexplained Death in Childhood (SUDC) Foundation was created and is the only organization dedicated to raising awareness and funding research on SUDC.[14] The CDC and the National Institutes of Health collaborate on the SUID and Sudden Death in the Young (SDY) Case Registry which gathers heath and investigative information on children and adolescents in certain states across the U.S.[15]

Medicolegal Death Investigations

Medicolegal death investigations are utilized to help determine cause and manner of unexplained or unnatural deaths involving a coroner or medical examiner. They are conducted independently, but cooperatively, with law enforcement. These investigations are not only important for collecting evidence and information for use in the criminal justice and child protection systems but also to provide surveillance information for public health epidemiology and prevention programs. During a medicolegal death investigation an autopsy or external examination and various laboratory tests may be conducted as well as collection of medical history and scene information to help make a cause of death determination.

There are two main medicolegal death investigation systems across the United States: coroner systems and medical examiner systems.[16] Coroner systems consist of an elected or appointed individual that usually serves a single county. While requirements vary across the country not all coroners are required to have any medical training or serve as a physician. In these systems a forensic pathologist works closely with the coroner to perform autopsies. Medical examiner systems can exist at the county, regional or state level and are typically appointed. Most frequently medical examiners are physicians or forensic pathologists. Twenty-three states, including Virginia and DC, have medical examiner systems while 20 states utilize a

[11] Rogers C, Hall J, Muto J. Findings in newborns of cocaine-abusing mothers. J Forensic Sci. 1991;36(4):1074–1078

[12] https://www.cdc.gov/sudden-infant-death/media/pdfs/2024/04/SUIDI-Guidelines-Singles_tag508.pdf

[13] Sudden Unexpected Infant Death Investigation Reporting Form Working Group. Sudden Unexpected Infant Death Investigation Reporting Form. Atlanta, GA: Centers for Disease Control and Prevention. 2021. Available from: https://www.cdc.gov/sudden-infant-death/php/suidrf/index.html.

[14] https://sudc.org/about-us/our-vision-mission-and-value/

[15] https://www.cdc.gov/sudden-infant-death/php/case-registry/index.html

[16] https://www.cdc.gov/nchs/comec/Medical-Death-Investigation-System-by-County.pdf

coroner system. The other seven states utilize other county officials or have a wide mix of different systems throughout their counties.

While each system has its own jurisdiction determined by statues and regulations, The National Association of Medical Examiners (NAME) Forensic Autopsy Performance Standards[17] suggest the following deaths receive a medicolegal death investigation:

- Deaths due to violence
- Known or suspected non-natural deaths
- Unexpected or unexplained deaths when in apparent good health
- Unexpected or unexplained deaths of infants and children
- Deaths occurring under unusual or suspicious circumstances
- Deaths of persons in custody
- Deaths known or suspected to be caused by diseases constituting a threat to public health
- Deaths of persons not under the care of a physician

The Office of the Chief Medical Examiner

In 1946, Virginia became one of the first states to establish a statewide medical examiner system which replaced the previous Coroner's office. Shortly after, in 1950, the Office of the Chief Medical Examiner (OCME) was moved to a division under the Virginia Department of Health. The OCME has a two-fold mission focusing on medicolegal investigations and public health efforts. The medicolegal mission includes efforts on death investigations, examinations, and testifying in court proceedings while the public health mission focuses on reducing violent death through review and surveillance, identifying potential disease outbreaks, enhancing organ and tissue donation and transplant, and providing cadavers for medical education.

The OCME is mandated by the Code of Virginia[18] to investigate the following deaths:

MEDICOLEGAL DEATH INVESTIGATION STAFF

Medicolegal Death Investigator (MDI): A professional having the legal authority to investigate deaths for a medicolegal (medical examiner/coroner) jurisdiction, who performs scene investigations, collects evidence, and develops decedents' medical and social histories to assist in determining the cause and manner of death. There are no universal requirements to become a medicolegal death investigator resulting in each medical examiner/coroner office having different hiring requirements. Registry Certification by the American Board of Medicolegal Death Investigators (ABMDI) is available through examination to those who have a high school diploma or equivalent, are currently employed to conduct medicolegal death investigations, and have 650 hours of experience. Board Certification by the ABMDI is available through examination to those who hold at least an associate degree, are currently employed to conduct death scene investigations, and have a minimum of 4,000 hours of experience investigating deaths in the past six years.

Forensic Pathologist: Specializes in determining cause and manner of death by performing autopsies and collecting medical evidence. Becoming a forensic pathologist requires medical school, residency training in anatomic pathology and additional fellowship training in forensic pathology, with certification in anatomic and forensic pathology through examination given by the American Board of Pathology. Typically employed by states, counties/cities, medical schools, military services, or the federal government.

[17] https://name.memberclicks.net/assets/docs/2024%20NAME%20Forensic%20Autopsy%20Standards%209-22-2024.pdf

[18] https://law.lis.virginia.gov/vacode/title32.1/chapter8/section32.1-283/

- 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.

Deaths that fall under the above statutory authority receive a medicolegal death investigation conducted by one of the OCME district offices based in Manassas, Norfolk, Richmond, or Roanoke. A medicolegal death investigator typically serves as the initial point of contact for the hospital or law enforcement reporting the death. Each district has board certified forensic pathologists who serve as Assistant Chief Medical Examiners (ACMES) and conduct autopsies. Typically, death investigators have a background in forensic science. The majority of calls for infant deaths come from the hospital where the medicolegal death investigator may respond to take photos and document findings that may change by the time the forensic pathologist has the ability to examine the body, such as blood pooling patterns. In coordination with the medicolegal death investigators, law enforcement will schedule a baby doll reenactment with the individuals who were last with the infant. In addition to the medicolegal death investigators employed at the OCME, Virginia utilizes a per diem contract system of medicolegal death investigators across the state. The per diem medicolegal death investigators typically have a background in medicolegal death investigation, forensic science, law enforcement, or are a paramedic or registered nurse. Contract per diem medicolegal death investigators receive $50 per case which is significantly lower compared to other states who utilize a contractor system. For example, North Carolina provides $200 per case and Maryland provides $120 per case with additional compensation for infant investigations which are usually more time consuming. Most offices across the U.S. have dedicated death investigators on staff and have moved away from this contract system.

The OCME determines 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.

The OCME has provided additional information to physicians and hospital staff regarding which cases to report. [19] These are:

- All traumatic deaths regardless of cause or manner
- All cases suspected of child abuse or neglect
- Infant or child deaths that occur suddenly or unexpectedly without a known cause
- Deaths of infants and children who do not have a physician
- Any death suspected of being due to Sudden Infant Death Syndrome (SIDS)

These cases are to be reported to the appropriate district office where a medicolegal death investigator or Assistant Chief Medical Examiner determines the OCME's jurisdiction.

[19] https://www.vdh.virginia.gov/medical-examiner/information-on-infant-deaths/

Police Investigations

While medicolegal death investigations are focused on the deceased, police investigations oversee the crime scene. The goal of police scene investigation is to gather information to determine if a criminal investigation is warranted and help the courts determine what happened.

The Children's Justice Act (CJA), Section 107 of CAPTA, provides federal grants to states to develop programs designed to improve the child protection system in the following areas[20]:

- Handling of child abuse and neglect cases in a way that limits additional trauma to the child;
- Handling of cases of suspected child abuse and neglect related fatalities;
- Investigation and prosecution of cases of child abuse and neglect, including sexual abuse and exploitation; and
- Handling cases of children with disabilities who are victims of abuse and neglect.

Virginia's CJA Program, administered by the Department of Criminal Justice Services (DCJS), provides training and technical support to jurisdictions to enhance the investigation, prosecution, and judicial handling of child maltreatment. One of the trainings offered through the program is the Child Death Investigation Protocol Training. This training was created after identification by the State Child Fatality Review Team of the need for improved collaboration between law enforcement and Child Protective Services for child death investigations. A protocol was developed by DCJS in collaboration with law enforcement and CPS investigators across Virginia, and training on the protocol started in 2023. The protocol emphasizes a uniform and collaborative response that is consistent across disciplines. The foundational principles for the protocol and training are that any unexplained death of a child should be investigated as suspicious until proven otherwise and that there must be a multi-disciplinary response to the investigation. There is currently no mandate to utilize the protocol or attend the training. Localities can request the training and they are made public for additional prosecutors, CPS workers, and law enforcement in the area to attend.

Multidisciplinary Teams (MDTs)

Multidisciplinary Teams (MDTS) are viewed as the gold standard for investigation and review of child fatality cases. These teams should consist of various agencies and representatives that have potential touchpoints with the family/child or are involved in the investigation of the fatality such as medical professionals, child protective services, law enforcement, child advocates, and court services. With multiple agencies involved, the conversation provides a deeper understanding of case details and the larger environment within which the fatality occurred, potentially revealing details that would have been missed by a single agency. There are currently no federal requirements or organizing agency for MDTs. What works best for MDTs varies by localities and agencies involved so they are usually hyper-localized to the area's needs. Successful MDTs operate in accordance with regularly updated Memoranda of Understanding which include written protocols and well-defined responsibilities of each agency to ensure consistency in case investigation and reviews and to build trust among the members.

[20] https://www.dcjs.virginia.gov/safer-communities-youth-services/childrens-justice-act-cja

Virginia code section § 15.2-1627.5[21] requires the attorney for the Commonwealth in each jurisdiction to establish an MDT to respond to cases of child sexual abuse and, at the request of any team member, to review other reports of child abuse and neglect in their jurisdiction. The teams should include representatives from law enforcement, child protective services, and a children's advocacy center if one exists in the jurisdiction. If a Child Advocacy Center (CAC) does exist in the jurisdiction, the Commonwealth Attorney usually defers the coordination of the MDT to the CAC. If there is not a CAC in the area, the Commonwealth Attorney usually works with the Victim Witness and LDSS offices to coordinate and pull cases for review. The MDTs are required to meet frequently enough that no new cases go more than 60 days without being reviewed. There are no established parameters on what case conditions result in an MDT review; such decisions are left up to the locality.

Similarly, local departments of social services are able to establish MDTs to provide consultation on investigations of child abuse and neglect cases, pursuant to VA Code § 63.2-1503.[22] These teams can include law enforcement, the guardian ad litem or other court-appointed child advocate. Local departments are encouraged to develop protocols and agreements that govern the work of the MDTs.

Nationally, some of the typical activities funded by the CJA funds in other states include establishing local or state child fatality review teams, including multidisciplinary team training and development, and the establishment or enhancing of child advocacy centers.[23] The Department of Criminal Justice Services, with support from the MDT Stakeholder Group, started offering training and technical assistance for local and regional MDTs in 2023. The MDT Stakeholder Group is a collaborative partnership between DCJS, VDSS, the Commonwealth Attorney Services Council, and the Child Advocacy Centers of Virginia.[24] Multidisciplinary Teams are intended to be flexible to the needs of the community; therefore, the MDT Stakeholder Group does not prescribe a specific model for MDTs but rather provides sample documents for MDTs to develop their own protocols and process.[25] There is currently no administrator or entity providing oversight of MDT functions across Virginia. Through the MDT Stakeholder Group, DCJS has taken the lead on developing an MDT survey that will collect demographic data on all MDTs, not just those for child sexual abuse. The plan is for this survey to be updated annually, and additional secondary surveys will assess the different needs and support for the child sexual abuse MDTs.

The Office of the Children's Ombudsman (OCO) 2024 report[26] found several jurisdictions did not have functional MDTs. The lack of coordination in investigations increased re-traumatization and even left children in unsafe situations. In one case, the alleged abuser was allowed contact with the children during their interview due to lack of communication and collaboration across agencies. The OCO recommended local departments of social services, local Commonwealth's Attorneys, and Child Advocacy Centers review their policies and protocols to ensure proper procedures for MDT functioning and joint investigations, as well as developing strong

[21] https://law.lis.virginia.gov/vacode/title15.2/chapter16/section15.2-1627.5/

[22] https://law.lis.virginia.gov/vacode/title63.2/chapter15/section63.2-1503/

[23] https://acf.gov/cb/grant-funding/childrens-justice-act

[24] https://www.dcjs.virginia.gov/safer-communities-youth-services/childrens-justice-act-cja

[25] https://www.dcjs.virginia.gov/safer-communities-youth-services/virginias-multidisciplinary-teams

[26] https://www.oco.virginia.gov/media/governorvirginiagov/oco/reports/annual-reports/2024-Annual-Report-of-the-Office-of-the-Children's-Ombudsman-WEB.pdf

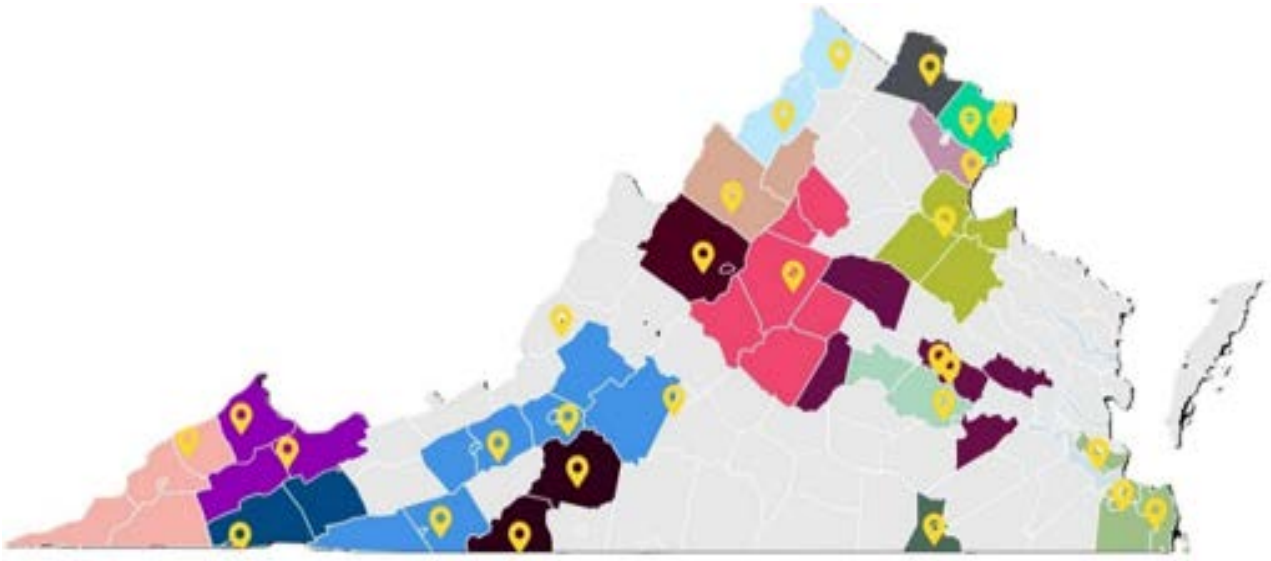
Memoranda of Understanding that outline expectations and responsibilities for all agencies involved.

Child Advocacy Centers

Children's Advocacy Centers (CACs) are child-focused, facility-based programs in which representatives from many disciplines work together to conduct interviews and make team decisions on cases of child abuse. In addition to conducting forensic interviews and providing coordination of agencies responding to these cases, many CACs offer specialized support services for both the impacted child and family members involved with the child.

Child Advocacy Centers of Virginia (CACVA) was formed in 2002 as a membership organization to provide technical assistance and training for Virginia CACs. It serves as an accredited chapter of the National Children's Alliance. Virginia has 19 CACs and 10 satellite locations throughout the state. The map below shows the areas currently covered.[27]

CACs utilize MDTs to minimize re-traumatization of children who may be experiencing abuse. Teams of medical professionals, law enforcement, child protective services, victim advocates, and mental health professionals work together to make decisions on how to best help the child based on a single trauma-informed interview. This prevents children and caregivers from repeating their story multiple times to different professionals for each service. Each participating agency benefits from the knowledge of other members and the collaboration keeps lines of communication open, optimizing quality responses. Collaborative responses to investigations are vital to ensuring that all avenues and details are properly considered as contributing factors to abuse and neglect of children, especially in fatalities.



[27] https://www.cacva.org/find-a-cac/

Child Abuse Pediatricians

In 1962, Dr. C. Henry Kempe published "The Battered-Child Syndrome" which laid the groundwork not only for child abuse to be identified and treated by physicians but also for reporting guidelines and the Child Abuse Prevention and Treatment Act (CAPTA).[28] Physicians have often been at the forefront of raising awareness for abuse and neglect and play a significant role in identification and assessment of child maltreatment, including fatalities.

The board certification process for child abuse pediatrics was created in 2009 by the American Board of Pediatrics. Child Abuse Pediatricians diagnose and treat children who are suspected to be victims of abuse or neglect. Some Child Abuse Pediatricians practice in clinical settings such as Child Advocacy Centers (CACs) or hospitals, but many work in research and education with a consultative role in patient care.[29] In order to become a certified Child Abuse Pediatrician, a physician must have a certification in general pediatrics, participate in a three-year Child Abuse Pediatrics fellowship accredited by the Accreditation Council for Graduate Medical Education (ACGME), and pass the Child Abuse Pediatrics subspecialty board examination. These physicians often work collaboratively with child welfare systems, law enforcement, and courts in the investigation and prosecution of child maltreatment.

The American Academy of Pediatrics (AAP) has recommended pediatrician involvement in child death review and investigation since 1999[30] with another clarification in 2019 on the role of pediatricians in identifying child abuse infant deaths.[31] Due to the complexity of differentiating manner of death in infants, the AAP notes the importance of consultations between medical examiners/forensic pathologists and child abuse pediatricians to ensure potential evidence of maltreatment is reviewed.[32] In 2024, the AAP released a policy statement recommending that all child fatality review teams have a pediatric physician present and that pediatricians use recommendations from these teams to inform policies and legislation to reduce preventable child deaths.[33]

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[28] *AMA J Ethics.* 2023;25(2):E148-152. doi: 10.1001/amajethics.2023.148.

[29] https://www.pedsubs.org/about-cops/subspecialty-descriptions/child-abuse/

[30] Kairys SW, Alexander RC, Block RW, et al. Investigation and review of unexpected infant and child deaths. *Pediatrics*. 1999;104(5 Pt 1):1158–1160

[31] Palusci VJ, Kay AJ, Batra E, et al. Council on Child Abuse and Neglect; Section on Child Death Review and Prevention; Task Force on Sudden Infant Death Syndrome; National Association of Medical Examiners. Identifying child abuse fatalities during infancy. *Pediatrics*. 2019;144(3):e20192076

[32] A. Legano, Stephen A. Messner, Bethany Anne Mohr, Rebecca L. Moles, Shalon Marie Nienow, Carol Berkowitz, Howard Needelman, Timothy Corden, Robert Darnall, Lori Feldman-Winter, Michael Goodstein, Fern R. Hauck; Identifying Child Abuse Fatalities During Infancy. *Pediatrics* September 2019; 144 (3): e20192076. 10.1542/peds.2019-2076

[33] Erich K. Batra, Kyran Quinlan, Vincent J. Palusci, Howard Needelman, Abby Collier, AAP SECTION ON CHILD DEATH REVIEW AND PREVENTION, COUNCIL ON INJURY, VIOLENCE, AND POISON PREVENTION, COUNCIL ON CHILD ABUSE AND NEGLECT; Child Fatality Review. *Pediatrics* March 2024; 153 (3): e2023065481. 10.1542/peds.2023-065481

CHILD ABUSE PEDIATRICIANS IN VIRGINIA

In 2024, Virginia had 0.1 specialized pediatricians per 100,000 children across the state.[34] The only states that rank lower than Virginia are those who do not have *any* child abuse pediatricians. CHKD in Hampton Roads currently provides the only ACGME accredited Child Abuse Pediatrician fellowship in Virginia; however, the ACGME requires two board-certified Child Abuse Pediatricians to run the program and CHKD currently has only one.[35] The University of Virginia and Virginia Commonwealth University are in the process of developing a fellowship that will meet the faculty requirement with fellows splitting time between the two universities.

The Children's Hospital of Richmond requires all resident interns to rotate through the Child Protection Team which covers abuse and neglect. In their second-year, residents can choose the Child Protection Team as a subspeciality track. Additionally, The Child Abuse Project ECHO, hosted through the Children's Hospital of Richmond, provides a virtual space for community providers to connect with child abuse and maltreatment specialists. During sessions, participants discuss de-identified cases and share resources to further an understanding of child abuse identification in medical practice.[36]

Child Abuse Pediatrics is the smallest pediatric subspeciality and faces significant workforce challenges across the United States.[37] Secondary trauma, decreased financial compensation compared to other medical fields, and workforce retention and recruitment struggles highlight a few of these challenges. Due to lack of subspecialists across the country, many children are evaluated by general pediatricians or other physicians who may lack experience in child abuse training. Education on abuse and neglect in general pediatrics varies by educational program; however, most commonly there is relatively little training on the complexities of abuse and neglect injuries. There are currently only 33 ACGME accredited Child Abuse Pediatrician fellowships across the U.S. which accounted for only 58 fellowship positions for the 2022-2023 academic year. For comparison, there were 153 ACGME accredited fellowship programs in child and adolescent psychiatry (966 filled positions) and 64 accredited fellowship programs in pediatric cardiology (480 filled positions) during the 2022-2023 academic year.[38] As of June 2023, only 425 physicians have been board certified in Child Abuse Pediatrics and only 85% were actively enrolled in maintaining their certification. This equates to 0.5 Child Abuse Pediatrician subspecialists per 100,000 children aged 0-17 across the U.S. Twenty-one percent of these subspecialists were 61-70 years old, making Child Abuse Pediatrics one of the pediatric subspecialities with the oldest workforce who may soon exit to retirement. Almost half (48.9%) of full-time Child Abuse Pediatricians reported working over 50 hours a week on average during the last six months. When evaluating compensation, lifetime earnings for subspecialists with similar income to Child Abuse Pediatricians result in a pay reduction greater than $1 million compared to generalized

[34] https://www.abp.org/dashboards/pediatric-subspecialty-us-state-and-county-maps

[35] https://www.evms.edu/pediatrics/fellowships/child_abuse/

[36] https://www.vcuhealth.org/services/telehealth/for-providers/education/child-abuse-project-echo/

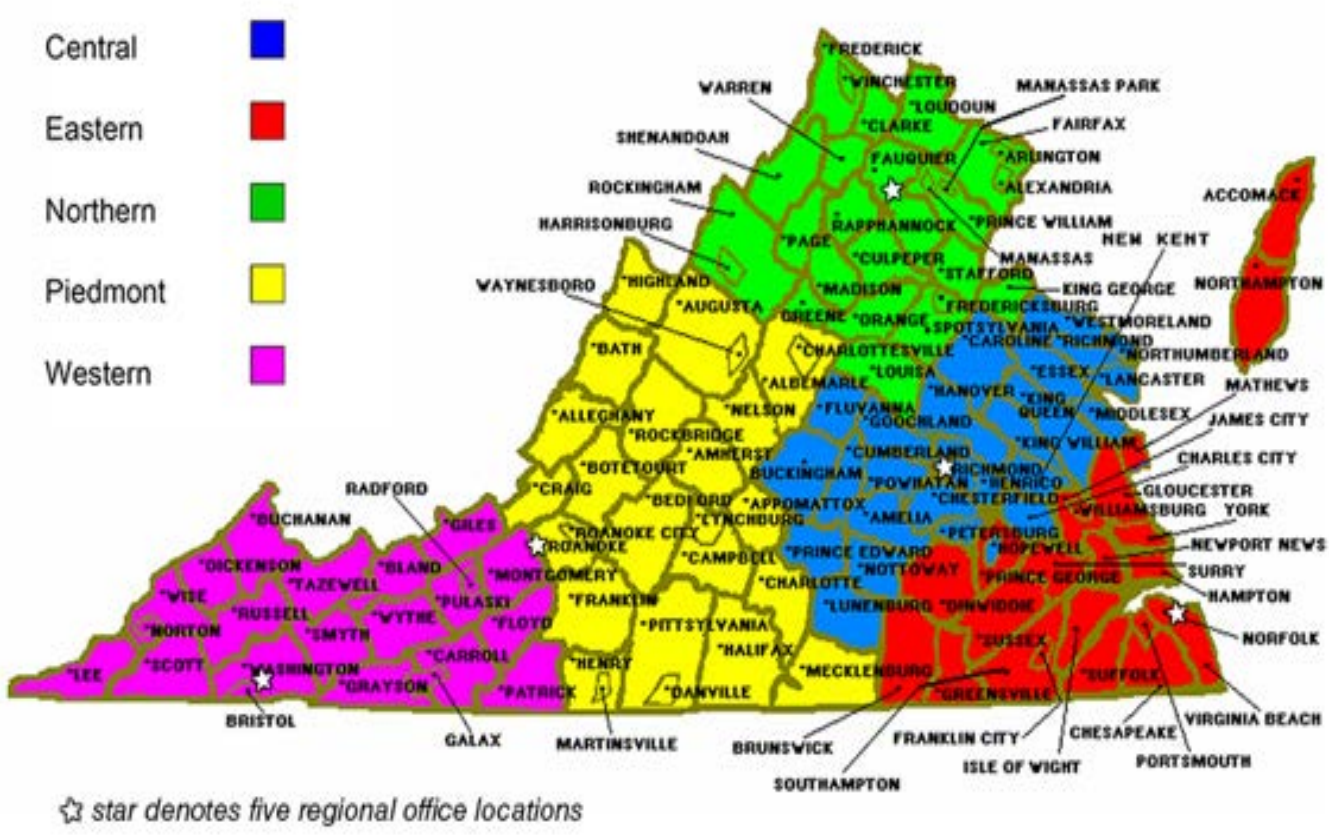
[37] Brett Slingsby, Angela Bachim, Laurel K. Leslie, Mary E. Moffatt; Child Health Needs and the Child Abuse Pediatrics Workforce: 2020–2040. *Pediatrics* February 2024; 153 (Supplement 2): e2023063678F. 10.1542/peds.2023-063678F

[38] https://www.abp.org/dashboards/pediatric-program-map-and-listing

pediatricians. Child Abuse Pediatricians play a crucial role in identifying abuse and neglect and have additional expertise to catch often missed evidence of intentional harm in autopsies.

Virginia Department of Social Services

The Virginia Social Services System is a state-supervised, locally administered human services model with the mission to "design and deliver high-quality human services that help Virginians achieve safety, independence, and overall well-being."[39] There are 120 Local Department of Social Services (LDSS) that are supervised by the Virginia Department of Social Services (VDSS). VDSS has five regional offices that provide oversight, consultation, and monitoring to the LDSS in the Central, Eastern, Northern, Piedmont, and Western regions of Virginia. Each region currently has one CPS Practice Consultant. Another Practice Consultant will be added to each region in 2025; however, more are still needed to provide full coverage and oversight. The map below shows the counties covered by each region.[40]



[39] https://www.dss.virginia.gov/about/mission_plan/

[40] https://www.dss.virginia.gov/division/regional_offices/

VDSS REGION DEMOGRAPHICS

The following demographic data is compiled from the most recent available sources for each individual category rather than all data categories showcasing the same year.

	Central	Eastern	Northern	Piedmont	Western
Total Population[41]	1,434,353	1,991,722	3,516,501	1,147,343	567,580
% of Population that are Children (ages 0-17)[41]	21.2% (304,152)	21.7% (433,303)	23.6% 828,496	19.8% (227,069)	17.8% (100,965)
Racial demographics[41]					
White	831,080	1,098,275	2,041,049	856,276	517,495
Black or African American	398,712	602,051	417,052	185,991	19,225
American Indian and Alaskan Native	3,418	5,536	15,484	2098	680
Asian	55,333	74,816	430,799	24,272	8,386
Native Hawaiian and Other Pacific Islander	908	1,964	1,780	538	489
Other	55907	46,107	225,152	19,652	4,726
Two or more Races	88,995	162,973	385,185	58,516	16,579
Average Mean Family Household Income	$113,666	$113,454	$151,787	$102,341	$87,428
# of children living in families 200% below poverty line[41]	94,361	155,258	169,742	92,544	44,065
% of ALICE* households in 2022[42]	31.2%	31.1%	25.5%	32.8%	32.7%
Average rate of children in foster care per 1000 children (SFY2020)[43]	1.39	1.55	1.84	2.53	5.62
# of CPS referrals (SFY24)[44]	19,935	29,218	47,898	28,122	17,187
# of founded CPS investigations (SFY24)	752	1,050	1,554	1,151	1,571
# of Substance Exposed Infants Referrals (SFY24)	159	97	144	296	146
Total # of child fatalities (SFY23)	199	269	311	153	69
# of child fatalities investigated by DSS (SFY23)[45]	22	50	50	37	12

*Asset Limited, Income Constrained, Employed

[41] Calculated from American Community Survey 5 Year Estimates, 2019-2023, https://www.census.gov/data/developers/data-sets/acs-5year.html

[42] Calculated from data table downloaded from: https://www.unitedforalice.org/state-overview/Virginia

[43] Calculated from data table downloaded from https://datacenter.aecf.org/data/tables/9176-rate-of-children-entering-foster-care-per-1000-children?loc=48&loct=5#detailed/5/6812-6945/false/2071/any/18196

[44] https://www.dss.virginia.gov/files/about/reports/children/cps/all_other/2024/CPS_Accountability_Referrals_Type_of_Abuse_Annual_Report_sfy2024.pdf

[45] https://www.dss.virginia.gov/files/about/reports/children/cps/all_other/2024/Child_Maltreatment_Death__Inv_SFY2023_REPORT_final.pdf

Child Protective Services (CPS) programs within local departments are responsible for the identification, assessment, investigation, and service provision to abused or neglected children. CPS investigates all child deaths suspected of child abuse and/or neglect. Information collected during this investigation includes child demographics, description of the fatal injury including type of abuse and/or neglect, supervisor at the time of death (demographics and relationship to the child), child's legal caretakers, and the status of other children in the home during and after the investigation.

When a call comes into the CPS hotline, local agency, or the Mandated Reporter Portal reporting the death of a child alleged to be abuse or neglect the following occurs:

- The LDSS evaluates the information of the report and determines its validity. In the case of a child fatality, an investigation is required for all validated referrals. The Code of Virginia § 63.2-1508[46] outlines four criteria that must be satisfied to validate a complaint of abuse or neglect requiring a family assessment of an investigation.
    - The alleged victim must be under the age of 18 at the time of the report.
    - The alleged abuser is the child's parent or other caretaker, or an intimate partner of a parent or caretaker.
    - The local department has jurisdiction. If not, they will forward the complaint to the appropriate local department.
    - The circumstances described alleged child abuse or neglect as defined by 22 VAC 40-705-30.[47]
- The LDSS is required to contact the District Office of the Chief Medical, as well as the Commonwealth's Attorney and local law enforcement Examiner (22 VAC 40-705-50[48]).
    - Within five working days of notification to the OCME, the Family Services Specialist at LDSS must request a written copy of the autopsy report.
- The CPS Practice Consultant should be contacted immediately (22 VAC 40-705-50) and will ensure the Preliminary Child Fatality/Near-Fatality Information Form is completed and forwarded to the CPS Program Manager within two working days. The CPS Program Manager then informs the VDSS Commissioner's Office.
- If the fatality occurred in foster care, the LDSS Family Services Supervisor must immediately notify the LDSS with legal custody of the child and notify the Foster Care Practice Consultant.
- A safety assessment must be completed in all investigations involving a child's death. If there are other children in the home, the assessment will be either conditionally safe, which requires a safety plan, or unsafe, which requires a court order. If there is a child under the age of two in the home, written information on safe sleep practices will be provided and documented.
- Whenever a parent/caretaker's actions resulted in the death of a child due to abuse or neglect, a policy override is in place to assess the risk as very high regardless of the CPS Risk Assessment Tool's indication. Cases that are determined to be low or moderate risk can be closed while those at high or very high risk are recommended

[46] https://law.lis.virginia.gov/vacode/title63.2/chapter15/section63.2-1508/
[47] https://law.lis.virginia.gov/admincode/title22/agency40/chapter705/section30/
[48] https://law.lis.virginia.gov/admincode/title22/agency40/chapter705/section50/

to open a case for In-Home Services. If there are no other children in the home, it is not necessary to provide services.

The Preliminary Child Fatality/Near-Fatality Information Form includes the following information:

- Logistical Information (name of LDSS, investigating worker, Family Services Supervisor, and CPS Practice Consultant; date of complaint; referral number; person making complaint)
- Demographic Information (name of child and alleged abuser/neglector; relationship to the child; type of alleged abuse/neglect; child's date of birth and death; sex and race of the child)
- Reporting Requirements (dates reported to the CPS Practice Consultant, Commonwealth's Attorney, law enforcement, OCME, and CPS Program Manager)
- Circumstances Surrounding Child's Death (detailed description of the child's death; information on the family's prior involvement with the LDSS; information on the alleged perpetrator and their relationship to the victim; identification of siblings and safety plan)
- LDSS' Plan of Action (description of the investigation plan; the CPS Practice Consultant's involvement; date the disposition is due; additional comments)

The CPS Manual section on Child Deaths[49] details suggested questions to guide investigations of child fatality. General information such as who called 911, when the child was last seen alive, any prior child welfare involvement, the alleged abuser/neglector's demeanor at the time of death, and additional information about the child's appearance and developmental level should be collected. Information should be obtained about the child's physical health and pregnancy as well as the mental health of the child and caretakers. Any substance use by the child, alleged abuser/neglector, and caretakers should be documented, including the last date of use and if any substances were in the home. When observing the home, CPS workers should document the functionality of house utilities, presence of food or formula, any hazards inside or outside the home, pets, description of the sleep spaces, and access to weapons or medications. If there are surviving siblings, information on their childcare arrangements, where the sibling was during the death, and when they last saw the victim child. If the sibling is able to describe what they know about the death, the relationship to the alleged abuser/neglector, and how the caretaker disciplined the victim child, this information should also be recorded.

In 2023, VDSS Division of Local Training and Development created a Child Fatality Investigations training for Family Services Specialist who conduct CPS investigations. The training is required within the first two years of work for anyone who will participate in fatality cases. In some localities this might be a few well-established workers who cover all fatalities in their area compared to assigning them equally across all workers. This course takes place in-person over two days and covers the following topics:

- The investigation process
- Collaboration with law enforcement, the Commonwealth's Attorney and other MDT members

[49] https://www.dss.virginia.gov/files/division/dfs/cps/intro_page/manuals/03-2025/March_2025__section_6_child_deaths.pdf

- Understanding fatality causes and safe sleep practices
- Interviewing
- Assessing and planning for the safety of siblings
- Evidence collection
- Working with regional consultants
- Completing the Preliminary Child Fatality/Near Fatality form
- Working with the Medical Examiner
- Understanding Child Fatality Review Teams and preparing for participation
- Professional self-care and resources for support

According to the Virginia Child Welfare Staff and Provider Training Plan[50], this course will eventually transition to a blended model with eLearning covering the portions on policy and protocol and an instructor-led section on emotional trauma involved with child fatality cases. Additional online courses are available on Working with Families of Substance Exposed Infants (required training), Child Fatality Investigative Team Collaboration, and the Substance Exposed Infant and Child Fatality Decision Tree Tools.

Child Fatality Review

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. 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.

In 2002 the Michigan Public Health Institute was awarded funding through the Maternal and Child Health Bureau to start the National Center for Fatality Review and Prevention (CFRP). The CFRP serves as technical support for CFR teams and Fetal and Infant Mortality Review programs across the United States. In 2005 they created the National Fatality Review-Case Reporting System (NFR-CRS) database for fatality teams to enter information about their reviews.

While autopsies are used to identify the medical cause of death for an individual, 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.

The CRFP provides six steps to effective reviews to ensure thorough examination of all factors involved in a child's death.[51]

1. Share, question, and clarify all case information.
    a. Agency representatives take turns sharing information they have connected to the child and fatality. This is an opportunity for team members to ask questions and get clarification on the details leading to the fatality and the history each

[50] https://www.dss.virginia.gov/files/division/dfs/cfs/CFSP_2025-2029/Appendix_E-1_Virginia_Child_Welfare_Staff_and_Provider_Training_Plan-Final.pdf

[51] https://ncfrp.org/cdr/cdr-process/

agency had with the family/child prior to death. The intention is not to place blame on any agency or person but to ensure all circumstances of the death have been explored.

2. Discuss the investigation.
    a. Examples of questions during this section of the meeting include:
        i. Who is the lead investigative agency?
        ii. Was there a death scene recreation with photos?
        iii. Were other investigations conducted?
        iv. What were the key findings?
        v. What more do we need to know?
        vi. Does the team have suggestions to improve the investigative system?
3. Discuss the delivery of services.
    a. Examples of questions on service delivery include:
        vii. Were there any services that the family was accessing prior to the death?
        viii. Were services provided to family members as a result of the death?
        ix. Are there additional services that should be provided to anyone? For example: siblings, classmates, responders, and the larger community
4. Identity risk factors.
    a. Risk factors can be grouped into the following general categories: health, social, economic, behavioral, environmental, system (agency policies and procedures), and product safety. Teams are encouraged to examine the death in as broad of an ecological perspective as possible rather than focusing solely on behaviors and actions of the family or individual.
5. Recommend systems improvements.
    a. Identify gaps or barriers in procedure and policy in response to the death that create limitations in review.
6. Identify and take action to implement prevention recommendations.
    a. The review team may not be the group to engage in implementing preventive actions identified, but providing recommendations and appropriate follow up to the key players can foster community accountability for implementing the review recommendations.

National Perspective

Function and Structure

In 2021, the CFRP published a report entitled Keeping Kids Alive: Child Death Review in the United States[52] which details similarities and differences across state and local review teams as of 2020. While all states, along with the District of Columbia and several indigenous tribes, have some form of CFR program, their structure, funding, and protocol varies widely. The majority of states, 71%, including Virginia, mandate a state level CFR program and another 16% have legislation or administrative rules that permit the function of a CFR program. These mandates or permits are intended to help create pathways for teams to access case records and reporting

[52] https://ncfrp.org/wp-content/uploads/Status_CDR_in_US_2020.pdf

protocols. Slightly over half of states, 55%, have teams led by their state health department while others are led by various state level agencies such as social services, medical examiners offices, or the attorneys general. Only 37% of states mandate local level CFR teams and another 26% permit them.

CFR teams vary in agency and professional representatives; however, most teams consist of at least one representative from: law enforcement, child protective services, public health, pediatricians, medical examiner/coroner, emergency medical services, and a prosecutor or district attorney. Additional representatives may be from domestic violence agencies, schools, juvenile justice, mental health agencies, home visiting programs, and child abuse prevention organizations. The CFRP provides further examples of agency representatives in their Child Death Review Program Manual.[53] These multidisciplinary reviews help to create a better knowledge base of the complex factors that play a role in the health and safety of children.

Almost all states, 43, have a CFR state advisory board. These advisory boards serve to compile findings and create state-level recommendations for governors and legislatures to prevent further fatalities. These state advisory boards commonly have subcommittees that provide recommendations for specific types of fatalities such as sleep-related deaths or child abuse and neglect. Virginia's state CFR team, led by the OCME, also serves this function rather than having a separate advisory board.

Case Selection

Case selection criteria also vary by state based on statutory requirements, lead agency, and program capacity. The majority, 78%, of teams review only deaths for children through 17 years old. Four states also include young adults over 18 years old in their reviews. As of 2020, Sudden and Unexplained Infant Deaths (SUID) are the only case review that occurs in 100% of states. Unintentional injuries, abuse and neglect, and undetermined cause cases are reviewed by 98% of states, followed by suicides and cases with a history with social services in 96% of states. An increasing number of states, 76% in 2018 to 92% in 2020, are reviewing cases where the child was a ward of the state. Medical death cases are the least reviewed occurring in only 69% of states. Occasionally teams who review medical deaths find occurrences of medical neglect (parent or guardian's failure to provide adequate medical care) which presents an argument for the review of all child deaths to prevent cases slipping through the cracks. Ten states also review near fatalities or serious injuries to inform injury and death prevention efforts. In 2020, all state-level reviews were retrospective and 10% of states conducted some local level reviews within 48 hours of the death.

Collaboration

Collaboration with other agencies and fatality review teams is recognized as best practice for in-depth multi-disciplinary child fatality review. Common agency collaborations across states included maternal child health programs, injury prevention programs, Safe Kids coordinators and suicide prevention coordinators. In 18 states, CFR teams also serve as the CAPTA Citizen Review Panel (CRP) which requires ongoing monitoring and reporting to meet child protection requirements. Other state CFR teams collaborate with their CRPs, as well as Maternal Mortality

[53] https://ncfrp.org/wp-content/uploads/NCRPCD-Docs/ProgramManual.pdf

Review, Fetal & Infant Mortality Review, overdose review, domestic violence fatality review, and child protective services review teams. Forty-seven states have an internal review of child deaths at the agency-level to improve agency policy and practices. In addition to the CFR team, 35 states have separate child abuse and neglect death reviews.

Funding and Staffing

The average amount of funding for state-level programs was $247,708 and ranged from programs with $0 to $1.2 million per year of dedicated funding. Commonly this funding comes from federal grants, such as Health Resources and Services Administration (HRSA)-administered Title V Block Grants or Maternal Child Health Block Grants, with state general funds and agency funds being the most common for local CFR teams. Additional funding sources utilized by states include CAPTA funding and Sudden Unexpected Infant Death/Sudden Death in the Young Case Registry funds. Staffing for CFR teams is influenced by the dedicated budget for the team; however, the average dedicated staff at the state level was 1.8 full-time positions and 2.14 at the local level.

CHILD ABUSE PREVENTION AND TREATMENT ACT (CAPTA)

Enacted in 1974, the Child Abuse Prevention and Treatment Act (CAPTA) State Grant program provides funding for states to improve their child protective services systems through the prevention, assessment, investigation, prosecution, and treatment of child abuse. CAPTA provided $105 million in state grants for Federal FY2024, including $2.6 million to Virginia. In order to be eligible for funding, states must submit a state plan that includes an assurance that the state is operating a statewide program that has:

- procedures for reporting suspected child abuse and neglect with mandatory reporting requirements for certain individuals
- policies and procedures to address infants born substance exposed, including notifying child protective services of the occurrence and developing a plan of safe care
- procedures for screening, risk and safety assessment, and investigation of reports
- provisions allowing for public disclosure of findings or information on cases involving a child fatality or near fatality
- procedures requiring a guardian ad litem or a court appointed special advocate be appointed to represent the child in judicial proceedings
- establishment of no less than three citizen review panels to examine/evaluate policies, procedures, and practices of the state regarding child protection and prepare a public annual report with recommendations
- provisions to assure the state does not require reunification of a child with a parent who has been found guilty of murder, manslaughter, felony assault, or sexual abuse of their child

In addition to funding, CAPTA also established the Office on Child Abuse and Neglect, set a federal definition of child abuse and neglect, and established a national clearinghouse of child abuse and neglect information, the Child Welfare Information Gateway. Additional information on CAPTA and its requirements can be found here: https://www.govinfo.gov/content/pkg/USCODE-2017-title42/html/USCODE-2017-title42-chap67.htm

Virginia's CAPTA Plan 2024 update can be found here: https://dss.virginia.gov/files/division/dfs/cfs/apsr/2024/CAPTA_2024_Update-Final.pdf

Virginia's State Child Fatality Review Team

Virginia mandates general parameters for state level reviews conducted by VDH through the OCME. Additional review of suspected abuse and neglect fatality cases occurs at the regional level and is coordinated through VDSS. The State Child Fatality Review (CFR) Team was established in 1995 and is tasked with reviewing "violent and unnatural child deaths, sudden child deaths occurring within the first 18 months of life, and those fatalities for which the cause or manner of death was not determined with reasonable medical certainty".[54] The code details the team as chaired by the Chief Medical Examiner and 16 members with required representatives from the Commissioner of Behavioral Health and Developmental Services, the Director of Child Protective Services, the Superintendent of Public Instruction, the State Registrar of Vital Records, and the Director of the Department of Criminal Justice Services. Additional representatives from local law-enforcement, local fire department, local departments of social services, the Medical Society of Virginia, the Virginia College of Emergency Physicians, the Virginia Pediatric Society, local emergency medical services, attorneys, and community service boards are appointed by the Governor for three-year terms. Staffing for state-level child fatality work includes one full-time program manager, one research assistant, and one research associate.

The CFR team is responsible for improving the identification, data collection, and record keeping on the causes of child death and recommending prevention education and training opportunities. Local CFR teams may be established and receive technical assistance from the state CFR team. Like many other state mandated CFR review teams, Virginia Code § 32.1-283.1 created a pathway for the state CFR to obtain records from various sources on a child's death and carved out confidential exceptions to public meeting requirements for case review. The State CFR team meets six times per year and information on upcoming meetings can be found on the Commonwealth Calendar.[55]

Since its creation, Virginia's State CFR Team has reviewed and reported on deaths based on specific categories of child deaths, such as sleep-related deaths or drownings.[56] Topics are chosen based on data analysis, national data trends, and at the team's discretion. Reviewing in a topical manner provides the team an opportunity to develop specific recommendations for intervention and prevention associated with the chosen type of death. Through these reviews, the State CFR Team has found child death to be patterned and largely preventable. Trends identified in these topical reviews included the presence of family violence and economic instability in homicide cases, family substance use and mental health problems in sleep-related infant deaths, and the importance of adult supervision for preventing unintentional injuries.

Until 2023, the state CFR team served as one of the three CAPTA CRPs for Virginia. This change was due to staffing availability and public meeting requirements. VDSS has taken on the role of coordinating a new CRP not focused on child fatality, in addition to the two currently established CRPs: the Child Abuse & Neglect Advisory Committee and the Children's Justice Act/Court Appointed Special Advocate Committee.

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[54] https://law.lis.virginia.gov/vacode/title32.1/chapter8/section32.1-283.1/

[55] https://commonwealthcalendar.virginia.gov/

[56] https://www.vdh.virginia.gov/medical-examiner/division-of-death-prevention/child-fatality-review-in-virginia/reports/

The State CFR team is funded through the Virginia Department of Health, Office of Family Health Services using Title V funds from the Maternal and Child Health Bureau at the U.S. Department of Health and Human Services. The Sudden Death in the Young Project is funded through a grant provided by the Centers for Disease Control and Prevention. In Federal Fiscal Year 2024, VDH was awarded $169,769 for the Sudden Death in the Young Project.[57]

Regional Child Fatality Review Teams

Regional CFR occurs in each of the five VDSS regions.[58] These multidisciplinary teams review cases that their local departments investigated as suspicious for child maltreatment. Appendix 1 shows the current regional team organizational makeup. Historically, these regional teams were tasked with reviewing all child deaths investigated by CPS; however, as of January 2024 the teams have been restructured to review only cases that meet the following criteria: 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. This new structure aligns with the statutory authority given to the Office of the Children's Ombudsman to investigate child fatalities.[59] While this change in structure is an effort to increase consistency and depth to these reviews across the regional teams which previously operated independently, it has resulted in fewer cases being reviewed overall. In addition to reviews, the regional teams identify risk factors and trends to develop recommendations and action plans.

Office of the Children's Ombudsman

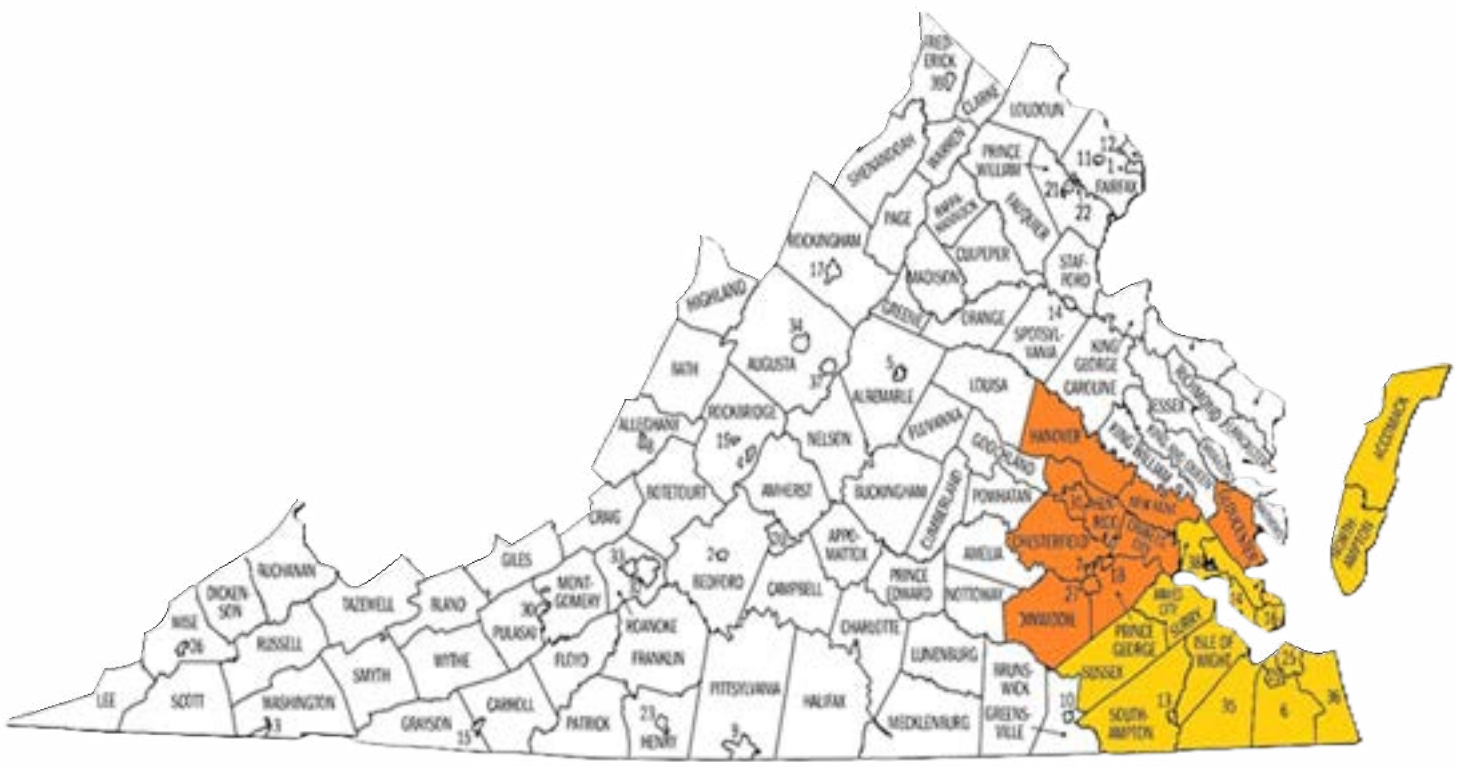
The Office of the Children's Ombudsman (OCO) was created during the 2020 General Assembly session[60] which provided the statutory authority to receive and investigate complaints of agency actions regarding children who are receiving child protective services, in foster care or awaiting adoption. In addition to CPS and foster care investigations, the OCO has the statutory authority to investigate child deaths when the families had prior involvement with child protective or foster care services. Specifically, the OCO's authority allows investigations for fatalities that have a current open DSS referral/case; 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.[61] Data collected by the OCO on these cases includes demographic data, description of CPS or foster care involvement prior to death, and whether the child was found to be substance exposed at birth or had caretakers with substance use.

[57] https://rga.lis.virginia.gov/Published/2025/RD115/PDF
[58] https://law.lis.virginia.gov/vacode/title32.1/chapter8/section32.1-283.2/
[59] https://law.lis.virginia.gov/vacode/title2.2/chapter4.4/section2.2-443/
[60] https://law.lis.virginia.gov/vacode/title2.2/chapter4.4/section2.2-439/
[61] https://law.lis.virginia.gov/vacode/title2.2/chapter4.4/section2.2-443/

Sudden Death in the Young Project

The Sudden Death in the Young (SDY) Project, funded by the Centers for Disease Control and Prevention (CDC), focuses on children and youth ages 0-19 years old whose cause of death was undetermined or not fully understood.[62] Each case receives a multidisciplinary review and in-depth data collection looking into family medical histories, experiences with social services, school records, and other relevant data to the fatality. 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. These reviews are incredibly robust compared to other CFR efforts in Virginia and cover a wider range of children compared to other teams.

Parts of the Eastern and Central regions of the Commonwealth are participating in the project, making Virginia one of ten states included in the project nationwide. In 2015, the cities of Hampton, Newport News, Norfolk and Virginia Beach joined the project with Chesapeake, Suffolk, Portsmouth, and the counties of Accomack, Northampton, and York joining in 2018. Additional parts of the Western Tidewater region and the Central region were added to the project in 2023.[63] The map below showcases the participating Virginia localities.



[62] https://www.cdc.gov/sudden-infant-death/php/case-registry/index.html

[63] https://www.vdh.virginia.gov/content/uploads/sites/18/2024/08/Annual-Report-2022.pdf

Fatality Data Surveillance Projects

In addition to the Virginia CFR team and death investigations, Virginia has several data surveillance projects through the OCME that collect, analyze, and interpret data related to various types of death in the Commonwealth.

Virginia Violent Death Reporting System

The Virginia Violent Death Reporting System (VVDRS), created in 2003 as part of the CDC's National Violent Death Reporting System (NVDRS), collects 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. Child fatalities that fall under these categories would be catalogued in the VVDRS. The OCME maintains this system and generates reports focused on specific types of death or special populations. The most recent publication was released in 2017 and showcases trends for violent deaths in the Virginia's Hispanic community.

Infant and Child Mortality Surveillance

Created in 2015, the Infant and Child Mortality Surveillance System provides reports on child deaths, ages 0-17 years old, to inform fatality discussions and enhance legislative action. A new database, in partnership with the National Child Fatality Data Coordinating Center, began being developed 2023 to build on the SDY Case Registry by collecting data on all child deaths that fall under OCME's statutory authority. The new system is projected to be completed by the end of 2025 or early 2026.

Virginia Department of Health's Office of Family Health Services

The Office of Family Health Services (OFHS) reports to the Deputy Commissioner for Population Health and Preparedness under VDH. The focus areas of OFHS are child and family health, prevention and health promotion, and healthy eating. These areas include a wide variety of programs surrounding reproductive health, maternal mental health and substance use, newborn screening, early childhood, school nursing, and multiple data surveillance projects. OFHS is responsible for the administration of Virginia's Title V Maternal and Child Health Services Block Grant funding which supports both the State CFR and maternal mortality review teams.

Substance Exposed Infants & Plans of Safe Care

Substance exposed infants are at an increased risk of mortality and have continually represented a large number of fatality cases in Virginia.[64] A 2021 study of more than one million infants found that infants who were not diagnosed with neonatal opioid withdrawal syndrome

[64] https://www.oco.virginia.gov/media/governorvirginiagov/oco/reports/annual-reports/2024-Annual-Report-of-the-Office-of-the-Children's-Ombudsman-WEB.pdf

had a 72% increased chance of fatality.[65] Those who were identified and diagnosed had similar fatality levels to the control population. The early identification of these infants - regardless of the perceived severity of withdrawal symptoms - and support offered to both the child and family are crucial in the prevention of their deaths.

The Child Abuse Prevention and Treatment Act (CAPTA) was amended in 2016 by the Comprehensive Addiction and Recovery Act (CARA) to include requirements related to Plans of Safe Care. Plans of Safe Care (POSC) intend to improve the well-being of SEI and caregiver recovery. Additionally, the CARA update required data reporting by states on the number of infants identified as SEI and the number of POSC developed. States were to develop monitoring systems to oversee localities implementation of referrals and delivery of appropriate services for both the infant and caregiver. In 2017, Virginia passed legislation amending § 63.2-1505, 63.2-1506, and 63.2-1509 related to CPS investigations to comply with these changes. The Code of Virginia (§ 63.2-1509(B)) requires a report to CPS by health care providers if any of the following circumstances occur: a finding within the first six weeks after birth that the child is affected by substance use or is experiencing withdrawal symptoms; a diagnosis of fetal alcohol spectrum disorder within the first four years after birth; or a diagnosis with a reasonable degree of medical certainty to be attributed to exposure to a controlled substance in utero.

Each licensed hospital is mandated to have a protocol requiring written discharge plans for substance using postpartum women and their infants (§§ 32.1-127 B6 and 63.2-1509 B). This plan is expected to include, to the extent possible, the other caregiver and extended family who participate in follow-up care for the parent and infant. They are also required to report to the local Community Service Board (CSB), who appoint a discharge plan manager that will implement and manage the discharge plan. The POSC is required whether or not a finding of abuse or neglect is made by the local Department of Social Services (LDSS) during a family assessment. The LDSS is one of multiple agencies that can provide a POSC for the SEI and caregiver, along with substance use disorder treatment providers or other community prevention services.

During the 2018 General Assembly session, VDH was made the lead agency for the development, coordination, and implementation of a service plan for substance-exposed infants.[66] In 2003 an amendment to CAPTA required that states create "plans of safe care" for infants exposed to illegal substances which expanded to all substances in 2016. The strategic plan, known as the Pathways to Coordinated Care (PCC) approved in Fiscal Year 2021, established four pillars under the plan: Screening, Coordination, Education, and Communication.[67] Each pillar contains short term, moderate term, and long term approaches to the following objectives.

- The Screening Pillar encompasses identifying and establishing a standard policy and protocol for screening all women of child-bearing age and all pregnant and post-partum persons.
- The Coordination Pillar focuses on increasing the number of qualified peer recovery specialists, perinatal/women's community health workers, doulas, and/or home visitors to work with pregnant/postpartum women with a substance use disorder.

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[65] Leyenaar JK, Schaefer AP, Wasserman JR, Moen EL, O'Malley AJ, Goodman DC. Infant Mortality Associated With Prenatal Opioid Exposure. *JAMA Pediatr.* 2021;175(7):706–714. doi:10.1001/jamapediatrics.2020.6364

[66] https://law.lis.virginia.gov/vacode/32.1-73.12/

[67] https://rga.lis.virginia.gov/Published/2023/RD781/PDF

Additionally, providers, hospitals and communities will be educated on the value of these services and develop a coordinated approach to assessing and serving families.

- The Education Pillar includes statewide provider awareness with the identification and treatment of substance use disorder during pregnancy/postpartum and infants exposed to substance in-utero. Community awareness and education will be provided to families on the effects of substance use during pregnancy and parenting, substance use resources, medicated assisted treatment, mental health services, and case management programs.
- The Communication Pillar discusses the development of a toolkit for partners containing screening tools, reporting requirements, and referral information. The development of a toll-free hotline or addition to current services such as 211 Virginia would also be established for neonatal abstinence syndrome questions and referrals.

The execution of this plan is conducted by staff at OFHS. As of December 2023, after delays due to the COVID-19 pandemic, the PCC workgroup is reevaluating the PCC to address new challenges and determine additional resources for implementation.[68] The Office of the Children's Ombudsman 2024 annual report noted the importance of resuming these efforts due to a significant number of child fatality cases reviewed by the Office that involved substance-exposed infants and parents with a history of substance use.[69]

What the Data Tells Us

OCME

The most recent annual report from the OCME, published August 2024, covered deaths that occurred in 2022.[70] They investigated 380 child deaths in 2022 with the majority of cases classified as undetermined (127) and accidents (112). Accidental deaths decreased by 3.4% compared to 2021, while undetermined deaths increased by 11.4%.

The vast majority of all cases in 2022 involved children under the age of one (85 male infants and 54 female infants); however, deaths for male children started to rise again at ages 15-17 years old with 91 male deaths compared to 38 female deaths in the same age range. Of the total 127 undetermined child deaths, 82.7% (105) were children under the age of one. Approximately 25% of all OCME investigated child deaths were infants under the age of one certified as Sudden Unexpected Infant Death (SUID) which accounted for 74% of all undetermined child death. For children ages 1-4 years old, 49 of total child cases, 42.8% were classified as an accident and 26.5% homicide. When broken down by race, Black children experienced a significantly higher rate of death per 100,000 children (55.6 for male, 32.8 for female) compared to white (19.5 for male, 12.4 for female), Asian (4.5 for male, 6.3 for female), and Hispanic (12.8 for male, 7.2 for female) children.

[68] https://rga.lis.virginia.gov/Published/2023/RD781/PDF

[69] https://www.oco.virginia.gov/media/governorvirginiagov/oco/reports/annual-reports/2024-Annual-Report-of-the-Office-of-the-Children's-Ombudsman-WEB.pdf

[70] https://www.vdh.virginia.gov/content/uploads/sites/18/2024/08/Annual-Report-2022.pdf

Table 1. OCME Child Death Investigations by Manner, 2020-2022

	2020	2021	2022
Accident	100	116	112
Homicide	58	57	63
Natural	35	49	24
Suicide	51	45	54
Undetermined	100	115	127
Total (0-6 year olds)	**182**	**204**	**198**
Total (17 and younger)	**344**	**382**	**380**

While representing only 16.6% of all child deaths in 2022, child homicide increased 8.6% compared to 2021. Seventeen-year-olds experienced the highest number of homicides (21 male, 2 female); however, the highest number of female homicide victims (3) were less than one year old. Homicide child deaths included 48 Black children, 76% of child homicide deaths, with seven white children as the second highest by race. The most common method of homicide was gunshot wounds (69.8%) followed by beatings at 19%.

DSS

In State Fiscal Year (SFY) 2023, local departments of social services investigated 173 child deaths suspected of abuse or neglect.[71] Of these investigations, 107 were unfounded and 38 child deaths were founded to be the result of abuse or neglect. Just over half (51%) of unfounded reports were sleep-related. Additional investigations were pending[72] or appealed at the time of the report. The Western region had the highest rate of child deaths with 4.7 deaths per 100,000 children and the Eastern and Northern regions investigated the most child deaths. The majority of deaths (65%) involved the child's biological parents as caretakers. Seventy-five percent of children who died from abuse or neglect were ages three and under. Slightly more of the deaths (21) were male children and 45% of all children who died from abuse and neglect were White and 39% were African American. Of the 38 founded cases, 74% involved physical neglect and 24% involved physical abuse. The most prevalent type of neglect found was inadequate supervision. Almost three quarters of cases (71%) had prior or active child welfare involvement at the time of the death.

[71] https://www.dss.virginia.gov/files/about/reports/children/cps/all_other/2024/Child_Maltreatment_Death__Inv_SFY2023_REPORT_final.pdf

[72] Pending investigations may be captured in the CPS Fact Sheets as they close. https://www.dss.virginia.gov/geninfo/reports/children/cps/all_other.cgi

OCO

In SFY 2024, the OCO received 54 notifications of child fatalities.[73] The majority of notifications, 56%, were for children 6 months of age or younger, with the highest number of cases, 10, involving children one month old at the time of the fatality. In almost half, 44%, of all cases, the LDSS had still not received the final medical examiner's report, meaning the cause and manner of the deaths were still unknown at the time of the report.

Slightly under half, 46%, of all notifications involved a history of parental substance use. THC, cocaine, methamphetamine, heroin, and fentanyl were the most prevalent non-prescription drugs present in these cases. Medicated assisted treatment (MAT) was present in six cases. The decedent child was born substance exposed in 30% of cases. Nine out of these 16 children were exposed prenatally to THC. The OCO has recommended proper implementation of the federally required Plans of Safe Care to address the alarming number of fatalities involving substance use.

Unsafe sleep conditions were reported in 44% of death notifications. Some of these conditions included co-sleeping with adults or other children, with blankets and pillows, or face down. Unsafe sleep conditions were present in 12 of the 25 cases involving parental substance use.

Comparative Data

Appendix 2 includes a flowchart that details when a child fatality would be reviewed under current jurisdictions for the various CFR teams discussed above. 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. Table 2 shows the total number of fatalities that VDH recorded for 0–6-year-olds contrasted to the number of investigations CPS investigated per region for the same age range in the calendar years 2020-2022. Ages 0-6 years old were chosen due to making up almost 90% of all CPS fatality investigations. Approximately 1/5th of annual child deaths ages 0-6 years old were investigated by CPS for abuse or neglect during 2020-2022 with an average founded rate around 30%.

In 2022, out of the 706 total child fatalities for ages 0-6 that occurred in Virginia, 198 were investigated by the OCME and 152 of those 198 cases were also investigated by CPS for abuse or neglect. Because of the limited scope of CFR in Virginia, in 2022 approximately 24% of child deaths, ages 0-6 years old, that fell under the OCME jurisdiction never reached a CFR team unless covered under the SDY Project areas or selected for topical review by the state team. Out of the total 380 child deaths investigated by the OCME in 2022, 171 were reviewed by CPS meaning 55% of those child deaths likely never reached a CFR team.

[73] https://www.oco.virginia.gov/media/governorvirginiagov/oco/reports/annual-reports/2024-Annual-Report-of-the-Office-of-the-Children's-Ombudsman-WEB.pdf

Table 2. Total Child Fatalities (ages 0-6) Recorded by VDH Contrasted to CPS Investigations (ages 0-6) per VDSS Region in Calendar Years 2020-2022*

	VDH 2020	VDSS 2020	VDH 2021	VDSS 2021	VDH 2022	VDSS 2022
Central	126	19	136	22	140	19
Eastern	209	55	185	54	189	47
Northern	184	19	214	28	235	39
Piedmont	93	27	105	26	103	36
Western	36	11	41	12	39	11
TOTAL	**648**	**131**	**681**	**142**	**706**	**152**

**Due to the requirement for investigations to be completed before any child fatality review occurs, not all cases may have been reviewed during the calendar year that the investigation occurred; however, this is a close approximation to the number of cases being reviewed by the regional review teams compared to the total number of deaths.*

Previously the VDSS regional child fatality review teams would review all fatalities investigated by CPS but due to the recent restructuring of VDSS regional review teams, fewer cases will be reviewed by these teams going forward. The new restructuring aligns the regional teams with the same jurisdiction as the OCO which received only 36 child fatality notifications between June 25th, 2021 and September 30th, 2022. According to the most recent comparable data available, CPS investigated 171 child deaths in SFY 2023 and the OCO received 51 notifications of fatalities during the same time period meaning only 29.2% of those fatalities would be reviewed by the regional review teams under the new structure.

LESS THAN 15% OF THE CHILD FATALTIES INVESTIGATED BY THE OFFICE OF THE CHIEF MEDICAL EXAMINER IN STATE FISCAL YEAR 2023 WOULD HAVE REACHED A REGIONAL CHILD FATALITY REVIEW TEAM

Table 3. Virginia Fiscal Year 2023 Comparison of Total Child Fatalities (ages 0-17), OCME Investigations, LDSS Investigations and Founded Outcomes, and OCO Notifications.

	VDH FY2023	OCME FY2023	VDSS FY2023	OCO FY2023
Central	199	84	22 – 3 founded (14%)	9
Eastern	269	101	50 – 13 founded (26%)	9
Northern	311	100	50 – 9 founded (18%)	17
Piedmont	153	63	37 – 8 founded (22%)	13
Western	69	20	12 – 5 founded (42%)	3
TOTAL	**1001**	**368**	**171 – 38 founded (22%)**	**51**

Lack of Sufficient Public Data

CAPTA requires provisions allowing for public disclosure of findings or information on cases involving a child fatality or near fatality. Section 63.2-217 of the Code of Virginia[74] covers the CAPTA related provisions on public disclosure of findings about child fatalities or near fatalities that were a result of abuse or neglect. Agencies are required to release the following information providing that it will not endanger life or safety of a child or compromise investigations by CPS, civil, criminal, or judicial proceedings.

- The fact that a report has been made concerning the alleged victim child or other children living in the same household;
- Whether an investigation has been initiated;
- The result of the completed investigation;
- Whether previous reports have been made concerning the alleged victim child or other children living in the same household and the dates thereof, a summary of those previous reports, and the dates and outcome of any investigations or actions taken by the agency in response to those previous reports of child abuse or neglect; and
- The agency's activities in handling the case.

Virginia provides this information by annual public disclosure through the VDSS Child Maltreatment Death Investigations report.

The Lives Cut Short project[75] is dedicated to more transparency for child fatality data. They have created the Child Abuse and Neglect Deaths Integrated Database (CANDID) data system using only publicly available data such as media articles, death archives, state-issued child fatality reports and medical examiner records. In 2022, the CANDID count was able to report 26 child deaths in Virginia compared to the 51 deaths reported in the National Child Abuse and Neglect Data System (NCANDS) which utilizes state submitted data.[76] The

[74] https://law.lis.virginia.gov/admincode/title22/agency40/chapter910/section100/
[75] https://livescutshort.org/
[76] https://livescutshort.org/map/virginia/

discrepancy in these two numbers highlights the profound lack of available public data on child deaths due to maltreatment in Virginia.

Only 11 states (Arizona, Arkansas, Colorado, Florida, Nevade, Oregon, Pennsylvania, Rhode Island, Tennessee, Texas, and Wisconsin) currently post public notifications about child fatalities or near fatalities. The Arizona Department of Child Safety releases preliminary information on any report of a child death that was determined to be a result of abuse, abandonment, or neglect.[77] The determination can be made by a conviction related to the incident, a court finding that allegations of abuse or neglect lead to the death or near-death, or the Department of Child Safety substantiating findings of abuse or neglect leading to the death or near death. In the case of near-fatality, a medical professional must determine that the child was in serious or critical condition. After the preliminary report has been published a full summary report of the case and a statement on the fatality or near fatality is published. Florida hosts a weekly updated Child Fatality Prevention website that includes information on all child fatalities reported to the Florida Abuse Hotline.[78] Supporting documentation for each fatality is published once the case is closed and reviewed by one of their six regional child fatality prevention specialists. In addition to case reports, they also maintain charts that showcase the causes of fatalities and prior involvement with child welfare that can be filtered by county. Screenshots from the Arizona and Florida websites can be found in Appendix 3.

While Michigan's Department of Health and Human Services does not have public notification, their Office of the Child Advocate (similar to Virginia's OCO) does publish public versions of individual case reports, including child fatalities. These reports include the case background, initial complaint, agencies involved, research, findings, and responses.

Without public notification in Virginia, we are left to rely on published trends data. Due to the retrospective nature of child fatality data trends, public data lags far behind making timely prevention efforts difficult. As of publication of this report, the most recent available data for Virginia includes:

- Infant and Child Mortality Surveillance System report on infant mortality trends from 2014-2016, published in 2018.
- State Child Fatality Review Team Report on Child Drowning Deaths in 2014-2016, published in 2019.
- Office of the Chief Medical Examiner Annual Report on deaths in 2022, published August 2024
- Virginia Department of Social Services Child Maltreatment Death Investigations in Virginia During State Fiscal Year 2023 (July 1, 2022 – June 30, 2023), published in June 2024
- The Office of the Children's Ombudsman Annual Report for Fiscal Year 2024 (July 1, 2023 – June 30, 2024), published in 2024.
- There are no public reports available from the regional child fatality review teams or the Sudden Death in the Young project.

Even with the data available, the numbers are often incomparable. The Virginia Department of Health and the OCME capture and publish data on a calendar year basis compared to VDSS and

[77] https://dcs.az.gov/news-reports/child-fatalities-near-fatalities-information-releases
[78] https://myflfamilies.com/childfatality

the OCO who publish on a fiscal year basis. Additionally, the VDSS regions do not align with the VDH health districts making regional data comparisons inaccurate.

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 THEN REVIEWED.

Areas for Improvement

Based on the information reviewed, we have identified the following areas to improve Virginia's child fatality investigation and review systems and inform efforts to prevent additional child deaths in Virginia.

1. **Increase Inter-agency Coordination.** Throughout our research, we continually noticed a lack of communication or coordination between agencies at both the local and state level during investigations and reviews. These silos needlessly hinder the investigations by CPS, law enforcement, and the OCME preventing a full understanding of the case. Each of these agencies has different methods, standards, and objectives for investigating child deaths and would benefit from collaboration of resources and findings to further support their individual goals. In our review, lack of follow up between agencies delayed cases or left gaps in information for significant periods of time that could have been prevented with continued collaboration and communication.

   The MDTs represent a valuable opportunity to coordinate the various investigations of child fatalities in a way that ensures collaboration on details and information from a variety of perspectives. However, most MDTs are lacking the depth and connection between partners to effectively carry out the responsibility. Child Advocacy Centers are currently the best model of MDTs for child abuse cases but there is not currently CAC coverage throughout all of Virginia. Increasing CAC coverage throughout the state would improve responses to abuse and neglect cases. CACs provide vital resources such as child interviewing methods that can assist in fatality investigations where there are other children in the home. During our case reviews we discovered that other children in the home were often not interviewed due to their age; however, expertise from a CAC in age-appropriate child interviewing could have resulted in a better understanding for what the child witnessed or may know about the fatality. In areas without CACs, strong memorandums of understanding (MOUs) that provide detailed responsibility for all parties and are reaffirmed at least annually are crucial to the effective engagement of agencies. Additionally, having

coordination, support and oversight of the MDTs at a state level could ensure compliance and proper functionality of these groups across Virginia while still allowing for the flexibility needed to tailor the programs to locality needs.

Due to review teams needing finalized investigations prior to review and high staff turnover rates across various departments, staff who directly worked the investigation may not be available to present at the fatality review meeting. Coordination across the various agencies, through the MDTs, CACs, or otherwise, would help bridge the gap ensuring that at least one individual would have a detailed understanding of the child fatality investigation procedures to provide the review team with information that may not be captured in a single agency's report.

2. **Increase the Number and Scope of Child Death Reviews.** Virginia falls drastically behind other states on the number and types of child deaths that are reviewed by a multidisciplinary team. The vast majority of child deaths never reach a child fatality review team. Those that do reach regional review teams are only those that have been brought to the attention of CPS as identified for potential abuse and neglect and have a narrowly defined previous history with the agency. This results in missing some of the most vulnerable children, those who never came to the attention of the agency at all. Such data would provide useful insights into the prevention of abuse and neglect deaths that are currently flying under the radar. Some of these children may never come to the attention of the agency due to their age and lack of exposure to mandated reporters or the abuse or neglect was subtle enough to go unidentified by outsiders. Exploring the factors in these cases could help educational efforts in the identification of abuse and neglect before it reaches the point of fatality. By having the regional fatality review teams utilize the same criteria as the OCO, there may be an unnecessary duplication of efforts for a narrow type of case. In order to maintain the goal of intended standardization efforts for the regional review teams, the criteria could be adjusted to outside of the OCO's jurisdiction to cover a wider variety of cases across the two agencies.

   Almost all states have a separate group that compiles findings from state child fatality reviews and provides recommendations to legislators and other agencies. Some even have committees that look at certain types of death like drownings or heat-related deaths. Currently, the Virginia child fatality review team, conducted through the OCME, serves more similarly to other state's version of these advisory groups than a review team by only reviewing certain types of deaths over a limited time span of a few years. Without looking at similar deaths more regularly, there is a lack of data to compare how Virginia is doing over time in the prevention of these cases. For example, reports on drowning deaths are noncomparable to previous reports on heat-related deaths as the circumstances call for different areas of prevention and identification. Outside of the narrow scope of abuse and neglect cases investigated and reviewed by DSS, we do not have a clear picture on child fatality trends in Virginia over time. More robust reviews of child deaths at the state or regional level outside of DSS would provide Virginia with a better understanding

of trends and potentially identify cases of abuse and neglect that were not brought to the attention of social services.

3. **Increase Education and Support of Professionals.** The topic of children dying in any setting is a difficult one. Training and supporting professionals involved in these cases is crucial to a system that is effectively responding and ultimately developing effective strategies to prevent further deaths. In conversations we had with individuals across various sectors of child death investigations, a common theme emerged of lack of support and education for staff. One of the best pieces of education that Virginia has is the Child Death Investigation protocol and associated training developed in collaboration with national death investigation experts. There is currently no requirement to use the protocol or to attend a training on the protocol at the local level in any agency. Requiring this training for professionals involved in these cases across all sectors would provide a standardized baseline for agencies to collaborate and ensure a detailed investigation is completed.

   Virginia's per diem death investigators are the lowest paid across the U.S. which does not provide enough incentive for more individuals to join the program. This is leaving a handful of individuals in local areas to be on-call for significant periods of time without relief by another available individual. Increased compensation for death investigators or the ability to have more full-time staff dedicated to medicolegal death investigation would ensure that death investigations are completed thoroughly without burning out a single individual. Full-time staff would allow for increased educational opportunities to improve death investigations in accordance with updated best practices. Additionally, the OCME continues to have difficulty hiring forensic pathologists who are board-certified and autopsy technicians in the midst of increasing caseloads. The increase in caseloads and lack of staffing put Virginia's accreditation at risk if they are unable to complete 90% of cases within 90 days. The OCME has requested budget amendments in previous years to increase the compensation for death investigation staff. These have not been successful. Virginia has an opportunity to attract additional workers through competitive compensation compared to other states.

   Workforce capacity and hiring difficulties is also a problem for Family Services Specialists (FSS) at DSS. In a recent presentation to the CAN Advisory Committee[79], VDSS stated that the current vacancy rate is 20% with the current turnover rate at 40%. On average, FSS are staying with the agency for only two years and the training required for the position takes over a year to complete. The average salary for FSS in Virginia is $36,000/year. Due to high turnover and vacancy rates, staff are carrying high workloads on top of the secondary trauma frequently experienced in the field through witnessing traumatic events. A workload study is in development to review accurate workloads for CPS and In-Home Services staff. The outcomes of this

[79] https://www.fact.virginia.gov/wp-content/uploads/2025/06/GP_6-4-25-CAN-Committee-Meeting-Minutes-DRAFT.pd

study, along with staff support efforts such as those from the Office of Trauma and Resilience Policy, are investments not only in the staff but also the children and families the staff serve.

There is a national effort to increase certified child abuse pediatricians. Virginia has an opportunity to provide a fellowship program through Old Dominion University to increase the field; however, that program is currently paused because there is only one credentialed child abuse pediatrician in the area and national standards require fellowship programs to have two. A new fellowship opportunity being developed through a partnership with Virginia Commonwealth University and University of Virginia already has significant interest from several candidates who would like to train and practice in Virginia. Prioritization of these efforts presents a great opportunity for Virginia to become a national leader in supporting child abuse pediatricians and increase the safety of children. Additionally, due to the gap of child abuse pediatricians, increase in general educational efforts for medical staff in other fields on the intricacies of child abuse and neglect identification can ensure that maltreated children are identified earlier before a fatality occurs. Increasing and expanding the efforts of the Project ECHO trainings provided through the Children's Hospital of Richmond would aid in access to this education for providers and non-clinical staff. Virginia has multiple medical schools and nursing programs that can prioritize this type of in-depth child maltreatment education.

Continued education related to Plans of Safe Care are crucial to preventing fatalities among substance exposed infants. The conflicting information and current policies for reporting substance exposed infants have led to inconsistencies in the implementation of Plans of Safe Care. The Virginia Department of Health resumed statewide implementation efforts in FY2024 which should continue with involvement of all agencies across social services, behavioral health, health care providers, and early childhood. Statewide coordination of these efforts will better ensure that consistency is achieved in proper response to these cases that are guided by continually updated best practices. The issue of substance use among caregivers of infants is showing up at an alarming rate in child fatalities. Proper identification and support for these children and their families is vital to prevention efforts.

Research on deaths classified as unsafe sleep is consistently changing as new potential causes of SUIDS have been identified. Continued education efforts for investigators around these new developments and others in the area of child fatalities can help to properly identify factors contributing to child death. As discussed in the beginning of this report, proper identification of child maltreatment through autopsy alone can be difficult and often not accurate. Accurate identification of cause of death in these cases often requires additional information gathered through the investigation. Misclassifying an unsafe sleep death can leave other children vulnerable to potential maltreatment and/or ignore other factors that contributed to the child's death that could lead to targeted prevention strategies. Unsafe sleep deaths are often viewed as cut and dry cases when further in-depth

investigation or review could uncover other contributing factors. These factors could be considered in developing more effective strategies to prevent further children from dying in the same manner.

4. Collect Comprehensive and Robust Data. Central to developing any effective policy and practice for effective responses and prevention strategies is accurate information. Child fatality data in Virginia is scattered across various agencies and not readily comparable. One of the most glaring examples of this is that the OCME and VDH collect and release data on a calendar year basis while DSS collects and releases data on a fiscal year basis. Multiple data requests to different agencies were needed to achieve the comparisons in this report and there is no available comparative data available to the public. In order to review data on child fatality investigations or reviews, an individual must know the specific agency that holds the data and then access a recent report that has been published. During the writing of this report, the child fatality information through the OCME was taken down due to website maintenance and remains unavailable as of publishing. Even with the retrospective nature of fatality review data, Virginia lags massively behind, in some cases nearly a decade, in what the public is able to review. The most timely public notification of child fatalities often comes from news sources which do not have complete information and usually only involve "sensational" cases where an individual has been arrested, or a tragic accident occurred. The general public is unaware of the rate of child fatalities occurring in Virginia. Finding the data for those who seek to understand the issue is a challenge.

As discussed in this report and shown in the appendices, other states provide an opportunity for timely publication of maltreatment fatality data. Virginia can follow these other state examples to provide public data that still falls within the confidentiality laws governing investigations and reviews. Publicly available data also allows local agencies to identify trends faster and make changes to policies and procedures without having to wait for a state level report to be completed.

Another effort that could increase the available data and potential comparisons would be to implement a standardized child fatality review protocol for Virginia. Across the various child fatality review teams, a standardized protocol would not only ensure proper in-depth reviews but also provide consistent data standards to compare over time. Collaboration across agencies utilizing a standard review protocol could result in cross-agency reports that showcase the totality of child fatality information throughout Virginia. Additionally, the CPS regional review teams could publish reports that would be comparable across regions allowing for trend and variance identification.

While the absence of substantial outcome data related to the health and welfare of children involved with child welfare systems is relevant across all states, the issue is further compromised in Virginia because of the antiquated Child Welfare Information System (CWIS), OASIS, currently in use. Years after the funding was secured to

update the system, VDSS still does not have a contract for a new system. Case documentation within the existing system varies widely across the cases our team reviewed. Some local agencies provided in-depth notes while others provided little detail outside of required data fields. These case notes are crucial to fatality review teams, especially if there is staff turnover and the individual assigned to the case is no longer working with the agency. Additionally, updating the system can provide an opportunity to insert additional fields required for fatality investigations to make case reviews easier to standardized.

5. **Conduct Evaluations to Improve Prevention Efforts.** Even through our robust research review, there are still unanswered questions about child fatality investigations and reviews in Virginia. Through conversations with the various sectors involved in these cases, we often found that there is a difference in the way that things are supposed to be done and the reality of what is happening. Various factors cause these discrepancies such as lack of staffing, education, budget, or state level oversight. Proper evaluation of protocols, procedures, and educational efforts is needed to ensure Virginia is providing responses to the best of our ability.

   Additionally, prevention efforts need proper outcome evaluation to ensure they are reaching families and causing changes in behavior. If not, then changes need to be made based of these findings or additional research to bolster efforts further in a way that is approachable, understandable, and actionable for families and providers.

Appendices

Appendix 1. Composition of VDSS Five Regional CFR Teams

VDSS local agency representatives consist of Assistant Directors/Directors, Family Services/CPS Supervisors, or lead workers.

Representatives from the same agency/organization hold different positions that have been valuable to the team.

Central

- VDSS- CPS Practice Consultant, In-home/Prevention Practice Consultant, Petersburg, Richmond City, Richmond County, Chesterfield, Henrico
- VCU Health
- Virginia Office of Emergency Medical Services
- Greater Richmond SCAN
- ChildSavers (2 reps)
- Prevent Child Abuse Virginia
- Richmond Police Department
- Virginia Department of Health
- Children's Hospital of The King's Daughters
- Office of Chief Medical Examiner (Family Violence Programs Manager)
- Family and Children's Trust Fund of Virginia

EASTERN

- VDSS- CPS Practice Consultant, In-home/Prevention Practice Consultant, Training (3 reps), Virginia Beach (3 reps), Isle of Wight, Suffolk, Newport News, Norfolk (2 reps), York – Poquoson (2 reps)
- Office of Chief Medical Examiner (2 reps)
- Emeritus, Prevent Child Abuse Hampton Roads
- Suffolk Police Department (2 reps)
- Virginia Beach City Government
- Suffolk Department of Fire & Rescue
- Virginia Beach Court Appointed Special Advocates
- CHIP South Hampton Roads
- U.S. Navy- LCSW
- Virginia Department of Health (11 reps)
- The Up Center (2 reps)
- Mathews County Commonwealth Attorney
- Gloucester Chief Deputy Commonwealth Attorney
- Eastern Shore Community Services Board
- Virginia Department of Education

NORTHERN

- VDSS- Regional Director, CPS Practice Consultant, In-home/Prevention Practice Consultant, Permanency Practice Consultant (2 reps), Family Services/Quality Review, Loudoun County, Fauquier County (2 reps), Fairfax County (2 reps), Fredericksburg City (2), Prince William County (2 reps), King George
- Virginia Department of Health (3 reps)
- Virginia Department of Education
- Warrenton Police Department (2 reps)
- Healthy Families Skyline CAP
- SCAN VA
- Office of Chief Medical Examiner (Assistant Chief ME)
- Loudoun County Sheriff's Office
- Rappahannock-Rapidan Health District

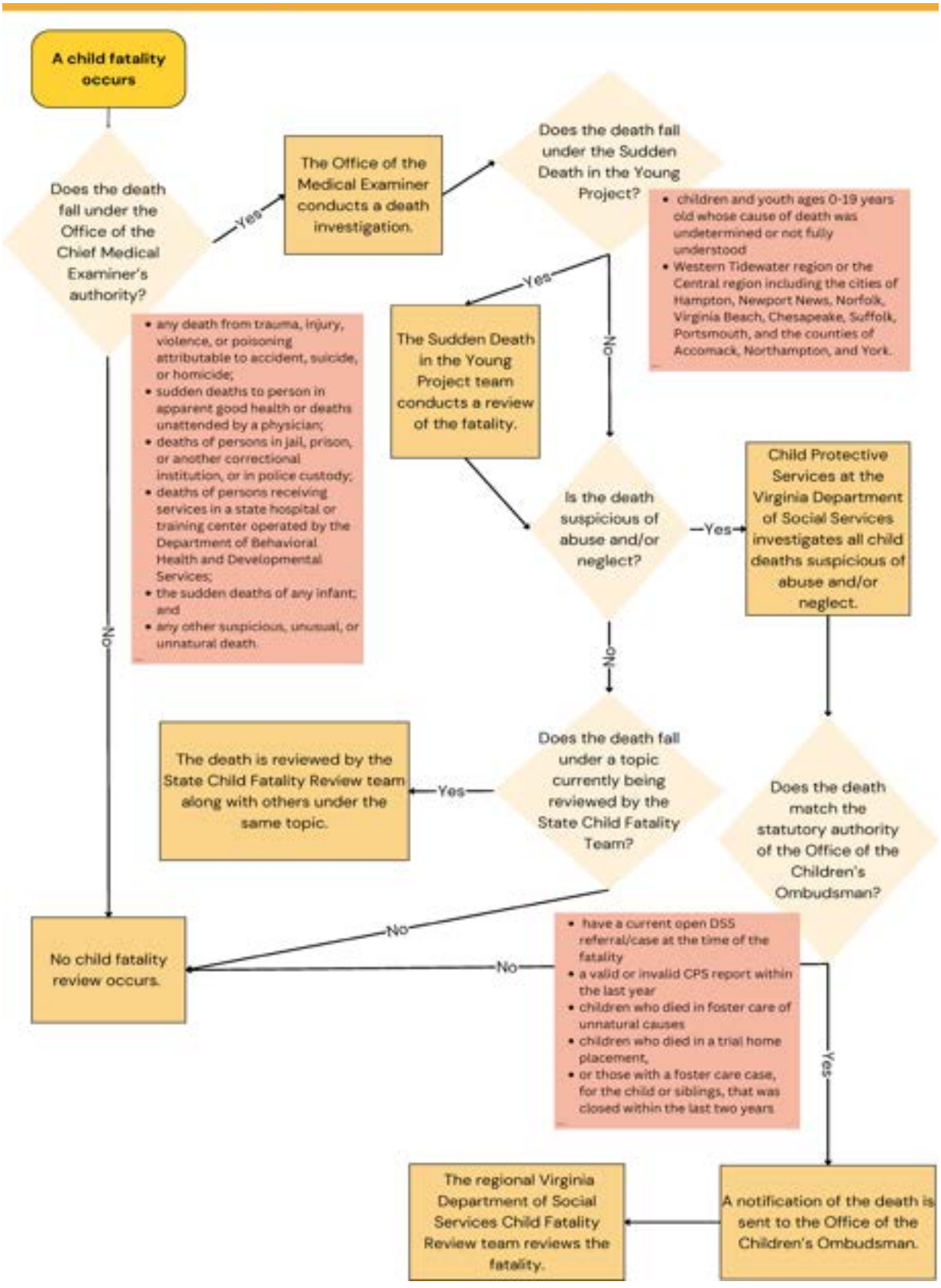
PIEDMONT

- VDSS- CPS Practice Consultant, In-Home/Prevention Practice Consultant, City of Roanoke, Charlottesville, Halifax County, Roanoke County
- Office of Chief Medical Examiner (Forensic Pathologist)
- Hope Tree Family Services
- Blue Ridge Behavioral Healthcare
- Carilion Health Organization (4 reps)
- Salem City Schools
- CHIP of Roanoke Valley (2 reps)
- Rabason (Business Coach/Motivational Speaker with LE background)
- Augusta Health (2 reps)
- Waynesboro Public Safety
- Valley Children's Advocacy Center
- Children's Trust Roanoke Valley
- VA Department of State Police
- Delta Response Team

WESTERN

- VDSS- CPS Practice Consultant, In-home/Prevention Practice Consultant, Permanency Practice Consultant, Bland County, Carroll County (2), Giles County (2), Pulaski County, Norton, Washington County, Wythe, Scott,
- Office of Chief Medical Examiner (Forensic Pathologist)
- Giles Sheriff's Office
- NRV Cares (3 reps)
- Virginia Department of Education
- SAFE Center of SWVA
- Frontier Health
- Norton Police Department (2)
- Pediatric Medicine Specialist (private practice pediatrician)
- Highlands Community Services
- Virginia Department of Health (4 reps)
- Ballad Health

Appendix 2. Flowchart of Child Fatality Investigation and Review in Virginia



Appendix 3. Examples of Public Disclosure Websites from Arizona and Florida.

Arizona:

Find a Report

Search by name

Search by Year

-Year

Search

Reset

PRELIMINARY REPORT POST DATE	SUMMARY REPORT POST DATE	RIBBON	NAME	PRELIMINARY REPORT	SUMMARY REPORT	STATEMENT
04/15/2025	04/15/2025		Baby Girl Taylor	Report	Report	Statement
04/14/2025	04/14/2025		Near Fatality	Report	Report	
04/11/2025	04/11/2025		Near Fatality	Report	Report	Statement
03/19/2025	03/19/2025		August Walton	Report	Report	Statement
02/12/2025	02/12/2025		Rose Rodriguez-Delp	Report	Report	

Florida: