A Deeper Look at Child Fatalities: Case Studies of Selected CPS Investigations

The Family and Children's Trust Fund

Family & Children's Trust Fund OF VIRGINIA

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Introduction and Process

In conjunction with the Family and Children's Trust Fund's (FACT) Child Fatality Investigations and Review Report, the Child Abuse and Neglect (CAN) Advisory Committee created a workgroup to conduct independent reviews of child fatalities investigated by local Departments of Social Services (LDSS). The workgroup reviewed two child death cases from each of the five regions of the Virginia Department of Social Services (VDSS) from State Fiscal Year (SFY) 2023.

The reviews summarized here were conducted using a standardized format recommended by the National Center for Fatality Review and Prevention's comprehensive child death review and focused specifically on the role of local departments of social services in investigating child deaths reported as suspicious for child abuse and/or neglect. Pursuant to requirements of the Child Abuse Prevention and Treatment Act (CAPTA), states are required to establish citizen review panels to examine child protective services policies, procedures, and practices. The CAN Committee is a citizen review panel in Virginia.

For each case, the workgroup discussed:

- A summary of case information including location, child's age and race, overview of the case narrative, previous Child Protective Services (CPS) history, the cause and manner of death, other children in the home, the allegations, and investigation findings.
- The investigation response, including identification of gaps and omissions in LDSS response. Common discussions included whether there was a death scene reenactment, the level of detail provided in the case file, and if there were previous screened out referrals concerning the child and/or the other family members.
- Which services were provided before and after the fatality.

CHILD DEATH REVIEW

To briefly summarize: Child Death Review involves retrospective review of child deaths to:

(1) understand how and why children die;
(2) identify risk factors that likely contributed to the death;
(3) describe what involvement, if any, child protective entities such as law enforcement, child protective services, health care providers, and family members or caregiver's played in the child's life; and
(4) identify intervention and prevention efforts that would have protected the child.

Robust child death review involves multidisciplinary teams of professionals and advocates who can use review information to make the necessary changes to reduce premature and preventable risk of injury and death among children.

- Identification of risk factors for the child and caregivers from a broad ecological perspective.
- Recommendations for improvement such as how a similar case should be handled, what interventions could have been provided to prevent the fatality, and what if any touchpoints could have identified safety concern for the child prior to the fatality.

Included in this report are fictionalized examples of real cases the workgroup reviewed. Names have been changed and specific details have been edited to maintain anonymity. However, the content is consistent with the information available and the trends in circumstances surrounding these cases. Outside of news reports, which do not always provide an accurate picture, there are no published stories of child fatalities in Virginia. While data on trends is vital for prevention efforts, the workgroup believes the public should be made aware of the stories of these children. More information on the publishing of public child fatality data and examples from other states can be found in the Child Fatality Investigations and Review Report.

Data Overview

FACT received case file data for all child fatalities reported to VDSS in SFY 2023. Additional information on these investigations can be found in the VDSS Child Maltreatment Report from 2024.[1]

- A total of 171 child fatality investigations involving 173 child deaths were conducted by LDSS.
    - 50 (29%) of those cases were found to have resulted from abuse and/or neglect.
    - Investigation results for 112 children were unfounded.
- Six reports were still pending at the time the data was reviewed. The majority of investigations (145, or 84%) involved allegations of neglect and 51 (29%) involved allegations of abuse. Some investigations involved allegations of both abuse and neglect.

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

State Fiscal Year 2023 Child Death Investigations, Founded and Unfounded Rates by VDSS Region

VDSS REGION	Completed Investigations	Founded	Founded Rate	Unfounded Rate
Central	22	6	0.24	0.76
Eastern	50	14	0.29	0.71
Northern	50	11	0.22	0.78
Piedmont	37	14	0.42	0.58
Western	12	5	0.42	0.58
STATEWIDE	**171**	**50**	**0.29**	**0.71**

Themes

The following five case summaries reveal the various ways that child abuse and neglect deaths are investigated and defined across regions of Virginia; levels of cooperation in child death investigations among law enforcement, social services, and the medical examiner; with differing conclusions among LDSS about whether or not child abuse and neglect played a role in the death.

Inconsistency in Investigation Response

In Virginia, local Departments of Social Services (LDSS) are responsible for the identification, assessment, investigation, and service provision to abused or neglected children. While this local autonomy allows each department to adapt to the unique needs of their agency and community, it also creates differing practices and therefore inconsistencies in Virginia's response to child abuse and neglect. Additionally, details included in reporting by frontline LDSS workers in the state case management system (OASIS) often varies significantly even within the same locality. Some case files include a wealth of information on the family background and case details while others have the bare minimum. These inconsistencies make comparisons of data between localities highly unreliable; nearly identical cases can have completely different outcomes based on the locality where the incident occurred. Until there is consistency on what constitutes a finding of abuse and neglect, we cannot have an accurate or consistent picture of rates within Virginia or even within a single region.

CASE 1:

Cara is the mother of three-month-old, Thomas, and 2-year-old, Theo. Cara fell asleep around 3:00 A.M. on the couch with Thomas lying on her chest. Although Cara had received safe sleep education at the hospital during Thomas' birth, this is the way that they always slept and how Cara slept with Theo when he was younger. About six hours later, she woke up to see that Thomas' lips were pale.

The day of the fatality, LDSS workers conducted a home visit with Cara and Theo, requested medical records for Thomas, and notified the Medical Examiner's Office of the request for autopsy results. While awaiting the autopsy results, a Family Partnership Meeting (FPM) was conducted to discuss the needs of the family and assess support systems.

The autopsy reported that Thomas died of accidental suffocation due to unsafe sleep. Due to Cara's acknowledgement of receiving previous safe sleep education, the investigation was Founded at Level 1 for Physical Neglect.

CASE 2:

Daphne recently had her first child, Max. The pregnancy went smoothly with minimal complications and Daphne received adequate prenatal care. During birth, Daphne was educated on safe sleep practices by hospital staff and received follow up education from Max's pediatrician. Daphne has support from Max's father and additional family members with a toddler who also live in the home.

At one month old, Max was found unresponsive while sharing a bed with Daphne. When investigating the scene, marijuana was found in the room. Both parents admitted smoking marijuana in the evening that the fatality occurred.

The autopsy determined the cause of death to be Sudden Unexpected Infant Death associated with co-sleeping and soft bedding. The investigation was unfounded.

Lack of Communication and Collaboration

Similar to the findings in the previous Child Fatality Investigations and Review Report, the workgroup noticed a continual lack of collaboration and communication between LDSS and other agencies. In some cases, communication between different LDSS localities was also lacking. This lack of communication was not always attributable

to the LDSS; some cases had many documented efforts by local departments to follow up with outside agencies, such as law enforcement, with no response. Cases with strong collaboration among partners were often investigated through multidisciplinary teams and/or a local Child Advocacy Center.

CASE 3:

Amelia lived with her mother and two siblings, ages three and four. During a family outing to visit a friend's home, Amelia was happily playing with her siblings when she suddenly became very tired. Her mother placed her on the couch to nap, assuming it was due to her recent infection. Four hours later, she was unresponsive.

Despite Amelia being two years old, the LDSS worker and police assumed the death was caused by unsafe sleep practices. The autopsy reported her cause of death as fentanyl toxicity. Amelia's mother had no explanation about how she would have had fentanyl in her system and assumed it must have come from the friend's home. The siblings were not interviewed reportedly due to their age. The LDSS worker reached back out to police to follow up after the autopsy results but was unable to get a response. Due to the limitations of DSS investigations focusing solely on caregivers, they were unable to investigate the family friend and without a police response, the case came back as unfounded for the parents but founded for an "unknown abuser." The case was transferred to in-home services which included random drug screenings and monitoring.

Low Level of Suspicion

In multiple cases, the workgroup found a low level of suspicion for child maltreatment displayed by LDSS workers. Any unexplained death of a child should be investigated as suspicious of maltreatment until proven otherwise.[2] This is not to further punish grieving parents but rather an important opportunity to use a public health approach for prevention of future fatalities. Lack of appropriate consideration for the role that child maltreatment may have played in a child's death may leave additional children at risk and misses crucial opportunities for preventing other deaths. Prior to fatality, multiple cases had previous screened out calls and/or closed assessments or investigations without resolution.

[2] Child Death Investigation Protocol, Virginia Children's Justice Act Program, 2023

CASE 4:

Jamal, Dyon, Brook, and Mariah all live with their father Omar who receives childcare assistance from his parents. Jamal's family had previously come to the attention of DSS multiple times from reports of domestic violence and drug use occurring in front of the children and Brook testing positive for marijuana at birth. Many of these referrals were screened out. Shortly after Jamal's birth, their mother was incarcerated. One Family Assessment was conducted based on a referral that Omar was leaving Dyon and Brook unattended and smoking marijuana around the children.

Jamal was only a month old when he tragically passed away while co-sleeping with his father. During the investigation, a safety plan was made to have the other children stay with their grandparents; however, during an unannounced visit Dyon, Brook, and Mariah were all at Omar's home.

The CPS worker worked to build trust with the family after the fatality and continually reassured them that once the autopsy results were received the investigation would conclude and the children would return home. The manner of death was reported as undetermined, and the cause was Sudden Unexplained Infant Death associated with co-sleeping. The investigation was unfounded. When the CPS worker went to deliver the autopsy results and investigation report, Omar was found smoking inside the home with the children present. The family did not request any additional services, so the case was closed.

The lack of suspicion is further exacerbated by inadequate education and communication on the different roles involved in child fatality investigations. Law enforcement, prosecutors, medical examiners, and LDSS workers all play unique roles with differing expertise, professional objectives and standards of proof. While these individual investigations should inform each other through collaboration, they should not dictate each other's outcomes. A common example of this in multiple cases reviewed is the heavy reliance on autopsy results for the final LDSS determination. The 2025 Annual Report from the Office of the Children's Ombudsman reported similar findings with some LDSS staff reporting that "they are reluctant to make a finding of abuse or neglect in the death investigation if the manner of death is undetermined" (Page 24, 2025 OCO Annual Report[3]). Undetermined should serve more as "still

[3] https://www.oco.virginia.gov/media/governorvirginiagov/oco/reports/annual-reports/2025-OCO-ANNUAL-REPORT.pdf

unknown" that requires additional investigation efforts rather than a premature determination that no maltreatment occurred.

CASE 5:

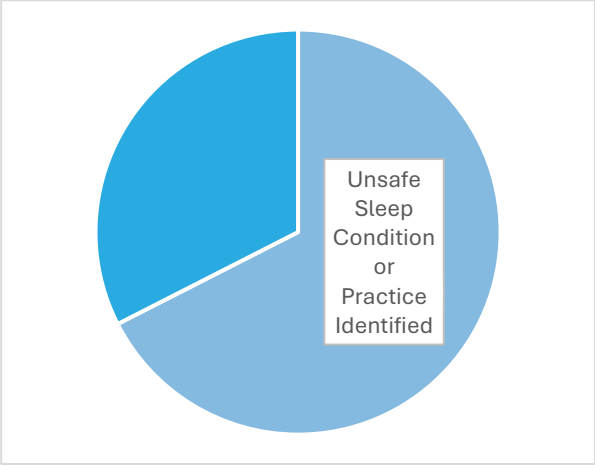
Lily, one-year-old, was visiting her uncle's house one evening and playing with her siblings. When her aunt came in to check on her in the morning, Lily was unresponsive.

Lily's family had a significant history with the LDSS including multiple screened out referrals for an older sibling. Charlie, Lily's uncle, had previously been charged with murder of another child who was found to have traumatic injuries during autopsy.

The initial autopsy of Lily showed no significant injuries. Due to these findings, the local police department did not respond to requests from the LDSS worker for a joint investigation. Law enforcement told the family not to be concerned as the police investigation was going to be closed. They seemed to not understand why CPS would be involved in this case after the preliminary autopsy results. The police's comments to the family created significant distrust with the CPS worker which impacted their ability to do their job effectively.

Due to the manner of death being listed as undetermined, the case was unfounded. The family stated they were not in need of additional services so no follow up occurred.

Common Risk Factors Identified



67.5% of all investigations for children under the age of one year old involved some element of unsafe sleep conditions such as bed sharing or co-sleeping, soft sleeping surface, and/ or items in the sleeping area. It was noted that even when parents were informed about the dangers of unsafe sleep and had a safe sleep option available, they continued to co-sleep with their children. The current education and messaging for caregivers about these issues may not be sufficient to counter these unsafe sleep practices and conditions.

Unsafe sleep practices continue to occur even when parents/caregivers are made aware of their danger.

36% of investigations involved a reported history of or current use of substances, including children who were born substance exposed and fatalities that were linked to substances upon autopsy. Substance exposure during pregnancy can also lead to premature birth and low birth weight which also carry a higher risk of child health complications requiring complex medical attention and mortality.

Approximately one-third of investigations involved families who had prior child welfare history. This includes prior referrals, family assessments, and foster care involvement. **42.6% of fatality investigations among those who had prior child welfare involvement were founded due to abuse and/or neglect.**

Structural Context for Child Welfare

The following are structural issues impacting child welfare outcomes, including child fatality investigations. Many of these issues were identified in FACT's previous report and were noted in the cases the workgroup reviewed.

Workforce

Difficulties with recruiting and retaining a child welfare workforce continue to impact local departments. The VDSS Office of Trauma and Resilience Policy reported an average turnover rate of 40% for entry level positions with most leaving after only 11 months.[4] Reasons for leaving often include burnout, unsatisfactory pay, agency culture, and high caseloads.[5] The OCO also reported that workforce challenges were a leading cause in many of the practice issues in their case reviews and investigations.

Plans of Safe Care (POSC)

The Child Abuse Prevention and Treatment Act (CAPTA) was updated in 2016 to include requirements related to infants who are exposed to substance use during pregnancy. Substance exposed infants have an increased risk of fatality; however,

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[4] https://www.dss.virginia.gov/files/division/otrp/intro_page/workforce_trauma/Cost_of_Child_Welfare_Turnover_Report.pdf

[5] https://www.dss.virginia.gov/files/division/otrp/intro_page/workforce_trauma/Vicarious_Trauma_in_the_Human_Services_Workforce_Capstone_Project_Report.pdf

when identified and provided intervention services early the risk is decreased. A Plan of Safe Care (POSC) is intended to be a collaborative effort across multiple agencies to improve the well-being of both the infant and caregiver. Efforts in Virginia to implement POSC have been inconsistent and delayed. The Virginia Department of Health has restarted these efforts with the development of a state plan for POSC implementation.

Family First Prevention Services Act (FFPSA)

In 2021, the Family First Prevention Services Act (FFPSA) was implemented through federal law to prioritize keeping children at risk for abuse and/or neglect safely at home with family or with kin. Virginia has worked to bolster kinship care resources and move towards foster care as a placement of last resort. While the intent of these policies is positive, there is a lack of available data on the outcomes or impacts of the policy on the safety and wellbeing of children in these cases.

In some reviewed cases involving families who previously interacted with DSS, children were placed with family members or were asked to complete voluntary services. The workgroup reviewed multiple cases where other family members were placed as caregivers for the child, but the parent was still allowed unsupervised access which directly contributed to the fatality. While it is impossible to know if a different intervention strategy would have prevented the fatalities, it highlights the need for better discretion and data rather than a prescriptive model of services.

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Outdated Child Welfare Information System (CWIS)

Virginia's current system for tracking child welfare information, OASIS, was developed in 1997 to track reporting for adoption and foster care cases, with child protective services cases added in 1999. Since its inception, OASIS has failed to meet the needs of LDSS staff and has often required significant time and effort while not providing adequate ability to collect accurate case data. [6] In 2022, VDSS was awarded funding through the General Assembly to develop and purchase a new CWIS; however, a new system has yet to be established. The limitations of the outdated system

[6] https://jlarc.virginia.gov/pdfs/reports/Rpt247.pdf

continue to make accurate and timely documentation incredibly difficult for staff who are already overburdened.

Throughout the workgroup's reviews, the OASIS documentation varied significantly. Some files had detailed information on a family's prior history while others had conflicting information and/or the bare minimum of case information

Conclusion

To obtain a better understanding of child fatality cases, the Child Abuse and Neglect Advisory Committee workgroup conducted independent reviews to uncover themes in responses by local Departments of Social Services. The workgroup found inconsistencies in investigation response and documentation, a lack of communication and collaboration, and a low level of suspicion. These factors are exacerbated by structural issues such as workforce recruitment and retention, a lack of appropriately coordinated Plans of Safe Care, a lack of data on Family First Prevention Services Act outcomes, and a severely outdated Child Welfare Information System. In line with similar reviews, the workgroup identified unsafe sleep conditions and practices, substance use of caregivers, and prior child welfare involvement to be common risk factors in child fatalities.

The reviews conducted by the workgroup highlight the same areas for improvement addressed in the Child Fatality Investigations and Review Report.

- Increasing inter-agency communication
- Increasing the number and scope of child death reviews
- Increasing education and support of professionals
- Collecting comprehensive and robust data
- Conducting evaluations to improve prevention efforts

The stories of the children who are dying in Virginia too often go unnoticed or unmentioned. Each of the cases highlighted in this report showcase larger trends across a multitude of cases. In order to effectively prevent these deaths, we need consistent and reliable data collected over time and public awareness of these fatalities and their risk factors. The workgroup hopes that by highlighting these cases, Virginians can understand the deep impact on children and families when system efforts are inefficient and the greater need to continue sharing their stories publicly.