

**REPORT ON CHILD DEATHS  
DUE TO ABUSE OR NEGLECT IN VIRGINIA  
DURING STATE FISCAL YEAR 2010**

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January 2011

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# **REPORT ON CHILD DEATHS DUE TO ABUSE OR NEGLECT IN VIRGINIA DURING STATE FISCAL YEAR 2010**

## **EXECUTIVE SUMMARY**

The goal of Child Protective Services (CPS) is to identify, assess and provide services to children and families in an effort to protect children, preserve families, whenever possible, and prevent further maltreatment. Child Protective Services is non-punitive in its approach and is directed toward enabling families to provide adequate care for their children.

The CPS program in Virginia is state supervised and locally administered. The Virginia Department of Social Services (VDSS) provides guidance and technical assistance for the 120 local departments of social services authorized by the Code of Virginia to respond to CPS reports. Reports alleging child abuse or neglect must be screened by the local department of social services to determine if the report meets validity criteria as set out in [§ 63.2-1508](#) of the Code of Virginia. Reports that fail to meet the statutory validity criteria are screened out by the local department, meaning that CPS does not have the authority to respond; however, screened out reports may be referred for community services or to another appropriate agency.

Local departments have the authority to initiate a CPS response to valid referrals and must respond with either a family assessment or an investigation. Family assessments are the preferred response when a child is not in immediate danger and when the alleged abuse or neglect is less severe. Family assessments include initial safety assessments, and the development of safety and family service plans to remedy maltreatment and/or prevent risk of future maltreatment. Investigations are conducted when there are immediate concerns for child safety, or the reported allegation is severe involving sexual abuse, fatality, serious injury or abandonment to name a few. CPS investigation includes assessing immediate safety and risk of future maltreatment of the victim/siblings at the conclusion of the investigation. The disposition at the conclusion of an investigation may be founded or unfounded. A founded disposition means that a preponderance of the evidence shows that child maltreatment has occurred, and this determination is to be based primarily upon “first source,” or direct evidence. An unfounded investigation means the evidence is insufficient to warrant a disposition of “founded.”

When a local department validates a report of a child fatality, it must be investigated per [§ 63.2-1506\(C\)](#) of the Code of Virginia. The local department immediately informs the VDSS CPS Regional Consultant of the CPS fatality investigation. The CPS Regional Consultant provides guidance/technical assistance, reviews the records and advises on improving practice and procedures of the local department, especially with families that are known to the agency. This report summarizes the data collected on the founded fatalities investigated during state fiscal year (SFY) 2010.

- Local departments of social services investigated 78 reports of child deaths suspected to be caused by child maltreatment for state fiscal year (SFY) 2010. This is an increase of six reports from SFY 2009.

- Reports were founded for 44 children, 10 more founded child abuse fatalities than in SFY 2009. There were 32 reports that were unfounded. One report is still pending; one is on appeal.
- The children who died as a result of child abuse or neglect ranged in age from birth through 15 years. Of the 44 children who died from maltreatment, 26 (59.1%) were less than one year of age. This is consistent with national data and previous state data that have found young children to be the most vulnerable.
- Twenty-two children who died as a result of child maltreatment were African-American, 19 children were white, two children were multi-racial, and one was Asian. The past two years have seen a trend in the increase of child deaths among African-American children. This is consistent with national data that shows African-American children to be over-represented in child deaths due to child maltreatment.
- Sixteen (36.4%) females and 28 (63.6%) males died due to abuse or neglect, which is consistent with national data that finds males to have a higher rate of child maltreatment fatalities than females.
- Thirty-one children died as victims of physical neglect; 23 children died as victims of physical abuse and nine children died due to medical neglect. Some children were abused or neglected in more than one way and/or by more than one caretaker.
- Fourteen children died from lack of supervision; 16 children died from shaking injuries; and seven drowned due to lack of supervision.
- Of the 63 caretakers in founded investigations, 35% were mothers, 27% were fathers and 2% were stepparents. This total of 64% is slightly below previous state data that found that parent(s) were responsible for about 66% of child maltreatment deaths in SFY 2009.
- Eight of the 63 (12.7%) caretakers were child care providers, and one was a foster parent.
- Of the 63 caretakers found responsible for the 44 child deaths, 33 were women and 26 were men. The gender of four caretakers was unknown because the abuser could not be determined. This is similar to the national data that have found more female than male perpetrators.
- Thirty-four (54%) of the 63 perpetrators were between the ages of 20 and 29. These data are similar to national data and previous state data that confirm most caretakers to be young adults in their mid-twenties.
- The families of 14 children who died as a result of child abuse or neglect were known to the child welfare system in some capacity.

# REPORT ON CHILD DEATHS DUE TO ABUSE OR NEGLECT IN VIRGINIA DURING STATE FISCAL YEAR 2010

## CHILD DEATHS

**Table 1: Dispositions of CPS Complaints with a Child Death by Locality, SFY 2010**

Local Department	Founded	Unfounded	Pending/Appealed	Total
Accomack	1	1	0	2
Alexandria	1	0	0	1
Augusta	0	2	0	2
Bedford Co.	1	1	0	2
Botetourt	1	0	0	1
Campbell	1	0	0	1
Charlotte	0	1	0	1
Chesapeake	2	1	0	3
Chesterfield	2	0	0	2
Danville	2	0	0	2
Fairfax Co.	3	1	0	4
Fauquier	1	0	0	1
Franklin Co.	0	1	0	1
Gloucester	0	1	0	1
Greensville	1	0	0	1
Halifax	1	0	0	1
Harrisonburg	0	1	0	1
Henrico	2	0	0	2
Loudoun	0	1	0	1
Mecklenburg	0	1	0	1
Montgomery	1	0	0	1
Newport News	3	2	0	5
Norfolk	5	8	1	14
Orange	0	1	0	1
Petersburg	1	1	0	2
Portsmouth	0	1	0	1
Prince George	1	0	0	1
Prince William	3	1	0	4
Pulaski	1	0	0	1
Richmond	1	1	0	2
Roanoke	2	1	0	3
Roanoke Co.	0	1	0	1
Spotsylvania	1	1	0	2
Stafford	1	0	1	2
Staunton	1	0	0	1
Virginia Beach	3	0	0	3
Wise	1	0	0	1
York	0	2	0	2
<b>Total</b>	<b>44</b>	<b>32</b>	<b>2</b>	<b>78</b>

Source: Virginia Department of Social Services, January 2011

**Table 2: Death Rate of Children Due to Abuse or Neglect  
SFY 2001 – SFY 2010**

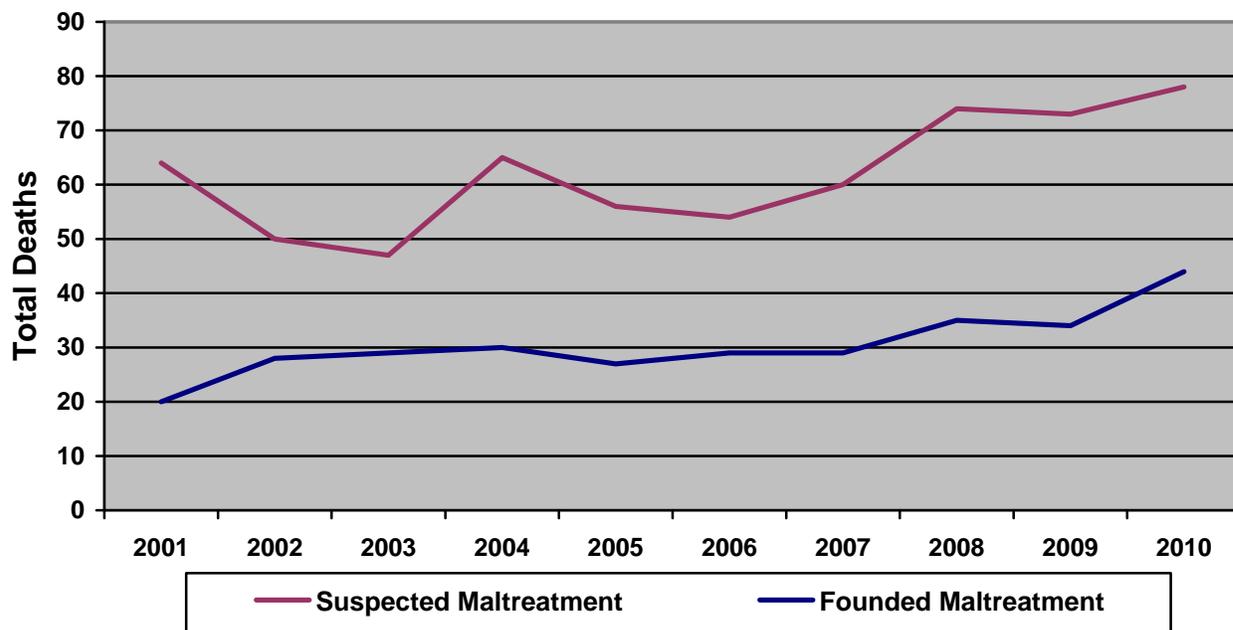
<b>State Fiscal Year</b>	<b>Number of Death Reports Investigated</b>	<b>Number of Deaths Due to Abuse/Neglect</b>	<b>Death Rate (per 100,000 children)<sup>1</sup></b>
2001	64	20	1.02
2002	50	28	1.41
2003	47	29	1.45
2004	65	30	1.49
2005	56	27	1.33
2006	54	29	1.42
2007	60	29	1.42
2008	74	35	1.71
2009	72	34	1.66
2010	78	44	2.38

<sup>1</sup>Death rate is calculated as number of deaths due to abuse/neglect divided by the state child population  
Sources: Virginia Department of Social Services, January 2011; Census State Population Estimates

The number of children who died as the result of child maltreatment increased from SFY 2009 to SFY 2010. In SFY 2010, the child death rate due to abuse or neglect increased to 2.38 from 1.66 in SFY 2009. The data indicates an increase in the child death rate from 1.02 in SFY 2001 to 2.38 in SFY 2010. In 2009 (the most recent national data pulled by federal fiscal year), the Virginia rate was 1.5 against a national rate of 2.3 per 100,000 children (see national trend data in Chart 2).

While the number of founded fatalities for SFY 2010 increased from the previous year, it should be noted that the total number of reports accepted by local departments for CPS response also increased from 33,405 in SFY 2009 to 35,853 in SFY 2010 (7.33% increase).

**Chart 1: Child Deaths in Virginia, by Suspected and Founded Maltreatment, Annually, SFY 2001-2009**

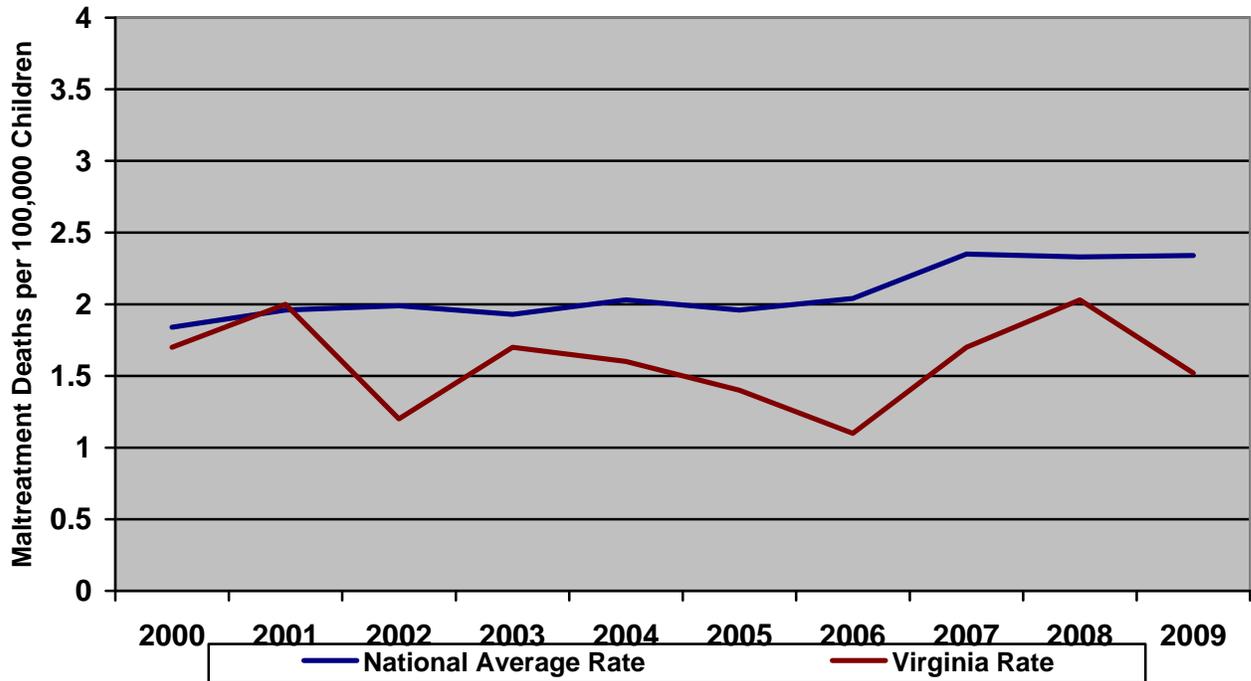


Source: Virginia Department of Social Services, January 2011

The graph above presents the number of child death reports that were investigated and the number of deaths that were a result of founded abuse or neglect. In SFY 2010, the number of child deaths due to abuse or neglect (the bottom line of the graph) increased after a period of stability between SFY 2002 and SFY 2007. The number of reports of child deaths (the top line in the graph) has fluctuated since SFY 2001 but has increased between SFY 2007 and SFY 2010.

## Comparison of Child Deaths Due to Abuse and Neglect to National Data

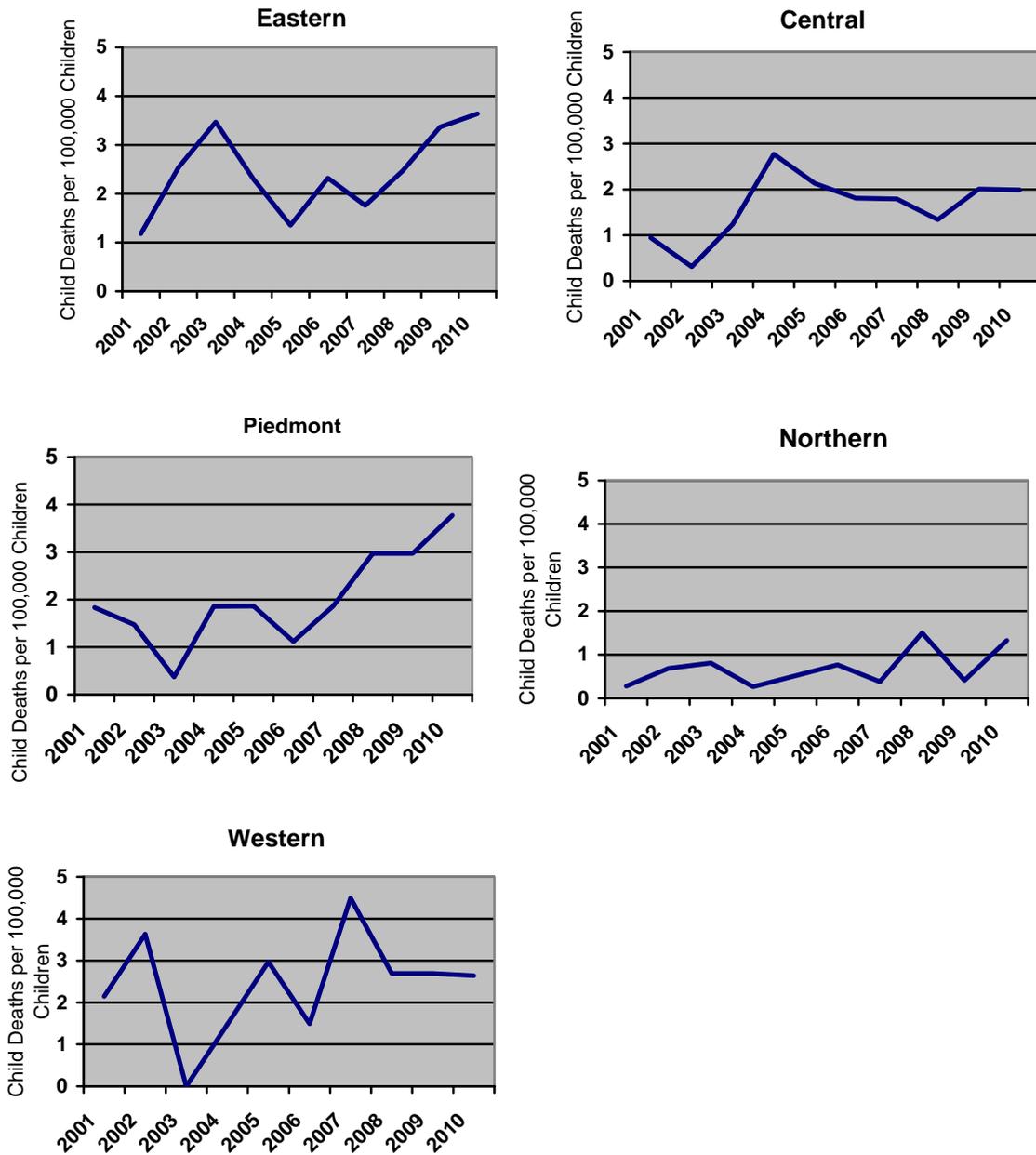
Chart 2: Rates of Child Deaths Due to Abuse and Neglect, 2000-2009



Source: Administration for Children and Families Statistics and Research  
[http://www.acf.hhs.gov/programs/cb/stats\\_research/index.htm](http://www.acf.hhs.gov/programs/cb/stats_research/index.htm)

The National Child Abuse and Neglect Data System (NCANDS) 2009 data (pulled by federal fiscal year) documents that Virginia's rate of founded child maltreatment deaths has been slightly lower than the national average over the past eight years. Virginia's rate increased from 2006 to 2007 and sharply decreased from 2008 to 2009. In 2009 (the most recent national data), the Virginia rate was 1.5 against a national rate of 2.3 per 100,000 children. However, as referenced in Table 2, in SFY 2010, Virginia's rate mirrors the national rate of 2.3 per 100,000 children.

**Chart 3: Rates of Founded Maltreatment Deaths by Region, SFY 2001-2010**



Source: Virginia Department of Social Services, January 2011 and United States Census Bureau Population Estimates Retrieved January 11, 2011 from:

<http://www.census.gov/popest/counties/asrh/CC-EST2008-agesex.html>

In SFY 2010, there was an increase in the number of founded child deaths in three regions as follows: Eastern region had 16 child deaths; Northern region had 10 deaths; and the Piedmont region had nine deaths. Totals for the Central and Western regions remained at six and three, respectively. There was also an increase in overall accepted reports in the Eastern and Northern regions.

Since FY 2001, the *number* of child deaths due to founded maltreatment has been highest in the Eastern region, an average of 12 deaths per year compared to three deaths per year in the Western region. This is partly because the Eastern region is relatively populous. However, over the past ten years displayed, the *rate* of child deaths due to founded maltreatment has been highest in the Western region for a majority of those years. In addition, the rate in the Piedmont and Eastern regions has been steadily increasing over time. In other words, adjusting for population, the Western region has the highest death rate due to founded maltreatment. The Northern region has had the lowest death rate. Keep in mind that these comparisons across regions are based on small numbers.

**Table 3: Children Who Died From Abuse or Neglect by Age  
SFY 2008 - 2010**

Age Category	State Fiscal Year 2008		State Fiscal Year 2009		State Fiscal Year 2010	
	Number	Percent	Number	Percent	Number	Percent
Birth to 12 months	12	34.3	20	58.8	26	59.1
13 months to 3 years	11	31.4	8	23.5	13	29.5
4 to 7 years	5	14.3	4	11.8	4	9.1
8 to 12 years	4	11.4	1	2.9	0	0.0
13 years and over	3	8.6	1	2.9	1	2.3
Total	35	100.0	34	100.0	44	100.0

Source: Virginia Department of Social Services, January 2011

Children who died from child maltreatment in SFY 2010 ranged in age from birth through 15 years. Of the 44 children who died from child maltreatment, 26 (59.1%) were less than one year of age. This is consistent with national data that have found young children to be the most vulnerable and is an increase from past state data. The oldest victim was a 15 year old who was killed by her father who also killed the mother during the same violent incident.

**Table 4: Children Who Died From Abuse or Neglect by Race  
SFY 2008 - 2010**

Race	State Fiscal Year 2008		State Fiscal Year 2009		State Fiscal Year 2010	
	Number	Percent	Number	Percent	Number	Percent
African-American	10	28.6	15	44.1	22	50.0
White	21	60.0	13	38.2	19	43.2
Multi-racial	4	11.4	6	17.6	2	4.5
Asian	0	0.0	0	0.0	1	2.3
Total	35	100.0	34	100.0	44	100.0

Source: Virginia Department of Social Services, January 2011

In SFY 2010, 22 children who died as a result of child maltreatment were African-American, 19 children were white, two children were multi-racial, and one child was Asian. Prior to SFY 2009, more white children died as a result of abuse or neglect than African-American children.

The past two years have seen a trend in the increase of child deaths among African-American children. This is consistent with national data that shows African-American children to be over-represented in child deaths due to child maltreatment.

**Table 5: Children Who Died From Abuse or Neglect by Gender  
FY 2008 - 2010**

Gender	State Fiscal Year 2008		State Fiscal Year 2009		State Fiscal Year 2010	
	Number	Percent	Number	Percent	Number	Percent
Female	17	48.6	20	58.8	16	36.4
Male	18	51.4	14	41.2	28	63.6
Total	35	100.0	34	100.0	44	100.0

Source: Virginia Department of Social Services, January 2011

In SFY 2010, there were 16 (36.4%) females and 28 (63.6%) males who died due to abuse or neglect. This differs from the 20 females (58.8%) and 14 (41.2%) males in SFY 2009 who died from abuse or neglect. However, data for SFY 2010 is consistent with national data that finds males to have a higher rate of child maltreatment fatalities than females.

## CARETAKERS

**Table 6: Caretakers in Child Deaths from Abuse or Neglect  
SFY 2008 - 2010**

Caretaker Type	State Fiscal Year 2008		State Fiscal Year 2009		State Fiscal Year 2010	
	Number	Percent	Number	Percent	Number	Percent
Mother	18	40.0	15	31.9	22	34.9
Father	18	40.0	14	29.8	17	27.0
Stepparent	0	0.0	2	4.3	1	1.6
Grandparent	1	2.2	4	8.5	1	1.6
Aunt	0	0.0	0	0.0	0	0.0
Uncle	0	0.0	1	2.1	0	0.0
Cousin	0	0.0	0	0.0	0	0.0
Paramour	3	6.7	2	4.3	8	12.7
Babysitter	0	0.0	0	0.0	0	0.0
Group Home Staff	0	0.0	0	0.0	0	0.0
Daycare Provider	3	6.7	2	4.3	8	12.7
Other	2	4.4	7	14.9	6	9.5
Total Caretakers	45	100.0	47	100.0	63	100.0

Source: Virginia Department of Social Services, January 2011

Local departments of social services found 63 caretakers to be responsible for the deaths of 44 children due to child abuse/neglect in SFY 2010. Some victims were abused by more than one caretaker.

Most caretakers were related to the victim or resided with the victim. Out of the 63 caretakers, 40 (63.5%) were biological, adoptive parents or stepparents. This is comparable to the percent in SFY 2009 that found 66.0% of caretakers to be parents of the child victim.

Eight of the 63 (12.7%) caretakers were out of family child care providers. Three were babysitters in non-regulated settings. Five were caretakers in regulated child care settings, but three of these caretakers were involved in once incident as they all had access to the child. This is an increase from SFY 2009 that found 4.3% of all caretakers were in out of family settings.

Eight caretakers (12.7%) were the parent’s paramour. This is a substantial increase over the number of paramours in SFY 2009.

Of the “other” caretakers one was a foster parent and other relationships were identified as friends of the family in the home, other adult or unknown.

**Table 7: Caretakers in Child Deaths from Abuse or Neglect by Race  
SFY 2008-2010**

Race	State Fiscal Year 2008		State Fiscal Year 2009		State Fiscal Year 2010	
	Number	Percent	Number	Percent	Number	Percent
Black	17	37.8	24	51.1	31	49.2
White	27	60.0	19	40.4	26	41.3
Asian	0	0.0	0	0.0	1	1.6
Unknown	1	2.2	4	8.5	5	7.9
Total Caretakers	45	100.0	47	100.0	63	100.0

Source: Virginia Department of Social Services, January 2011

In SFY 2010, 31 (49.2%) caretakers were African-American, and 26 (41.3%) were white. The race of five (7.9%) caretakers was unknown due to the fact that the abuser was unknown as multiple caretakers had access to the victim.

**Table 8: Caretakers in Child Deaths from Abuse or Neglect by Gender  
SFY 2008 - 2010**

Gender	Fiscal Year 2008		Fiscal Year 2009		Fiscal Year 2010	
	Number	Percent	Number	Percent	Number	Percent
Female	24	53.3	22	46.8	33	52.4
Male	20	44.4	21	44.7	26	41.3
Unknown	1	2.2	4	8.5	4	6.3
Total Caretakers	45	100.0	47	100.0	63	100.0

Source: Virginia Department of Social Services, January 2011

In SFY 2010, of the 63 caretakers found to be responsible for child deaths there were 33 females and 26 males. The gender of four caretakers was unknown due to the fact that the abuser was unknown as multiple caretakers had access to the victim. This is similar to the gender of caretakers in previous state data that finds more female than male caretakers responsible for child deaths.

**Table 9: Caretakers in Child Deaths from Abuse or Neglect by Age  
SFY 2010**

<b>Age Category</b>	<b>Number of Caretakers</b>	<b>Percent</b>
Under 20 years	7	11.1
20 to 29 years	34	54.0
30 to 39 years	8	12.7
40 to 49 years	5	7.9
50 or older	5	7.9
60 or older	0	0.0
Unknown	4	6.3
<b>Total</b>	<b>63</b>	<b>100.0</b>

Source: Virginia Department of Social Services, January 2011

Thirty-four (54.9%) of the 63 perpetrators were between the ages of 20 and 29. These data are similar to national data and previous state data that confirm most caretakers to be young adults in their mid-twenties.

## **TYPES OF ABUSE AND NEGLECT**

**Table 10: Types of Abuse in Child Deaths from Abuse or Neglect  
SFY 2010**

<b>Abuse Type</b>	<b>Number</b>	<b>Percent</b>
Medical Neglect	9	14.3
Physical Neglect	31	49.2
Physical Abuse	23	36.5
<b>Total Incident Count<sup>1</sup></b>	<b>63</b>	<b>100.0</b>

<sup>1</sup>Duplicated count because some children experienced more than one type of neglect or abuse;

Source: Virginia Department of Social Services, January 2011

In SFY 2010, 44 children died as a result of at least one type of abuse or neglect. Some children were neglected or abused in more than one way. Thirty-one (49.2%) children died with findings of physical neglect. Twenty-three (36.5%) children died from physical abuse and nine (14.3%) children died with a finding of medical neglect. This data is consistent with national data that shows physical neglect is responsible for most child deaths.

**Table 11: Type of Neglect in Child Deaths  
SFY 2008-2010**

Type of Neglect	State Fiscal Year 2008		State Fiscal Year 2009		State Fiscal Year 2010	
	Number	Percent	Number	Percent	Number	Percent
Abandonment	0	0.0	0	0.0	0	0.0
Drowning/Lack of supervision	1	3.6	6	20.7	7	17.5
Inadequate or dangerous shelter	2	7.1	0	0.0	0	0.0
Lack of supervision	15	53.6	19	65.5	14	35.0
Other/Unspecified sub-type	5	17.9	2	6.8	9	22.5
Medical Neglect	3	10.7	1	3.4	9	22.5
Malnutrition	1	3.6	1	3.4	1	2.5
Gunshot	1	3.6	0	0.0	0	0.0
Total children <sup>1</sup>	28	100.0	29	100.0	40	100.0

<sup>1</sup>Duplicated count because some children experienced more than one type of neglect or abuse;  
Count of children by type of neglect includes medical neglect – this type is broken out in Table 10 above  
Source: Virginia Department of Social Services, January 2011

The most prevalent type of neglect is lack of supervision. There were 14 (35.0%) founded incidents of this type of neglect. There were six founded cases from unsafe sleep practices or co-sleeping with substance using caretakers. When not supervised, one child ingested illegally obtained methadone, and another child was left on a daycare van. One infant, with placenta still attached, was left unattended immediately following the child's birth. One child asphyxiated on a piece of plastic bag when left unattended, and two infants died from improper supervision by daycare providers who had too many children in their care. Some of these victims were also victims of other or unspecified types of general neglect (in addition to lack of supervision) indicating dehydration or inadequate hygiene. Seven children drowned when improperly supervised around a pool, lake or tub.

**Table 12: Type of Abuse in Child Deaths  
SFY 2008-2010**

Type of Physical Abuse	FY 2008		FY 2009		FY 2010	
	Number	Percent	Number	Percent	Number	Percent
Asphyxiation	0	0.0	1	6.3	1	4.3
Battered child syndrome	0	0.0	0	0.0	0	0.0
Bone Fracture	1	5.6	2	12.5	0	0.0
Bruises	2	11.1	2	12.5	2	8.7
Drowning	2	11.1	1	6.3	0	0.0
Gunshot	4	22.2	0	0.0	1	4.3
Poisoning	0	0.0	0	0.0	0	0.0
Shaking	8	44.4	6	37.5	16	69.6
Stabbing	0	0.0	2	12.5	1	4.3
Other or Unspecified Type	1	5.6	2	12.5	2	8.7
Total children <sup>1</sup>	18	100.0	16	100.0	23	100.0

<sup>1</sup>Duplicated count because some children experienced more than one type of neglect or abuse  
Source: Virginia Department of Social Services, January 2011

In SFY 2010, 23 children died as a result of at least one type of abuse. Some children were neglected or abused in more than one way. Sixteen (69.6%) children died from injuries caused by shaking. The “other” type of physical abuse includes internal injuries or head injury.

## **FAMILIES AND THE CHILD WELFARE SYSTEM**

**Table 13: Initial Safety Outcomes for Other Children in Home  
SFY 2010**

<b>Safety Outcome</b>	<b>Family</b>
Emergency Removal/Foster Care	3
Relative Placement w/ Safety Plan	18
Remain in the Home w/ Safety Plan	10
Total families	31

When initiating a response to a child fatality report, CPS will initiate a safety assessment of immediate harm or threats of harm for any siblings or other children in the home. Based on this safety assessment, a safety plan will likely be initiated with the family to outline a course of action to mitigate danger/threats of harm and protect a child from abuse/neglect. The possible outcomes for these other children may be to remain in the home with a safety plan, place with other relatives as part of the safety plan or agreement with the parents, or emergency removal with custody to the local department when there are no other alternatives less drastic.

Of the 44 founded CPS fatality reports for state fiscal year SFY 2010, 31 families had other children for whom initial safety had to be assessed. Of the 28 families where the siblings or other children were not placed in foster care, services to the family included mental health services, substance abuse assessment and treatment, parent education, psychiatric evaluations, in-home services, anger management, victim/witness services via the court, financial assistance and daycare.

**Table 14: History / Other Family Characteristics Noted in CPS Fatalities\*  
SFY 2010**

Substance/Drug Abuse	12
Substance Exposed Infants	4
Mental Health Issues	7
Military Involvement	7
Domestic Violence	8

\* Some families may have had more than one factor noted while others were not noted or not present. Information obtained from child fatality forms completed by local departments.

In the 12 families with substance use or drug abuse noted, seven cases indicated that substance abuse was a factor in the fatality incident. Four victims were previously reported to CPS as a substance exposed infant at birth. Mental health issues noted in cases ranged from history of depression, post-partum depression, bipolar disorder, to psychiatric hospitalization. Of the

families with military involvement, six families had members in active military service (in three families the alleged abuser was not the service member), and one was retired. Eight families had a prior history of domestic violence issues; however, in six cases domestic violence was not noted as a factor during the incident of abuse/neglect under investigation. Two child fatalities occurred during domestic violence where the mother was also killed.

**Table 15: Prior Abuse and/or Neglect in Child Deaths from Abuse or Neglect SFY 2010**

<b>Prior Abuse/Neglect</b>	<b>Number</b>	<b>Percent</b>
Yes	14	31.8
No	30	68.2
Unknown	0	0.0
Total	44	100.0

Source: Virginia Department of Social Services, January 2011

Of the 44 victims in founded CPS fatality investigations, there were 14 families with prior child welfare involvement or current, open child welfare cases compared to 12 families from SFY 2009. Prior involvement may mean that the abuser, victim, or siblings was previously or currently the subject of a family assessment, investigation, or ongoing services or foster care case. There may have been referrals to CPS that were screened out, not meeting the validity criteria authorizing CPS to respond. It may also mean that the caretaker had prior involvement as a victim.

When a local department of social services validates a CPS report alleging abuse and neglect in a child fatality, it must be investigated. Critical decision points for all valid CPS reports include assessing response priority, initial safety, and risk of future maltreatment at the conclusion of the investigation. Some local departments have been piloting the use of Structured Decision Making® (SDM) tools at these three critical decision points to help determine response time, safety, and risk at the conclusion of the CPS investigation. The SDM risk assessment tool does not predict reoccurrence of abuse, but reviews common risk factors associated with abuse and neglect to help guide decisions for opening a case for ongoing services. SDM pilot agencies are noted in the following summary.

The following summarizes the prior or current involvement of the families of the 14 founded fatality victims known to the child welfare system:

- A one month old infant died from unsafe sleeping practices with a caretaker using substances at the time. This occurred during the course of an assessment for a substance-exposed infant report. The mother was referred for treatment. Prior to the child's death it was noted that the worker cautioned the caretaker about the dangers of co-sleeping. There was a family assessment for neglect a year prior to this report. (not SDM pilot)
- A report of physical abuse was unfounded due to lack of medical evidence two months prior to the victim's death from shaking injuries. Because of the initial report and risk assessment a case was open for services to offer parenting classes, CPR and Child Health

Investment Partnership (CHIP) support. While the case was open to services the fatality occurred from a shaking incident. (not SDM pilot)

- A three year old died from ingesting illegally obtained methadone when the caretakers did not seek immediate medical treatment for the poisoning. There were two prior CPS reports related to lack of supervision with substance abuse reported. During the time of the fatality, the family was receiving ongoing services due to a founded CPS report related to neglect and substance abuse. The parent was under a protective order for substance abuse treatment. (not SDM pilot)
- A seven month old infant with medical needs died from neglect with caretaker substance abuse noted. This family had a history of five prior reports for neglect with substance abuse reported. This victim was removed from the mother due to a founded report of neglect two months prior to death. The victim was in the legal custody of the local department and physical custody was with the father with the mother to remain out of the home. After a court review, the mother was allowed back in the home two days prior to the infant's death. (not SDM pilot)
- The child was abandoned at the hospital at birth and tested positive for drugs. The child was placed in foster care and died at ten months old from physical abuse by the foster mother. (not SDM pilot)
- During an open investigation for neglect (inadequate supervision) involving alcohol abuse, a one and a half year old asphyxiated on a piece of plastic bag while not properly supervised. (utilizing SDM)
- A two week old infant died when the caretaker rolled onto the child while asleep on the couch. Substance abuse was reported as part of the incident. The mother had two previous CPS neglect reports involving substance abuse where two other children were removed and remained out of her care. The mother had been incarcerated throughout much of the pregnancy with victim and had tested negative for drugs after her release. Due to the history, an emergency protective order for the victim was issued but not yet served when the fatality occurred. (not SDM pilot)
- The father stabbed and killed his three year old child and the mother. The family had a history of CPS involvement for domestic violence and physical abuse two years prior to the child's death. The family had received domestic violence and mental health services when the child was placed in foster care for a year due to safety issues. The child was placed with the mother, and there was a protective order on the father with supervised visitation for him out of the home. The parents were responsive to all services, and the court dismissed the protective order two weeks prior to the child's death. (utilizing SDM)
- A six year old child drowned in the bathtub when left unsupervised. A prior CPS investigation for neglect (inadequate supervision) was unfounded two months prior to death. At the time of the child's death there was an ongoing investigation for neglect and the family was receiving counseling, parenting and daycare services. (utilizing SDM)

- A four month old infant died from lack of supervision when a substance abusing caretaker fell asleep in the bed while feeding the twins. The victim had healing internal injuries. The victim child and twin were subjects of a substance exposed infant report at birth, and the mother was referred for substance abuse services. (not SDM pilot)
- A four year old child drowned in a pool due to lack of supervision. The family and this child had a prior family assessment for inadequate supervision from 2007 (no other information available). (not SDM pilot)
- A three year old child died (findings of abuse, medical neglect and malnutrition) and the body was recovered at the landfill. Previously, the child had been in foster care for a year and a half when removed from parents for medical neglect when victim was a year old. The family received counseling, parenting, anger management, and medical support services prior to child being returned home. The foster care case closed four months prior to child's death. (not SDM pilot)
- A seven month old infant died from physical abuse with shaking-related injuries inflicted by a babysitter. There was a prior unfounded substance exposed infant report on the victim. (not SDM pilot)
- A seven year old child with cerebral palsy and special feeding needs died of severe neglect with indicators of lack of supervision, lack of food and inadequate shelter. The family had three years of extensive medical/health support and parent education services after child was born. There was a report of inadequate supervision of a sibling in 2009 which was incomplete as the family moved out of state and could not be located. (utilizing SDM)

Of the 14 families known to the system, four of the victims were reported as substance exposed infants at birth. Six of these 14 families had caretaker substance use or abuse (alcohol or drugs) noted as a factor in the CPS fatality investigation. Four victims had foster care involvement.

## **STRATEGIES FOR PREVENTION IN SFY2010-2011**

### **Abusive Head Trauma / Shaken Baby Syndrome**

Nationally, it is estimated that each year approximately 1,200 to 1,400 babies die or suffer injury from abusive head trauma. Of the 16 child fatalities due to shaking injuries in SFY 2010, five were caretakers in regulated child care settings, three were babysitters in non-regulated settings, and one was a foster parent. During the 2010 Session of the General Assembly, legislation was passed regarding prevention efforts for Shaken Baby Syndrome (SBS), also known as Abusive Head Trauma. House Bill 411 required VDSS to make information about SBS, its effects, and resources for help and support for caretakers in a printable format, with links to information about SBS and its effects in an audiovisual format, available to the public on its website. This information is required to be provided to every child welfare program that is licensed by VDSS at the time of initial licensure and upon request. Training provided to operators and staff of licensed child day programs now includes printed and audiovisual information regarding SBS, its

effects, and resources for help and support for caretakers. Prospective foster or adoptive parents are now informed that information about SBS, its effects, and resources for help and support for caretakers is available on the VDSS website. These requirements were enacted July 1, 2010. The Department's SBS website ([http://www.dss.virginia.gov/family/cps/shaken\\_baby.cgi](http://www.dss.virginia.gov/family/cps/shaken_baby.cgi)) includes the following: a printable brochure, audiovisual clips, links to national and state resources and supports, advice on coping with frustration and triggers, tips to soothe a crying child, and where to get help in Virginia. The Department will continue to update its website with current materials and ensure that providers are trained as directed by the statute. The CPS Program will work with the Division of Licensing Programs to make sure that information available on the VDSS website about choosing a quality child care provider is shared with community stakeholders.

House Joint Resolution 632 introduced during the 2011 Session of the General Assembly directs the Joint Commission on Health Care to study the costs of medical treatment of SBS, identify evidence-based practices in reducing the incidents of SBS and abusive head trauma and the cost of implementing those practices. Various state agencies are directed to work cooperatively on this study which will be submitted to the 2012 Session of the General Assembly.

### **Improving CPS Assessment Processes**

Improving response time and assessment of safety and risk of children are primary goals of Virginia's Program Improvement Plan. Specific strategies include revising CPS procedures by implementing the Structured Decision Making (SDM) model to complement clinical judgment by providing structure to consistently assess response time, immediate safety and risk factors for children. SDM is a process that uses a set of research and evidence based assessment tools to help caseworkers make appropriate decisions at key stages in the CPS process. The Department has developed an intensive, two-day training for local departments to address CPS intake, safety and risk assessments using SDM. Revised state CPS guidance will provide the basis for the training, which will begin in late spring 2011 for statewide SDM implementation by July 2011.

### **Foster Care Reunification Assessment**

Three of the four child fatality victims with foster care involvement had recently been placed back into the home of the abuser. Virginia's Program Improvement Plan outlines strategies for improving assessment and service planning along the child welfare continuum. Foster Care Program staff will examine current safety assessment tools and develop guidance and training for foster care workers regarding safety and risk assessments prior to reunification.

### **State Child Fatality Review Team**

There were six founded child fatalities due to unsafe sleeping practices or co-sleeping. The State Child Fatality Review Team is focusing its work on deaths to infants that are related to unsafe sleeping arrangements. These include three categories:

- Sudden Infant Death syndrome ("natural" deaths) – SIDS;
- Sudden Unexpected Infant Deaths (where forensic pathology suggests that the cause and/or manner of death are undetermined) – SUIDS; and
- Unintentional Injury Deaths caused by asphyxia/suffocations injuries related to unsafe sleeping – accidental deaths.

The Team is in the process of reviewing all 2009 deaths that fall into these three categories. The Team's findings will be used by the Virginia Regional Perinatal Councils, which provide maternal and child health services around the Commonwealth. The findings will also be shared with local departments of social services to provide information to families about safe sleeping practices.

### **Substance Abuse**

Twelve families of fatality victims had substance use or drug abuse noted, and seven cases indicated that substance abuse was a factor in the fatality incident. Four victims were previously reported to CPS as a substance exposed infant at birth. The Department of Behavioral Health and Developmental Services (DBHDS) is in the process of completing its website on substance abuse screening and brief intervention services. There will be a section on screening pregnant women and women of child bearing age, which includes a variety of screening tools and guidance information for medical providers, behavioral health care providers and other professionals. The DBHDS is also working on a substance use curriculum for home visitors as the Home Visiting Consortium (HVC) is interested in a curriculum on screening women and intends to encourage all home visiting programs to include screening for substance abuse, emotional health and intimate partner violence.

### **Strengthening Families**

Eight caretakers responsible for child fatalities were the parent's paramour. VDSS is developing an agency-wide approach to strengthening families that focuses on reducing out-of-wedlock births, reconnecting fathers with their children, and encouraging the formation and maintenance of two-parent families. The Strengthening Families Initiative, which focuses on a holistic approach that looks beyond clients as individuals and focuses on strengthening the family unit, is based on the fundamental belief that children do better when raised in safe, stable, intact, two-parent families. Key strategies include the development of a practice model that clearly articulates the values and principles of the initiative, the establishment of outcome measures, the alignment of policies and programs, the maximization of Department resources, and the integration of performance-based contracting strategies. In addition, the initiative will include a social marketing campaign aimed at VDSS staff, local department staff, and community stakeholders as well as local program opportunities through the use of grant funds.

### **General Prevention Efforts to Support Families**

The Child Abuse Prevention Committee (CAPC) continues to work on activities related to the nine strategies of the Blue Ribbon Plan for Child Abuse Prevention. CAPC is supporting the effort to launch a pilot project to prevent Inflicted Traumatic Brain Injury. Dr. Michelle Clayton, CAPC Chairperson, is working through Children's Hospital of the King's Daughters and has continued to seek grant funding for the project.

CPS Prevention Staff at VDSS provide ongoing grant management for 39 Healthy Families (HF) programs funded by the General Assembly and 21 prevention programs funded through the Community-Based Child Abuse and Neglect Prevention (CBCAP) program and the Virginia Family Violence Prevention Program (VFVPP) Child Abuse and Neglect Prevention funding streams. There were 4,790 families served by the Healthy Families grants, and 1,771 families were served by the CBCAP and VFVPP Child Abuse Prevention grants during SFY 2010.

## **APPENDIX**

### **Table of Cases**

Agency	Child Sex	Child Race	Child Age at Death	Date of Death	Complaint Date	Abuser Relation	Abuser Age	Abuser Race	Abuser Sex	Type Abuse/Neglect Resulting in Death	Criminal Justice Involvement	Prior Abuse/Neglect	Summary
Stafford	Male	White	1 month 3 years, 5 months	7/1/2009	7/1/2009	Father	29	White	Male	Physical Abuse	Yes	No	Father reported attempting to feed child when he noticed child was having trouble breathing. Medical diagnosis is shaken Baby Syndrome as a result of child abuse. Autopsy showed child suffered craniocerebral and spinal injuries, healing fractures, hemorrhages of lungs and liver, and healing injuries to tongue and frena.
Greenville	Male	White	1 year, 1 month	7/4/2009	7/4/2009	Father	49	White	Male	Physical Neglect	Yes	No	Child and 5 year old sibling were playing at lake unsupervised. Child drowned.
Richmond	Male	Black	4 months	7/6/2009	7/6/2009	Child care worker - reg	23	Black	Male	Physical Neglect	Yes	No	Child found at approximately 4:30pm in daycare van. Child was put on van in the morning. It appears child was left in van all day, and child was discovered when van driver left daycare to load up children for their return home. Child pronounced dead at hospital.
Danville	Male	Black	1 month	7/7/2009	7/8/2009	Mother Father	19 26	Black Black	Female Male	Medical Neglect Medical Neglect	no	No	Child born premature and sent home with special medical monitoring needs and was receiving professional nursing care. When nurse arrived that morning, noticed that monitors were disconnected and child not breathing. Parents failed to follow through with complete regimen of care prescribed and necessary for child's health.
Montgomery	Female	White	2 months	7/10/2009	7/10/2009	Mother Mother's paramour	34 35	White White	Female Male	Physical Neglect Physical Neglect	no	Yes	Child sleeping in bed with mother and 2 other siblings. Someone rolled over on baby. Mother tested positive for drugs and admitted to taking drugs prior to going to bed.
Virginia Beach	Male	White	7 months	7/10/2009	7/10/2009	Mother Grandmother Father	29 55 33	White White White	Female Female Male	Physical Neglect Physical Neglect Physical Neglect	no	No	This began as a family assessment for neglect as mother had substance abuse problem. Child found unresponsive by grandfather and mother could not be woken up for some period of time. Mother was not to be left alone with child and grandmother was to supervise but didn't follow safety plan.
Roanoke	Female	Black	2 years, 5 months	7/13/2009	7/7/2009	Father	19	Black	Male	Physical Abuse	Yes	Yes	Mother placed child for adoption. Child in adoptive home when biological father learned of placement, petitioned for and obtained custody. Father and child were receiving supportive services. Child removed from life support having been in hospital for a week due to shaking-related injuries. Dad confessed to shaking child.
Newport News	Female	Black	1 year, 5 months	8/2/2009	8/3/2009	Father Mother	23 23	Black Black	Male Female	Physical Neglect Medical Neglect	no	No	Baby was unresponsive and was taken to hospital where she was pronounced dead. Conditions of home were concerning. Baby had severe diaper rash with open sores but no physical trauma. Cause of death was determined as SIDS; however, there were indicators of neglect.
Norfolk	Female	Black	4 months	7/31/2009	8/3/2009	Mother Mother's paramour	22 19	Black Black	Female Male	Medical Neglect Physical Abuse	Yes	No	Autopsy revealed extensive internal injuries, broken ribs and bruises from being punched, squeezed or both.
Henrico	Male	White	4 months	8/9/2009	7/10/2009	Child care worker - reg	49	White	Female	Physical Abuse	Yes	No	Child in care of sitter when he became symptomatic. Reportedly child fell out of a jumperoo onto carpeted floor. Exam revealed subdural bilateral hemorrhages indicative of abusive head trauma.
Chesterfield	Male	Black	3 years, 6 months	8/20/2009	8/21/2009	Father	24	Black	Male	Physical Neglect	no	Yes	Child and siblings were in care of father, who fell asleep while feeding sibling. Woke up and found victim unresponsive. Father admitted to smoking marijuana daily(last time was night before while drinking an alcoholic beverage).
Spotsylvania	Male	Black	2 months	9/9/2009	9/8/2009	Child care worker - unreg	27	Black	Female	Physical Abuse	Yes	No	Child's mother reported that child was fine when she dropped off at sitter's. CT scan revealed bilateral subdural hematomas, retinal hemorrhages, consistent with severe shaking causing child to become immediately comatose. Sitter confessed to shaking child.
Pulaski	Male	Multi-racial	8 months	9/30/2009	9/30/2009	Mother Mother's paramour	38 31	White White	Female Male	Physical Neglect Medical Neglect	Yes	Yes	Child ingested methadone that mother had obtained illegally. Medical help not sought until child was found unresponsive later.
Prince George	Female	White	2 months	10/7/2009	10/12/2009	Father	29	White	Male	Physical Abuse	Yes	No	Father reported child was not breathing well and waited two hours before calling 911. Child died from injuries consistent with shaking.
Prince William	Female	Black	2 months	10/10/2009	10/10/2009	Mother	22	Black	Female	Physical Neglect	Yes	No	Mother left child unattended in bathtub and came back to find child had drowned.
Norfolk	Male	Black	3 years, 1 month	10/30/2009	11/3/2009	Father	21	Black	Male	Physical Abuse	Yes	No	Father found infant not responding. Autopsy revealed old and new bleeds, bruises to buttocks and marks on face. Child hospitalized 2 times since birth for breathing problems. ME indicated cause of death was traumatic brain injury or shaken baby.
Norfolk	Female	Black	3 years, 1 month	10/29/2009	10/30/2009	Mother's paramour Unknown	38 Unknown	Black Unknown	Male Unknown	Medical Neglect Physical Abuse	Yes	No	Mother's paramour reported child "pooped" in her pants; he beat her and shook her. Child died from inflicted brain trauma or shaken baby.

Agency	Child Sex	Child Race	Child Age at Death	Date of Death	Complaint Date	Abuser Relation	Abuser Age	Abuser Race	Abuser Sex	Type Abuse/Neglect Resulting in Death	Criminal Justice Involvement	Prior Abuse/Neglect	Summary
Halifax	Male	Black	1 year, 10 months	11/16/2009	11/16/2009	Mother	23	Black	Female	Physical Neglect	No	No	Child wandered out into yard and was found in pond. Child drowned. Report indicates child had been in water for approximately 50 min.
Bedford Co.	Male	White	4 years, 10 months	7/14/2009	7/14/2009	Mother	25	White	Female	Physical Neglect	No	Yes	Mother and child staying in living room of friend's house. Child went outside and drowned in the pool. Mom woke up later and found him floating in pool.
Staunton	Female	Black	2 months	11/19/2009	11/19/2009	Mother	17	Black	Female	Physical Abuse	Yes	No	Mother reported child was not breathing. Mother admitted to dropping and smothering child.
Wise	Female	White	7 months	11/27/2009	11/27/2009	Mother	23	White	Female	Physical Neglect	Unknown	Yes	Mom alone with child. Child was born premature, had sleep apnea and respiratory infection. Child had been placed on stomach to sleep. Mother tested positive for drugs and child was not checked on for several hours. Child had been removed for neglect and placed with father with mother out of home. Two days prior to the child's death, mother was allowed back in home.
Campbell	Female	White	0 months	12/11/2009	12/11/2009	Mother Unknown	21 Unknown	White Unknown	Female Unknown	Physical Neglect Physical Abuse	No	No	This was live-birth, full term baby born at home. Upon delivery, mother covered baby with clothing and bedding cover to conceal cries. Grandparents discovered child in distress and called EMS. Baby and mother transported to hospital where child pronounced dead. Criminal charges not pursued due to baby being attached to umbilical cord/placenta which was factor in interpreting law at that time. Code of Virginia §18.2-32.3 was amended due to this case.
Virginia Beach	Male	White	8 months	1/8/2010	1/8/2010	Child care worker - unreg	59	White	Female	Physical Neglect	Yes	No	Child put down for nap by sitter and not checked on or fed for hours. Child was found not breathing. Nine children in care at time of incident.
Roanoke	Male	Black	3 years	1/14/2010	1/14/2010	Mother Stepparent	23 24	Black Black	Female Male	Physical Neglect Medical Neglect	Yes	Yes	On 1/14/10 mother and stepfather told police child had been abducted. On 1/19/10 stepfather admitted child was dead before he called 911. Child's body was later found at landfill with indicators of severe abuse, neglect and malnutrition.
Virginia Beach	Male	White	10 months	2/7/2010	2/7/2010	Foster parent	28	White	Female	Physical Abuse	Yes	Yes	Child in foster care. Foster mother found child unresponsive. Autopsy findings are diagnostic of inflicted head trauma and child neglect.
Fairfax Co.	Male	White	4 months	1/30/2010	1/31/2010	Father Mother	22 20	White White	Male Female	Physical Neglect Physical Neglect	Yes	No	Child was pronounced DOA at hospital. Preliminary cause of death appeared to be neglect. Child appeared emaciated, dehydrated and was dirty.
Fairfax Co.	Male	Black	2 months	2/15/2010	2/15/2010	Mother Father	16 18	Black Black	Female Male	Physical Neglect Physical Neglect	no	No	Dispatcher received call that baby was in cardiac arrest and later died. Home and bedroom in disarray and crib was full of stuff. Prelim autopsy indicates child was suffocated probably due to co-sleeping with parents.
Chesapeake	Female	White	10 months	2/20/2010	2/22/2010	Father	29	White	Male	Physical Abuse	Yes	No	Child in high chair. Father was practicing drawing gun aimed at statue that was above the child. Death due to gunshot wound.
Newport News	Female	White	1 year, 6 months	3/3/2010	3/2/2010	Mother Mother's paramour	22 24	White White	Female Male	Medical Neglect Physical Abuse	Yes	No	Child brought to hospital for shallow breathing. Child had bruises on face, back, side and had head trauma. Child died a couple of days later. Stories of how injuries occurred were not consistent with injuries.
Petersburg	Female	Black	8 months	3/9/2010	3/8/2010	Child care worker - unreg	56	Black	Female	Physical Abuse	Yes	Yes	Child came to hospital in full cardiac arrest from sitter's who reported child unresponsive after falling off couch onto hardwood floor. No visible external injuries. Condition consistent with shaken baby.
Accomack	Male	Black	10 months	3/12/2010	3/12/2010	Mother's paramour	25	Black	Female	Physical Abuse	Yes	No	Child taken to hospital with internal bleeding and bruising under eyes. Parent states 2 y/o sibling pulled 17 pound sibling out of crib. Story doesn't match injuries. Child died from injuries consistent with inflicted head trauma - shaking.
Norfolk	Male	Black	1 year, 10 months	3/20/2010	3/20/2010	Mother's paramour	21	Black	Male	Physical Neglect	No	Yes	Mother left child with paramour and thought child was asleep on couch. Child choked on piece of plastic while left asleep on couch, but had not been checked on.
Danville	Male	Black	2 months	3/22/2010	3/20/2010	Father	26	Black	Female	Physical Abuse	yes	No	Child brought to hospital with injuries and no previous medical history. Father reported he fell while holding baby. Skeletal survey indicated battered child as there were several old and new broken bones and bruises. Also visible bruises on chest. Injuries suggestive of non-accidental trauma and shaken baby.
Fauquier	Male	White	2 weeks	3/28/2010	4/2/2010	Mother Other	27 25	White White	Female Male	Physical Neglect Physical Neglect	Unknown	Yes	Initial report was baby was found not breathing and blue. Had been with mother's friend on couch in living area when mother went to sleep on floor in front of couch. Mother woke up and found child between friend and back of couch. Mother aware others in house were drinking, including the man she gave child to on couch before she went to sleep on the floor.
Prince William	Male	White	4 years, 1 month	3/31/2010	4/1/2010	Mother	29	Black	Female	Physical Neglect	Unknown	No	Mother left child unattended in tub and found child submerged. Child pronounced DOA at hospital.

Agency	Child Sex	Child Race	Child Age at Death	Date of Death	Complaint Date	Abuser Relation	Abuser Age	Abuser Race	Abuser Sex	Type Abuse/ Neglect Resulting in Death	Criminal Justice Involvement	Prior Abuse/ Neglect	Summary
Alexandria	Female	Black	3 years, 7 months	4/11/2010	4/11/2010	Father	34	Black	Male	Physical Abuse	Yes	Yes	Police responded to report of domestic dispute and found mom and child deceased. Father confessed to others that he stabbed them with a knife.
Henrico	Male	Black	3 years, 5 months	4/15/2010	4/15/2010	Mother's paramour	45	Unknown	Male	Physical Abuse	Yes	No	Child and sibling were being watched by mother's paramour and reported to have beaten the child many times. Child appears to have been beaten to death as there was massive head trauma and significant bruising and marks all over child's body.
Norfolk	Male	White	1 month	5/25/2010	5/25/2010	Child care worker - reg Child care worker - reg Child care worker - reg	46 53 56	Black Black Black	Female Female Female	Physical Neglect Physical Neglect Physical Neglect	no	No	10 babies being cared for by 1 staff present at the time (3 staff assigned to infants, but not consistently present during day). Infant put on stomach, room was warm, and staff was not in room at all times with infants.
Prince William	Female	Multi-racial	6 years, 2 months	5/24/2010	5/21/2010	Mother	21	Black	Female	Physical Neglect	Yes	Yes	Child drowned in bathtub. Mother was elsewhere in home and came back to find child submerged in water.
Chesapeake	Male	Black	2 years, 10 months	6/6/2010	6/7/2010	Mother	25	Black	Female	Physical Neglect	Yes	No	Child was with mother and friends who were setting up for a graduation party at park. Child was at playground with no adult supervision and wandered off. Child drowned in lake. Pronounced dead at hospital.
Newport News	Male	White	7 years, 1 month	6/7/2010	6/9/2010	Mother	26	White	Female	Physical Neglect	Unknown	Yes	Child had cerebral palsy and feeding tube with other medical needs. Medical report indicated that neglect was contributing factor of death. Child weighed 28 lbs. and was severely dehydrated.
Fairfax Co.	Female	Asian	15 years, 1 month	6/14/2010	6/15/2010	Father	49	Asian	Male	Physical Abuse	Yes	No	Child and her mother were beaten to death by the dad. Father admitted to strangling child.
Botetourt	Male	White	2 months	5/26/2010	5/28/2010	Father Mother Unknown	34 20 Unknown	White White Unknown	Male Female unknown	Physical Abuse Physical Abuse Physical Abuse	Yes	No	Child pronounced dead upon examination by doctor at hospital. Reported that child aspirated on milk while being fed. ME reports trauma to head and absence of milk in lungs or stomach.
Chesterfield	Male	Black	2 months	6/26/2010	6/23/2010	Father	17	Black	Male	Physical Abuse	Yes	No	Child at hospital with subdural hematoma, and parents could not account for how child sustained injury. Three days later child died due to pulmonary arrest secondary to subdural hematoma and suspected non-accidental injury consistent with shaken baby.