

**PRELIMINARY REPORT
ON CHILD DEATHS
DUE TO ABUSE OR NEGLECT
IN VIRGINIA
DURING STATE FISCAL YEAR 2011**

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February 2012

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Table of Contents

| | |
|---|-----------|
| EXECUTIVE SUMMARY | 2 |
| I. CHILD DEATHS | 3 |
| <i>Table 1: Dispositions of CPS Complaints with a Child Death by Locality</i> | |
| <i>Table 2: Death Rate of Children Due to Abuse or Neglect</i> | |
| <i>Chart 1: Child Deaths in Virginia, by Suspected and Founded Maltreatment</i> | |
| <i>Chart 2: Rates of Child Deaths Due to Abuse and Neglect</i> | |
| <i>Table 3: Child Deaths Due to Abuse and/or Neglect and Rates by Region</i> | |
| <i>Table 4: Children Who Died From Abuse or Neglect by Age</i> | |
| <i>Table 5: Children Who Died From Abuse or Neglect by Race</i> | |
| <i>Table 6: Children Who Died From Abuse or Neglect by Gender</i> | |
| II. CARETAKERS | 8 |
| <i>Table 7: Caretakers in Child Deaths from Abuse or Neglect</i> | |
| <i>Table 8: Caretakers in Child Deaths from Abuse or Neglect by Race</i> | |
| <i>Table 9: Caretakers in Child Deaths from Abuse or Neglect by Gender</i> | |
| <i>Table 10: Caretakers in Child Deaths from Abuse or Neglect by Age</i> | |
| III. CATEGORIES OF ABUSE AND NEGLECT | 11 |
| <i>Table 11: Type of Neglect in Child Deaths</i> | |
| <i>Table 12: Type of Abuse in Child Deaths</i> | |
| IV. FAMILIES AND THE CHILD WELFARE SYSTEM | 12 |
| <i>Table 13: Initial Safety Outcomes for Other Children in Home</i> | |
| <i>Table 14: Prior Abuse and/or Neglect in Child Deaths from Abuse or Neglect</i> | |
| V. UNFOUNDED REPORTS | 14 |
| VI. ACTIONS TO INCREASE AWARENESS AND IMPROVE CHILD DEATH INVESTIGATIONS | 14 |
| VI. APPENDIX | |
| <i>Table of Cases</i> | |

PRELIMINARY REPORT ON CHILD DEATHS DUE TO ABUSE OR NEGLECT IN VIRGINIA DURING STATE FISCAL YEAR 2011

EXECUTIVE SUMMARY

This is a preliminary report on child deaths that were reported to local departments of social services (LDSS) during SFY 2011. In SFY 2010, there were a significant number of child fatalities in Virginia which prompted the State Board of Social Services to direct the Virginia Department of Social Services (VDSS) to implement child fatality review teams in each of the five regions of the state. The Eastern Regional Child Fatality Review Team has existed for a number of years. VDSS is working collaboratively with the Office of the Chief Medical Examiner in establishing the teams. The teams are expected to be operational by March 2012 and are charged with reviewing the child deaths investigated by Child Protective Services (CPS) in SFY 2011. The teams will submit their findings and recommendations to VDSS upon completion of their review. VDSS will review the findings, identify trends, and make recommendations for the prevention of future child deaths.

The goal of 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.

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. CPS investigations involving a child fatality include assessing immediate safety and developing a safety plan, if needed, for any siblings of the deceased victim. At the conclusion of the investigation, a risk assessment is completed for the family to determine the likelihood of future maltreatment. Additionally, CPS makes a disposition of founded or unfounded. A founded disposition means that a preponderance of the evidence shows that child maltreatment has occurred. 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.”

Preliminary Findings

- Local departments of social services investigated 86 reports of child deaths suspected to be caused by child maltreatment for state fiscal year (SFY) 2011. This is an increase of eight reports from SFY 2010.
- There were 30 children who died as a direct result of child abuse or neglect. This is 14 *fewer* founded child abuse fatalities than in SFY 2010. There were 52 reports that were unfounded. Two reports are still pending; two are on appeal.
- The children who died as a result of child abuse or neglect ranged in age from birth through 16 years. Of the 30 children who died from maltreatment, 18 (60.0%) were less

than one year of age. All but four children were under four years of age. This is consistent with national data and previous state data that have found young children continue to be the most vulnerable.

- Seventeen (56.7%) children who died as a result of abuse or neglect were White; ten (33.3%) were African-American; two (6.7%) were Asian; and one (3.3%) was multi-racial. African-American children are over represented when compared to the percent of African Americans in the general population (19.4%).
- Twelve (40%) females and 18 (60%) male children 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.
- Physical abuse caused the death for 12 children and included six incidents of Abusive Head Trauma (AHT). Physical neglect caused the death of 12 children and included five children who died as a result of unsafe sleep practices. Medical neglect was cited in six child deaths. Some children died as a result of more than one type of abuse or neglect.
- Forty caretakers were responsible for the death of 30 children in SFY2011. Out of the 40 caretakers, 24 (60.0%) were biological parents. This is comparable to the percentage in SFY 2010 that found 63.5% of caretakers to be parents of the child victim.
- Four (10%) of the 40 caretakers were out of family child care providers. Three were babysitters in non-regulated settings. One caretaker was in a regulated child care setting. This is a slight decrease from SFY 2010 where eight (12.7%) of 63 caretakers were in out of family settings.
- Of the 40 caretakers responsible for the 30 child deaths, 23 were women and 16 were men. The gender of one caretaker was unknown because the abuser could not be determined. This is similar to the national data that have found more female than male perpetrators.
- Twenty-two (55.0%) of the 40 perpetrators were less than 30 years old. This statistic is similar to national data and previous state data that confirm most perpetrators in child fatalities tend to be young adults in their mid-twenties.
- The families of 13 children who died as a result of child abuse or neglect or their caretakers were known to the child welfare system in some capacity.

I. CHILD DEATHS

Local departments of social services investigated 86 reports of child deaths suspected to be caused by child maltreatment for SFY 2011. There were 30 children who died as a result of child abuse or neglect; 52 reports that were unfounded; two reports are still pending and two are on appeal.

The Eastern region investigated the most reports (40) in SYF2011 followed by Piedmont region (16) and the other regions each investigated 10 reports. Regional populations vary, with the Northern Region having the most children in the state. According to the 2010 Census, the Northern Region has 758,704 children, which is 41% of the total population of persons in Virginia less than 18 years of age (1,853,677).

**Table 1: Dispositions of CPS Complaints with a Child Death by Locality
SFY 2011**

| Local Department | Founded | Unfounded | Pending/Appealed | Total |
|-------------------------|----------------|------------------|-------------------------|--------------|
| Accomack | | 1 | | 1 |
| Albemarle | 1 | 1 | | 2 |
| Alexandria | | 1 | | 1 |
| Chesapeake | 1 | 3 | | 4 |
| Chesterfield | 1 | | | 1 |
| Danville | 1 | | | 1 |
| Dickenson | 1 | | | 1 |
| Dinwiddie | | 1 | | 1 |
| Fairfax Co. | 1 | 1 | | 2 |
| Fauquier | | 1 | | 1 |
| Franklin Co. | | 1 | | 1 |
| Giles | | | 1 | 1 |
| Gloucester | 1 | | | 1 |
| Grayson | 1 | | | 1 |
| Halifax | | 1 | | 1 |
| Hampton | 2 | 4 | | 6 |
| Henry-Martinsville | | 1 | | 1 |
| Hopewell | | 1 | | 1 |
| Isle of Wight | 1 | | | 1 |
| King William | 1 | | | 1 |
| Lancaster | 1 | | | 1 |
| Lynchburg | 1 | 1 | | 2 |
| Mecklenburg | | 1 | | 1 |
| Newport News | 2 | 8 | | 10 |
| Norfolk | 1 | 2 | | 3 |
| Orange | | | 1 | 1 |
| Page | | 1 | | 1 |
| Petersburg | 1 | 1 | | 2 |
| Pittsylvania | 1 | 1 | | 2 |
| Portsmouth | | 3 | | 3 |
| Prince Edward | | 1 | | 1 |
| Prince William | 3 | 1 | | 4 |
| Richmond City | | 3 | | 3 |
| Roanoke City | 1 | 2 | | 3 |
| Roanoke Co. | 2 | | | 2 |
| Scott | | 1 | | 1 |
| Smyth | 1 | 1 | | 2 |
| Tazewell | 1 | | | 1 |
| Virginia Beach | | 6 | 2 | 8 |
| Washington | 1 | | | 1 |
| Wise | | 1 | | 1 |

| | | | | |
|---------------|-----------|-----------|----------|-----------|
| Wythe | 1 | | | 1 |
| York-Poquoson | 1 | 1 | | 2 |
| Total | 30 | 52 | 4 | 86 |

Source: Virginia Department of Social Services, January 2012. Information obtained from local departments.

The number of children who died as the result of child maltreatment *decreased* significantly from SFY 2010 to SFY 2011. SFY 2010 had an unusually high death rate compared to the previous 10 years. The number of children who died compared to the total population of children in Virginia is 1.62 per 100,000 children. This is the *lowest* it has been in three years. The national rate per 100,000 children is 2.07. SFY 2011 rate is well below this rate. (See national trend data in Chart 2). Virginia's population less than 18 years old is 1,853,677, according to the United States 2010 census. The number of child death investigations continues to increase every year. In SFY 2011 however, there were 14 fewer deaths due to abuse or neglect compared to the previous year.

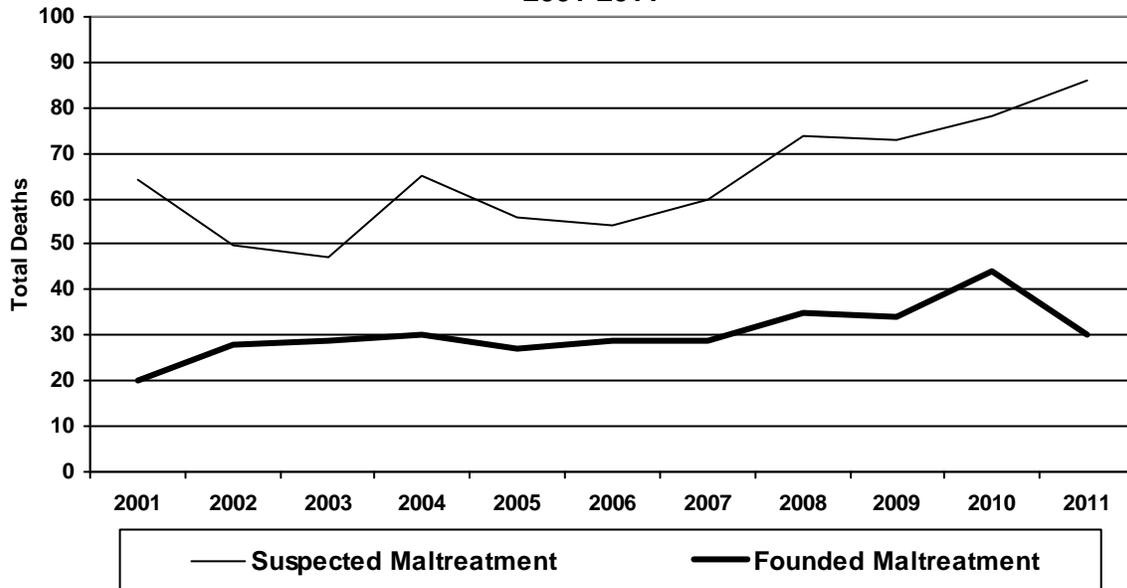
**Table 2: Death Rate of Children Due to Abuse or Neglect
2001 – 2011**

| State Fiscal Year | Number of Death Reports Investigated | Number of Deaths Due to Abuse/Neglect | Death Rate (per 100,000 children)¹ |
|--------------------------|---|--|--|
| 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 |
| 2011 | 86 | 30 | 1.62 |

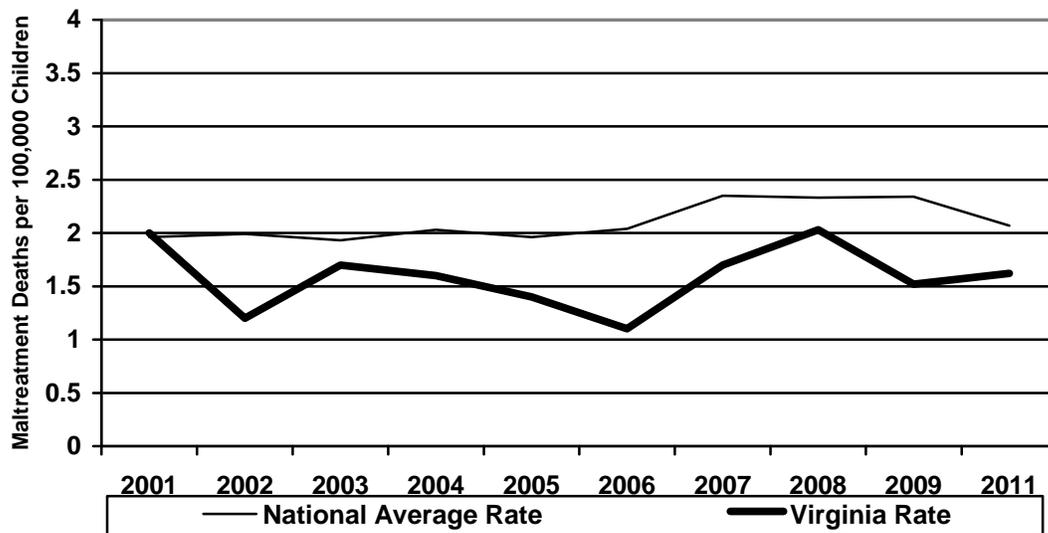
¹Death rate is calculated as number of deaths due to abuse/neglect divided by the state child population

Sources: Virginia Department of Social Services, January 2012. Information obtained from local departments, and United States Census 2010.

**Chart 1: Child Deaths in Virginia,
by Suspected and Founded Maltreatment
2001-2011**



**Chart 2: Rates of Child Deaths Due to Abuse and Neglect
2001-2011**



Source: Administration for Children and Families Statistics and Research
<http://www.acf.hhs.gov/programs/cb/pubs/cm10/index.htm>

The National Child Abuse and Neglect Data System (NCANDS) 2010 data (based on FFY2010) documents that Virginia's rate of founded child maltreatment deaths has been slightly lower than the national average over the past 10 years. In SYF2011, the Virginia rate was 1.62 compared to a national rate of 2.07 per 100,000 children.

**Table 3: Child Deaths Due to Abuse and/or Neglect and Rates by Region
2010-2011**

| Region | 2010 Deaths | 2010 Per 100,000 | 2011 Deaths | 2011 Per 100,000 |
|-----------------|------------------------|-----------------------------|------------------------|-----------------------------|
| Eastern | 16 | 3.64 | 9 | 2.05 |
| Central | 6 | 1.99 | 4 | 1.33 |
| Piedmont | 9 | 3.77 | 7 | 2.93 |
| Northern | 10 | 1.33 | 4 | .53 |
| Western | 3 | 2.64 | 6 | 5.28 |

In SFY 2011, there was a *significant* decrease statewide in child deaths due to abuse or neglect in all regions except Western. The Western region had a total of six child deaths in SFY2011, an increase from three deaths in SFY2010.

**Table 4: Children Who Died From Abuse or Neglect by Age
2009 – 2011**

| Age Category | 2009 | | 2010 | | 2011 | |
|-----------------------------|---------------|----------------|---------------|----------------|---------------|----------------|
| | Number | Percent | Number | Percent | Number | Percent |
| Birth to 12 months | 20 | 58.8 | 26 | 59.1 | 18 | 60.0 |
| 13 months to 3 years | 8 | 23.5 | 13 | 29.5 | 8 | 26.7 |
| 4 to 7 years | 4 | 11.8 | 4 | 9.1 | 1 | 3.3 |
| 8 to 12 years | 1 | 2.9 | 0 | 0.0 | 2 | 6.7 |
| 13 years and over | 1 | 2.9 | 1 | 2.3 | 1 | 3.3 |
| Total | 34 | 100.0 | 44 | 100.0 | 30 | 100.0 |

Source: Virginia Department of Social Services, January 2012. Information obtained from local departments.

Children who died from child maltreatment in SFY 2011 ranged in age from birth through 16 years. Of the 30 children who died from child maltreatment, 18 (60%) were less than one year of age. This is consistent with national data that finds young children to be the most vulnerable. The oldest victim was a 16 year old who was not being properly supervised and committed suicide.

**Table 5: Children Who Died From Abuse or Neglect by Race
2009 – 2011**

| Race | 2009 | | 2010 | | 2011 | |
|------------------|--------|---------|--------|---------|--------|---------|
| | Number | Percent | Number | Percent | Number | Percent |
| African-American | 15 | 44.1 | 22 | 50.0 | 10 | 33.3 |
| White | 13 | 38.2 | 19 | 43.2 | 17 | 56.7 |
| Multi-racial | 6 | 17.6 | 2 | 4.5 | 1 | 3.3 |
| Asian | 0 | 0.0 | 1 | 2.3 | 2 | 6.7 |
| Total | 34 | 100.0 | 44 | 100.0 | 30 | 100.0 |

Source: Virginia Department of Social Services, January 2012. Information obtained from local departments.

Seventeen (56.7%) children who died as a result of abuse or neglect were White; Ten (33.3%) were African-American and two (6.7%) were Asian. This is consistent with previous years where there has been an over-representation of African-American children both nationally and in Virginia.

**Table 6: Children Who Died From Abuse or Neglect by Gender
2009 – 2011**

| Gender | 2009 | | 2010 | | 2011 | |
|--------|--------|---------|--------|---------|--------|---------|
| | Number | Percent | Number | Percent | Number | Percent |
| Female | 20 | 58.8 | 16 | 36.4 | 12 | 40.0 |
| Male | 14 | 41.2 | 28 | 63.6 | 18 | 60.0 |
| Total | 34 | 100.0 | 44 | 100.0 | 30 | 100.0 |

Source: Virginia Department of Social Services, January 2012. Information obtained from local departments.

In SFY 2011, there were 12 (40%) females and 18 (60%) males who died due to abuse or neglect. This data is consistent with national data that finds males have a higher rate of child maltreatment fatalities than females. (NCANDS)

II. CARETAKERS

Local departments of social services found 40 caretakers to be responsible for the deaths of 30 children due to child abuse/neglect in SFY 2011. Some victims were abused by more than one caretaker.

**Table 7: Caretakers in Child Deaths from Abuse or Neglect
2009 – 2011**

| Caretaker Type | 2009 | | 2010 | | 2011 | |
|-------------------------|-----------|--------------|-----------|--------------|-----------|--------------|
| | Number | Percent | Number | Percent | Number | Percent |
| Mother | 15 | 31.9 | 22 | 34.9 | 16 | 40.0 |
| Father | 14 | 29.8 | 17 | 27.0 | 8 | 20.0 |
| Stepparent | 2 | 4.3 | 1 | 1.6 | 0 | 0.0 |
| Grandparent | 4 | 8.5 | 1 | 1.6 | 5 | 12.5 |
| Aunt | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 |
| Uncle | 1 | 2.1 | 0 | 0.0 | 0 | 0.0 |
| Paramour | 2 | 4.3 | 8 | 12.7 | 5 | 12.5 |
| Babysitter | 0 | 0.0 | 0 | 0.0 | 3 | 7.5 |
| Group Home Staff | 0 | 0.0 | 0 | 0.0 | 1 | 2.5 |
| Daycare Provider | 2 | 4.3 | 8 | 12.7 | 0 | 0.0 |
| Other | 7 | 14.9 | 6 | 9.5 | 1 | 2.5 |
| Unknown | - | - | - | - | 1 | 2.5 |
| Total Caretakers | 47 | 100.0 | 63 | 100.0 | 40 | 100.0 |

Source: Virginia Department of Social Services, January 2012. Information obtained from local departments.

Most caretakers were related to the victim or resided with the victim. Sixty percent of the caretakers were biological parents. This is comparable to the percent in SFY 2010 that found 63.5% of caretakers to be biological parents of the child victim.

Four (10.0%) of the 40 caretakers were in out of family settings. Three were babysitters in non-regulated settings. One caretaker was in a regulated child care setting, specifically a residential treatment center. This is a decrease from SFY 2010 which found 8 (12.7%) of the 63 caretakers were in out of family settings. Five caretakers (12.5%) were the parent’s paramour. This is a slight decrease from the previous year but statistically higher than two years ago. The other caretaker was a friend of the family who lived in the home. One caretaker was unknown as there had been more than one person identified having access to the child.

**Table 8: Caretakers in Child Deaths from Abuse or Neglect by Race
2009-2011**

| Race | 2009 | | 2010 | | 2011 | |
|-------------------------|-----------|--------------|-----------|--------------|-----------|--------------|
| | Number | Percent | Number | Percent | Number | Percent |
| Black | 24 | 51.1 | 31 | 49.2 | 11 | 27.5 |
| White | 19 | 40.4 | 26 | 41.3 | 24 | 60.0 |
| Asian | 0 | 0.0 | 1 | 1.6 | 1 | 2.5 |
| Unknown | 4 | 8.5 | 5 | 7.9 | 3 | 7.5 |
| Multi-racial | - | - | - | - | 1 | 2.5 |
| Total Caretakers | 47 | 100.0 | 63 | 100.0 | 40 | 100.0 |

Source: Virginia Department of Social Services, January 2012. Information obtained from local departments.

In SFY 2011, the majority of caretakers (60%) were White. The race of three (7.5%) caretakers was unknown. While the number of African- American caretakers is significantly lower than previous years, it is still higher than Virginia’s general population (19.4%).

**Table 9: Caretakers in Child Deaths from Abuse or Neglect by Gender
2009 – 2011**

| Gender | 2009 | | 2010 | | 2011 | |
|------------------|--------|---------|--------|---------|--------|---------|
| | Number | Percent | Number | Percent | Number | Percent |
| Female | 22 | 46.8 | 33 | 52.4 | 23 | 57.5 |
| Male | 21 | 44.7 | 26 | 41.3 | 16 | 40.0 |
| Unknown | 4 | 8.5 | 4 | 6.3 | 1 | 2.5 |
| Total Caretakers | 47 | 100.0 | 63 | 100.0 | 40 | 100.0 |

Source: Virginia Department of Social Services, January 2012. Information obtained from local departments.

In SFY 2011, of the 40 caretakers found to be responsible for child deaths there were 23 (57.5%) females and 16 (40.0%) males. The gender of one caretaker was unknown as the abuser’s identity was unknown. These numbers are aligned with the national data (NCANDS) that finds more female (53.6%) than male (45.2%) caretakers are responsible for child deaths.

**Table 10: Caretakers in Child Deaths from Abuse or Neglect by Age
2010-2011**

| Age Category | 2010 | | 2011 | |
|----------------|--------|---------|--------|---------|
| | Number | Percent | Number | Percent |
| Under 20 years | 7 | 11.1 | 4 | 10.0 |
| 20 to 29 years | 34 | 54.0 | 18 | 45.0 |
| 30 to 39 years | 8 | 12.7 | 8 | 20.0 |
| 40 to 49 years | 5 | 7.9 | 4 | 10.0 |
| 50 or older | 5 | 7.9 | 4 | 10.0 |
| Unknown | 4 | 6.3 | 2 | 5.0 |
| Total | 63 | 100.00 | 40 | 100.0 |

Source: Virginia Department of Social Services, January 2012. Information obtained from local departments.

Twenty two (55%) of the 40 perpetrators were less than 30 years old. These data are similar to national data and previous state data that confirm most caretakers to be young adults in their mid-twenties.

III. CATEGORIES OF ABUSE AND NEGLECT

In SFY 2011, 30 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.

**Table 11: Type of Neglect in Child Deaths
2009-2011**

| | 2009 | 2010 | 2011 |
|----------------------------|---------------|---------------|---------------|
| Type of Neglect | Number | Number | Number |
| Abandonment | 0 | 0 | 0 |
| Inadequate Supervision | 19 | 14 | 15 |
| Inadequate Shelter | 0 | 0 | 0 |
| Malnutrition | 1 | 1 | 0 |
| Medical Neglect | 1 | 9 | 6 |
| Other/Unspecified sub-type | 2 | 9 | 2 |

Source: Virginia Department of Social Services, January 2012. Information obtained from local departments.

The main cause of death for 12 was physical neglect. The most prevalent type of neglect is lack of supervision. This is a broad term and included lack of supervision that resulted in one child drowning; one child dying from a firearm; two children left in a hot car; and seven children found to have been in unsafe sleep environments. Medical neglect contributed to the death of six children.

**Table 12: Type of Abuse in Child Deaths
2009-2011**

| | 2009 | 2010 | 2011 |
|----------------------------------|---------------|---------------|---------------|
| Type of Abuse | Number | Number | Number |
| Asphyxiation | 1 | 1 | 1 |
| Bone Fracture | 2 | 0 | 0 |
| Bruises | 2 | 2 | 4 |
| Gunshot | 0 | 1 | 1 |
| Poisoning | 0 | 0 | 2 |
| Abusive Head Trauma ¹ | 6 | 16 | 6 |
| Stabbing | 2 | 1 | 0 |
| Internal Injuries | | | 4 |
| Head Injury | - | - | 4 |
| Other or Unspecified Type | 2 | 2 | 2 |

¹Abusive Head Trauma, also known as Traumatic Inflicted Brain Injury or Shaken Baby Syndrome

Source: Virginia Department of Social Services, January 2012. Information obtained from local departments.

In SFY 2011, the main cause of death for 12 children was physical abuse. Some children died from more than one type of abuse. There was a significant *decrease* from SFY 2010 in deaths attributed to Abusive Head Trauma (AHT), previously referred to as Shaken Baby Syndrome (SBS).

IV. FAMILIES AND THE CHILD WELFARE SYSTEM

When initiating a response to a child fatality report, CPS will initiate an 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 may be initiated with the family for a course of action to mitigate danger/threats of harm and to protect a child from abuse/neglect.

Of the 30 founded CPS fatality reports for SFY 2011, twenty-two families had other children for whom initial safety was assessed. Four families had siblings who were removed from the home and placed into foster care, 11 families placed siblings with relatives and seven families had siblings who remained in the home with a safety plan. Services provided to families included mental health services, substance abuse assessment and treatment, parent education, psychiatric evaluations, in-home services, anger management, victim/witness services, financial assistance, daycare and referral for grief counseling.

**Table 13: Initial Safety Outcomes for Other Children in Home
2011**

| Safety Outcome | Family |
|-----------------------------------|--------|
| Emergency Removal/Foster Care | 4 |
| Relative Placement w/ Safety Plan | 11 |
| Remain in the Home w/ Safety Plan | 7 |
| Total families | 22 |

Source: Virginia Department of Social Services, January 2012. Information obtained from local departments.

**Table 14: Prior Abuse and/or Neglect in Child Deaths from Abuse or Neglect
2010-2011**

| Prior Abuse/Neglect | 2010 | | 2011 | |
|---------------------|--------|---------|--------|---------|
| | Number | Percent | Number | Percent |
| Yes | 14 | 31.8 | 13 | 43.3 |
| No | 30 | 68.2 | 17 | 56.7 |
| Unknown | 0 | 0 | 0 | 0 |
| Total | 44 | 100.0 | 30 | 100.0 |

Source: Virginia Department of Social Services, January 2012. Information obtained from local departments.

Of the 30 victims in founded CPS fatality investigations, there were 13 families (43.3%) with prior child welfare involvement or open child welfare cases compared to 14 families (31.8%) from SFY 2010. While the actual number of child deaths decreased from the previous year, the percentage of cases with prior history did *increase*.

Prior involvement may mean that the abuser, victim, or siblings were previously or currently the subject of a family assessment, an investigation, or an ongoing service or foster care case. It may also mean that the caretaker had prior involvement as a victim when they were a child.

The following summarizes the prior or current child welfare involvement of the 13 families with founded fatality victims:

- A two month old child died as a result of a roll over sleeping incident. Both parents were using alcohol and drugs. The family had one prior report in 2008 that involved drug allegations and an unsafe home environment.
- An 11 year old child shot himself with a loaded firearm while home alone. This child had been abused in 2007 and 2010. He was removed from his biological parents and placed with relatives as a result of CPS involvement.
- A one month old died in a sleep related incident while in the care of her mother. The mother was not allowed unsupervised contact per a court order and the child had been placed with a relative; however the relative disobeyed that court order. There had been four prior CPS reports. Various types of intervention had been used with this family, to include court ordered services, domestic violence counseling and substance abuse counseling.
- A five month old child was suffocated by her mother because she was crying. One prior report had been received and services had been offered. A service case was opened but the mother failed to follow through with recommended services.
- A six month old child died from a fatal head injury while in the care of the mother's boyfriend. He had been involved in three reports regarding his own children and one additional report which involved this child. No services had been provided to the family.
- A 21 month old child was left in a hot car along with an older sibling and an elderly relative with Alzheimer's disease. The child died from hyperthermia. CPS had responded to one report in January 2010 and had found no services were needed.
- A one year old child died from extensive internal injuries after having been kicked by a friend of the family. This adult had been abused as a child and had been in foster care until he was emancipated, just two months before the child's death. The mother of the child had also been involved with social services as a youth.
- A two year old child died after overdosing on Oxycodone, a pain medication that had been prescribed for the mother and her boyfriend. There had been one prior CPS report involving an older sibling.
- A one month old child died as a result of abusive head and neck trauma while in the care of his father. A report had been made four days earlier indicating the mother had been involved in a domestic violence incident.
- A two and half year old child died from due to blunt force trauma. The mother and her boyfriend were responsible for his death. There had been five prior CPS reports with the most recent one being in February 2009. There were services provided by CPS and court

involvement which included removal of the child. In December 2010 the court returned custody of the child back to the mother. The child died two months later.

- A five month old child died from shaking. No abuser was identified due to more than one person having access to the child. The mother had two prior reports, one involved selling drugs with a child present. The father of the child also had a founded investigation for physical abuse.
- A one and a half year old child died in July 2010 from extensive physical abuse. The mother's boyfriend was responsible. There had been a prior report completed in October 2009 with no indication that services were provided.
- A five and half year child was given an overdose of medication that had been prescribed for him. The family had ten prior reports. The prior reports were due to neglect and abuse. The family had been involved with several service providers over the years.

V. UNFOUNDED REPORTS

There were 52 unfounded child fatality investigations. An unfounded investigation does not mean the abuse or neglect did not occur. Unfounded means that a review of the facts does not support a finding that abuse or neglect occurred.

- Forty-six (88.5%) of the 52 unfounded reports involved a child under one year of age.
- Thirty-seven (71.2%) of the 52 deaths were related to the sleep environment. This means the actual surface the child slept on, with whom the child was sleeping with, or how the child was sleeping.
- Sudden Infant Death Syndrome (SIDS) or Sudden Unexplained Infant Death (SUID) was listed as cause of death for 22 (42.3%) children.
- Six children died as a result of accidental asphyxiation.
- Three children accidentally drowned.

VI. ACTIONS TO INCREASE AWARENESS AND IMPROVE CHILD DEATH INVESTIGATIONS

Abusive Head Trauma/ Shaken Baby Syndrome

House Joint Resolution 632 was introduced during the 2011 Session of the General Assembly and directed the Joint Commission on Health Care to study the costs of medical treatment of Shaken Baby Syndrome (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 were directed to work cooperatively on this study. The preliminary results were received in January 2012. ([House Joint Resolution 632](#)) As a direct result of this report, there is pending legislation to declare the third week in April as Shaken Baby Awareness Week. April is currently Child Abuse Prevention Month.

CPS Assessment Process

On July 1, 2011 VDSS implemented statewide use of research and evidence based tools to improve child safety and risk assessments. The CPS policy and guidance manual was revised to reflect the changes. Statewide implementation of the Structured Decision Making (SDM) model provides structure and consistency when assessing initial response times, immediate safety and risk factors for future maltreatment of children. VDSS provided two-day training sessions on the policy changes and use of the new tools for over 1500 CPS workers and supervisors, including those workers who perform on-call functions.

Child Fatality Investigations Training

On November 29, 2011 a conference on Child Death Investigations was held in Norfolk, Virginia for approximately 100 participants. It was sponsored by the Hampton Roads Child Fatality Review Team and VDSS. The participants included local agency CPS staff, commonwealth attorneys, public health, and community partners. Participants received information from several perspectives on how to conduct a child fatality investigation. Presenters included a local law enforcement officer, pediatric physician, medical examiner, CPS investigator and a commonwealth attorney. This multi-disciplinary event was the third training session held in the Tidewater region in the past ten years. This type of event helps improve the skill levels of all professionals involved in investigating child fatalities.

Regional Child Fatality Review Teams

In SFY 2010, local departments of social services investigated the highest number of child deaths (78) of which 44 were determined to be founded for abuse/neglect. Additionally, 14 of those cases were previously known to the child welfare system. In response, the State Board of Social Services established a subcommittee of the Board to study this issue. One of the recommendations of the subcommittee and the Board was to develop regional child fatality review teams throughout Virginia. The only established regional team is in the Eastern Region.

The review of child deaths reported to CPS can best be achieved through a multi-agency, multi-disciplinary process that routinely and systematically examines circumstances surrounding reported deaths of children. The purpose of the review is to enable the VDSS, the local departments of social services, and local community agencies to identify important issues related to child protection and to take appropriate action to improve our collective efforts to prevent child fatalities. The review process at all levels emphasizes that CPS is not alone in its responsibility to protect children, and team reports should address issues of interagency collaboration, communication, and decision-making. The investigation and prevention of childhood fatalities are responsibilities shared by all agencies that serve the community. Regional team members may include CPS, medical examiner, law enforcement, commonwealth attorney, child advocates, public health, military family advocacy, forensic pediatric specialists and other persons who play a role in child protection. All regional teams are expected to be operational by the end of March 2012. ***A final child fatality report will be developed incorporating the findings and recommendations from all five regions.***

VII. APPENDIX

Table of Cases

| Preliminary Report on Child Deaths Due to Abuse or Neglect in Virginia During State Fiscal Year 2011 | | | | | | | | | | | | |
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| Appendix A: Table of Founded Investigations with a Child Death | | | | | | | | | | | | |
| Locality | Date of Death | Date of Birth | Age (yrs) | Sex | Race | Abuser (s) | Age | Race | Sex | Abuse Type | Previous History | Summary |
| Grayson | 7/16/10 | 5/28/10 | 0.1 | F | W | Mother Father | 22 29 | W W | F M | Physical Neglect | Yes | An infant died while sleeping with her parents. Both parents tested positive for barbituates and alcohol. The death was ruled as Sudden Unexplained Infant Death (SUID). |
| Newport News | 7/20/10 | 1/29/09 | 1.5 | M | AA | Paramour | 22 | AA | M | Physical Abuse | Yes | Mother 's boyfriend was watching the child. The child was found to have bruises to his stomach, head, face and chest. The boyfriend was charged with the child's death. Drugs and firearms were found in the apartment. |
| Lancaster | 9/15/10 | 3/24/10 | 0.5 | M | W | Father | 18 | W | M | Physical Abuse | Yes | Father was watching the child while mother was at work. The child had multiple bruises on his face, neck and leg; bite marks on his right ear and his left eye was swollen. Later testing showed he had extensive retinal hemorrhages and suffered from Abusive Head Trauma. Father was charged with homicide. |
| Isle Of Wight | 9/18/10 | 5/10/10 | 0.4 | M | W | Mother | 25 | W | F | Physical Abuse | Yes | Mother was drinking alcohol and smoking marijuana. She passed out on the couch with baby on her chest and rolled over and suffocated the baby. Mother was also taking prescribed medication for mental health issues. She admitted she had blacked out and couldn't remember what happened. Mother was charged with neglect. |
| Roanoke | 9/23/10 | 9/1/09 | 1.3 | M | A | Babysitters-unregulated | unk unk | W W | M F | Physical Neglect | No | Two unregulated babysitters swaddled the child and placed him on his back among four pillows because he was irritable and wouldn't sleep. The child was found under one of the pillows. |

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| York | 9/30/10 | 3/15/01 | 9.5 | M | W | Father | 34 | W | M | Physical Neglect | No | A special needs child was at home with his father, who left him unattended in the bathtub and he drowned. |
| Chesapeake | 10/17/10 | 9/5/10 | 0.1 | M | W | Paramour | 31 | W | M | Physical Abuse | No | Child was found to have injuries consistent with Abusive Head Trauma. The abuser admitted to shaking the child and throwing him on a bed. He was charged with the child's death. |
| Tazewell | 10/22/10 | 5/19/10 | 0.5 | M | W | Unknown | Unk | Unk | Unk | Physical Abuse | Yes | Mother went to babysitter's home and found her child unresponsive. Cause of death was Abusive Head Trauma. It could not be determined who had injured the child. The abuser is listed as unknown. |
| Petersburg | 10/24/10 | 2/24/94 | 16.7 | F | W | Child care worker-regulated | 32 | Unk | F | Physical Neglect | No | Teenager hung herself in a psychiatric facility. She was admitted because of suicidal ideation and a failed suicide attempt two days earlier. She had been placed on close observation but residential staff did not follow the recommended guidelines. |
| Norfolk | 11/24/10 | 5/28/10 | 0.5 | F | AA | Father | 19 | AA | M | Physical Abuse | No | While mother was at work and the baby was left in care of the father and two other relatives. Father admitted to shaking the child and throwing her against the wall. Her injuries were consistent with Abusive Head Trauma. |
| Fairfax Co. | 11/30/10 | 6/2/08 | 2.5 | F | A | Grandmother | 50 | A | F | Physical Abuse | No | Grandmother confessed to throwing her grandchild over a 6th floor sky-bridge at a mall. She was criminally charged and has been found guilty. |
| Wythe | 1/16/11 | 1/16/11 | 0.0 | F | W | Mother Grandmother | 20 60 | W W | F F | Medical Neglect | No | A newborn infant was buried by the mother and grandmother near their home. Although they stated she died at birth, the autopsy revealed child had been born alive. |
| Pittsylvania | 1/17/11 | 7/10/10 | 0.6 | M | AA | Mother Father | 21 unk | AA AA | F M | Physical Abuse Medical Neglect | No | During a domestic violence episode, the father fired a gun and the baby, who was in a car seat on the floor, was shot in the head. No one contacted police or medical services for over an hour. The father was charged with 2nd degree murder. |

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| Chesterfield | 1/30/11 | 7/19/10 | 0.6 | F | AA | Mother | 24 | AA | F | Physical Abuse | Yes | Mother confessed to being upset with her child because she was crying. She put the child on the floor and covered her with several pillows and blankets and left her under the pile all night. The child suffocated and died. Mother was charged criminally and pleaded guilty. |
| Roanoke Co. | 1/31/11 | 12/4/09 | 1.2 | M | W | Mother | 33 | W | F | Physical Neglect | No | The child died from ingesting his mother's methadone, which had not been properly stored. |
| Hampton | 2/3/11 | 2/12/10 | 1.0 | F | W | Mother | 23 | W | F | Physical Abuse | No | Mom admitted to shaking baby out of frustration when she was fussy and crying. She was charged with murder and felony child abuse. . |
| Dickenson | 2/7/11 | 6/1/08 | 2.7 | M | W | Paramour Mother | 31 22 | W W | M F | Physical Abuse Physical Neglect Medical Neglect | Yes | The medical examiner's report indicated blunt force trauma to the child's abdomen, approximately 20 bruises in different stages of healing and an old factured rib. No medical treatment had been sought for child prior to his death when he was reportedly very ill. Both mother and her boyfriend tested positive for drugs at the time of the child's death. Both were charged criminally. |
| Smyth | 2/10/11 | 7/13/99 | 11.6 | M | W | Grandmother Grandfather | 56 unk | W W | F M | Physical Neglect | Yes | Grandparents left 11 year old home alone and returned home to find he had been shot with a gun that wasn't secured in the gun safe and the ammunition had been left out. |
| Hampton | 03/05/11 | 11/24/04 | 5.5 | M | multi | Mother | 25 | W | F | Physical Abuse | Yes | Mother gave the child extra doses of his medication that had been prescribed for his behavior problems and he died from poisoning. |
| Prince William | 3/15/11 | 2/7/11 | 0.1 | M | AA | Mother Father Grandmother | 24 30 53 | AA AA multi | F | Physical Neglect | Yes | Mother reported giving the child a bottle and placing him on her chest until he fell asleep. She put him in his bassinet and was found unresponsive. The child was not supposed to be left alone with the mother, per a protective order. |
| Washington | 3/24/11 | 3/23/09 | 2.0 | M | W | Mother Paramour | 36 35 | W W | F M | Medical Neglect Physical Neglect Physical Abuse | Yes | Child died from overdose of Oxycodone, marijuana & other opiates & benzodiapines. Child also had a busted lip and a linear bruise above his ear. Mother and paramour tested positive for drugs. |

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| Newport News | 3/25/11 | 2/25/11 | 0.1 | M | AA | Father | 26 | AA | M | Physical Abuse | Yes | Medical examiner ruled cause of death as abusive head and neck trauma in a setting of unexplained infant deaths. Father had been primary caretaker at the time of death. |
| Lynchburg | 4/3/11 | 11/22/10 | 0.4 | F | AA | Mother | 19 | AA | F | Physical Neglect | No | The mother had not sought medical treatment for the child's chronic medical condition and had not been properly supervising the child. |
| Prince William | 4/20/11 | 7/16/10 | 0.9 | F | W | Babysitter unregulated | 24 | W | F | Physical Abuse | No | An unlicensed babysitter confessed to shaking the baby and hitting her head on the wall resulting in injuries consistent with abusive head trauma. |
| Roanoke Co. | 5/23/11 | 12/29/10 | 0.5 | F | W | Father Mother | 26 22 | W W | M F | Physical Neglect | No | Child was found unresponsive on her stomach. There was a "Boppy pillow" stuffed into the bassinette. The child suffocated as a result of an unsafe sleep environment. |
| Albemarle | 5/26/11 | 5/27/10 | 1.0 | F | AA | Family Friend | 18 | AA | M | Physical Abuse | Yes | Mother's friend confessed to kicking the child with such force that she died from lacerations to her pancreas, intestines, and liver. The child also had 3 broken ribs. The abuser was arrested and charged with 2nd degree murder. |
| Gloucester | unknown | 8/3/07 | 0.7 | M | W | Father | 29 | W | M | Medical Neglect | No | The child's remains were found buried on the family property. The father did not get the child medical attention after discovering him not breathing. The mother and father buried the body in the backyard. Both were charged with felony neglect and murder. |
| Danville | 6/25/11 | 9/30/09 | 1.7 | M | AA | Mother | 36 | AA | F | Physical Neglect | Yes | The child was found in a car unresponsive with her sibling and grandmother. The temperature outside was 93 with heat index of 104. The sibling and grandmother survived. Mother was charged and found guilty of neglect. |
| King William | 6/30/11 | 1/14/11 | 0.5 | F | W | Mother | 21 | W | F | Physical Abuse Medical Neglect | No | Medical Examiner concluded the child's death was caused by blunt force trauma. The child's injuries were consistent with Abusive Head Trauma. Mother was charged criminally. |
| Prince William | 6/17/11 | 7/16/08 | 2.9 | M | W | Mother | 40 | W | F | Physical Neglect | No | Child died after being left in a car all day by his mother, who forgot to drop him off at daycare. The child died as result of hyperthermia due to exposure to extreme heat inside vehicle. Mother was charged criminally. |