

Virginia Department of Social Services  
Regional Child Fatality Review Team

Final Report for Child Deaths for Fiscal  
Year 2010-2011

June, 2013

---

## *Executive Summary*

This is a report on child death investigations conducted by local departments of social services (LDSS) and subsequently reviewed by regional Child Fatality Review Teams for SFY 2011. The Virginia Department of Social Services (VDSS) has worked collaboratively with the Virginia Department of Health, Office of the Chief Medical Examiner in establishing four new regional teams. The Eastern Regional Child Fatality Review Team has existed for a number of years. The Central, Northern, Piedmont and Southwestern, teams have been operational since March 2012 and were charged with reviewing the child deaths investigated by Child Protective Services (CPS) in SFY 2011. VDSS has reviewed their findings, identified trends, and made recommendations for the prevention of future child deaths.

Highlights of this report include:

- Regional teams reviewed 81 child deaths.
- Most children were infant or toddler males. And while White and African American children died in nearly equal numbers, African American children were at higher risk than White children.
- The majority of children died in their own homes under the care of their parents.
- Fifty-nine percent of child death investigations are unfounded.
- Inadequate supervision was the most prevalent type of neglect.
- Teams reviewed a number of child death cases related to unsafe sleep. These cases were undetermined in terms of cause or manner of death.
- Abusive Head Trauma was the most prevalent type of abuse.
- Most abusers were young parents.
- Thirty-six percent of founded cases had prior contact with the child welfare system. In most cases, that prior contact involved family assessments or prior services. Two cases involved a prior founded complaint and two involved prior removals. Of the cases reviewed, none were open at the time of the fatality.
- Of the 81 deaths, 69% were determined by the teams to be preventable.
- Regional teams identified a wide range of risk factors in their reviewed cases. The top five of these were: unsafe sleep environments; unstable or inadequate housing; substance abusing caregivers; domestic violence; and unrelated caregivers in the lives of children. Findings and recommendations address these risk factors.
- Regional teams and the Virginia Department of Social Services will address these recommendations in the coming year.

- Regional teams have been encouraged to address child death cases with CPS/DSS prior contact with more depth and breadth as they develop capacity and trust among team members.

# Contents

<i>Executive Summary</i> .....	2
I. Introduction .....	6
II. Demographic Profiles - Decedent Children.....	6
Table 1: Age of decedent children investigated by DSS region .....	6
Table 2: Race of decedent children investigated by DSS region.....	7
Table 3: Race of all children by DSS region .....	7
Table 4: Gender of decedent children investigated by DSS region .....	7
III. Characteristics of Injury and Death Event.....	8
Table 5: Premise of fatal injury by DSS region .....	8
Table 6: Disposition of CPS fatality investigations by DSS region.....	8
Table 7: Disposition of all investigations by DSS region .....	9
Table 8: Types of neglect investigated by DSS region and disposition .....	9
Table 9: Types of abuse investigated by DSS region and disposition .....	10
Table 10: Manner of death by DSS region and disposition.....	11
IV. Demographic Profile - Caretakers.....	11
Table 11: Number of caretakers investigated by DSS region.....	11
Table 12: Age of caretakers investigated by DSS region.....	12
Table 13: Race of caretakers investigated by DSS region .....	12
Table 14: Race of all adults by DSS region .....	13
Table 15: Gender of caretakers investigated by DSS region.....	13
Table 16: Relationship between caretaker and child in founded investigations by DSS region.....	14
V. Contact with Child Welfare System .....	15
Table 17: Prior contact with child welfare system in founded investigations by DSS region.....	15
VII. Conclusions .....	17
Table 18: Team determination of preventability by DSS region.....	17
VIII. Risk Factors .....	17
Health.....	17
Social .....	18
Economic.....	18
Behavioral .....	18
Environmental.....	18

Systematic (agency policies and procedures).....	18
Product safety .....	19
IX. Findings- by Region .....	19
Central.....	19
Piedmont.....	19
Western.....	20
Eastern .....	20
Northern .....	21
X. Recommendations- Strategies for Prevention.....	21
A. Strengthening Individual Knowledge and Skills.....	21
B. Promoting Community Education .....	21
C. Training Providers .....	22
D. Fostering Coalitions and Networks.....	22
E. Changing Organizational Practices.....	23
F. Mobilizing Neighborhoods and Communities.....	24
G. Influencing Policy and Legislation .....	24
XI. Regional Plans for Action .....	24
Piedmont Region.....	24
Central Region.....	25
Eastern Region .....	25
Northern Region .....	25
Western Region.....	25
XII. VDSS Initiatives .....	25
XIII. Summary and Conclusions.....	26

## I. Introduction

In December of 2011, Virginia adopted a statewide practice of conducting child death reviews at the regional level. Child fatality review is a process that strives to understand the specific circumstances surrounding child deaths in order to prevent harm to other children. In collaboration with the Virginia Department of Health, Office of the Chief Medical Examiner (OCME) and Virginia Department of Social Services (VDSS), each of the five regions within the VDSS system now has an operating Child Fatality Review Team (CFRT).

Each team was asked to review the child fatalities that were investigated by local departments of social services in their region from July 1, 2010 through June 30, 2011. A total of 81 cases were reviewed. Each team was asked to collect data on each case to be reported to the National Center for the Review and Prevention of Child Death. In addition, each team was asked to identify risk factors, make findings regarding trends or patterns, and to develop three to five action recommendations. Most of the teams developed more than five recommendations. This report includes demographic information about decedent children and their caretakers, recommendations by region, and actions to be taken by each team in the coming year. This report also outlines key projects and activities to be undertaken by VDSS.

## II. Demographic Profiles - Decedent Children

This section shows demographic information for the children whose deaths were investigated by Child Protective Services (CPS) in SFY 2011. The following tables show the age, race and gender of all children identified in the child fatality investigations that were reviewed by the regional CFRT.

**Table 1: Age of decedent children investigated by DSS region**

	Central	Northern	Eastern	Piedmont	Western	Total
<b>&lt;1</b>	8	7	28	8	7	<b>58</b>
<b>1-4</b>	0	2	6	7	2	<b>17</b>
<b>5-9</b>	0	0	3	0	0	<b>3</b>
<b>10-14</b>	0	0	1	0	1	<b>2</b>
<b>15-17</b>	1	0	0	0	0	<b>1</b>
<b>Total</b>	<b>9</b>	<b>9</b>	<b>38</b>	<b>15</b>	<b>10</b>	<b>81</b>

Source: Regional Child Fatality Review Teams, May 2012.

Statewide, seventy-five (92.6%) of the 81 children identified and investigated as possible abuse or neglect were less than 4 years of age. There is a minor variation in regions regarding the age of decedent children.

**Table 2: Race of decedent children investigated by DSS region**

	Central	Northern	Eastern	Piedmont	Western	Total
<b>White</b>	2	2	16	4	10	<b>34</b>
<b>Black</b>	7	4	20	8	0	<b>39</b>
<b>Asian/ Pacific Islander</b>	0	2	0	1	0	<b>3</b>
<b>Native American/ Alaskan Native</b>	0	0	0	0	0	<b>0</b>
<b>Multiracial</b>	0	1	2	2	0	<b>5</b>
<b>Total</b>	<b>9</b>	<b>9</b>	<b>38</b>	<b>15</b>	<b>10</b>	<b>81</b>

Source: Regional Child Fatality Review Teams, May 2012.

The race of the children whose deaths were investigated shows a disparity in most regions with an over-representation of African American children. All decedent children investigated in the Western region were white.

**Table 3: Race of all children by DSS region**

	Central	Northern	Eastern	Piedmont	Western	Total
<b>White</b>	183,233 (54%)	560,236 (72%)	238,775 (56%)	180,193 (75%)	106,433 (94%)	1,268,870 (68%)
<b>Black</b>	103,555 (34%)	118,235 (15%)	164,457 (39%)	52,688 (22%)	4,981 (4%)	443,916 (24%)
<b>Other*</b>	13,617 (5%)	99,315 (13%)	20,173 (5%)	6,120 (3%)	1,535 (1%)	140,760 (7%)
<b>Total children 0-17</b>	300,405	777,786	423,405	239,001	112,949	1,853,546

\* Other includes Asian/ Pacific Islander and Native American/ Alaskan Native. Source: Virginia Department of Health, Division of Health Statistics.

Table 3 represents the race of all children and percentage of all children by DSS region. The overwhelming majority, 94%, of children in the Western region are white. This would factor into why all of the fatalities in Western involved white children.

**Table 4: Gender of decedent children investigated by DSS region**

	Central	Northern	Eastern	Piedmont	Western	Total
<b>Male</b>	6	3	30	7	7	<b>53</b>
<b>Female</b>	3	6	8	8	3	<b>28</b>
<b>Total</b>	<b>9</b>	<b>9</b>	<b>38</b>	<b>15</b>	<b>10</b>	<b>81</b>

Source: Regional Child Fatality Review Teams, May 2012.



LDSS in the Eastern region conducted significant number of child fatality investigations, roughly 49% of all child deaths investigated statewide, yet had the lowest founded percentage rate, 26%. Western region had a significant percentage of investigations that were founded compared to the rest of the state. There are many reasons why dispositions of all investigations, not just fatalities, are different throughout the state. Traditionally, the Eastern region has accepted more reported child fatalities for investigation. The majority of the unfounded cases in the Eastern region involved unsafe sleep practices or environments.

**Table 7: Disposition of all investigations by DSS region**

	Central	Northern	Eastern	Piedmont	Western	Total
<b>Founded</b>	39.5%	32.5%	37.6%	38.7%	53.6%	<b>38.2%</b>
<b>Unfounded</b>	57.2%	63.5%	59.5%	59.0%	44.9%	<b>58.8%</b>

Source: Virginia Child Welfare Outcome Reports, version 3.88.

Table 7 provides information about all investigations, including fatalities, conducted by CPS and the percentages of founded versus unfounded by region. Of interest is that the percentage of all investigations founded in the Eastern region is typically around 38% yet for fatalities the founded percentage drops to 26%. In the Western region, the opposite appears to be true; the typical percentage of founded investigations is about 54% yet in fatalities the percentage increases to 70%. This difference likely reflects variations among regions in the acceptance or reporting of all child deaths.

The next two tables reveal the types of allegations of abuse or neglect that were investigated. Some investigations included multiple allegations as children may have been neglected or abused in more than one way.

**Table 8: Types of neglect<sup>2</sup> investigated by DSS region and disposition**

	Central		Northern		Eastern		Piedmont		Western		Total	
	F*	U*	F	U	F	U	F	U	F	U	F	U
<b>Inadequate Supervision</b>	1	0	0	0	1	4	5	1	4	3	11	8
<b>Inadequate Shelter</b>	0	0	0	0	0	0	0	0	0	1	0	1
<b>Medical Neglect</b>	0	0	1	1	1	0	1	1	3	0	6	2
<b>Unspecified</b>	1	0	2	0	1	20	1	0	0	0	5	20
<b>Total</b>	<b>2</b>	<b>0</b>	<b>3</b>	<b>1</b>	<b>3</b>	<b>24</b>	<b>7</b>	<b>2</b>	<b>7</b>	<b>4</b>	<b>22</b>	<b>31</b>

\* F stands for Founded disposition and U stands for Unfounded disposition.

Source: Regional Child Fatality Review Teams, May 2012.

<sup>2</sup> Physical neglect occurs when there is the failure to provide food, clothing, shelter, or supervision for a child to the extent that the child's health or safety is endangered. This also includes abandonment and situations where the parent or caretaker's own incapacitating behavior or absence prevents or severely limits the performance of child caring tasks.

The most prevalent type of neglect in both founded and unfounded investigations was lack of supervision. This is a broad term and includes when the child has been left in the care of an inadequate caretaker or in a situation requiring judgment or actions greater than the child's level of maturity, physical condition, and/or mental abilities would reasonably dictate.

Eastern region has a particularly high number of unspecified neglect allegations. This number reflects the large number of child deaths reported that involved Sudden Infant Death Syndrome (SIDS), Sudden Unexplained Infant Deaths (SUID) and unsafe sleep environments or practices. Due to limited information available at intake when these types of deaths are reported, CPS is unable to select an exact type of neglect.

The most prevalent type of child maltreatment is neglect. In SFY 2011, 56% of all reports, including fatalities, involved some type of neglect.

**Table 9: Types of abuse<sup>3</sup> investigated by DSS region and disposition**

	Central		Northern		Eastern		Piedmont		Western		Total	
	F	U	F	U	F	U	F	U	F	U	F	U
<b>Asphyxiation</b>	0	0	0	0	1	1	0	2	0	1	1	4
<b>Bone Fracture</b>	0	0	0	0	0	0	2	1	0	0	2	1
<b>Bruises</b>	0	0	0	0	0	0	1	0	2	0	3	0
<b>Gunshot</b>	0	0	0	0	0	0	1	0	1	0	2	0
<b>Poisoning</b>	0	0	0	0	2	0	0	0	1	0	3	0
<b>Abusive Head Trauma (AHT)</b>	0	0	0	0	5	0	0	0	1	0	6	0
<b>Internal Injuries</b>	0	0	0	0	2	0	1	0	1	0	4	0
<b>Head Injury</b>	1	0	0	0	0	1	0	0	2	0	3	1
<b>Unspecified</b>	0	0	0	0	0	0	0	1	0	0	0	1
<b>Other</b>	0	0	1	3	0	0	0	0	0	3	1	6
<b>Total</b>	<b>1</b>	<b>0</b>	<b>1</b>	<b>3</b>	<b>10</b>	<b>2</b>	<b>5</b>	<b>4</b>	<b>8</b>	<b>4</b>	<b>25</b>	<b>13</b>

Source: Regional Child Fatality Review Teams, May 2012.

An allegation of physical abuse would require physical evidence to prove that abuse had occurred. This evidence is typically more obvious than in cases where neglect is suspected.

Of particular note, five of the six children identified with Abusive Head Trauma were in the Eastern region. All abusive head trauma child death investigations resulted in a founded disposition.

<sup>3</sup> Physical abuse occurs when a caretaker creates or inflicts, threatens to create or inflict, or allows to be created or inflicted upon a child a physical injury by other than accidental means or creates a substantial risk of death, disfigurement, or impairment of bodily functions.

**Table 10: Manner of death by DSS region and disposition**

	Central		Northern		Eastern		Piedmont		Western		Total	
	F	U	F	U	F	U	F	U	F	U	F	U
<b>Accident</b>	0	0	0	2	1	6	2	2	1	0	4	10
<b>Homicide</b>	1	0	3	0	7	0	2	0	4	0	17	0
<b>Suicide</b>	1	0	0	0	0	0	0	0	0	0	1	0
<b>Natural</b>	0	2	0	2	0	15	2	3	0	0	2	20
<b>Undetermined</b>	0	5	0	2	2	7	3	1	2	3	7	13
<b>Total</b>	2	7	3	6	10	28	9	6	7	3	31	50

Source: Regional Child Fatality Review Teams, May 2012.

The manner of death is determined by the medical examiner. This is not a finding of CPS. Table 10 shows that each of the identified homicides resulted in a founded disposition by CPS. It also reflects the majority of unfounded investigations involved natural or undetermined deaths. In 40% of the accidental deaths, there was evidence to support a finding of abuse or neglect by CPS. Accidental deaths that were determined to be founded were typically the result of an act of omission on the part of the caretaker.

#### IV. Demographic Profile - Caretakers

This section outlines demographic information for caretakers who were alleged to have abused or neglected children who died and who were investigated by CPS in SFY 2011. The following tables show the age, race, gender and relationship to victim of all involved caretakers reviewed by a regional CFRT. Overall demographic information of the caretakers mirrors those of the children who died.

**Table 11: Number of caretakers<sup>4</sup> investigated by DSS region**

	Central	Northern	Eastern	Piedmont	Western	Total
Caretakers	11	11	42	26	18	108
Rate per 100,000	1.07	.45	2.96	2.82	3.72	1.72
Total Population over age 18	1,027,033	2,395,088	1,416,990	921,044	482,903	6,243,058

Sources: Regional Child Fatality Review Teams, May 2012; Virginia Department of Health, Division of Health Statistics.

The data shows the highest rate of alleged abusers in the Western region.

<sup>4</sup> The number of caretakers does not match the number of child deaths investigated because there may have been more than one caretaker involved.

**Table 12: Age of caretakers investigated by DSS region**

	Central	Northern	Eastern	Piedmont	Western	Total
<b>11-19</b>	5	0	7	2	1	<b>15</b>
<b>20-29</b>	3	0	21	13	10	<b>47</b>
<b>30-39</b>	1	6	9	5	3	<b>24</b>
<b>40-49</b>	0	2	1	5	0	<b>8</b>
<b>50-59</b>	0	1	0	0	2	<b>3</b>
<b>60-69</b>	0	0	0	0	1	<b>1</b>
<b>70 or older</b>	0	0	0	0	0	<b>0</b>
<b>Unknown</b>	2	2	4	1	1	<b>10</b>
<b>Total</b>	<b>11</b>	<b>11</b>	<b>42</b>	<b>26</b>	<b>18</b>	<b>108</b>

Source: Regional Child Fatality Review Teams, May 2012.

The youngest involved caretakers were in the Central, Eastern and Piedmont regions. Western region had the oldest involved caretaker. The vast majority of all caretakers were between the ages of 20 and 29. Piedmont region had the most (5) caretakers between the ages of 40 and 49.

**Table 13: Race of caretakers investigated by DSS region**

	Central	Northern	Eastern	Piedmont	Western	Total
<b>White</b>	3 6.1%	2 4.0%	13 26.5%	13 26.5%	18 36.7%	<b>49</b> <b>99.7%</b>
<b>Black</b>	6 14.3%	6 14.3%	17 40.5%	13 31.0%	0 0%	<b>42</b> <b>100.1%</b>
<b>Other*</b>	0 0%	2 66.7%	1 33.3%	0 0%	0 0%	<b>3</b> <b>100%</b>
<b>Unknown</b>	2	1	11	0	0	<b>14</b>
<b>Total</b>	<b>11</b>	<b>11</b>	<b>42</b>	<b>26</b>	<b>18</b>	<b>108</b>

\* Other includes Asian/ Pacific Islander and Native American/ Alaskan Native

Source: Regional Child Fatality Review Teams, May 2012.

Table 13 shows the highest percentage of African American caretakers were in the Eastern region, which coincides with the region having the highest percentage of African Americans. As with the children, the Western region had no African American caretakers and is reflective of the overall population in that region. Northern region had the highest percentage of caretakers from other races, which includes Asian/Pacific Islander and Native American/ Alaskan Native.

**Table 14: Race of all adults by DSS region**

	Central	Northern	Eastern	Piedmont	Western	Total
<b>White</b>	682,448 14.8%	1,821,657 39.5%	895,966 19.5%	747,077 16.3%	457,820 9.9%	4,604,968 100%
<b>Black</b>	394,563 30.1%	287,440 21.9%	456,931 34.9%	154,561 11.8%	16,907 1.3%	1,310,402 100%
<b>Other</b>	40,022 9.6%	285,991 68.5%	64,093 15.3%	19,406 4.6%	8,176 2.0%	417,688 100%
<b>Total all adults &gt;18</b>	1,117,033	2,395,088	1,416,990	921,044	482,903	6,333,058

\* Other includes Asian/ Pacific Islander and Native American/ Alaskan Native.

Source: Virginia Department of Health, Division of Health Statistics.

Table 14 shows the regional differences of the adult population based on race. The highest percentage of whites is in the Northern region. The highest percentage of African Americans is in the Eastern region. The Northern region also has the highest percentage of non-white/African American adults.

**Table 15: Gender of caretakers investigated by DSS region**

	Central		Northern		Eastern		Piedmont		Western		Total	
	F	U	F	U	F	U	F	U	F	U	F	U
<b>Male</b>	1	2	2	0	7	12	4	7	5	2	19	21
<b>Female</b>	1	5	3	6	3	16	7	8	7	3	21	38
<b>Unknown*</b>	2	0	0	0	0	4	0	0	1	0	3	4
<b>Total</b>	4	7	5	6	10	32	11	15	13	5	43	65

\* Unknown indicates the abuser's identity is also unknown.

Source: Regional Child Fatality Review Teams, May 2012.

Most caretakers in both founded and unfounded investigations were female. This was found to be true in regions with the exception of the Northern region, which had more males than females in the founded investigations.

**Table 16: Relationship between caretaker and child in founded investigations by DSS region**

	Central	Northern	Eastern	Piedmont	Western	Total	
	F	F	F	F	F	F	U
<b>Mother</b>	1	2	5	5	6	19	28
<b>Father</b>	0	2	4	2	0	8	17
<b>Step-parent</b>	0	0	0	0	0	0	1
<b>Grandparent</b>	0	1	0	0	3	4	1
<b>Uncle</b>	0	0	0	1	0	1	0
<b>Paramour</b>	1	0	1	0	3	5	1
<b>Babysitter- non- regulated</b>	0	0	0	2	0	2	1
<b>Day Care Provider- regulated</b>	0	0	0	0	0	0	2
<b>Other</b>	2*	0	0	1**	0	3	0
<b>Unknown</b>	0	0	0	0	1	1	4
<b>Total</b>	<b>4</b>	<b>5</b>	<b>10</b>	<b>11</b>	<b>13</b>	<b>50</b>	<b>58</b>

Source: Regional Child Fatality Review Teams, May 2012.

\* Acute Mental Health Facility Staff

\*\* Legal guardian

The vast majority of involved caretakers were parents with minor variation by region. Central region was the only region with involved caretakers in a founded investigation in a regulated Out of Family setting. Western and Central region had no investigations involving non-regulated babysitters or regulated day care centers.

## V. Contact<sup>5</sup> with Child Welfare System

**Table 17: Prior contact with child welfare system in founded investigations by DSS region**

	Central	Northern	Eastern	Piedmont	Western	Total
Prior family assessment	2	0	1	1	3	7
Prior founded investigation	0	0	0	0	2	2
Prior unfounded investigation	1	0	1	0	0	2
Prior service case	2	0	0	1	2	5
Service case open at time of fatality	0	0	0	0	0	0
Prior removals	1	0	0	0	1	2
<b>Total Cases</b>	<b>3</b> <b>(25%)</b>	<b>0</b> <b>(0%)</b>	<b>2</b> <b>(17%)</b>	<b>2</b> <b>(17%)</b>	<b>5</b> <b>(41%)</b>	<b>12</b> <b>(100%)</b>

Source: Regional Child Fatality Review Teams, May 2012.

Table 17 reflects only those fatalities that were determined to be founded and does not include the unfounded child fatality investigations. Thirty-three of the 81 investigations reviewed resulted in a founded disposition. Twelve (36.3%) of those 33 cases had prior contact with the child welfare system. Table 17 represents cases with a history and does not indicate if there was more than one of any of the types of prior contact.

The Western region had the most cases with prior child welfare contact, 41% of all cases with history and 71% of the seven founded cases. This is almost double the percentage for all founded investigations. All three of Central region's founded investigations that were reviewed had prior history.

All regions, except Northern, reviewed at least one case where there was a prior family assessment conducted. Seven (58%) of the 12 cases with prior history had a family assessment and four (33.3%) had an investigation completed. A higher percentage of family assessments than investigations would be

---

<sup>5</sup> 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 CPS or foster care case.

expected considering the number of family assessments and investigations that are completed by CPS for all types of abuse and neglect in non-fatality cases. In SFY 2011, 65.4% of all valid CPS reports were responded to with a family assessment<sup>6</sup>.

Of the cases reviewed, there were no cases that were open at the time of the fatality.

Five (15%) of the 33 founded cases had prior service cases. A prior service case can include a case that was opened, services were recommended but the family did not participate in services.

Prior contact with the child welfare system does appear to be a significant risk factor for child fatalities. The Structured Decision Making (SDM) risk assessment tool that was mandated for use statewide, effective July 2011, includes assessing factors concerning history of contact with the child welfare system. Information is gathered throughout the CPS response to determine if anyone in the family had been involved in a previous family assessment or investigation relating to neglect. There is a greater weight factored into the total risk score relative to prior neglect. The risk score is also increased for prior founded physical abuse reports. Additionally, the risk assessment tool uses information regarding history of any prior services offered to the family and their failure to benefit from those services. This tool is intended to help identify those families who have high risk factors and target services to those families determined to be at high or very high risk of child maltreatment. The use of the SDM tool was not effective statewide until July 2011 and therefore, the families during this review period would not have been assessed using this research based tool.

CPS policy was revised in February 2013 as a result of a concern regarding track decision and the number of family assessments conducted with a family within a 12 month period. This number was reduced from three to two, after which an investigation is required. While both approaches, family assessment and investigation, are intended to engage the family to prevent future child maltreatment, the investigative approach is used when there are serious concerns about child safety.

In 2013 the CPS policy/ guidance manual was revised to provide additional information and direction on making track decisions and responding to family assessments. Statewide training on these revisions was conducted in the spring of 2013.

---

<sup>6</sup> Virginia Child Welfare Outcome Reports, version 3.88.

## VII. Conclusions

**Table 18: Team determination of preventability by DSS region**

	Central	Northern	Eastern	Piedmont	Western	Total
No, probably not	2	3	10	2	3	20
Yes, Probably	7	6	27	9	7	56
Team could not determine	0	0	1	4	0	5
<b>Total</b>	<b>9</b>	<b>9</b>	<b>38</b>	<b>15</b>	<b>10</b>	<b>81</b>

Source: Regional Child Fatality Review Teams, May 2012.

The regional teams asked could the death be prevented at each fatality review. A child's death is typically defined as preventable if the community or an individual could reasonably have done something that would have changed the circumstances that led to the death. The teams determined that 69% of the deaths were preventable.

## VIII. Risk Factors

Identifying risk factors involved in a child's death during the review process supports recommendations that the teams believe could reduce those same risk factors for other children, thereby preventing future deaths. These risk factors provide the basis for the findings of the teams. These findings are then used to generate recommendations for improved investigations, service delivery, and changes in systems, local ordinances, state legislation, or community or statewide prevention initiatives.

The following risk factors were identified by at least one team:

### Health

- **Unsafe sleep environments- (all 5 teams identified)**
- **Substance Exposed Infants- (2 teams identified)**
- **Infants less than one year of age - (2 teams identified)**
- **African American Males- (2 teams identified)**
- Little or no prenatal care
- Prematurity
- No flu vaccination
- Failure to follow up with recommended medical care
- Exposure to first and second hand smoke
- Prior Emergency Room visits

- Crying, fussy babies

## Social

- **Unrelated caregivers- (3 teams identified)**
- **Prior involvement of Child Welfare Services (2 teams identified)**
- **Young parents-(2 teams identified)**
- **Single mothers- (2 teams identified)**
- Rigid religiosity
- Gun culture
- Language barriers
- Suicide ideation
- Lack of support systems

## Economic

- **Poverty- (2 teams identified)**
- **Inadequate housing- (2 teams identified)**
- **Lack of stable housing- (2 teams identified)**

## Behavioral

- **Substance abusing caregivers- (4 teams identified)**
- **Domestic Violence-(4 teams identified)**
- **Serious mental illness-(2 teams identified)**
- **Prior criminal history- (2 teams identified)**
- Lack of supervision
- Caretaker history of childhood maltreatment

## Environmental

- Children left unsupervised in cars

## Systematic (agency policies and procedures)

- **Untimely or failure to report by healthcare providers or law enforcement-(2 teams identified)**
- **Inter-jurisdictional / inter-state coordination of response and services, particularly with neighboring states- (2 teams identified)**
- Overtaxed service system due to overwhelming caseloads

- Poor supervision in child care settings
- Lack of coordination between Domestic Violence (DV) and CPS
- Inadequate supervision of staff

### Product safety

- Misuse of consumer products for babies
- Administering over the counter medication to children under age two

## IX. Findings- by Region

### Central

1. Home visiting programs are administered inconsistently. The availability of funding for home visiting programs and eligibility are uneven and unpredictable, particularly in rural areas.
2. There is a lack of resources to support and assist new parents in caring for their children, particularly first time parents.
3. There is a need for intensive education about how to soothe a crying baby and safe sleep environments.
4. Local departments of social services do not have the authority to compel services to high risk families without a court order.
5. There is a lack of coordination and collaboration between agencies responsible for responding to incidents of child abuse or neglect.
6. Caretakers are using or misusing prescribed or over-the-counter drugs and sleeping with their children without recognizing the degree of impairment that is caused by these substances.

### Piedmont

1. Parents and caretakers are uninformed about safe sleep environments.
2. Despite a strong mandated reporter law in Virginia, Child Protective Services does not always receive calls for suspicions of child abuse and neglect.
3. Hospitals, departments of social services and substance abuse service providers in many communities do not have an effective system in place for implementing the new law regarding substance exposed infants. Mothers and their Infants are often discharged from the hospital prior to receiving results of toxicology or other studies which confirm in utero exposure to substances resulting in inadequate follow up.
4. There is a lack of sharing information and CPS history of families between Virginia and bordering states.

## Western

1. Hospitals do not keep admission blood after a child dies. This practice undermines a complete and thorough death investigation because it destroys potential evidence about toxicology at the time a child is first brought to a medical facility for treatment.
2. Local agencies and organizations responsible for investigating child injury and death do not always coordinate and collaborate on the investigations.
3. Parents and caretakers need education on safe sleep and on managing crying infants, which pose high risks for infant safety. New parents are overwhelmed with information and safety messages, mostly in the form of brochures, which do not distinguish these two key risks to infants.
4. While substance abuse is a profound problem in the western part of Virginia, services for substance abuse and mental illness that address problems of addiction are woefully inadequate.
5. Practice around Virginia is not consistent with regard to the availability and payment for full body scans of infants and children whose injuries are being investigated as suspicious for abuse or neglect. This team reviewed cases where prior abuse and neglect were only discovered at autopsy.
6. Current law requires CPS investigations to be completed within 45 days. This requirement does not permit a complete and thorough investigation in child death cases, where forensic and toxicological studies are not available within that timeframe.
7. The team's review revealed the children who died lived in families with multiple risk factors. CPS workers need ongoing support and training to work with these families.

## Eastern

1. Many child deaths are preventable.
2. Thirteen of the twenty-eight unfounded reports were associated with unsafe sleeping environments such as : soft bedding, being laid to sleep on their stomach, co-sleeping with an adult, and/or sleeping in an adult bed, couch, car seat or other surface not intended for infant sleeping.
3. In a few localities, law enforcement does not always contact CPS immediately or conduct joint investigations with CPS.
4. Parents and caregivers lack information about preventing child abuse and neglect. There is a need for more education regarding child abuse and neglect prevention across state programs such as Women Infant and Children (WIC), Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF) and Virginia Initiative for Employment not Welfare (VIEW).
5. There is a lack of communication between local departments of social services and other community agencies involved with the same family.
6. Caregivers and the general public lack information about safe sleep environments.

## Northern

1. There is a lack of information regarding safe sleep environments among child welfare workers, particularly new workers.
2. Immigrant families lack knowledge about the use of medical care systems.

## X. Recommendations- Strategies for Prevention

There are numerous frameworks which can help determine the best strategy for prevention. The *Spectrum of Prevention* describes seven levels at which prevention activities can take place. The recommendations and prevention strategies from the five regional teams have been sorted and presented here using the *Spectrum of Prevention*. Some recommendations could fit into more than one category. \* The Spectrum of Prevention model was created by Larry Cohen, M.S.W. and is based on the work of Dr. Marshall Swift.

### A. Strengthening Individual Knowledge and Skills

- The Central team discussed the critical need to extend messages about breastfeeding and safe sleep beyond parents to two other populations- grandparents and others who may influence parents' decisions and middle/ high school students (the parents of the future). This population would benefit from learning about these topics as part of life skills and before they decide to have a child. The prenatal period may be an optimal time for such public education messages, since parents are eager, in a learning mode, and not yet exhausted or overwhelmed with the care of an infant.
- The Piedmont team recognizes that new parents are exhausted and somewhat immune to information and safety messages. Given the significant loss of life, it is urgent to deliver messages about safe sleep using social media outlets used by young parents. Members of the Piedmont Child Fatality Review Team and the Virginia Chapter of the American Academy of Pediatrics will plan and implement a public education campaign to inform “parents-to-be” about the Text4Baby Campaign. Text4baby is a free mobile information system that sends expectant and new parents information about caring for themselves during their pregnancy and their infants in the first year of live. Many messages are devoted to safe sleep. The website is: [www.Text4baby.org](http://www.Text4baby.org). Team members will reach out to health care and service providers in their communities about this free educational program.

### B. Promoting Community Education

- Members of the Central team will work with healthcare providers in their communities to make materials regarding safe sleep practices and how to soothe crying infants, such as those used by the March of Dimes, available in patient waiting rooms, and in middle and high schools resource programs.

- Members of the Eastern Team recommend working with and/or encouraging other groups in the community to do media and public awareness campaigns around safe sleep practices.
- Team members in Piedmont discussed the need for regular training of mandated reporters in their communities.
- Northern team members will work with public health to educate child welfare staff about safe sleep environments.

### C. Training Providers

- The Western team recommends that health care providers (including obstetricians, gynecologists, pediatricians, labor and delivery nurses) be urged to purchase and offer video education on safe sleep and "purple crying" for parents of newborns. Hospitals should obtain training videos and require new parents to watch these prior to discharge of the infant.
- The Western team agreed to assist and advise the Western Regional CPS consultant in designing and providing training for CPS workers and other key stakeholders on the management of high risk cases. Topics to be included are: DV, substance use and abuse, unsafe sleep environments, and working with mental health and substance abuse providers.
- The Central team recommends VDSS develop training materials for Virginia's Juvenile Court judges that uses research on child abuse risk factors and outcomes to delineate clear thresholds or levels of child risk, and associate those risk factors and outcomes with best practice guidelines for court orders and decisions. Additionally, the team recommends VDSS collaborate with the Office of the Executive Secretary of the Supreme Court of Virginia to train Virginia judges on these best practice guidelines.
- The Eastern team recommends that parent educators do more to target and educate fathers on child development and care.
- Members of the Piedmont Child Fatality Review Team will develop a strategy for and provide training to professional colleagues who are mandated reporters in their communities.

### D. Fostering Coalitions and Networks

- The Western team recommends VDSS collaborate with Department of Criminal Justice Services, Children's Justice Act Program, in the development of local protocols for the joint investigation of child deaths and injury. The purpose of these protocols is to strengthen investigations and improve a community's coordinated response to child abuse and neglect by sharing information and resources.
- Team members from the Western region will identify key prevention partners in their communities and educate them on the importance of safe sleep.
- The Central team recognizes that new parents need support and assistance when caring for their children. It is important to have a live voice and a person who can talk to parents about their concerns and needs when they reach out for help. Prevent Child Abuse Virginia (PCAV) does provide this service along with additional resources but only part time. Funding cuts have left the program operating 8am to 9pm Monday through Saturday. The Central team recommends VDSS partner with PCAV and provide funding to assure around the clock access to the 1-800-CHILDREN hotline and continuous advertisement of its availability. Local DSS and health departments should refer parents and caregivers to the hotline.

- The Central team recommends local DSS collaborate with the Children's Justice Act Program and the Children's Advocacy Centers of Virginia to convene and build multi-disciplinary teams to coordinate investigations of child fatalities.
- The Central team recommends the Virginia Chapter of the American Academy of Pediatrics work with the Medical Society of Virginia to urge that continuing medical education (CME) modules on the risks of over-prescribing medications be developed and made available to health care providers in all sub-specialties.
- The Central team recognizes home visiting programs provide essential guidance and assistance to at-risk families. These consultations reflect an established set of best practices for reducing the incidence of abuse and neglect. These programs are not institutionalized as part of child safety and protection systems in Virginia. Eligibility is often limited to first time parents.
- The Central team supports Secretary Hazel's Healthcare Innovation for Early Childhood to embed home visitation programs in health care provider practices, which will create universal eligibility for all at-risk children and families in Virginia.
- The Northern team recommends Virginia Department of Social Services partner with the Virginia Department of Health's Office of the Chief Medical Examiner and send a letter to health care provider professional associations in Virginia. These letters should (1) educate leadership in those organizations about the risk factors found in unsafe sleep environments that result in infant deaths in Virginia; (2) provide links to resources on safe sleep environments for infants; and (3) urge their cooperation in educating their members and patients about these risks and resources.

## E. Changing Organizational Practices

- The Piedmont team recommends that the Virginia Hospital and Healthcare Association, VDSS, and the Virginia Department of Behavioral Health and Developmental Services collaborate to develop, and provide training on a protocol that assures that § 63.1-1509 (reports involving substance exposed infants) is properly implemented in the Commonwealth, so that mothers and children receive the necessary follow-up services to their health and safety.
- The Western team recommends CPS, law enforcement and Commonwealth's Attorneys be trained on the need to request retention of admission blood as part of strong child injury investigation practices.
- The Western team recommends VDSS investigate and resolve barriers to full body scans when requested by CPS or law enforcement during an investigation or when ordered by a physician who has a reasonable suspicion of abuse or neglect.
- The Central team recommends VDSS provide case-load calibrated levels of funding and staff for prevention efforts with high risk families in each local DSS.
- The Central team recommends universal screening for prescription drug abuse. The Virginia Hospital and Healthcare Association should urge all members to integrate the Prescription Monitoring Program (PMP) search icon with electronic medical records.
- The Eastern team will work to ensure that local agencies who do not currently conduct joint law enforcement/social service investigations of child deaths be encouraged to do so.
- The Eastern team recommends child welfare workers receive additional training on how to effectively screen and assess for domestic violence.
- The Eastern team recommends public assistance programs such as WIC, VIEW, SNAP, Medicaid and FAMIS be encouraged to distribute more prevention education ( topics such as safe sleep,

finding safe childcare, and domestic violence prevention) to their clients, particularly those with small children.

- The Eastern team recommends VDSS promote and support the development and implementation of "teaming" in child welfare cases so that multiple agencies working with the same families share vital information.
- The Eastern team recommends CPS policy/guidance be revised to emphasize the importance of prioritizing reports from home-based service providers and giving them more credibility.
- The Eastern team recommends VDSS develop an electronic method for mandated reporters and the public to report suspicions of abuse or neglect to CPS.

## **F. Mobilizing Neighborhoods and Communities**

- The Eastern team recommends increased funding be provided for more home-visiting services (such as CHIP, Healthy Families, and Parents as Teachers) to keep children safe.

## **G. Influencing Policy and Legislation**

- The Piedmont team recommends VDSS work with partners at the national level to establish a National Central Registry for recording perpetrators in founded child abuse or neglect investigations.
- The Western team recommends the Virginia Hospital and Healthcare Association urge or require Virginia hospitals to retain hospital admission blood for seven days for any child patient admitted for unknown reasons or trauma.
- The Western and Eastern teams recommend the State Board of Social Services work with the Department of Health Professions and support legislation that (1) requires all Virginia physicians register and use the Prescription Monitoring Program (PMP); and (2) adds CPS workers as permissible users of the search function of the PMP database when investigating CPS reports.
- The Eastern team supports legislation that would allow CPS investigations to be re-opened after the 60 day closure date if additional significant information such as a positive toxicology report or a confession becomes available that would potentially change the finding on a case.
- The Western team recommends increased funding for mental health and substance abuse addiction treatment services. These services must be timely, affordable, accessible, and comprehensive and should include both community and residential care options.

## **XI. Regional Plans for Action**

Each regional CFRT developed a regional plan of action based upon the risk factors identified and their findings. The key activities/projects are outlined below.

### **Piedmont Region**

Members of the Piedmont CFRT will contact health care and service providers in their communities and provide information about a free educational program called Text4baby. This is a free application for

mobile phones which provides new and expectant parents with information on caring for themselves and their infants less than one year old.

Members of the Piedmont CFRT will develop a strategic plan to identify and provide training for various professionals who are mandated reporters of suspected child abuse and neglect.

### **Central Region**

Members of the Central CFRT will work with healthcare providers in their communities to make available information regarding safe sleep practices and how to soothe crying infants.

### **Eastern Region**

Members of the Eastern CFRT will work with Eastern Virginia Medical School to produce a video regarding safe sleep practices and post it to the internet as part of their public awareness campaign on safe sleep.

Members of the Eastern CFRT will work to ensure that local agencies who do not currently conduct joint law enforcement /social service investigations of child deaths be encouraged to do so.

### **Northern Region**

Members of the Northern CFRT will work with public health to develop materials and training to educate child welfare staff about safe sleep practices.

### **Western Region**

Members of the Western CFRT will assist and advise the CPS regional consultant in providing training to local child welfare workers on the management of high risk cases.

Members of the Western CFRT will work with prevention partners in their communities to educate their staff on the importance of safe sleep environments.

## **XII. VDSS Initiatives**

- Collaborate with DCJS and OCME to develop a model joint investigation protocol for child fatality investigations and other serious injuries.
- Develop and implement an advanced training opportunity for experienced CPS workers and supervisors on injury identification in serious child maltreatment.
- Enhance all child welfare policy and guidance by providing evidence based screening and assessment tools for domestic violence.
- Explore the feasibility for electronic reporting of suspected child abuse and neglect by mandated reporters.
- Propose legislation permitting CPS workers read-only access to the Virginia Prescription Monitoring Program when responding to CPS reports
- Incorporate safe sleep information into existing policy for the assessment of the home environment of families with children less than one year of age.

- Enhance existing CPS policy for providing on-going services to families who have been identified as high or very high risk for future maltreatment.
- Collaborate with the OCME to establish a workgroup to investigate and resolve barriers to full body scans when requested by CPS or law enforcement during an investigation or when ordered by a physician who has a reasonable suspicion of abuse or neglect

### **XIII. Summary and Conclusions**

This report represents the diligent efforts of the five regional child fatality review teams to undertake the difficult and often stressful task of reviewing child deaths. This report has focused on the review of 81 deaths that were investigated due to suspected child abuse or neglect during SFY 2011. The overall purpose of the review is to better understand the circumstances of these child deaths, the factors that led to these deaths and to apply lessons learned toward preventing the deaths of other children. Whether from maltreatment, poor judgment and/or lack of information and resources, many of these deaths were preventable.

The next steps of each of these teams are to continue the process of systematic reviews of child deaths that occurred in SFY 2012. A preliminary review of those deaths has led to certain questions that will be asked in all reviews. These questions will center on the families who have had prior contact with the child welfare system as prior contact is a high risk factor. One of the main goals of the CFRT is to determine ways to enhance child welfare policy, regulation and improve the CPS response to these high risk families.