Child Maltreatment Death Investigations

In Virginia During State Fiscal Year 2024

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VIRGINIA DEPARTMENT OF SOCIAL SERVICES

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Child Death Investigations
During State Fiscal Year 2024

EXECUTIVE SUMMARY

This is a report on child deaths that were reported to local departments of social services (LDSS) and investigated during State Fiscal Year (SFY) 2024. This report includes a synopsis of data for all child abuse or neglect fatalities for SFY 2024, including demographic information pertaining to the victims, alleged abuser/neglector(s) and households impacted by those fatalities. It also highlights changes or trends from previous years. The information is used to evaluate and modify Virginia Department of Social Services (VDSS) policies, guidance, procedures, and best practices where warranted.

The purpose of this report is to provide information on all child deaths that were investigated, with an emphasis on those deaths that occurred as a result of substantiated abuse or neglect. This report includes an appendix which provides details on investigations that resulted in a founded disposition. A founded disposition means that a preponderance of the evidence demonstrates that child maltreatment occurred. This determination is based primarily upon first source, or direct evidence. A disposition of unfounded means there was not a preponderance of the evidence to warrant a founded disposition.

PRELIMINARY SUMMARY OF FINDINGS

In SFY 2024:

- LDSS investigated 165 child deaths suspected of being caused by abuse or neglect.
- Five child deaths suspected of being caused by abuse or neglect occurred in an out-of-family setting.
- There were 41 children whose deaths were the result of abuse or neglect.
- There were 117 investigations that resulted in an unfounded disposition; six investigations were pending at the time of this report.
- Sixty-six LDSS conducted at least one child death investigation.
- The Eastern Region investigated the most child deaths (53), while the Western Region experienced the highest rate of child deaths (7 deaths per 100,000 children).
- Children who died as a result of abuse or neglect ranged in age from birth to 17 years with 87% who were three and under.
- More female children (24) died from abuse or neglect than male children (17).
- The race of the children who died as a result of abuse or neglect included 32% who were White; 51% who were Black; and 15% who were multi-racial.

- Sixty-three caretakers were determined to be responsible for the deaths of 41 children; thirty-five of the caretakers were female and 27 were male.
- Fifty-one (81%) of the 63 caretakers were biological parents, and 24 (38%) of them were between 30 and 39 years old.
- Twenty-eight (68%) of the 41 abuse-or-neglect-related child deaths involved physical neglect, and 12 (29%) child deaths involved physical abuse. Some children died from more than one type of abuse and/or in combination with physical neglect or medical neglect.
- Twenty-three families (56%) had prior or active child welfare involvement.
- Twenty-eight families had other children living in the home at the time of the fatality.

I. CHILD DEATHS

LDSS conducted 164 investigations involving 165 child deaths suspected of being caused by child maltreatment in SFY 2024. LDSS determined that 41 children died as a result of abuse or neglect; 117 children were in unfounded reports; and six reports were pending at the time of this report.

The Eastern (53) Region investigated the most reports followed by Northern (35), Piedmont (30), Central (29), and Western (17).

As highlighted in **Table 1**, 66 (55%) of the 120 LDSS investigated at least one child death. Norfolk (11), Newport News (10) and Portsmouth (7) had the highest number of investigations, not all of which were founded.

Table 1: Dispositions of CPS Complaints with a Child Death by Locality SFY 2024

LDSS	Founded	Unfounded	Pending/ Appeal	Grand Total
Alleghany		2		2
Alexandria	1	1		2
Amherst	1	1		2
Arlington		1	1	2
Augusta		1		1
Bedford County			1	1
Botetourt	1			1
Buchanan		2		2
Carroll	2			2
Charlotte		1		1
Chesapeake	1	4		5
Chesterfield	1	4		5
Craig	1			1
Danville		3		3
Dinwiddie		1		1
Essex		1		1
Fairfax County		4	1	5
Fauquier		1		1
Floyd		3		3
Franklin County		3		3
Frederick		1		1
Fredericksburg	1	1		2
Gloucester		2		2
Greensville		1		1
Halifax		1		1
Hampton	2	1		3
Hanover		1		1
Harrisonburg	2	1		3
Henrico	1	3		4
Henry		2		2
Hopewell		3		3
James City County		1		1
Louisa		2		2
Lynchburg	2	1		3
Manassas		1		1
Mecklenburg		1		1
Middlesex		1		1
Montgomery	1			1
New Kent		1		1
Newport News	3	7		10
Norfolk	4	7		11
Northumberland		1		1
Orange		1		1
Page		1		1
Petersburg	2	3		5
Pittsylvania		2		2
Portsmouth	1	6		7
Powhatan	1	1		2
Prince George		2		2
Prince William	1	3		4
Pulaski	1			1
Richmond City	3	1		4
Roanoke	1	2		3
Rockbridge			2*	2
Rockingham		1		1
Smyth	2			2
Southampton		1		1
Spotsylvania	2	2	1	5
Stafford	1	3		4
Staunton		1		1
Suffolk		2		2
Tazewell	1	4		5
Virginia Beach		6		6
Washington		1		1
Westmoreland		1		1
York	1			1
GRAND TOTAL	**41**	**117**	**6***	**164**

Sources: VDSS, June 2025. Information obtained from LDSS
*One investigation involved the deaths of three children

As exhibited in **Table 2**, the percentages of **founded** versus **unfounded** dispositions involving child fatalities increased for founded (25%) dispositions.

Table 2: Dispositions of Child Death Investigations SFY 2022 – SFY 2024

	SFY 2022		SFY 2023		SFY 2024	
	Number	Percent	Number	Percent	Number	Percent
Founded	54	33%	38	22%	41	25%
Unfounded	101	62%	107	62%	117	71%
Pending/Appealed	9	5%	28*	16%	6*	4%
Total	**164**	**100%**	**171**	**100%**	**164**	**100%**

Sources: VDSS, June 2025. Information obtained from LDSS.
*One investigation involved the deaths of two children.

As shown in **Table 3**, the death rate for children who died from abuse or neglect increased from SFY 2023. According to the National Child Abuse and Neglect Data System (NCANDS) 2023 Child Maltreatment Report the national estimate of child deaths due to maltreatment has increased 9.6% since FFY 2019. Due to the relatively low frequency of child fatalities, the national rate is sensitive to which states report this data and changes in the child population estimates produced by the U.S. Census Bureau.[1]

Table 3: Death Rate of Children in Virginia Due to Abuse or Neglect SFY 2011 – SFY 2024

SFY	Death Reports Investigated	Deaths Due to Abuse/Neglect	Death Rate (per 100,000)	National Death Rate**
2011	86	30	1.6	2.0
2012	107	37	2.0	2.1
2013	105	33	1.8	2.2
2014	124	47	2.5	2.0
2015	131	52	2.8	2.1
2016	129	46	2.5	2.3
2017	124	46	2.5	2.3
2018	118	40	2.1	2.3
2019	144	51	2.7	2.4
2020	139	42	2.2	2.5
2021	171	59	3.2	2.4
2022	164	54	2.7	2.4
2023	171	38	2.0	2.7
2024	**164**	**41**	**2.2**	**2.7**

*Death rate is calculated as number of deaths due to abuse/neglect divided by the state child population (2023 = 1,876,826)
Sources: VDSS, June 2025, Kids Count Data Center from the Annie E Casey Foundation
** Source: Child Maltreatment 2023. U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau.

1 Source: *Child Maltreatment 2023*. U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau.

As exhibited in **Table 4**, there were six pending investigations in SFY2024. The Code of Virginia, specifically § 63.2-1505 B5, grants certain exceptions to the time frame for completing child death investigations, when such investigations require reports or records that are generated outside of the local department, such as an autopsy report. The time needed to obtain these reports or records is not counted towards the 45/60/90-day timeframes. The records must be necessary to complete the investigation and not available due to circumstances beyond the control of the local department.

Table 4: Child Fatality Investigations and Outcomes by Region SFY 2024

	Founded		Unfounded		Pending		Appealed		Total	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Central	8	28%	21	72%	0	0%	0	0%	29	100%
Eastern	12	23%	41	77%	0	0%	0	0%	53	100%
Northern	8	23%	24	68%	3	9%	0	0%	35	100%
Piedmont	6	20%	21	70%	3*	10%	0	0%	30	100%
Western	7	41%	10	59%	0	0%	0	0%	17	100%
Statewide	**41**	**21%**	**117**	**63%**	**6***	**14%**	**0**	**0%**	**164**	**100%**

Sources: VDSS, June 2025. Information obtained from LDSS.
*One investigation involved the deaths of two children

VDSS also reports by region the ratio of child deaths to the population of children less than 18 years of age, as well as examines the number of child deaths and the percentages of founded investigations.

As exhibited in **Table 5**, the rate of child deaths per 100,000 children has decreased in the Piedmont Region since SFY 2022. It should be noted that an increase of one or two child deaths would have a more significant impact on regions with a low child population (i.e. the Western Region) versus a region with a high child population (i.e. the Eastern Region).

Table 5: Child Deaths Due to Abuse or Neglect and Rates by Region SFY 2022 – SFY 2024

	SFY 2022		SFY 2023		SFY 2024	
	Deaths	Rate (Per 100,000)	Deaths	Rate (Per 100,000)	Deaths	Rate* (Per 100,000)
Central	10	3.4	3	1.0	8	**2.6**
Eastern	11	2.7	13	3.2	12	**2.9**
Northern	16	2.0	9	1.1	8	**1.0**
Piedmont	8	3.4	8	3.3	6	**2.7**
Western	9	8.5	5	4.7	7	**7.0**

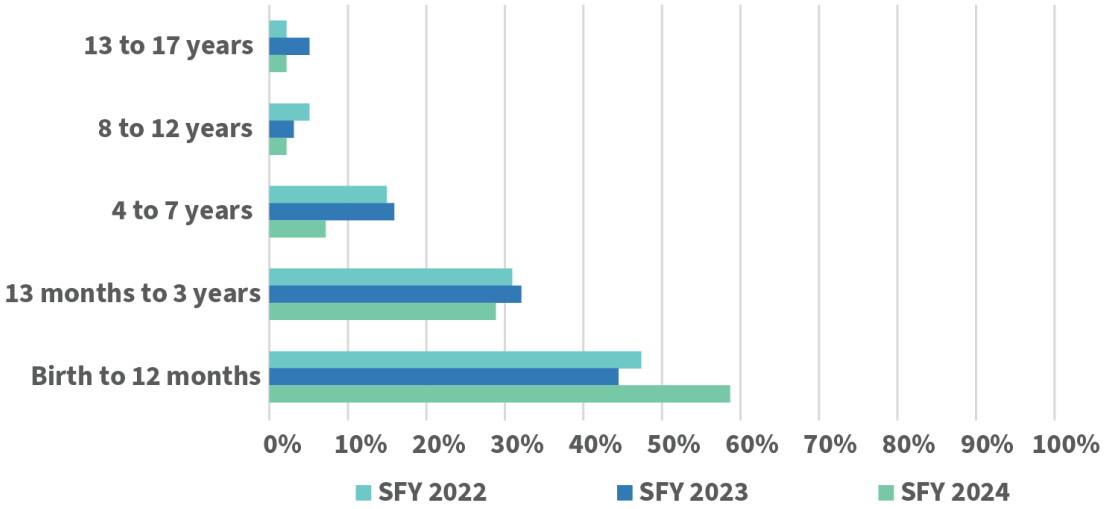
Sources: VDSS, June 2025. Information obtained from LDSS. Kids Count Data Center from the Annie E Casey Foundation. *The population data used to determine rate per 100,000 for children <18 years of age by region are: Central: 301,939; Eastern: 417,043; Northern: 822,524; Piedmont: 226,263; Western: 100,787.

II. CHILDREN

LDSS investigated the deaths of 165 children in SFY 2024; and 41 children were found to have died as a result of abuse or neglect. This section provides detailed demographic information and trends for the children involved in child death investigations and whose deaths were determined to be the result of abuse or neglect.

As highlighted in **Table 6**, children under the age of three continue to be the most vulnerable to die as a result of abuse or neglect. Virginia's percentage for SFY 2024 was 88%, which is higher than the percentage throughout the country. Nationally, 66.9% of all child fatalities in FFY 2023 were children younger than three years of age.[2]

Table 6: Children Who Died From Abuse or Neglect by Age SFY 2022 – SFY 2024



Sources: VDSS, June 2025. Information obtained from LDSS.

As shown in **Table 7**, there were more female child deaths than male in SFY 2024. This is inconsistent with the national data which indicates that boys experienced a higher fatality rate (3.15 per 100,000) than girls (2.30 per 100,000).[3]

Table 7: Children Who Died From Abuse or Neglect by GenderSFY 2022 – SFY 2024

	SFY 2022			SFY 2023			SFY 2024		
	#	%	Rate (per 100,000)	#	%	Rate* (per 100,000)	#	%	Rate* (per 100,000)
Female	23	42.6%	2.5	17	45%	1.8	24	59%	2.6
Male	31	57.4%	3.2	21	55%	2.1	17	41%	1.8
Total	**54**	**100%**	**2.9**	**38**	**100%**	**2.0**	**41**	**100%**	**2.2**

Sources: VDSS, June 2025. Information obtained from LDSS. Kids Count Data Center from the Annie E Casey Foundation. *The population data used to determine rate per 100,000 for children <18 years of age was females: 916,786 and males: 964,762.

[2,3] Source: *Child Maltreatment 2023*. U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau.

As exhibited in **Table 8**, 32% of the children who died as a result of abuse or neglect in Virginia were White and 51% were Black. The disproportionate rate of Black child deaths in Virginia is slightly below the national data.[4]

Table 8: Children Who Died From Abuse or Neglect by Race SFY 2022 – SFY 2024

	SFY 2022		SFY 2023		SFY 2024		
	Number	Percent	Number	Percent	Number	Percent	Rate* (per 100,000)
African-American	18	33%	15	39%	21	51%	5.8
White	32	59%	17	45%	13	32%	1.4
Multi-racial	3	6%	4	10%	6	15%	2.3
Asian	0	0%	0	0%	0	0%	N/A
Unknown	1	2%	2	5%	1	2%	N/A
Total	**54**	**100%**	**38**	**100%**	**41**	**100%**	**2.2**

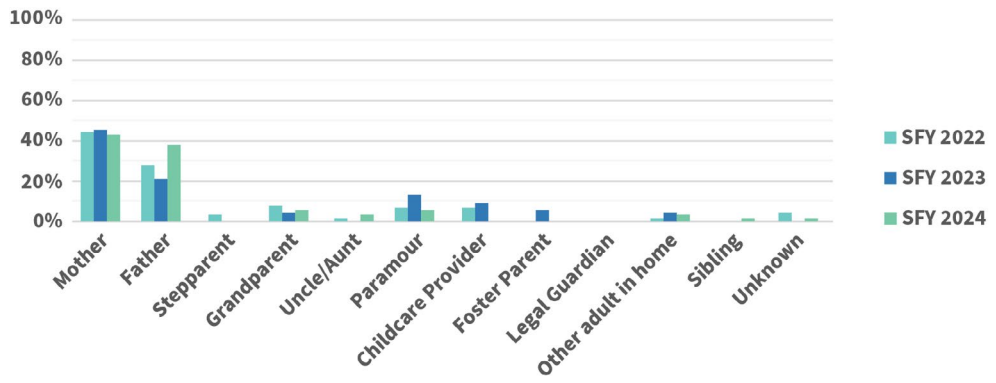
Sources: VDSS, June 2025. Information obtained from LDSS. Kids Count Data Center f/t Annie E Casey Foundation. *The population data used to determine rate per 100,000 for children <18 years of age was Black: 364,648; White: 952,469; multi-racial: 265,385; Asian: 119,515; total: 1,876,826.

III. CARETAKERS

CPS investigates child fatalities that are suspicious for abuse or neglect committed by a caretaker **only.**

As shown in **Table 9**, LDSS determined that there were 63 caretakers responsible for the deaths of 41 children due to abuse or neglect in SFY 2024. Twenty-one victims were abused or neglected by two different caretakers and one victim was abused or neglected by three different caretakers. The majority of caretakers (81%) were the biological parents, which is consistent with the national data (81.5%) that indicates the parents acted alone, together or with other individuals.[5] Caretakers also include regulated (licensed) childcare providers.

Table 9: Caretakers in Child Deaths from Abuse or Neglect SFY 2022 – SFY 2024



Source: VDSS, June 2025. Information obtained from LDSS.

[4,5] Source: *Child Maltreatment 2023*. U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau.

Nationally, more than 10 percent (13.7%) of fatalities did not have a parental relationship to their perpetrator.[6] Sometimes the identity of a caretaker is unknown. Unknown is used when an investigation reveals that the child was physically abused or neglected, but the LDSS is unable to establish the identity of the responsible caretaker. If new information is received regarding the identity of the caretaker, a new investigation may be conducted.

As highlighted in **Table 10**, the race of the caretakers was primarily White (56%) and Black (40%).

Table 10: Race of Caretakers in Child Deaths from Abuse or Neglect SFY 2022 – SFY 2024

	SFY 2022		SFY 2023		SFY 2024	
	Number	Percent	Number	Percent	Number	Percent
Black	21	29%	22	40%	32	50%
White	41	58%	31	56%	22	35%
Asian	0	0%	0	0%	0	0%
Unknown	9	13%	2	4%	8	13%
Multi-racial	0	0%	0	0%	1	2%
Total Caretakers	**71**	**100%**	**55**	**100%**	**63**	**100%**

Source: VDSS, June 2025. Information obtained from LDSS.

As shown in **Table 11**, there are typically more female perpetrators of child maltreatment than male perpetrators.

Table 11: Gender of Caretakers in Child Deaths from Abuse or Neglect SFY 2022 – SFY 2024

	SFY 2022		SFY 2023		SFY 2024	
	Number	Percent	Number	Percent	Number	Percent
Female	37	52%	35	63.6%	35	56%
Male	31	44%	20	36.4%	27	43%
Unknown	3	4%	0	0%	1	1%
Total Caretakers	**71**	**100%**	**55**	**100%**	**63**	**100%**

Source: VDSS, June 2025. Information obtained from LDSS.

[6] Source: *Child Maltreatment 2023*. U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau.

As exhibited in **Table 12**, the ages of caretakers ranged from 18 to 50 years in SFY 2024. The majority of the caretakers (76%) were between 20 and 39 years of age.

Table 12: Age of Caretakers in Child Deaths from Abuse or Neglect SFY 2022 – SFY 2024

	SFY 2022		SFY 2023		SFY 2024	
	Number	Percent	Number	Percent	Number	Percent
Under 20 years	3	4%	1	2%	4	6%
20 to 29 years	36	51%	19	35%	24	38%
30 to 39 years	18	25%	24	44%	24	38%
40 to 49 years	3	4%	4	7%	7	11%
50 or older	5	7%	7	12%	1	2%
Unknown	6	9%	0	0%	3	5%
Total	**71**	**100%**	**55**	**100%**	**63**	**100%**

Source: VDSS June 2025. Information obtained from LDSS.

IV. CATEGORIES OF ABUSE AND NEGLECT

In SFY 2024, 41 children died as a result of at least one type of abuse or neglect. Some children were abused or neglected in more than one way and by more than one caretaker. Of the children who died, 28 (68%) had been physically neglected and 12 (29%) had been physically abused. One child (3%) was medically neglected.

The type of abuse or neglect is not necessarily the *cause of death* for the child. For example, a child accidentally, fatally shot himself. The cause of death (determined by the medical examiner) would be gunshot wound of the head; the type of abuse or neglect (determined by CPS) would be neglect (failing to do something on behalf of the child).

As highlighted in **Table 13**, 28 (68%) of the child deaths involved some type of physical neglect. The two most prevalent types of neglect were Inadequate Supervision and Other/Unspecified sub-type. When determining the validity of a report, the alleged inaction by the caretaker may not clearly fit into the pre-defined sub-categories but still encompasses physical neglect so the Other/Unspecified sub-type is utilized by the LDSS.

Table 13: Types of Neglect in Child Deaths SFY 2022 – SFY 2024

	SFY 2022	SFY 2023	SFY 2024
Abandonment	0	0	0
Inadequate Supervision	12	10	13
Inadequate Shelter	0	1	0
Inadequate Food	0	0	0
Failure to Thrive	0	0	0
Medical Neglect	0	0	0
Other/Unspecified Sub-type	23	17	15

Source: VDSS, June 2025. Information obtained from LDSS

Medical neglect directly caused or contributed to the death of one child (3%). Medical neglect involves a caretaker's failure to obtain a child's necessary medical care or to follow doctor-recommended medical regimen for the child.

As illustrated in **Table 14**, 12 (29%) children died as a result of physical abuse in SFY 2024

Table 14: Types of Abuse in Child Deaths SFY 2022 – SFY 2024

	SFY 2022	SFY 2023	SFY 2024
Asphyxiation (accidental or intentional)	0	0	0
Bone Fracture	1	1	0
Burns	0	0	0
Bruises	0	0	1
Gunshot	1	0	0
Poisoning	3	2	1
Abusive Head Trauma	1	0	1
Stabbing	0	0	0
Internal Injuries	0	0	0
Head Injury	3	0	4
Chronic Physical Abuse[1]	0	0	0
Other or Unspecified Type	7	6	5

Source: VDSS, June 2025. Information obtained from LDSS.
[1]Chronic Physical Abuse, formerly known as Battered Child Syndrome.

V. FAMILIES AND THE CHILD WELFARE SYSTEM

When initiating a response to a child fatality report, CPS assesses immediate harm or threat of harm toward any sibling(s) or other child(ren) in the home. Based on this initial safety assessment, a safety plan may be developed with the family for a course of action to mitigate any danger(s) or threat(s) of harm. The following information identifies those families and the resulting protective action taken by the LDSS.

As shown in **Table 15**, there were 41 households that involved 41 child death investigations resulting in founded dispositions for SFY 2024; 28 (68%) of those households had other children for whom initial safety was assessed. All of the remaining households had no other children in the home.

Table 15: Initial Safety Outcomes for Other Children in the Household SFY 2022 – SFY 2024

	SFY 2022	SFY 2023	SFY 2024
	# Families	# Families	# Families
Safety plan with family	12	14	8
Safety plan with relatives/family friends	25	11	18
Emergency removal/foster care	0	2	2
Total Families	**37**	**27**	**28**

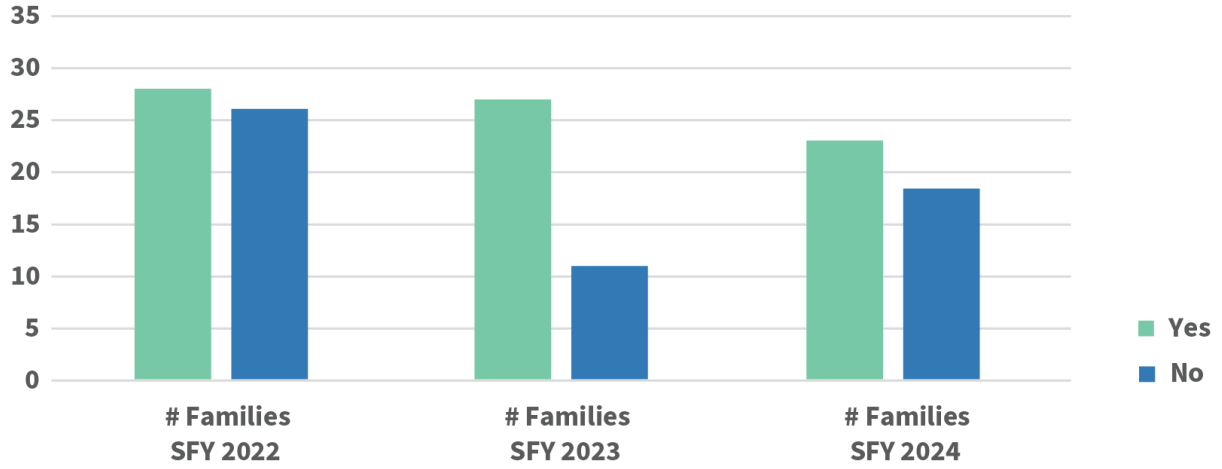
Source: VDSS, June 2025. Information obtained from LDSS.

In SFY2024, a plan was developed with 8 households that allowed the siblings to remain in their own homes. An additional 18 households temporarily placed their children with relatives or family friends, while maintaining legal custody of their children.

As a result of CPS involvement, families were provided services that include grief counseling; burial assistance; home visiting; parent education and mental health services; substance use assessments and treatment; intimate partner violence services; and protective orders.

As exhibited in **Table 16**, there were 41 victims (41 households) in founded CPS fatality investigations for SFY 2024; 23 families (56%) had prior or active child welfare involvement.

Table 16: Prior Family Child Welfare Involvement in Child Deaths from Abuse or Neglect SFY 2022 – SFY 2024



Source: VDSS, June 2025. Information obtained from LDSS.

Prior involvement means that the alleged abuser, victim child or siblings were previously the subject of a family assessment, an investigation, in-home services, or foster care case. It does not include any caretaker's history of abuse or neglect that occurred as a child. Prior involvement also includes any open family assessment, investigation, or case at the time of the child's death.

It may also have occurred in more than one locality or a locality different from where the child died. See the Table of Founded Child Deaths in **Appendix A** for further details

VI. REGIONAL CHILD FATALITY REVIEW TEAM ANALYSIS

Regional Child Fatality Review Teams (CFRT) convene to examine deaths that local departments of social services (LDSS) investigated. CFRTs focus on identifying risk factors, trends, and patterns, developing recommendations, and creating action plans. *The Code of Virginia*, specifically §32.1-283.2 provides the authority for the work of CFRT.

There is a CFRT, which is multidisciplinary in structure, in each of the five VDSS regions. As of January 1, 2024, the regional review teams were restructured in order to enhance the quality of the review process, enhance the quality of the recommendations that are developed during the meetings, and to increase capacity across programs within the Virginia Department of Social Services (VDSS) to strengthen prevention work. Historically, regional review teams reviewed every child death that was investigated by Child Protective Services. The regional review teams will only review the child fatality investigations that meet the following criteria:

1. Current open DSS referral/case at the time of the fatality
2. Valid or invalid CPS report within last 12 months
3. Child died while in foster care (not from natural death and no complaint in foster home)
4. Child died in foster care on a trial home placement
5. Foster care case involving decedent or decedent's siblings was closed within the last 24 months

This is the same criteria that requires VDSS to notify the **Office of the Children's Ombudsman** when an LDSS validates a CPS referral involving a child fatality.

Each Regional Child Fatality Review Team reports annually the significant findings and themes from the reviews as well as recommendations or initiatives that result from the team's discussion of that year's child death cases. Highlights of SFY 2023's regional recommendations:

- Increase safe sleep education and messaging for parents/caregivers with a history of substance use, as substance use continues to be a risk factor in many child fatality investigations.
- Collaborate with community health providers to create educational materials for parents/caregivers on the impact of substance use while pregnant, with an emphasis on the long-term impact and increased risk to infants who are born substance exposed.
- Create a public awareness campaign on gun safety and proper storage of firearms and ammunition.

In response to these recommendations, VDSS implemented the following projects and initiatives:

- VDSS was selected as an awardee of the Charlie's Kids Foundation's book grant program and received 720 copies of the Foundation's book titled "Sleep Baby Safe and Snug." VDSS partnered with the Department of Behavioral Health and Developmental Services' Project Link Program to distribute these books statewide to pregnant and parenting mothers affected by substance use disorders.
- VDSS developed and distributed two brochures *Guide for Using Recreational Marijuana While Parenting and Parent's Guide for Safe Storage of Marijuana* to local agencies and community partners to educate parents on safe marijuana use and storage.
- VDSS continues to disseminate educational materials via social media platforms around gun safety, water safety, safe sleep, and hot vehicle dangers.

The following are highlights of SFY 2024's regional recommendations:

- Decrease infant mortality, specifically Sudden Unexpected Infant Deaths (SUIDs), in cases where prevention efforts may have prevented the death. This includes a joint effort between VDSS and the Virginia Department of Health to advance education around safe infant sleep and to ensure Plans of Safe Care (POSC) are utilized for pregnant mothers and infants who were born substance exposed.
- Increase the proportion of High risk and Very High risk CPS referrals that are receiving In-Home

Case support. VDSS has recently embarked on a renewed focus of tracking and enhancing performance metrics for High and Very High risk CPS referrals being opened to In-Home services cases. This effort includes the identification of LDSS practice strengths and areas needing improvement, and development and monitoring of a technical assistance plan for the LDSS facilitated by Regional Practice Consultants.

» Enhance child fatality investigation training and materials, to include updating the Child Fatality Investigation Checklist, and update guidance manuals to ensure safe sleep education is being provided across all programs within the Division of Family Services.

VII. UNFOUNDED REPORTS

In SFY 2024, there were 117 (71%) child fatality reports and investigations with an unfounded disposition. An unfounded disposition does not mean the abuse or neglect did not occur. An unfounded disposition means the investigation lacked a preponderance of the evidence to warrant a disposition of founded.

Of the 117 unfounded reports:

» Eighty-three of the reports (71%) involved a child less than one year of age.

» Eighty-three of the 117 reports (71%) were sleep related. This means the actual surface the child slept on, with whom the child was sleeping, or how the child was sleeping. This includes children who suffocated or accidently asphyxiated due to their sleep environment.

Many of the sleep-related child deaths resulted in a determination by a medical examiner that the cause of death was Sudden Unexplained Infant Death (SUID). SUID is a diagnosis of exclusion, made when there is an absence of pathological findings revealing injury, violence, disease, or other fatal medical condition. A SUID diagnosis recognizes a host of confounding factors, most importantly, the presence of unsafe sleep factors and/or medical problems such as pneumonia, prematurity, or congestion.[7]

VIII. PATTERNS AND TRENDS

VDSS tracks additional data to identify trends or patterns that inform prevention initiatives throughout the state. In addition to demographic information on the victim children and the families impacted by those fatalities, factors that influence family health and functioning are collected when such information is available. This specific information is sensitive to which LDSS capture this information throughout the duration of their investigation.

In SFY2024, a substance use component was present in 64 (39%) of all fatality investigations. This

[7] Excerpt from Sleep-Related Infant Deaths in Virginia, a report from the Virginia State Child Fatality Review Team. http://www.vdh.virginia.gov/medExam/childfatality-reports.htm

could mean that substance use was occurring in the home at the time of the fatality, or the parent(s)/caregiver(s) has a documented history of substance use. This percentage also includes the 20 victim children who were born substance exposed. In 7 investigations, exposure to substances either contributed to or directly caused the child's death as determined by a medical examiner.

Because substance use remains prevalent across many fatality investigations, VDSS participates in a monthly collaborative of key state stakeholders, including the Department of Medical Assistance Services, the Department of Behavioral Health and Developmental Services, and the Department of Health, to improve the statewide response to Substance-Exposed Infants. Additionally, VDSS serves on the Steering Committee of a statewide workgroup, Pathways to Coordinated Care, led by the Virginia Department of Health (VDH). The workgroup consists of over sixty diverse members including public and private stakeholders and partners. The workgroup is focused on the needs of substance-exposed infants and their caregivers. The workgroup is currently working on revising and updating the State Plan for Substance Exposed Infants.

Data is also collected around which families have experienced intimate partner violence (IPV). Twenty-five (15%) families had a documented incident(s) of intimate partner violence prior to the child fatality. This could mean that CPS was previously involved with the family due to IPV or law enforcement reports prior IPV after the LDSS is notified about the child fatality.

IX. NEAR-FATALITIES

CAPTA (Child Abuse Prevention and Treatment Act) defines a "near fatality" as a*n act that, as certified by a physician, places the child in serious or critical condition (22VAC40-705-10). "Life-threatening condition" means a condition that if left untreated, more likely than not will result in death and for which the recommended medical treatments carry a probable chance of impairing the health of the individual or a risk of terminating the life of the individual.*

There were 34 near-fatalities reported and investigated by the LDSS for possible abuse or neglect. Thirteen of the 34 children were under the age of one, sixteen were between 13 months old and 3 years old, and the remaining five children ranged in age from five to 15 years old. Sixty-five percent (22) of the children were male and 35% (12) were female. The race of the children was 32% Black; 56% White; and 12% Multi-Racial. Twenty-four of the 34 investigations (71%) were founded for abuse or neglect; nineteen of the families had prior child welfare involvement.

X. APPENDIX

Preliminary Report on Child Deaths Due to Abuse or Neglect in Virginia During SFY 20204
A. Table of Founded Investigations with a Child Death

Child Sex	Child Age (Years)	Abuser (s)	Abuse Type	Previous History	Summary (SUID stands for Sudden Unexpected Infant Death)
Female	0.2	mother	Physical Neglect	In May 2023, the LDSS received a referral stating that the mother had her newborn (the decedent) in the hospital bed laying next to her, without the safety rails up and was yelling at her toddler. This referral was screened out. In May 2023, the LDSS received a second referral stating the mother and newborn were positive for marijuana. This referral was screened out; however, family support services were offered to the family which were declined.	Child was found unresponsive in the home. Cause of death is SUID associated with co-sleeping and soft bedding.
Male	2.5	aunt	Physical Neglect	None.	Child was found unresponsive in a pond. Cause of death is drowning.
Male	5	mother mother's paramour	Physical Neglect Physical Neglect	None.	Child was found unresponsive following a motor vehicle accident. Cause of death is blunt force trauma to the head.
Female	0.3	other mother	Physical Neglect Physical Neglect	Since 2015, the mother has been listed as an alleged abuser/neglector in nine different case types. One of the previous Investigations involved the death of another child who was in the care of the mother and maternal grandmother; this Investigation was unfounded. The most recent case was a Family Assessment which was opened after the decedent's birth as she was displaying signs of Neonatal Abstinence Syndrome (NAS) and the mother admitted to having a cocaine addiction. The decedent was placed in the care of her maternal grandmother as part of a safety plan; this Family Assessment was still open at the time of the fatality.	Child was found unresponsive in a family friend's home. Cause of death is SUID associated with cocaine exposure and unsafe sleep.
Female	0.3	father	Physical Abuse	None.	Child became unresponsive in the home. Cause of death is blunt force trauma to the head.
Male	5.3	mother's paramour	Physical Abuse	In December 2019, the LDSS received a report due to the mother and father (who were married at the time) having an incident of intimate partner violence in front of both children. This referral was screened out. The LDSS opened a Family Support case from December 2019 to January 2020; this case was closed due to the mother working with another community provider to obtain housing for herself and two children.	Child became unresponsive in the home. Autopsy report not documented.

The information contained in the appendix is included as required per CAPTA section 106(b)(2)(B)(x).

Preliminary Report on Child Deaths Due to Abuse or Neglect in Virginia During SFY 20204
A. Table of Founded Investigations with a Child Death
continued

Child Sex	Child Age (Years)	Abuser (s)	Abuse Type	Previous History	Summary (SUID stands for Sudden Unexpected Infant Death)
Male	2.7	mother father	Physical Neglect Medical Neglect	Since 2014, the parents were the subject of 21 various different case types, to include the investigation into the death of anoher child in 2020. The most recent referral was made to Roanoke City DSS in June 2023; this referral was screened out.	Child was found unresponsive in the home. Cause of death is undetermined.
Female	0.9	other	Physical Neglect	In 2023, the LDSS received four reports on the mother and decedent. All four referrals were screened out. The LDSS opened a Family Support case with the decedent's biological family in August 2023; this case was open at the time of the fatality. There is also CPS history with the caretaker in the fatality investigation. In June 2023, the LDSS opened a Family Assessment after the babysitter assaulted her 16-year-old child and was subsequently arrested. The assessed risk was low and the family was referred to services.	Child was found unresponsive in a vehicle. Cause of death is hyperthermia due to exposure to environmental heat (hot car death).
Female	0.7	mother	Physical Abuse	In April 2020, the LDSS opened a Family Assessment after receiving a referral for a Substance-Exposed Infant. The assessed risk was high, but ongoing services were not offered due to the family receiving services in the community. In January 2023, the LDSS opened a Family Assessment after receiving a referral for two Substance-Exposed Infants. The LDSS opened an in-home services case with the family which closed in July 2023 as the family was unable to be located.	Child was found unresponsive in the home. Cause of death is blunt force trauma to the head.
Male	15.3	father	Physical Neglect	The LDSS opened a Family Assessment in 2021 due to intimate partner violence in the home.	Child was found unresponsive in the home. Cause of death is self-inflicted gunshot wound.
Male	8.9	sibling	Physical Neglect	In May 2023, the LDSS opened a Family Assessment due to allegations of physical neglect of the decedent. In June 2022, the LDSS opened a Family Assessment due to allegations of physical neglect (condition of the home).	Child was found unresponsive following a motor vehicle accident. Cause of death is not documented.
Female	0.9	mother	Medical Neglect	None.	Child was found unresponsive in the home. Cause of death is SUID associated with co-sleeping and congenital abnormalities.

The information contained in the appendix is included as required per CAPTA section 106(b)(2)(B)(x).

Preliminary Report on Child Deaths Due to Abuse or Neglect in Virginia During SFY 20204
A. Table of Founded Investigations with a Child Death
continued

Child Sex	Child Age (Years)	Abuser (s)	Abuse Type	Previous History	Summary (SUID stands for Sudden Unexpected Infant Death)
Male	0.2	mother	Physical Neglect	In January 2021, the LDSS received two reports after the mother gave birth to a substance-exposed infant; a Family Assessment was opened with the family. In July 2022, the LDSS opened an Investigation after receiving a report regarding a child fatality. The cause of death was suffocation with methamphetamine exposure contributing; this Investigation resulted in a Level 2 finding for the mother. In August 2022, the LDSS opened a Family Assessment after the decedent was born substance exposed and was displaying withdrawal symptoms.	Child was found unresponsive in the home. Cause of death is undetermined.
Male	0.3	father	Physical Abuse	None.	Child was found unresponsive in the home. Cause of death is blunt force trauma.
Male	0.4	father	Physical Abuse	None.	Child became unresponsive in the home. Cause of death is blunt force trauma to the head.
Female	1.6	mother father	Physical Neglect Physical Neglect	Two reports were received, one in 2019 and one in 2022, that the children were substance-exposed infants. The LDSS offered Prevention Services to the family after each report was received, but services were declined.	Child was found unresponsive in a hotel room. Cause of death is marijuana, cocaine, and fentanyl toxicity.
Male	2	mother father	Physical Neglect Physical Neglect	In November 2021, the LDSS opened a Family Assessment after the decedent was born substance-exposed. In June 2023, the LDSS opened a Family Assessment to address concerns of the now five-month-old being born substance exposed. The local agency obtained a CPO requiring the parents to comply with In-Home and OEI services. The in-home case was still open at the time of the decedent's death. In September 2023, the local agency received a referral regarding the mother having a seizure at the pain clinic; this referral was screened out.	Child was found unresponsive in the home. Cause of death is complications of RSV bronchiolitis.
Female	0.1	mother father	Physical Abuse Physical Abuse	In September 2022, the LDSS opened a Family Assessment due to the children witnessing domestic violence. A Family Support case was opened following the Family Assessment and a protective order was put in place between the parents.	Child was found unresponsive in the home. Cause of death is abusive head trauma.
Female	3.3	father	Physical Neglect	None.	Child was found unresponsive in a vehicle. Cause of death is positional asphyxia.
Female	0.2	mother father	Physical Neglect Physical Neglect	None.	Child was found unresponsive in the home. Cause of death is not documented.

The information contained in the appendix is included as required per CAPTA section 106(b)(2)(B)(x).

Preliminary Report on Child Deaths Due to Abuse or Neglect in Virginia During SFY 20204
A. Table of Founded Investigations with a Child Death
continued

Child Sex	Child Age (Years)	Abuser (s)	Abuse Type	Previous History	Summary (SUID stands for Sudden Unexpected Infant Death)
Female	0.6	grandmother aunt	Physical Neglect Physical Neglect	There is CPS history with the maternal aunt. In 2021, the LDSS received a referral after the aunt's child was born substance exposed. This referral was screened out. In 2021, the LDSS opened a Family Assessment after receiving a referral that the infant was now showing signs of withdrawal.	Child was found unresponsive in the home. Cause of death is acute fentanyl toxicity.
Male	2.1	mother father	Physical Neglect Physical Neglect	In May 2022, the LDSS opened a Family Assessment due to concerns of physical neglect and substance use. In September 2022, the LDSS opened a Family Assessment due to concerns of physical neglect and exposure to domestic violence. In October 2023, the LDSS opened a Family Assessment due to concerns of medical neglect; this referral was still open at the time of the fatality.	Child was found unresponsive in a hotel room. Cause of death is undetermined.
Female	2.3	mother	Physical Neglect	None.	Child was found unresponsive in the home. Cause of death is self-inflicted gunshot wound.
Female	0.3	father mother	Physical Abuse Physical Neglect	Between March 2022 and November 2023, the LDSS opened three Family Assessments and screened out one referral on the family. The most recent Family Assessment, which was opened in November 2023, was still open at the time of the fatality	Child was found unresponsive in the home. Cause of death is undetermined.
Male	1	unknown	Physical Abuse	There is CPS history with the babysitter/caretaker. In September 2009, the LDSS opened a case with the babysitter and her family following a screened-out CPS referral. In September 2015, the LDSS opened a short-term assessment to provide financial assistance to the babysitter.	Child was found unresponsive in the babysitter's home. Cause of death is fentanyl and xylazine toxicity.
Female	1.7	mother father	Physical Abuse Physical Abuse	None.	Child was found unresponsive in the home. Cause of death is undetermined.
Female	1.7	father	Physical Neglect	None.	Child was found unresponsive in a pool. Cause of death is drowning.
Female	0.1	mother father	Physical Neglect Physical Neglect	In March 2024, the LDSS opened a Family Assessment after receiving a report that the decedent was born substance-exposed to marijuana and the family was leaving the hospital against medical advice (AMA).	Child was found unresponsive in the home. Cause of death is asphyxia due to wedging.
Female	0.3	grandmother	Physical Neglect	In May 2023, the LDSS received a report stating that the parents were involved in an incident of intimate partner violence in front of the oldest child (who was four months old at the time). This referral was screened out.	Child was found unresponsive in the grandmother's home. Cause of death is acute quetiapine toxicity; contributing, doxylamine use.

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Preliminary Report on Child Deaths Due to Abuse or Neglect in Virginia During SFY 20204
A. Table of Founded Investigations with a Child Death
continued

Child Sex	Child Age (Years)	Abuser (s)	Abuse Type	Previous History	Summary (SUID stands for Sudden Unexpected Infant Death)
Female	0	mother father	Physical Abuse Physical Abuse	None.	Child was brought to the hospital unresponsive. Cause of death is abusive blunt head and torso trauma, contributing to deep partial thickness burns of feet.
Female	6.2	mother	Physical Neglect	In June 2015, the LDSS opened a court-ordered Family Support case for the mother and her oldest child (who is now an adult) due to the child's criminal history and the mother's housing instability.	Child was found unresponsive in a pool. Cause of death is drowning.
Female	0.7	mother father	Physical Neglect Physical Neglect	In 2017, the father was the subject of two Investigations that resulted in him receiving multiple findings for physical neglect and physical abuse. As a result of these Investigations, the father's oldest children entered foster care and were subsequently adopted. In September 2023, the LDSS received a report when the decedent was born stating that the mother has a history of methamphetamine use, the family did not have baby supplies, and both parents had to be reminded to wake up to feed the decedent. This referral was screened out. In November 2023, the LDSS opened an Investigation after the father became intoxicated and dropped the decedent. This Investigation resulted in a Level II finding of physical abuse and physical neglect, and an In-Home case was opened with the family. The In-Home case was open at the time of the fatality.	Child was found unresponsive in the home. Cause of death is suffocation.
Male	0.3	father mother	Physical Abuse Physical Neglect	None.	Child was found unrepsonsive in the home. Cause of death is blunt injuries to the head and torso in the setting of Battered Child Syndrome.
Male	0.5	mother	Physical Neglect	None.	Child was found unresponsive in the home. Cause of death is not documented.
Male	0.4	mother father	Physical Abuse Physical Abuse	In January 2024, Louisiana received a referral regarding the decedent being born substance exposed but was not showing signs of withdraw. In March 2017, the LDSS opened an In-Home Services case due to concerns of substance use by the mother and pending custody matters regarding the decedent's sibling. This case was closed in June 2017, after the court ordered joint physical and legal custody of the sibling to both parents and the mother was receiving substance use treatment.	Child was found unresponsive in the home. Cause of death is not documented.

The information contained in the appendix is included as required per CAPTA section 106(b)(2)(B)(x).

Preliminary Report on Child Deaths Due to Abuse or Neglect in Virginia During SFY 20204
A. Table of Founded Investigations with a Child Death
continued

Child Sex	Child Age (Years)	Abuser (s)	Abuse Type	Previous History	Summary (SUID stands for Sudden Unexpected Infant Death)
Female	2.7	mother mother's paramour	Physical Neglect Physical Neglect	In February 2022, the LDSS opened a Family Assessment after receiving a report that the mother was not meeting the decedent's medical needs. In July 2022, the LDSS opened a Family Assessment after an incident of intimate partner violence between the mother and her paramour that resulted in law enforcement involvement.	Child was found unresponsive in the home. Cause of death is anoxic brain injury due to neck compression/ positional asphyxia.
Male	0.2	mother father grandmother	Physical Neglect Physical Neglect Physical Neglect	Between 2010 and 2013, LDSS's had open In-Home cases with the maternal grandmother due to her son (the decedent's maternal uncle) being involved with the juvenile justice system. In March 2024, the LDSS received a report alleging poor hygiene and lack of education for the mother's oldest child. This referral was screened out.	Child was found unresponsive in the home. Cause of death is SUID associated with co-sleeping.
Male	3.2	mother father	Physical Neglect Physical Neglect	None.	Child was found unresponsive in a pool. Cause of death is drowning.
Female	0.5	mother father	Physical Neglect Physical Neglect	None.	Child was found unrepsonsive in the home. Cause of death is SUID associated with buprenorphine exposure, unsafe sleep, evidence of remote subdural bleeding, infection, and laboratory evidence of kidney dysfunction.
Female	0	mother father	Physical Neglect Physical Neglect	None.	Child was found unresponsive in the home. Cause of death is SUID.
Female	3.4	father	Physical Neglect	None.	Child was found unresponsive in a pool. Cause of death is drowning.

The information contained in the appendix is included as required per CAPTA section 106(b)(2)(B)(x).

