Key Findings from Regional Child Fatality Review in Virginia

- Infants and toddlers are most at risk for deaths when there are allegations of abuse and/or neglect.
- While White and Black children die in nearly equal numbers, Black children are at a much higher risk of death than White children.
- Male and female child fatalities occur at the same rate.
- Caregivers for these children are generally young, female and the biological parent of the child.
- Many caregivers involved in child death have a history of criminal activity, domestic violence, and/or substance abuse. Some have been abused or neglected as children.
- Many of these vulnerable children and their families live at or below the poverty level.
- While some of the children were known to the child welfare system before their death, the majority were not. However, many families were in contact with other social services agencies providing health care, nutritional services, or financial support.
- Some children die as a result of abuse, but many more die in unsafe sleep environments. Teams noted the significance of proper supervision to the health and safety of infants and children.
- Teams determined that the majority of child deaths are preventable.

For more information about child fatality review, including information about the individual process in each of the 50 states, visit **http://www.childdeathreview.org/**

Please visit the following websites for Information on:

Injury Prevention
http://www.vdh.virginia.gov/ofhs/Prevention/injury/
http://www.nsc.org/pages/home.aspx

Child Abuse Prevention
http://pcav.org/
http://www.futureswithoutviolence.org/

Safe Sleep for Infants
http://www.dss.virginia.gov/family/safe_sleep.cgi

(10/14)

VIRGINIA DEPARTMENT OF SOCIAL SERVICES

Virginia Regional Child Fatality Review

Educating communities to prevent child deaths and improve systems of child welfare and safety.

EDUCATING COMMUNITIES TO PREVENT CHILD DEATHS AND IMPROVE SYSTEMS OF CHILD WELFARE AND SAFETY

WHAT IS CHILD FATALITY REVIEW?

Child fatality review is a method used to better understand how and why children die in an effort to prevent future deaths and ultimately keep kids alive. Review teams examine all available details of a child's life and death in order to identify areas where system improvements and prevention efforts are needed. Child death review teams are at work in all 50 states.

Child fatality review also provides an opportunity to evaluate laws, policies, resources, training, and procedures designed to keep children safe and healthy; and to find areas where changes may benefit the child safety net and improve the child injury and death investigation processes.

According to the National Center for the Review and Prevention of Child Death, there are six operating principles of child death review:

- The death of a child is a community responsibility
- A child's death is a sentinel event that should urge communities to identify other children at risk for illness or injury
- A death review requires multidisciplinary participation from the community
- A review of case information should be comprehensive and broad
- A review should lead to an understanding of risk factors
- A review should focus on prevention and should lead to effective recommendations and actions to prevent deaths and keep children healthy, safe and protected

In Virginia, the five regional child fatality review teams examine all infant and child deaths that were investigated by a local department of social services because it was suspicious for child abuse or neglect. While many of these deaths are not found to be the result of child abuse or neglect after these investigations, teams are still able to use review information to identify and understand risk factors for illness, injury and death in their communities.

Child deaths may not be reviewed before the social services agency has concluded its investigation and any criminal investigations are also complete. This is done to underscore the prevention purposes of review and emphasize that child death review is not a re-investigation of the death, but a way to understand what happened and what can be done to prevent it from happening again. Meetings are closed to the public and have significant confidentiality protections in place.

WHEN DID REGIONAL CHILD FATALITY REVIEW ORIGINATE ?

Virginia law (Code § 32.1-283.2) permits any Virginia community to establish a child fatality review team. Currently, there is a team in each of the five Virginia Department of Social Services (VDSS) regions. Teams were established in the Northern, Central, Western and Piedmont regions in 2011. The Eastern team was developed in 1994 and has served as a model for the rest of the state.

HOW ARE THE CHILD FATALITY REVIEW TEAMS FORMED?

Each VDSS region has a Child Protective Services (CPS) Regional Consultant who is responsible for team recruitment and coordination. Team participation is voluntary and drawn from a number of professionals in the region. A typical team is multidisciplinary and includes: Commonwealth Attorneys, social workers, family services specialists, law enforcement officers, physicians, substance abuse treatment providers, child advocates, public health workers, forensic pathologists and school officials.

HOW OFTEN DO THE TEAMS MEET?

The number of meetings will vary by team. The CPS Regional Consultant will determine the number of meetings necessary based upon the number of child deaths in his or her region during the state fiscal year (07/01—06/30) being reviewed.

WHAT HAPPENS AFTER THE REVIEW IS COMPLETED?

At the end of every team meeting, information from each case is added to the National Child Death Registry where statistical data are stored and disseminated as needed. At the end of each review year, teams analyze their findings and develop recommendations designed to prevent future child fatalities. These recommendations typically involve initiatives and/or campaigns to improve public awareness, education and training. A final report encompassing all of the teams' recommendations is then compiled by the Virginia Department of Social Services. Some recommendations are most practically carried out at the state level, while others are more appropriately implemented by regional teams in their communities.

WHERE CAN I FIND OUT MORE?

If you have additional questions about child fatality review, contact the CPS Regional Consultant for your area:

Central Regional Consultant @ (804) 662-9779
Eastern Regional Consultant @ (757) 491-3987
Northern Regional Consultant @ (540) 347-6309
Piedmont Regional Consultant @ (540) 204-9637
Western Regional Consultant @ (276) 676-5637; or the
CPS Program Manager @ (804) 726-7554