

# **CWS2041: Child Fatality Investigations LEARNER HANDOUTS**



**VIRGINIA DEPARTMENT OF  
SOCIAL SERVICES**

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## AGENDA

### **DAY ONE:**

- Introductions
- Why and How Children Die
- Reports of Child Fatality
- Collaborative Response
- Beginning the Investigation

### **DAY TWO:**

- Review / Check-In
- Self-Care / Resources
- Evidence in the Investigation
- Closing the Investigation
- Child Fatality Review Teams

**LEARNING OBJECTIVES**

AT THE END OF THIS TRAINING SESSION, THE LEARNER SHOULD BE ABLE TO:

- Complete the appropriate tools required for the intake and investigation of a report of Child Fatality, enter them into the Child Welfare Information System, and make required notifications as laid out in guidance.
- Describe the multidisciplinary response to child death investigations and the process of a Child Protective Services investigation of a child death, including the roles and responsibilities of each Multidisciplinary Team (MDT) member involved with the process.
- Plan for the safety of sibling children including follow-up planning with service providers, and accurately completing and entering the SDM Safety Assessment and SDM Safety Plan into the Child Welfare Information System.
- Identify signs of secondary trauma and describe ways to prioritize self-care by locating resources available to help prevent burnout.
- Thoroughly document each step of the investigation in the Child Welfare Information System, including obtaining medical records and attending the autopsy, to support a final disposition.
- Present necessary information at the Child Fatality Review Meeting and identify primary examples of prevention opportunities that could have been employed.

## DEATH TYPES, RISK FACTORS AND STATISTICS

### Types of Deaths:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_
6. \_\_\_\_\_

### Risk Factors:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_
6. \_\_\_\_\_
7. \_\_\_\_\_
8. \_\_\_\_\_
9. \_\_\_\_\_

### Statistics:

- In 2024, \_\_\_\_\_ % of child fatality victims in Virginia were 0-3 years old  
(Child Maltreatment Death Investigations In Virginia During State Fiscal Year 2024, 2025).
- \_\_\_\_\_ % of fatalities related to abuse and neglect had previously been reported to CPS in Virginia in 2024 (Child Maltreatment Death Investigations In Virginia During State Fiscal Year 2024, 2025).
- Children with a prior allegation of abuse or neglect were fatally injured at a rate that was more than \_\_\_\_\_ times that of children without a prior allegation (Putnam-Hornstein, E., 2011).
- In 2024, \_\_\_\_\_ % of fatalities in Virginia were related to an unsafe sleep environment  
(Child Maltreatment Death Investigations In Virginia During State Fiscal Year 2024, 2025).

## WATER SAFETY

### GUIDE YOUR CHILDREN TO **SAFE WATERS**

The Virginia Department of Social Services reports that a lack of proper supervision is a leading cause of drowning in children. Understanding the safety steps required to protect your children around any body of water they may encounter, especially during the summer months, is critical.



*It takes as little as 20 seconds  
for a child to drown.*

### Docks

- » Watch for tripping hazards on the dock and do not allow running on docks
- » Ensure that old boards are replaced and that there are no nails sticking up from the wood
- » Wear life jackets at all times (do not substitute water wings or other flotation devices for life jackets). Ensure that life jackets fit correctly and are up to date
- » Consider putting a gate at the front of docks and other forms of safety rails along the dock
- » Ensure that there is at least one throwable buoy on each dock
- » Know the depth of the water around your dock and do not allow diving from the dock
- » Put away all water toys and fishing equipment to prevent children from going to the water alone

### Pools

- » Children need constant supervision by a safe and sober caretaker while swimming
- » Teach your child to swim as early as possible and contact local community agencies for information about lessons
- » Swimming pools should be surrounded by a fence
- » Children should be wearing U.S. Coast Guard-approved life jackets while swimming







## Beaches

- » Do not go in the water with an open wound
- » Be aware that beaches have litter, sharp glass and other debris, and wear sand socks or water shoes for protection
- » Ensure that any child in the water is wearing a life jacket (do not substitute with water wings or other flotation devices), even if they know how to swim
- » Be aware of postings and notices regarding algae blooms and water conditions
- » Be aware of potential rip tides and teach children what to do if they encounter one
- » Ensure that all children are wearing sunscreen, even on cloudy days, and reapply often
- » Enroll children in swim lessons as soon as possible

## Boats

- » Ensure regular maintenance of boats, especially for electrical and fuel needs
- » Turn off portable heaters and other appliances when not on board the boat
- » Everyone on the boat should wear life jackets at all times while on and near the boat
- » Wear proper footwear at all times to avoid slipping or tripping
- » Ensure that children are secure while on board and maintain safe speeds



### Visit the resources below for additional information:

- » American Academy of Pediatrics - [www.aap.org](http://www.aap.org)
- » Pool Safely - [www.poolsafely.gov](http://www.poolsafely.gov)
- » Safe Kids Worldwide - [www.safekids.org](http://www.safekids.org)
- » Virginia Department of Health - [www.vdh.virginia.gov](http://www.vdh.virginia.gov)



## GUN SAFETY



If you have a firearm in your home, it is crucial to ensure appropriate supervision, safety and storage to reduce the risk of injury or death.

### Practice the Three S's of Gun Safety:



#### Speak Up

- » Talk with children about the risk of injury or death from firearms
- » Teach your child if they find a firearm to leave it alone and alert an adult right away



#### Safe Storage

- » Store firearms unloaded and separately from ammunition
- » Secure firearms in a locked safe or box; regularly change the lock combination or key location



#### Supervise

- » If a family member is experiencing increased mental health issues, consider removing any firearms from the home
- » As a parent or caregiver, ask about access to unsecured firearms when children are visiting someone else's home

*\*This information has been adapted from Virginia Department of Health resources on firearm safety and Lock and Talk Virginia\**

If you or someone you know is experiencing a life-threatening injury or act of violence, call 911 immediately.

For more information on the prevention of child fatalities, please contact your local department of social services or visit [www.lockandtalk.org](http://www.lockandtalk.org) to learn more about gun safety.

Poison Emergency: 1-800-555-1212

National Suicide Prevention Lifeline: 1-800-273-8255



## GUIDE FOR USING RECREATIONAL MARIJUANA WHILE PARENTING

Until more is known about the short- and long-term effects of marijuana exposure, it is safest to avoid using marijuana while parenting.



### Where can I get more information?

Contact your local department of social services.  
[www.dss.virginia.gov/localagency/index.cgi](http://www.dss.virginia.gov/localagency/index.cgi)

### Additional Resources

[www.dss.virginia.gov](http://www.dss.virginia.gov)  
[www.samhsa.gov/marijuana](http://www.samhsa.gov/marijuana)

### Acknowledgements

Some of this information is from the Public Health Agency of Canada and the Best Start Resource Centre. VDSS' Protection and In-Home Program Team and the SUD Team developed these materials.



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801 E. Main Street  
Richmond, Virginia 23219  
[www.dss.virginia.gov](http://www.dss.virginia.gov)

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DGS: Division of Purchases and Supply

B032-01-0002-01-ENG (02/2023)

## Guide for Using Recreational Marijuana While Parenting





## PARENTS' GUIDE FOR SAFE STORAGE OF MARIJUANA

**Marijuana can be harmful to children.**

**Products should be clearly labeled and stored in child-safe containers.**



### Where can I get more information?

Contact your local department of social services.  
[www.dss.virginia.gov/localagency/index.cgi](http://www.dss.virginia.gov/localagency/index.cgi)

### Additional Resources

[www.dss.virginia.gov](http://www.dss.virginia.gov)  
[www.samhsa.gov/marijuana](http://www.samhsa.gov/marijuana)

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## Parents' Guide for Safe Storage of Marijuana



## SAFE SLEEP



**Safe Sleep 365**

Infants should sleep

 <b>ALONE</b> on a firm, safe sleep space	 <b>APART</b> from blankets or objects	 <b>ALWAYS</b> on his/her back
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SafeSleep365.com  
800-05-0978-00-ENG 01/1/18

Approximately 3,700 infants die annually in the United States from sleep-related deaths, including sudden unexpected infant death syndrome (SUID), accidental suffocation and strangulation. The American Academy of Pediatrics (AAP) reports nearly one in five sleep-related deaths occur while an infant is in the care of someone other than a parent or usual caregiver.

To help caregivers of infants ensure a safe and healthy sleep environment, the AAP recommends the following sleep practices for children under one year of age:

- LAY INFANT ON FIRM SURFACE AND ON BACK**  
Infants should be placed to sleep on his/her back on a firm sleep surface with a tight-fitting sheet.
- ROOM SHARING, NOT BED SHARING**  
The safest place for an infant to sleep is in his/her own crib or bassinet, in a room with a caregiver.
- SUBSTANCE-FREE AND SMOKE-FREE**  
Tobacco, alcohol and drug use are major risk factors for SUID. Infants should remain in a smoke- and substance-free environment.
- OBJECT-FREE SLEEP SPACE**  
Bare is best when placing an infant to sleep in a crib. Toys, blankets or other objects can cause suffocation or strangulation.
- ENVIRONMENT-APPROPRIATE CLOTHING**  
Infants should be placed to sleep with his/her head uncovered and wearing no more than one additional layer than an adult.
- BREASTFEEDING**  
Breastfeeding improves breathing and swallowing coordination in infants, and is associated with a reduced risk of SUID.

**ADDITIONAL RESOURCES** For the complete list of AAP guidelines and additional safe sleep resources, visit [SafeSleep365.com](http://SafeSleep365.com).

☐ Preliminary Child Fatality Form  
☐ Near-Fatality Form

**The Preliminary Child Fatality/Near-Fatality Information Form provides initial or preliminary information and shall be completed with as much of the following information as possible.**

CAPTA (Child Abuse Prevention and Treatment Act) defines a “near fatality” as an act that, as certified by a physician, places the child in serious or critical condition.

A near-fatality requires that a physician certify that a child is in serious or critical condition at the time of the report. Such certification can be either in writing or verbal. Hospital records which indicate the child's condition is serious or critical and life threatening are sufficient. The physician certification must be documented in the automated data system.

Referral #:

Date of Complaint:

LDSS:	
Investigating Worker:	Phone or Email:
CPS Supervisor:	Phone or Email:
Person Making Complaint/Relationship:	

#### Section A: Referral Information

Name of Child:			
Child's Date of Birth:		Date of Child's Death/Significant Event:	
Sex of Child: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown		Race: <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Asian <input type="checkbox"/> Multi-Racial <input type="checkbox"/> Unknown	
Type of Alleged Abuse or Neglect: <input type="checkbox"/> Physical Neglect <input type="checkbox"/> Medical Neglect <input type="checkbox"/> Physical Abuse <input type="checkbox"/> Sexual Abuse <input type="checkbox"/> Mental Abuse/Neglect			
Name of Alleged Abuser/Neglector:			
Relationship of Alleged Abuser/Neglector to Child:	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Parents <input type="checkbox"/> Grandmother <input type="checkbox"/> Other	<input type="checkbox"/> Grandfather <input type="checkbox"/> Foster Parent <input type="checkbox"/> Uncle <input type="checkbox"/> Aunt <input type="checkbox"/> Child Care Worker (reg)	<input type="checkbox"/> Siblings <input type="checkbox"/> Stepparent <input type="checkbox"/> Father's Paramour <input type="checkbox"/> Mother's Paramour <input type="checkbox"/> Child Care Worker (unreg)
Name of 2 <sup>nd</sup> Alleged Abuser/Neglector:			
Relationship of 2 <sup>nd</sup> Alleged Abuser/Neglector to Child:	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Parents <input type="checkbox"/> Grandmother <input type="checkbox"/> Other	<input type="checkbox"/> Grandfather <input type="checkbox"/> Foster Parent <input type="checkbox"/> Uncle <input type="checkbox"/> Aunt <input type="checkbox"/> Child Care Worker (reg)	<input type="checkbox"/> Siblings <input type="checkbox"/> Stepparent <input type="checkbox"/> Father's Paramour <input type="checkbox"/> Mother's Paramour <input type="checkbox"/> Child Care Worker (unreg)

Section B: Reporting Requirements

Did fatality occur in an out-of-family setting? ☐ YES ☐ NO

CPS Regional Practice Consultant:	Date Reported:
Law Enforcement:	Date Reported:
Commonwealth's Attorney:	Date Reported:
Regional Medical Examiner:	Date Reported:
Regulatory Authority: (if fatality occurred in an out-of-family setting)	Date Reported:

Section C: Circumstances Surrounding the Child's Death/Significant Event

Detailed Description of the Child's Death/Significant Event (When, where, why, how, who, and any related problems.)

## Family's Prior Involvement with the LDSS:

Program
<p><b>CPS</b>  Case/Referral Number:  Summary of Involvement:  Open at the time of fatality: <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p><i>Example:</i>  Case/Referral Number: 123456  Summary of Involvement: Family Assessment (January 2020) – opened due to concerns of parental substance use, family completed services, assessed risk was moderate  <i>*If assessed risk is high or very high, please indicate if a case (and the type) was opened</i></p>
<p><b>In-Home/Prevention</b>  Case/Referral Number:  Summary of Involvement:  Open at the time of fatality: <input type="checkbox"/> YES <input type="checkbox"/> NO</p>
<p><b>FC/Adoption</b>  Case/Referral Number:  Summary of Involvement:  Open at the time of fatality: <input type="checkbox"/> YES <input type="checkbox"/> NO</p>
<p><b>Benefits</b>  Was decedent/decedent's family receiving benefits at the time of the fatality? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p><input type="checkbox"/> Medicaid  <input type="checkbox"/> SNAP  <input type="checkbox"/> TANF/VIEW  <input type="checkbox"/> Other:</p>



Siblings of the Victim Child and/or Other Children in the Care of the Alleged Abuser/Neglector – Requires conducting a safety assessment and development of a safety plan.

Per Section 6.3.2 of CPS Guidance: If there are other children in the home, the safety assessment will be either conditionally safe (requires a safety plan) or unsafe (requires a court order) as death of child will be recorded in safety factor #1 on the safety assessment tool.

Sibling/Child Name (relationship)	DOB	Race	Sex	Initial Safety Decision: Conditionally Safe or Unsafe
<i>Ex: Sarah Smith (sibling)</i>	<i>1/2/2018</i>	<i>White</i>	<i>F</i>	<i>Conditionally safe</i>

Safety Plan Summary:

LDSS Action Plan (describe Investigation Plan; Regional Specialist's planned involvement and assistance; and any additional comments and concerns.

Disposition Due Date:

Update/Addendum:

**TURNER FAMILY INTAKE SCENARIO**

Referral # 1234567

Reporter: Latoya Johnson, Medical Social Worker

On 04/01/2023 at 3:05pm, Valley DSS Hotline received the following CPS report:

Caller is reporting concerns regarding a 4-month-old male child named Gabe Turner. The caller reported that Gabe arrived at Valley Medical Center Emergency Department via ambulance at 10:30am in cardiac arrest. Caller stated that the child could not be revived and was pronounced dead at 10:50am. Caller stated that the mother arrived via the same ambulance and was at the child's bedside when he was pronounced dead.

Caller reported that Gabe resided with his mother, Monique Turner, father, Dante Turner and twin brother, Grayson Turner. Caller stated that the mother disclosed that she is the primary caretaker of the twins due to her husband being a truck driver and being on the road a lot. Caller reported that the mother also disclosed she and the twins co-sleep in a queen size bed. When questioned about this further, the mother stated that anytime the twins go to sleep, they are dressed in warm footed sleepers and usually placed on their backs like she was told by their pediatrician. Caller stated according to the mother, she got out of bed around 9am, saw the twins were still sleeping so, she took a quick shower. Caller stated that when the mother went to change the child around 10am, she found him on his belly, noticed he was not breathing so, she called 911. Caller stated that the mother recalled last observing the child active sometime between 6-8am this morning.

Caller stated that Gabe and his twin, Grayson, have a history of Sickle Cell Anemia. Caller stated that according to the mother, the twins are followed closely by their pediatrician.

Caller stated the mother also informed her that she has an 8-year-old son and 5-year-old daughter who are in the care and custody of the mother's paternal aunt. The names of the children and the aunt are unknown to the caller. The caller reported that the twin brother, Grayson, is currently with a cousin whose name is also unknown to the caller.

Caller stated that the Medical Examiner's office was contacted, and an autopsy will be performed. Caller stated that Officer Williams with Valley Police Department wanted to speak to the Department as well and asked if it would be ok to pass him the phone.

Officer Williams stated that he and EMS arrived at the home at the same time. Upon entering the home, they found the mother, twins and a female family member in the living room. Officer Williams stated that the female family member was later identified as Nikki Walker, the mother's cousin. Officer Williams stated that according to EMS, the infant was in cardiac arrest so, they transported the mother and child to the hospital. Officer Williams stated there was not time to interview the mother while at the house. He noted that the mother did appear upset (visibly shaking and crying). Officer Williams stated that in the living room, he observed a yellow footed sleeper on the floor next to where EMS was working on the infant. Officer Williams said he walked around the home and did a quick glance into each room but did not see anything notable. Officer Williams stated that this case will be reassigned to a Detective.

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### **Oasis Search**

Referral # 2456871 (4/15/2020), INV PN, Founded, Level 1: Mother put the children (ages 6 & 3) to bed on the night of 4/14/2020 at approximately 9:00pm, before going out with friends. When the children awoke the next morning around 7:30am, the mother still had not returned home. The 6-year-old fell off a chair while attempting to make breakfast and hurt his elbow. A neighbor who happened to be walking by heard the cries from inside the apartment and she knocked on the door. The 6-year-old opened the door and told her what was going on. The neighbor tried to reach the mother via cell phone, but there was no answer. The neighbor called 911 at 8:00am. It was later discovered that the 6-year-old had dislocated his elbow when he fell. The mother arrived at the hospital after being located by police. She was drug tested and tested positive for cocaine and THC. The mother admitted to leaving the children alone at home and stated that she did not intend to stay gone all night. CPS took custody of the children and placed them temporarily with their maternal great-aunt. The mother did not complete services as recommended by CPS. The great-aunt was granted full legal custody of the children.



## VIRGINIA DEPARTMENT OF SOCIAL SERVICES

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### **Child Fatality Investigation Recommendations for inclusion in Memorandums of Understanding (MOUs)**

The investigation of child deaths is one of the most challenging and complex responsibilities of the child welfare system. CPS has an integral role in the investigation regarding the victim child and family.

Child death investigations have the best outcomes when there is timely notification and when CPS and law enforcement (LE) conduct a joint investigation.

Many localities have high functioning MOUs; the use of MOUs between LE and the Local Department of Social Services (LDSS) to ensure notifications and collaboration with LE is recommended. Listed below are goals and guidelines for localities to consider including in these agreements.

Goals for existing MOUs:

- Ensure the protection of children and community safety by maximizing interagency cooperation and seeking the expertise of LE and CPS throughout the investigation
- Promote uniformity in the investigation of the child's death
- Assess the safety of any siblings
- Minimize repetitive interviews through coordination and collaboration at the onset of the joint investigation

**Notification of a child death:** Law enforcement is sometimes the only agency notified of a child's death. It is recommended that the locality's MOU include a mechanism for LE to contact CPS whenever a child death occurs or vice versa.

**Investigation of a child death:** It is recommended that the locality's MOU include how a joint investigative plan will be established, which can include but is not limited to, family and witness interviews, scene recreation, autopsy etc. It is expected during business hours that investigations will be conducted jointly by law enforcement and child protective services investigators. This is in accordance with section [63.2-1507 of the Code of Virginia](#).

**Interviews:** It is recommended that the locality's MOU address how joint interviews will be conducted during the child death investigation. [Virginia Administrative Code 22 VAC 40-705-80 A1-2](#) states that CPS shall conduct face-to-face interviews of any siblings within the determined response time (24 hours for a child death). If this requirement cannot be scheduled together with LE, the CPS worker will still respond and conduct a minimum facts interview to assess the safety of any

siblings and make safety arrangements if needed. Law enforcement and CPS will coordinate the completion of a forensic or fact-based interview later.

- Interviews with siblings: It is best practice that any sibling interview be conducted by a forensic interviewer at a Child Advocacy Center (CAC).
- Interviews with non-offending parents or caretakers: all efforts will be made for LE and CPS investigators to jointly interview these persons.
- Interviews with collaterals: all efforts will be made for LE and CPS investigators to jointly interview these witnesses and gather additional information regarding the child's death.
- Interview with alleged abuser or neglector: all efforts will be made for LE and CPS investigators to conduct the interview together. If CPS is not available, LE will provide all appropriate documentation to CPS.
  - Important note: Law enforcement may object to the CPS investigator informing the alleged abuser or neglector of his right to electronically record an interview, as it is believed such instruction will compromise the investigation of any criminal charges. If this objection is made, then the CPS investigator shall not advise the alleged abuser or neglector of that right.

**Autopsy:** It is recommended that the locality's MOU address the coordination and attendance of the autopsy by the LE and CPS investigators as appropriate, which may offer valuable first-hand observations to the investigators and can provide additional information to the medical examiner.

- If concerns arise that the child's death was related to a lack of medical care by the alleged abuser, any discussions with the medical provider(s) should be conducted jointly by LE and CPS.

**Safety Planning:** The locality's MOU should recognize that CPS responsibilities include the assessment of child safety, to make necessary plans and to coordinate with LE.

- Siblings: are included in the safety plan, have an intentional plan to reduce trauma that will be at the scene, etc.
- Support and resources: trauma informed support at the scene and referrals for services, etc.
- Removals: Issues that may necessitate a removal can include but are not limited to, the inability to develop a safety plan to address the safety factor(s) identified, criminal charges.
- Scene re-creation: The locality's MOU should have a plan to address attendance at the scene-recreation, particularly if such recreation identifies a practice by the caretaker(s), which may place other children at risk.

**Evidence Collection:**

- It is recommended that LE and CPS address who is responsible for the collection of evidence.

(December 2020)



## JOB AID FOR CHILD DEATH INVESTIGATIVE PROTOCOL



VIRGINIA DEPARTMENT OF  
SOCIAL SERVICES

**DFS** Division of  
Family Services

## Job Aid for Child Death Investigative Protocol

*As part of a child death investigation, it is important to ask questions and obtain information to understand the circumstances surrounding the child's death. The following is a list of suggested questions that can be used to guide the investigation:*

General Information	Physical Health	Mental Health	Substance Use	Home Observations	Siblings
<ul style="list-style-type: none"> <li><input type="checkbox"/> Demographics of victim child and caretaker</li> <li><input type="checkbox"/> Who called 911</li> <li><input type="checkbox"/> Details surrounding emergency care and who provided it</li> <li><input type="checkbox"/> Who found the victim</li> <li><input type="checkbox"/> When was the victim last seen alive</li> <li><input type="checkbox"/> Victim child's appearance at time of death</li> <li><input type="checkbox"/> Prior child welfare history</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Disabilities of victim child</li> <li><input type="checkbox"/> The health of the victim child</li> <li><input type="checkbox"/> Information about the pregnancy and prenatal care provided</li> <li><input type="checkbox"/> The child's medical history</li> <li><input type="checkbox"/> When the child was last seen by a medical provider</li> <li><input type="checkbox"/> Medications being taken</li> <li><input type="checkbox"/> Medical diagnoses for the child</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Diagnoses of the victim child or caretakers</li> <li><input type="checkbox"/> Mental health treatment received by victim child or caretakers</li> <li><input type="checkbox"/> Who was providing that care</li> <li><input type="checkbox"/> When services were last received</li> <li><input type="checkbox"/> Medications being taken</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Substance use (illegal and legal) by the child or caretakers</li> <li><input type="checkbox"/> When substances were last used and by whom</li> <li><input type="checkbox"/> Substances located in the home</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> The temperature in the home, including the water temperature</li> <li><input type="checkbox"/> Functionality of utilities</li> <li><input type="checkbox"/> Presence of food or formula</li> <li><input type="checkbox"/> Hazards inside and outside of the home</li> <li><input type="checkbox"/> Pets</li> <li><input type="checkbox"/> Sleep spaces</li> <li><input type="checkbox"/> Weapons and ammunition</li> <li><input type="checkbox"/> Medications</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Educational and childcare arrangements</li> <li><input type="checkbox"/> Location of siblings at the time of death</li> <li><input type="checkbox"/> When siblings last saw victim child alive</li> <li><input type="checkbox"/> Siblings reactions to victim child's death</li> <li><input type="checkbox"/> What the siblings know about the death</li> <li><input type="checkbox"/> Ask siblings about the victim child's relationship with caretakers</li> <li><input type="checkbox"/> Ask siblings about discipline used</li> </ul>

**TURNER FAMILY CASE FOLLOW-UP**

**Home Visit**

Detective Dan Wagstaff with Valley Police Department and FSS Kim Bryant with Valley DSS went to the Turner home later that day around 4:15pm, as Ms. Turner arrived home from the hospital. See home visit notes below:

Monique Turner greeted them as she pulled into the driveway and allowed them into her home. Detective Wagstaff and FSS Bryant both expressed their condolences to the mother and her family. The Detective and FSS explained their roles and the need to gather more information. FSS Bryant then explained the CPS investigation process, offered to record the interview (which Ms. Turner agreed to), and provided the CPS Investigation brochure.

Detective Wagstaff asked Mrs. Turner questions about the moments leading up to the tragedy. Mrs. Turner stated that she got out of bed around 9am, took a shower, and recalled getting a phone call from her husband around 9:40am. Mrs. Turner stated that she was in the kitchen while talking to her husband. Mrs. Turner said she heard what she thought were the babies making noises, so she hung up the phone and went to check on them in the bedroom. Mrs. Turner stated that is when she found Gabe.

Detective Wagstaff asked her if she recalls what position Gabe was laying in and any other details that could help them figure out what happened to him. Mrs. Turner said she found him lying on his belly, but she swears she saw him on his back before going to take a shower. Detective Wagstaff asked Mrs. Turner when the twins' last feeding was, and she said around 6:00am. Detective Wagstaff asked her if she recalls any certain details from that feeding. Mrs. Turner said "Not really. I mean I remember feeling exhausted and wanting them to hurry up to eat so, we could go back to sleep."

Detective Wagstaff asked Mrs. Turner to show them where this all took place. Mrs. Turner led them to her bedroom. FSS Bryant noticed there was a queen size bed, nightstand, dresser, and TV in the room. FSS Bryant observed there to be two empty baby bottles and a wine glass on the nightstand next to the bed. FSS Bryant noticed there was a throw blanket and one pillow towards the right side of the bed, and nothing on the left side near the wall.

FSS Bryant also noticed that the sheet covering the mattress was bunched up in the left corner, exposing the bare mattress. Detective Wagstaff asked Mrs. Turner where she found Gabe and she pointed to the area on the bed where the sheet was bunched up. FSS Bryant asked Mrs. Turner if the sheet was like that when she found him and she said, "I'm not sure, it's all a blur." The Detective took photographs of the home, including the bed, before collecting the sheets as evidence.

Mrs. Turner showed them the rest of the house. There were 3 bedrooms in the home. One bedroom appeared to be the twins' bedroom; it had two cribs, a dresser, and some baby toys in it. The other bedroom appeared to be used for storage. FSS Bryant asked Mrs. Turner if the twins ever use their cribs and she replied with "I know they should but, no not really." FSS Bryant asked her the reason behind choosing to co-sleep even though she has cribs and Mrs. Turner stated, "It's easier when you have two of them to care for by yourself."

FSS Bryant gently stressed the importance of carefully observing Grayson, the surviving twin, for any signs of injury and recommended that he receive a medical evaluation as soon as possible. She explained that, because the infants are twins, any underlying medical condition or possible maltreatment could place both children at risk. Ensuring Grayson's immediate evaluation was viewed as an essential step to protect his safety and prevent delayed symptoms from going unnoticed while under a safety plan. Ms. Turner expressed understanding and agreed to have Grayson medically evaluated.

Mrs. Turner also stated, "I didn't think twice about it because I co-slept with my other two kids, and they are fine."

FSS Bryant asked Mrs. Turner about the situation with her other children. Mrs. Turner stated that two years ago, she lost custody of her son, Roger Watts (age 6), and her daughter, Raquel Watts (age 3), due to addiction issues. FSS Bryant asked Mrs. Turner what her involvement with her children is currently and she said that she gets them for visitation when she can. Mrs. Turner said the kids are doing very well with their maternal great-aunt, so she doesn't have any plans on trying to get custody back as of now. Mrs. Turner provided FSS Bryant with the maternal great-aunt, Wanda Shipp's contact information.

Detective Wagstaff pointed out the wine glass and asked Mrs. Turner if she used any drugs, alcohol, or medications last night. Mrs. Turner admitted to having a couple glasses of wine and taking sleeping medication last night. Mrs. Turner stated that she has not been sleeping well and the stress of caring for the twins all by herself was starting to take a toll on her. FSS Bryant asked Mrs. Turner when her husband is expected to return home from the road. Mrs. Turner said “tomorrow.”

The mother’s cousin came into the home with Grayson. FSS Bryant and Detective Wagstaff met with the mother’s cousin, Nikki Walker, in the twins’ bedroom. Ms. Walker stated that she can continue to care for Grayson, but she would like to stay in the home with Mrs. Turner, since all the necessities to care for him are here. FSS Bryant developed a safety plan with Mrs. Turner and Ms. Walker regarding the care and safety of Grayson Turner. FSS Bryant gave Mrs. Turner her business card and requested that her husband call her upon his return to town. Mrs. Turner signed a safety plan agreeing to the above. Safe sleep education was provided to both Mrs. Turner and Ms. Walker.

---

**As a group, discuss the following:**

1. Does anything change if the father is appropriate? What about if the father is not appropriate or says he cannot be the full-time caretaker of Grayson?
  
  
  
  
  
  
  
  
  
  
2. Does there need to be any contact with the maternal great-aunt of the older children? Why or why not?
  
  
  
  
  
  
  
  
  
  
3. What would you expect the mother to be feeling at the time of safety planning for Grayson?
  
  
  
  
  
  
  
  
  
  
4. In what ways can you, as the Family Services Specialist, minimize the implication that you are accusing the mother of wrongdoing at this point in the investigation? What could you say and how can you express empathy while ensuring Grayson's safety?



**NOTIFICATIONS IN A CHILD FATALITY**

**1. Law Enforcement**

Contact: \_\_\_\_\_

**2. Commonwealth's Attorney**

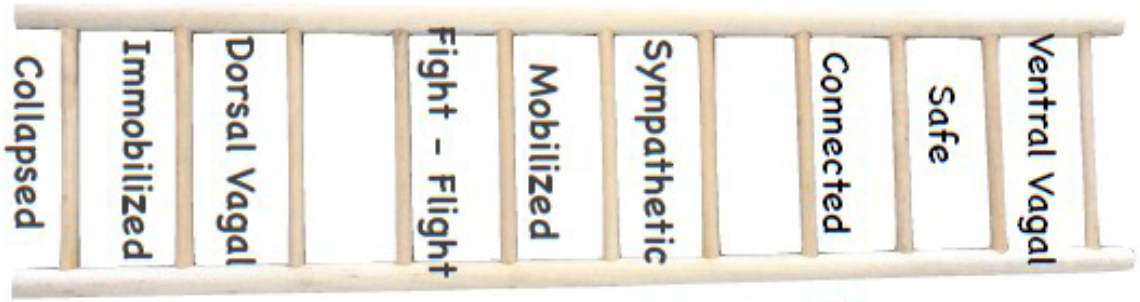
Contact: \_\_\_\_\_

**3. District Office of the Chief Medical Examiner**

Contact: \_\_\_\_\_

**4. CPS Regional Practice Consultant**

Contact: \_\_\_\_\_



The world is...  
I am...

The world is...  
I am...

The world is...  
I am...

## HANDOUT H-1

### SAMPLE NOTIFICATION LETTER TO MEDICAL EXAMINER

The following letter can be used to provide notification of a child death and to request a written copy of the autopsy report.

---

Month, Date, Year

Department of Health  
Office of Chief Medical Examiner  
Street Address  
City, VA Zip

In Re: Child Who Is A Victim  
DOB: 2 digits/2 digits/4 digits

Parent: First/Last Name and First/Last Name  
Resident at time of death:  
Street Address  
City, VA Zip

Dear Office of Chief Medical Examiner:

I am writing to provide notification of the death of above referenced child pursuant to §63.2-1503 E of the Code of Virginia. The date of death is 2 digits/2 digits/4 digits.

I am a Family Services Specialist at *(insert agency name)* and I have been assigned the death investigation of the child who is a victim reference above. As part of the death investigation, the *(insert agency name)* Department of Social Services requests a written copy of the completed autopsy report.

Please forward the information to:

- *(Insert agency name)* Department of Social Services,
- Attention: *Assigned Worker Name*, Family Services Specialist
- Street Address • City, VA Zip

If you have any questions, I may be reached at xxx-xxx-xxxx.  
Thank you for your immediate attention in this matter.

Sincerely,

Worker Name  
Family Services Specialist

## EVIDENCE IN THE TURNER SCENARIO

As a table group, make a list of the various types of evidence you would be gathering in the Turner scenario.

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

## CHILD FATALITY CHECKLIST

Revised 04-2024

Child Welfare Information System/Notifications	Date Completed
Report entered in Child Welfare Information System	
Fatality box checked on A/N Allegation screen	
Determine validity and assign response priority (must be placed in Investigation track) <ul style="list-style-type: none"> <li>If victim is in agency's custody, request a neighboring locality to investigate.</li> <li>If victim is in another agency's custody, notify that locality immediately.</li> </ul>	
Contact CPS Practice Consultant immediately. If the victim child was in foster care, contact the CPS <i>and</i> Foster Care Practice Consultants.	
Complete the Preliminary Child Fatality/Near-Fatality Form and send to CPS Practice Consultant within two working days.	
Notify the regional Office of the Chief Medical Examiner immediately and request a copy of the autopsy report in writing.	
Notify Commonwealth's Attorney immediately, but no later than two hours from the time of the report.	
Notify law enforcement immediately, but no later than two hours from the time of the report.	
Notify the Regulatory Authority if the fatality occurred in an out-of-family setting.	

Investigation (Conduct INV according to sections 4 & 6 in the guidance manual)	Date Completed
Assess immediate safety of siblings or other children under the supervision of the alleged abuser/neglector. <ul style="list-style-type: none"> <li>Be sure to check safety factor #1 on the safety assessment if there are surviving children.</li> </ul>	
Assess risk (policy override to "very high" if a caretaker caused the child's death).	
All contacts and notifications must be documented in the Child Welfare Information System.	
Suspensions: Document request in the Child Welfare Information System and get supervisory approval. <ul style="list-style-type: none"> <li>Notify the alleged abuser and family in writing of the suspension.</li> <li>Document monthly contacts in the Child Welfare Information System.</li> </ul>	
Document the information contained in the autopsy report in the Child Welfare Information System, to include cause and manner of death.	
Consult with CPS Practice Consultant to review case prior to disposition.	
Regional Child Fatality Review to be scheduled by home office staff if fatality meets criteria for review. <ul style="list-style-type: none"> <li>Review is postponed until the completion of the criminal case unless consent is given by the Commonwealth's Attorney.</li> </ul>	



## DISPOSITIONAL ASSESSMENT DOCUMENTATION EXAMPLES IN CHILD FATALITY CASES

### Unfounded:

Following a thorough Child Protective Services investigation, and a case staffing between **CPS Worker's name** and **CPS Supervisor's name**, on **date of staffing**, this Department has determined the disposition to be **UNFOUNDED**, for **type of abuse/neglect** of **Victim Child's name** by **Alleged abuser/neglector's name**. "Unfounded" means a review of the facts does not show by a preponderance of the evidence that child abuse/neglect occurred. (Child Protective Services Policy Manual, Section 4.6.30). "Preponderance of evidence" means just enough evidence to make it more likely than not that the asserted facts are true. It is evidence which is of greater weight or more convincing than the evidence offered in opposition (22 VAC 40-705-10).

A definition of the specific type of child abuse/neglect investigated in this case can be found in the Child Protective Services Policy Manual, Section **\*\*\***. Basis for this finding:

*(Select One of the Following)*

- No evidence to support abuse/neglect.
- Insufficient evidence to support abuse/neglect.
- A preponderance of the evidence does not exist to support a finding of abuse/neglect.

List facts gathered during this investigation and state how the facts do not support a finding.

**Founded:**

Following a thorough Child Protective Services investigation, and a case staffing between **CPS Worker's name** and **CPS Supervisor's name**, on **date of staffing**, this Department has determined the disposition to be **FOUNDED, LEVEL \***, for **type of abuse/neglect** of **Victim Child's name** by **Alleged abuser/neglector's name**. The definition of a founded disposition as defined in the definition section of the Virginia Administrative Code (22 VAC 40-705-10) is: "Founded" means that a review of the facts shows by a preponderance of the evidence that child abuse and/or neglect has occurred. A determination that a case is founded shall be based primarily on first source evidence; in no instance shall a determination that a case is founded be based solely on indirect evidence or an anonymous complaint. "Preponderance of evidence" means just enough evidence to make it more likely than not that the asserted facts are true. It is evidence which is of greater weight or more convincing than the evidence offered in opposition (22 VAC 40-705-10).

- Copy and paste the **definition** of the specific type of child abuse/neglect that was investigated from the CPS Manual C Section 2.
- Copy and paste the corresponding **disposition level** from the CPS Manual C Section 4.
- Copy and paste the **risk level**.

This disposition is based on the following evidence gathered throughout the course of this investigation:

- List facts gathered during this investigation and state how they support the finding and level you have chosen.

**Disposition Levels (CPS Manual Section 4):**

**4.6.34.1 Level 1.** This level includes those injuries/conditions, real or threatened, that result in or were likely to have resulted in serious harm to a child.

**4.6.34.2 Level 2.** This level includes those injuries/conditions, real or threatened, that result in or were likely to have resulted in moderate harm to a child.

**4.6.34.3 Level 3.** This level includes those injuries/conditions, real or threatened, that result in minimal harm to a child.

**Risk Levels (CPS Manual Section 4):**

**4.6.25**

**Low Risk-** The assessment of risk related factors indicates that there is a low likelihood of future abuse or neglect, and no further intervention is needed.

**Moderate Risk-** The assessment of risk related factors indicates that there is a moderate likelihood of future abuse or neglect, and minimal intervention may be needed.

**High Risk-** The assessment of risk related factors indicates there is a high likelihood of future abuse or neglect without intervention.

**Very High Risk-** The assessment of risk-related factors indicates there is a very high likelihood of future abuse or neglect without intervention.

## TURNER CASE AUTOPSY

### **Autopsy Results**

FSS Bryant submitted a written request to obtain a written copy of the autopsy report from the Medical Examiner's Office. FSS Bryant reviewed the following results:

**Cause of Death:** SUID associated with unsafe sleep

**Manner of Death:** Undetermined

Detective Wagstaff informed FSS Bryant that, at this time, his department will not be filing criminal charges against the mother, and he will be closing his case.

FSS Bryant staffed this investigation with CPS Supervisor Sherry Dunkin to discuss the facts in the case and to determine the final disposition.

---

**QUESTIONS TO GUIDE THE VERBAL PRESENTATION AT A  
REGIONAL CHILD FATALITY REVIEW MEETING**

1. How was the agency notified of the fatality?
2. What were the circumstances of the death? How was the injury described and explained? What was the supervision of the child? Were other persons present and what did they report?
3. What was the agency's initial response? Who responded and when? What was happening upon arrival? What were the responses of those present? Who was interviewed? What did they say? What was observed?
4. Was the child or family known to DSS? If so, how?
5. Were there any prior family assessments or investigations? What did they involve? What was the outcome and risk level? What were the outcomes of those interventions?
6. What safety factors and protective capacities were identified? What risk factors were identified?
7. What services have been provided to the family before and after the fatality?
8. Did CPS and law enforcement conduct a joint investigation of the child death?

NOTE: The presenter must bring a copy of the case record, including any photographs.

## **CHILD FATALITY REVIEW TEAM TIP SHEET**

The following information is borrowed from The National Center on Child Fatality Review and has been edited for Virginia teams. Attending a Child Fatality Review Team (CFRT) meeting for the first time may seem somewhat overwhelming. LDSS may ask their staff to attend to present a case or staff may wish to attend a meeting for training purposes as an introduction to the concept of child death reviews. Attending a CFRT meeting can also enhance the worker's investigative skills. CPS staff that have had a child death on their caseload can benefit from attending a meeting so that they can share firsthand case experience and be an integral part of the response to that death. Firsthand observations have substance and texture that are lost in the text of written reports.

### **Who can attend a CFRT?**

Some LDSS staff may want to take a co-worker or supervisor to their first meeting. Time with a co-worker or supervisor after the meeting may provide a resource and opportunity to debrief.

### **What to bring to a meeting?**

Please bring the entire record including any photographs. For those who are presenting information at the CFRT, preparation is imperative, which means bringing all information about the case that might be helpful to the team. If presenting, staff should also make sure they are familiar with their agency's official protocols for sharing case material. Be sure to bring the National Maternal Child Health (MCH) Center for Child Death Review Case Report tool, having completed as much as possible during the investigation.

### **What to expect at the meeting?**

As a first-time presenter to the CFRT meeting, you may know some of the team members. Introductions should help you meet others you don't know. You may want to talk to some of them before or after the meeting, as they may bring you resources for other cases. You may have a chance to ask a question of an expert who would otherwise be lost in a chain of command between agencies. Take advantage of the opportunity.

Most people on child fatality review teams want to be helpful. Distractions may exist in the room. Your agency might be defensive, resistant to sharing, and even concerned about blame. You may feel awkward about speaking in a group. Focus on why you are there. Teams are generally protective of each other, even if you are a new member or a visitor. Don't be afraid to ask questions about what you don't understand.

Some people attending a CFRT meeting may feel quite anxious as they approach and enter the room. Others may consider it just another meeting. You will be asked to sign a Confidentiality Agreement before each case presentation. Prior to the presentation of cases, you will be asked to introduce yourself. Your team coordinator or chair may inform you of the process that cases are presented. Cases are reviewed one by one. Each agency will have a turn to share what they know about the death. The process is simple. During the meeting, if you are attending for a specific case, you may be asked to present if you have knowledge of the case or have recommendations. Just relax; be honest and responsible. During most of the meeting, you will have the opportunity to listen to others. If you have something to add, share it.

Be factual. It is not necessary to use names while presenting a case. For example, you can use terms such as victim child, siblings, parents, maternal grandparents, neighbors, etc.



## **Case Presentation**

Be thorough yet succinct in presenting your case to the team. Avoid reading from your records. Provide a summary of the agency's involvement with the family and response to this child's fatality. Imagine presenting the information as if telling a story of the incident. It may be helpful to start with the injury and/or death notification to your agency and then move (1) forward to describe your investigation and conclusions on the death and (2) backward from the death to other knowledge and/or contact with the child and his/her family and caregivers. Some suggested questions to answer:

- How was your agency notified of the death? When? Why? By whom?
- What were the circumstances of the death? How was the child's injury described and explained? What did the primary caregiver report about behavior and supervision of the child around the time of the injury? Were other persons present in the household? What did they report about the incident?
- What was your agency's response? Who responded? When? What was going on when you arrived and what did you do while you were there? What was the response from the family/parents/witnesses upon your arrival? What did you do while you were there? With whom did you speak? Were they cooperative? What was the affect of the individuals during your interaction or observation?
- Was the family known to your agency prior to this fatality? Why?
- If your agency did assessments of the child or caregivers, what were the outcomes of those assessments?
- What risk and protective factors were present in the child's life?
- Were you already providing services to this family at the time of the fatality? Had you previously provided services? Did you provide services after this fatality? Describe all services provided.

## **Confidentiality**

Honor confidentiality. The basic rule is that everything stays in the room. The exception is that members may continue contact after the meeting to gather information useful for a case. Material taken to court should be collected separately from the team process. Sometimes, the possibility of a subpoena or court order may be the deciding factor in how information is shared. The rules for sharing records are complicated by different laws and different legal opinions on the meaning of the same law.

Most guidelines define what you should not do. Review of child death brings up the counter question regarding the legal hazards of not sharing. Agencies can be held liable for what they don't do, as well as what they do. You should not share specific case information or team comments outside of the team. The exception is for necessary case management. Ask for assistance or have your team manage this process. You may share general information on the process with a colleague in your agency. You may want to share general comments with no possible case identifiers with your family or friends to debrief yourself and manage your personal reaction to the death of a child. However, families and friends might not want to hear such material.

Ask questions if you want to know how much and with whom you can share information. If the material bothers you, look for a safe outlet. Protect and respect the process.

## CHILD FATALITY REVIEW PRESENTATION TEMPLATE

### Child Fatality Review

Date

Locality Name  
Referral #

- Date referral was received?
- How was the agency notified of the fatality?
- What were the circumstances reported?

#### Response

- Was there an immediate response?
  - ~ Who responded and where?
  - ~ If delayed, explain reason and when response did occur.
- Who was present at the response location?
- Were there any surviving siblings?
  - ~ List their ages, outcome of the safety assessment and what the safety plan stated.

#### Household Information

- Describe the child's residence:
  - ~ Single-family home, apartment, trailer, etc.?
  - ~ Number of bedrooms?
  - ~ Condition of the residence?
  - ~ Anything notable about the location of the residence?
- Who was the victim child residing with?
  - ~ Use identifiers (mother/father). DO NOT include names.
- Where there any immediate family members not residing in the home?
  - ~ Who and where are they?

\*Picture slide (if applicable include a picture of the conditions of the residence).

#### Interviews

- Who was interviewed (state their relationship to the child and role in the investigation)?
- Give brief details of the interview.

Interviews Continued.....

#### Child Welfare History

- Create a timeline of the family's child welfare history.
  - ~ List date of referral, locality, track decision, outcome and risk level.

History Continued.....

Other Important Information

- Was the family receiving benefits from DSS?  
~ Which family members and what type of benefit?
- Was the family receiving services from a community resource at the time of the fatality?  
~ What service and from who?

Outcome of the Fatality Investigation

- What was the disposition?
- What evidence was used to make that disposition? (Include information from the autopsy, criminal investigation, etc.)

Overview of Autopsy Findings  
(to be presented by the OCME if present)

- Details:
- Cause of death:
- Manner of death:

Overview of Criminal Investigation

(to be presented by the Commonwealth Attorney or Law Enforcement if present)

- Was anyone criminally charged? If so, who and why?
- What were the charges?
- What was the outcome of the criminal proceedings?

**Strengths of Family**

- Click to add text



**Needs of Family**

- Click to add text



Were new or revised services recommended or implemented as a result of the death?

- Click to add text

Questions?

## VIRGINIA REGIONAL CHILD FATALITY REVIEW TEAMS

### CONFIDENTIALITY STATEMENT

The purpose of the Regional Child Fatality Review Teams is to conduct an in-depth review of child deaths in their respective jurisdictions, to better understand how and why children die and to take action to prevent other deaths.

Fatality Review Teams are diverse, multidisciplinary groups of professionals who come together to understand the complex, multifaceted factors surrounding the death of a child. The interdisciplinary nature of fatality review helps to foster the belief that child fatality prevention is a community's responsibility as a whole and prevention strategies need to be created in a multi-agency, multi-pronged approach.

In order to assure a coordinated response that fully addresses all systemic concerns surrounding child fatalities, all relevant information, including historical information concerning the deceased child and his or her family, must be shared during the review. Much of this information is confidential and protected from public disclosure by law therefore, reviews are closed to the public and all team members must execute a sworn statement to honor the confidentiality of the information, records, discussions, and opinions disclosed during any closed meeting to review a specific child death. Failure to maintain confidentiality is punishable by law.

*I, the undersigned, agree to abide by the terms of this confidentiality statement. I understand that all information, records, discussions, and opinions shared with me during the review shall remain confidential and shall not be used for reasons other than those required under Virginia code §32.1-283.2. I understand that violations of this shall be punishable as a Class 3 misdemeanor.*

**Region:**

**Date of Review:**

**Print Name:**

**Electronic Signature:**

**Agency or Organization:**