Overdose Poisoning Deaths to Children in Virginia, 2009-2013

Executive Summary and Recommendations

A report from the

VIRGINIA STATE CHILD FATALITY REVIEW TEAM

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OVERDOSE POISONING DEATHS TO CHILDREN IN VIRGINIA

MISSION STATEMENT

As an interdisciplinary team, we review and analyze sudden, violent, or unnatural deaths of children so that strategies can be recommended to reduce the number of preventable child deaths in Virginia.

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EXECUTIVE SUMMARY

The Virginia State Child Fatality Review Team was established by the General Assembly in 1994 as a multidisciplinary public health effort to understand why infants and children die. Through these reviews, the Team identifies gaps in laws, policies, and programs designed to keep children safe and healthy; and develops recommendations to address these gaps, to prevent similar deaths in the future, and to improve child death investigations in the state. For this report, the Team reviewed cases of overdose poison deaths to infants and children up to age 17 and occurring in Virginia for the five year period between 2009 and 2013. Through this examination, Team members sought to answer this question: how is the overdose problem - now described by the Centers for Disease Control and Prevention (CDC) as a public health epidemic – impacting infants and children and their families in Virginia? Which children are at risk, where are they at risk, how are they at risk, and what can be done to further promote health and safety in their lives?

To set the stage for this review: both prescription opioid sales and drug overdose deaths have nearly quadrupled in the United States (U.S.) since 1999. Poisoning is now the overall leading cause of injury death in the nation.[1] Poisoning deaths result from an intentional or unintentional overdose due to the ingestion, administration, or misuse of prescription or illicit drugs, over-the-counter medications, or household items not meant for human consumption such as cleaning products or batteries. The over-prescribing of controlled substances, overuse of medications, and subsequent rise in the use of heroin has made poisoning a significant threat to public health. As a result, the CDC declared that drug overdoses had reached epidemic levels.[2]

Unfortunately, this epidemic has not spared citizens of the Commonwealth. In 2014, drug overdoses became the most common cause of accidental death in Virginia, surpassing deaths from motor vehicle collisions.[3] Virginia was one of eleven states where the drug overdose death rate

[1] Centers for Disease Control and Prevention (2016). *Injury Prevention and Control: Opioid Overdose, Understanding the Epidemic.* Retrieved from https://www.cdc.gov/drugoverdose/epidemic / Accessed September 25, 2015.
[2] Centers for Disease Control and Prevention, National Center for Health Statistics (2016). *NCHS Data on Drug-poisoning Deaths.* Retrieved from http://www.cdc.gov/nchs/data/factsheets/factsheet_drug_poisoning.htm / Accessed September 25, 2015.
[3] Virginia Department of Health, Office of the Chief Medical Examiner (2014). *Office of the Chief Medical Examiner's Annual Report, 2014.* Retrieved from http://www.vdh.virginia.gov/content/uploads/sites/18/2016/04/Annual-Report-2014-FINAL.pdf / Accessed September 25, 2015.

increased significantly from 2013 to 2014 – a 14.7% increase in one year.[4] In September 2014, Governor Terry McAuliffe established the Governor's Task Force on Prescription Drug and Heroin Abuse to address these issues in Virginia, and at the same time, the Team began its comprehensive review of child poisoning deaths.

Within the five year timeframe of the State Child Fatality Review Team's focus on these overdose deaths, 41 infants, young children, and adolescents died as a result of poisoning in Virginia. This represents approximately 8 child deaths from poisoning each year. After reviewing the circumstances of child overdose fatalities, the Team identified two distinct child populations at risk: (1) teenagers who died as a result of suicidal or accidental drug overdose, and (2) infants and young children age six and under who died after unintentionally ingesting a fatal substance when left unsupervised, or after a caregiver administered medication to manage the child's behavior or sleeplessness. Throughout the review period, no children between ages seven and twelve died from poisoning. Prescription drugs were identified as the main contributor to child poisoning deaths, causing or contributing to more than two-thirds of these overdoses. The findings, conclusions and recommendations from the Team's review are presented in the following report. Key findings are listed below.

Key Findings on Child Overdose Deaths in Virginia

I. Teenagers

- Nearly two-thirds of child overdose victims were teenagers between the ages of 13 and 17. These adolescents were most commonly male (54%) and white (89%). Their deaths were typically attributed to accidental circumstances (65%) or to suicide (27%). Teenagers most at risk for an overdose death lived in the Southwest (1.38 per 100,000) or Northwest (1.11 per 100,000) Health Planning Regions of Virginia. See Appendix C for a map outlining Virginia's five Health Planning Regions.

[4] Centers for Disease Control and Prevention (2016). *Injury Prevention & Control: Opioid Overdose, Drug Overdose Death Data.* Retrieved from https://www.cdc.gov/drugoverdose/data/statedeaths.html / Accessed October, 27 2016.

- Almost one-half of teenagers had a history of misusing prescription medications. Drugs of abuse were most often hydrocodone and oxycodone, followed by alprazolam (Xanax), clonazepam (Klonopin), amphetamine, methadone, and morphine.
- Nearly three-quarters of adolescents had a history of illicit substance use (73%) that mainly involved marijuana use (69%) followed by heroin, MDMA/ecstasy, cocaine, inhalant (huffing), Lysergic Acid Diethylamide (LSD), and methamphetamine.
- About three-fourths of teens had a diagnosed mental or behavioral health condition at the time of their death or in their past. Diagnoses included depression, Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder (ADD/ADHD), anxiety, and Oppositional Defiant Disorder (ODD). More than one-half of these teens had received some form of treatment in their past. Treatment was typically with medication and did not involve counseling or therapy.
- While mental health disorders and substance misuse were frequently co-occurring conditions, coordinated and concurrent treatment for both was rarely provided.
- Adolescents often had prior suicidal ideations (46%) and at least one prior suicide attempt (31%). Females constituted the vast majority of those with prior suicidal ideations (71%) and suicide attempts (88%).
- Most of the teenagers had troubled lives, reflected by prior contacts with law enforcement and/or the juvenile justice system. School records revealed a history of poor attendance and performance, disciplinary issues, suspensions and expulsions. They grew up in substance abusing families, witnessed or experienced domestic violence at home, and were described as having serious interpersonal conflicts with family and friends.

II. Young Children

- Infants and young children up to age seven represented 37% of all child victims from overdose poisoning.
- These young children were more often male (60%) than female. Rates per 100,000 suggest that black children are at higher risk for such deaths (.58) when compared with white (.20) or asian children (.27). Their deaths were from undetermined circumstances (47%), from accidental

ingestions, (40%), or from intentional homicidal poisonings (13%). Like teenagers, young children in the Southwest Health Planning Region were at highest risk for an overdose death (.98).

- Poisonings among infants and young children were caused by caregiver neglect, by inappropriate and unsafe storage of medications and household products, and by caregivers administering incorrect medications and/or dosages of medications.
- In 53% of cases, the child's caregiver or caregivers had a history of substance misuse. Substance misuse often impaired caregivers' ability to appropriately supervise the child and keep them safe from harm.
- Toddlers have an innate curiosity that prompts them to put objects into their mouths. Given this tendency, inadequate caregiver supervision and inappropriate storage of fatal substances, 47% of children under age 7 died from ingesting a poisonous substance that was often mistaken for candy or a drink.

III. Children of All Ages

- Prescription medications caused or contributed to more child deaths than any other substance (68%). More specifically, methadone and oxycodone were detected in more deaths than any other substances, causing or contributing to six deaths each. Morphine was the second most common substance detected, accounting for five non-heroin deaths. Diphenhydramine (Benadryl) and fentanyl caused or contributed to four deaths each, and fluoxetine (Prozac) and hydrocodone were each responsible for three deaths.
- Familial substance misuse was prevalent throughout the review. One-half of biological parents had substance misuse histories. Particularly among teenagers, parents or caregivers facilitated the child's substance misuse by providing drugs or using drugs with their children.
- Some or all of the fatal substances were obtained from the child's own home in nearly three-fourths of cases. Children were most likely to ingest the fatal substance(s) at their own home (85%).
- The majority of children grew up in poor families which were unstable and chaotic. Over one-half were receiving Medicaid, indicating families lived at or below poverty level.

EXECUTIVE SUMMARY

- After careful review and discussion of each child poisoning overdose case, the Team concluded that close to three in four children were inappropriately supervised or supervised by an incapacitated caregiver at the time of the fatal incident (73%).
- The Team determined that 93% of child poisoning deaths reviewed were preventable. Safe storage of medication and other hazardous household materials is critical to infant and child safety, including teenagers. The other critical factors needed are readily available points of intervention that can assist in identifying children at risk; creating an efficient route to get children, parents and caregivers in touch with services and treatment; and providing a robust and responsive mental and behavioral health system with the capacity to comprehensively respond to Virginia's overdose crisis.
- To these ends, the State Child Fatality Review Team offers the following recommendations to strengthen Virginia's capacity to respond to drug use and misuse.

TEAM RECOMMENDATIONS

The Virginia State Child Fatality Review Team carefully reviewed all child poisoning cases over a five-year time period, amassed data garnered throughout the review, and analyzed the data to obtain an accurate, comprehensive picture of child poisoning deaths in the Commonwealth. Following careful consideration of the compiled evidence, the State Child Fatality Review Team presents the following recommendations to improve Virginia's response to substance misuse among caregivers and children, to promote and strengthen communication and collaboration among state and local agencies providing services to families, and to enhance child death investigative practices throughout Virginia. The Team hopes the information published in this report along with its recommendations will be used in the continued effort to prevent the premature death of Virginia's children.

1. The State Child Fatality Review Team supports the position of Virginia's State Drug Court Advisory Council encouraging all Virginia localities to establish family drug courts. In his role as Chair of the Advisory Council, the Chief Justice of the Supreme Court of Virginia should enable the training of judges about the value of drug courts and work with the Governor and the General Assembly to expand funding for these community based initiatives.

2. The Department of Behavioral Health and Developmental Services should require all programs that utilize opioid replacement treatment to (1) provide all patients with information about the risks of overdose to themselves and to infants and children in their homes and (2) send patients home with a prescription for naloxone. Educational materials should include the importance of safe storage for all medication, the value of lock boxes for safeguarding medication around children, information about the short-acting nature of naloxone for reversing overdose, and the urgency of calling 9-1-1 because naloxone is short-acting and requires further medical treatment after administration.

3. The Departments of Behavioral Health and Developmental Services (DBHDS), Social Services (DSS) and Health (VDH) should work together to develop guidelines and training for implementing a multidisciplinary Plan of Safe Care for infants born and identified as being affected by parental substance abuse or withdrawal symptoms. The plan should address the

safety and well-being of the infant following release from the care of a health care provider, as well as the health of the affected caregiver. DBHDS should lead in addressing the substance use disorder and mental health treatment of the caregiver. DSS should address other needed services for the caregiver in terms of child safety. DSS should also address screening, safety, risk assessment, and referral to early intervention services for infants and children born substance exposed. In addition, DSS should monitor child safety and service compliance. Any subsequent valid report to CPS regarding an infant or child identified as substance exposed at birth should receive an R1 (24 hour) response from the local Child Protective Services program.

4. Amend and reenact §§ 63.2-1505 and 63.2-1509 of the Code of Virginia relating to investigations by local departments of social services and mandated reporting requirements. Amendments to § 63.2-1505 would permit local departments to conduct a child abuse and neglect investigation when an infant is suspected to have been born substance exposed or dependent and would remove the statutory exemption from such investigations when mothers sought counseling or treatment for their drug abuse while pregnant. Amendments to § 63.2-1509 would clarify conditions where a reason to suspect that a child is abused or neglected involves substance abuse. (See Appendix B for a full text of the proposed changes to the Code of Virginia.)

5. Pursuant to § 37.2-505 of the Code of Virginia, Community Services Boards should provide health care providers and health care facilities in their communities with a resource list of providers and services to facilitate screening, assessment, referral and treatment of their drug misusing patients. Resource lists should be updated on a regular basis to support timely and appropriate referrals.

6. The Virginia Hospital and Healthcare Association should collaborate with representatives from the Virginia Chapter of the American Academy of Pediatrics, the Virginia College of Emergency Physicians, forensic nurse examiners, the National Association of Social Workers of Virginia (including hospital based social workers), and the Virginia Emergency Nurses Association to establish policies and protocols whereby children and adolescents presenting for treatment in a

hospital for a substance overdose, testing positive on a drug screen, or presenting under the influence of a controlled substance, shall be provided a list of community resources for assistance with assessment and treatment. A list of local resources and services including Community Services Boards will be incorporated into the child's written discharge plan and will be communicated clearly with the child and his or her family prior to discharge.

7. The Virginia Chapter of the American Academy of Pediatricians should establish policies and protocols whereby child and adolescent patients presenting with a substance abuse problem, testing positive on a drug screen, or presenting under the influence of a controlled substance, shall be given a list of local resources and services including Community Services Boards where the child and his or her family can receive further assessment and treatment.

8. Amend and reenact § 22.1-277.2:1 A of the Code of Virginia relating to the disciplinary authority of school boards under certain circumstances to require students found in possession or under the influence of drugs or alcohol on school property, on a school bus, or at a school-sponsored activity to undergo evaluation and, if recommended, treatment. (See Appendix A for a full text of the proposed change to the Code of Virginia.)

9. Working with the Virginia Hospital and Healthcare Association, the Virginia College of Emergency Physicians should ensure that records from Emergency Department visits are routinely shared with primary health care providers.

10. Virginia's health insurance providers and the Virginia Department of Medical Assistance Services should reimburse providers for assessment and treatment of drug abusing clients as required by insurance parity policy and law.

11. Early Impact Virginia should develop on-line training modules to assist home visitor staff in recognizing risk factors and red flags for substance misuse, making referrals for assessment and treatment, and talking with families about substance use and misuse.

12. The Virginia Department of Health should partner with the Virginia Pharmacists Association to develop educational materials about safe storage of medications in homes with children and adolescents. These materials would be provided to parents and caregivers as the medications are being dispensed.

13. The Virginia Department of Health and the Virginia Office of the Attorney General should partner to distribute medication lock boxes to families through Virginia's home visiting programs.

14. The Virginia Department of Health should develop an injury prevention curriculum for use in prenatal classes at Virginia hospitals. The curriculum should use the findings from this review and emphasize common sense approaches to safe storage of medications, poisons, and other potentially harmful substances in the home.

15. The Virginia Department of Criminal Justice Services should develop a law enforcement model policy on the investigation of unexpected infant and child deaths.

16. The Office of the Chief Medical Examiner should work with the Virginia Hospital and Healthcare Association to explore the feasibility of establishing policies, procedures and protocols whereby hospitals keep and preserve patient blood samples taken at admission in cases of suspicious or critical illness and death. These specimens are critical to understanding causes of death and may be used as evidence for criminal wrongdoing. Any new policies and procedures should be integrated with hospital information technology systems to ensure that physicians are flagging cases relevant for this specimen retention when entering initial orders in the case.

17. In its role of promoter of consumer protection, the Consumer Product Safety Commission should develop and implement new laws to address children's access to medications and poisons, including medication packaging standards that are fully child resistant.

18. In the interest of providing safer packaging for all medications, poisons, and other potentially deadly substances in the home, Virginia's Poison Centers should report case specific information to the Consumer Product Safety Commission when the packaging of a fatal substance was a factor in the death.

19. The State Child Fatality Review Team recognizes the valuable role Virginia's Poison Centers play in intervention and education. These Centers are critical resources for both our medical providers and our communities. Because they minimize inefficient uses of emergency departments, the efforts of Poison Centers reflect significant cost savings to Virginia's hospitals, insurance providers and citizens. The Governor should review the effectiveness of Virginia's Poison Center, with an eye to expanding their activities and capacities with additional funding and staff support. This is particularly important for their prevention training and responses to families and others in crisis. Increased support will allow Poison Centers to ensure that messages about the risks of harm or death from poisons, medications, or abused substances are routine, pervasive and consistent across the Commonwealth.

APPENDIX A: Amend and reenact § 22. 1-277.2:1 A of the Code of Virginia

APPENDIX A - Amend and reenact § 22. 1-277.2:1 A of the Code of Virginia relating to the disciplinary authority of school boards under certain circumstances.

A. A school board may, in accordance with the procedures set forth in this article, require any student who has been (i) charged with an offense relating to the Commonwealth's laws, or with a violation of school board policies, on weapons, alcohol or drugs, or intentional injury to another person, or with an offense that is required to be disclosed to the superintendent of the school division pursuant to subsection G of §16.1-260; (ii) found guilty or not innocent of an offense relating to the Commonwealth's laws on weapons, alcohol, or drugs, or of a crime that resulted in or could have resulted in injury to others, or of an offense that is required to be disclosed to the superintendent of the school division pursuant to subsection G of § 16.1-260; (iii) found to have committed a serious offense or repeated offenses in violation of school board policies; (iv) suspended pursuant to § 22.1-277.05; or (v) expelled pursuant to § 22.1-277.06, 22.1-277.07, or 22.1-277.08, or subsection B of § 22.1-277, to attend an alternative education program. A school board may require such student to attend such programs regardless of where the crime occurred. School boards ~~may~~ shall require any student who has been found, in accordance with the procedures set forth in this article, to have been in possession of, or under the influence of, drugs or alcohol on a school bus, on school property, or at a school-sponsored activity in violation of school board policies, to undergo evaluation for drug or alcohol abuse, or both, and, if recommended by the evaluator and with the consent of the student's parent, to participate in a treatment program.

APPENDIX B: Amend and reenact §§ 63.2-1505 and 63.2-1509 of the Code of Virginia

APPENDIX B – Amend and reenact §§ 63.2-1505 and 63.2-1509 of the Code of Virginia relating to investigations by local departments of social services and reporting requirements for mandated reporters of suspected child abuse and neglect.

§ 63.2-1505. Investigations by local departments.

A. An investigation requires the collection of information necessary to determine:
   1. The immediate safety needs of the child;
   2. The protective and rehabilitative services needs of the child and family that will deter abuse or neglect;
   3. Risk of future harm to the child;
   4. Alternative plans for the child's safety if protective and rehabilitative services are indicated and the family is unable or unwilling to participate in services;
   5. Whether abuse or neglect has occurred;
   6. If abuse or neglect has occurred, who abused or neglected the child; and
   7. A finding of either founded or unfounded based on the facts collected during the investigation.

B. If the local department responds to the report or complaint by conducting an investigation, the local department shall:
   1. Make immediate investigation and, if the report or complaint was based upon one of the factors specified in subsection B of § 63.2-1509, the local department may file a petition pursuant to § 16.1-241.3;
   2. Complete a report and ~~transmit it forthwith to the Department, except that no such report shall be transmitted in cases in which the cause to suspect abuse or neglect is one of the factors specified in subsection B of § 63. 2-1509 and the mother sought substance abuse counseling or treatment prior to the child's birth~~ enter it into the state automated system;

3. Consult with the family to arrange for necessary protective and rehabilitative services to be provided to the child and his family;
4. Petition the court for services deemed necessary including, but not limited to, removal of the child or his siblings from their home;
5. Determine within 45 days if a report of abuse or neglect is founded or unfounded and transmit a report to such effect to the Department and to the person who is the subject of the investigation. However, upon written justification by the local department, the time for such determination may be extended not to exceed a total of 60 days or, in the event that the investigation is being conducted in cooperation with a law-enforcement agency and both parties agree that circumstances so warrant, as stated in the written justification, the time for such determination may be extended not to exceed 90 days. If through the exercise of reasonable diligence the local department is unable to find the child who is the subject of the report, the time the child cannot be found shall not be computed as part of the total time period allowed for the investigation and determination and documentation of such reasonable diligence shall be placed in the record. In cases involving the death of a child or alleged sexual abuse of a child who is the subject of the report, the time during which records necessary for the investigation of the complaint but not created by the local department, including autopsy or medical or forensic records or reports, are not available to the local department due to circumstances beyond the local department's control shall not be computed as part of the total time period allowed for the investigation and determination, and documentation of the circumstances that resulted in the delay shall be placed in the record. In cases in which the subject of the investigation is a full-time, part-time, permanent, or temporary employee of a school division who is suspected of abusing or neglecting a child in the course of his educational employment, the time period for determining whether a report is founded or unfounded and transmitting a report to that effect to the Department and the person who is the subject of the investigation shall be mandatory, and every local department shall make the required determination and report within the specified time period without delay;

6. If a report of abuse or neglect is unfounded, transmit a report to such effect to the complainant and parent or guardian and the person responsible for the care of the child in those cases where such person was suspected of abuse or neglect; and
7. If a report of child abuse and neglect is founded, and the subject of the report is a full-time, part-time, permanent, or temporary employee of a school division located within the Commonwealth, notify the relevant school board of the founded complaint.

   Any information exchanged for the purposes of this subsection shall not be considered a violation of § 63.2-102, 63.2-104, or 63.2-105.

C. Each local board may obtain and consider, in accordance with regulations adopted by the Board, statewide criminal history record information from the Central Criminal Records Exchange and results of a search of the child abuse and neglect central registry of any individual who is the subject of a child abuse or neglect investigation conducted under this section when there is evidence of child abuse or neglect and the local board is evaluating the safety of the home and whether removal will protect a child from harm. The local board also may obtain such a criminal records or registry search on all adult household members residing in the home where the individual who is the subject of the investigation resides and the child resides or visits. If a child abuse or neglect petition is filed in connection with such removal, a court may admit such information as evidence. Where the individual who is the subject of such information contests its accuracy through testimony under oath in hearing before the court, no court shall receive or consider the contested criminal history record information without certified copies of conviction. Further dissemination of the information provided to the local board is prohibited, except as authorized by law.

D. A person who has not previously participated in the investigation of complaints of child abuse or neglect in accordance with this chapter shall not participate in the investigation of any case involving a complaint of alleged sexual abuse of a child unless he (i) has completed a Board-approved training program for the investigation of complaints involving alleged sexual abuse of a child or (ii) is under the direct supervision of a person who has completed a Board-

approved training program for the investigation of complaints involving alleged sexual abuse of a child. No individual may make a determination of whether a case involving a complaint of alleged sexual abuse of a child is founded or unfounded unless he has completed a Board-approved training program for the investigation of complaints involving alleged sexual abuse of a child.

§ 63.2-1509. Requirement that certain injuries to children be reported by physicians, nurses, teachers, etc.; penalty for failure to report.

A. The following persons who, in their professional or official capacity, have reason to suspect that a child is an abused or neglected child, shall report the matter immediately to the local department of the county or city wherein the child resides or wherein the abuse or neglect is believed to have occurred or to the Department's toll-free child abuse and neglect hotline:

1. Any person licensed to practice medicine or any of the healing arts;
2. Any hospital resident or intern, and any person employed in the nursing profession;
3. Any person employed as a social worker or family-services specialist;
4. Any probation officer;
5. Any teacher or other person employed in a public or private school, kindergarten or nursery school;
6. Any person providing full-time or part-time child care for pay on a regularly planned basis;
7. Any mental health professional;
8. Any law-enforcement officer or animal control officer;
9. Any mediator eligible to receive court referrals pursuant to § 8.01-576.8;
10. Any professional staff person, not previously enumerated, employed by a private or state-operated hospital, institution or facility to which children have been committed or where children have been placed for care and treatment;

11. Any person 18 years of age or older associated with or employed by any public or private organization responsible for the care, custody or control of children;
12. Any person who is designated a court-appointed special advocate pursuant to Article 5 (§ 9. 1-151 et seq.) of Chapter 1 of Title 9.1;
13. Any person 18 years of age or older who has received training approved by the Department of Social Services for the purposes of recognizing and reporting child abuse and neglect;
14. Any person employed by a local department as defined in § 63.2-100 who determines eligibility for public assistance;
15. Any emergency medical services provider certified by the Board of Health pursuant to § 32.1-111.5, unless such provider immediately reports the matter directly to the attending physician at the hospital to which the child is transported, who shall make such report forthwith;
16. Any athletic coach, director or other person 18 years of age or older employed by or volunteering with a private sports organization or team;
17. Administrators or employees 18 years of age or older of public or private day camps, youth centers and youth recreation programs; and
18. Any person employed by a public or private institution of higher education other than an attorney who is employed by a public or private institution of higher education as it relates to information gained in the course of providing legal representation to a client.

    This subsection shall not apply to any regular minister, priest, rabbi, imam, or duly accredited practitioner of any religious organization or denomination usually referred to as a church as it relates to (i) information required by the doctrine of the religious organization or denomination to be kept in a confidential manner or (ii) information that would be subject to § 8.01-400 or 19.2-271.3 if offered as evidence in court.

    If neither the locality in which the child resides nor where the abuse or neglect is believed to have occurred is known, then such report shall be made to the local

department of the county or city where the abuse or neglect was discovered or to the Department's toll-free child abuse and neglect hotline.

If an employee of the local department is suspected of abusing or neglecting a child, the report shall be made to the court of the county or city where the abuse or neglect was discovered. Upon receipt of such a report by the court, the judge shall assign the report to a local department that is not the employer of the suspected employee for investigation or family assessment. The judge may consult with the Department in selecting a local department to respond to the report or the complaint.

If the information is received by a teacher, staff member, resident, intern or nurse in the course of professional services in a hospital, school or similar institution, such person may, in place of said report, immediately notify the person in charge of the institution or department, or his designee, who shall make such report forthwith. If the initial report of suspected abuse or neglect is made to the person in charge of the institution or department, or his designee, pursuant to this subsection, such person shall notify the teacher, staff member, resident, intern or nurse who made the initial report when the report of suspected child abuse or neglect is made to the local department or to the Department's toll-free child abuse and neglect hotline, and of the name of the individual receiving the report, and shall forward any communication resulting from the report, including any information about any actions taken regarding the report, to the person who made the initial report.

The initial report may be an oral report but such report shall be reduced to writing by the child abuse coordinator of the local department on a form prescribed by the Board. Any person required to make the report pursuant to this subsection shall disclose all information that is the basis for his suspicion of abuse or neglect of the child and, upon request, shall make available to the child-protective services coordinator and the local department, which is the agency of jurisdiction, any information, records, or reports that document the basis for the report. All persons required by this subsection to report suspected abuse or neglect who maintain a record of a child who is the subject of such a report shall cooperate with the

investigating agency and shall make related information, records and reports available to the investigating agency unless such disclosure violates the federal Family Educational Rights and Privacy Act (20 U.S.C. § 1232g). Provision of such information, records, and reports by a health care provider shall not be prohibited by § 8.01-399. Criminal investigative reports received from law-enforcement agencies shall not be further disseminated by the investigating agency nor shall they be subject to public disclosure.

B. For purposes of subsection A, "reason to suspect that a child is abused or neglected" shall include (i) a finding made by a health care provider within six weeks of the birth of a child that the results of toxicology studies of the child indicate the presence of a controlled substance ~~not prescribed for the mother by a physician~~; (ii) a finding made by a health care provider within six weeks of the birth of a child that the child was born ~~dependent on a controlled substance which was not prescribed by a physician for the mother and has demonstrated~~ affected by illegal substance abuse or experiencing withdrawal symptoms resulting from prenatal drug exposure; (iii) a diagnosis made by a health care provider at any time following a child's birth that the child has an illness, disease or condition which, to a reasonable degree of medical certainty, is attributable to in utero exposure to a controlled substance ~~which was not prescribed by a physician for the mother or the child~~; or (iv) a diagnosis made by a health care provider at any time following a child's birth that the child has a fetal alcohol spectrum disorder attributable to in utero exposure to alcohol. When "reason to suspect" is based upon this subsection, such fact shall be included in the report along with the facts relied upon by the person making the report.

C. Any person who makes a report or provides records or information pursuant to subsection A or who testifies in any judicial proceeding arising from such report, records, or information shall be immune from any civil or criminal liability or administrative penalty or sanction on account of such report, records, information, or testimony, unless such person acted in bad faith or with malicious purpose.

D. Any person required to file a report pursuant to this section who fails to do so as soon as possible, but not longer than 24 hours after having reason to suspect a reportable offense of child abuse or neglect, shall be fined not more than $500 for the first failure and for any subsequent failures not less than $1,000. In cases evidencing acts of rape, sodomy, or object sexual penetration as defined in Article 7 (§ 18.2-61 et seq.) of Chapter 4 of Title 18.2, a person who knowingly and intentionally fails to make the report required pursuant to this section shall be guilty of a Class 1 misdemeanor.

E. No person shall be required to make a report pursuant to this section if the person has actual knowledge that the same matter has already been reported to the local department or the Department's toll-free child abuse and neglect hotline.

This report is available at the following website:
http://www.vdh.virginia.gov/medical-examiner/fatality-review-surveillance-programs-reports/child-fatality-review-in-virginia/reports/

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