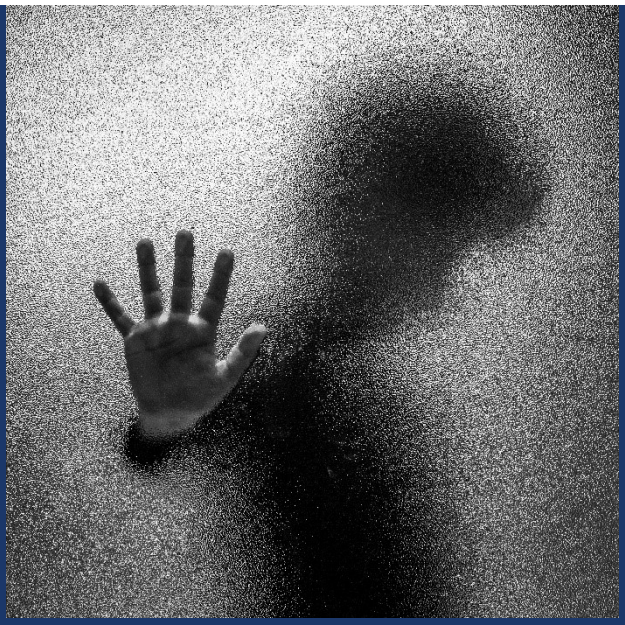

CRITICAL INCIDENT ANNUAL REPORT

Child Fatalities and Near Fatalities Due to Abuse/Neglect

WEST VIRGINIA Department of Health & Human Resources
BUREAU FOR SOCIAL SERVICES

Office of Quality Initiatives

Division of Planning and Quality Improvement

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Executive Summary

The West Virginia Department of Health and Human Resources (DHHR) is the state agency responsible for child welfare as defined in Chapter 49 of the West Virginia Code. Incidents of abuse and neglect are investigated by Child Protective Services (CPS) located within DHHR's Bureau for Social Services (BSS).

Child Fatality Review and Report

A review of child fatalities is conducted by several entities in West Virginia: the Supreme Court of Appeals of West Virginia, the West Virginia Child Fatality Review Team, and the Infant Mortality Review Team. The Supreme Court of Appeals of West Virginia analyzes the court system's performance and recommends changes that need to be made. The West Virginia Child Fatality Review Team and the Infant Mortality Review Team are conducted by the Commissioner of DHHR's Bureau for Public Health. The West Virginia Child Fatality Review Team reviews all deaths of children under the age of 18, and the Infant Mortality Review Team examines, analyzes, and reviews the deaths of infants and women who die during pregnancy or at the time of birth and children who die within one year of birth. W. Va. Code §61-12A-1, *et seq.* created the Fatality and Mortality Review Team (FMRT). The FMRT is required to establish four advisory panels**:**

1. An unintentional pharmaceutical drug overdose fatality review panel to examine, analyze, and review deaths resulting from unintentional prescription or pharmaceutical drug overdose;
2. A child fatality review panel to examine, analyze, and review deaths of children under the age of 18 years;
3. A domestic violence fatality review panel to examine, analyze, and review the deaths of infants and women who die during pregnancy, at the time of birth or within one year of birth of a child; and
4. An infant and maternal mortality review panel to examine, analyze, and review the deaths of infants and women who die during pregnancy, at the time of the birth, or within one year of the birth of a child.

Since 2000, BSS has submitted information related to child abuse and neglect, including child fatalities as a result of abuse and neglect, to the National Child Abuse and Neglect Data System (NCANDS), which is submitted based on the federal fiscal year (FFY) October 1 to September 30. When there is a history of CPS involvement, case level information, known as the Child File, is collected by NCANDS directly from the West Virginia Statewide Automated Child Welfare Information System (SACWIS), known as the Families and Children Tracking System (FACTS). Additional information about abused and neglected children with no prior history with CPS is obtained from DHHR's Office of the Chief Medical Examiner by BSS staff and submitted to NCANDS in the Agency File. This report is to fulfill the needs of gathering and analyzing this information.

The Critical Incident Review Team

In 2014, BSS established what is now known as the Critical Incident Review Team. The review process focuses on fatalities or near fatalities of children known to the child welfare system through CPS or Youth Services within the last 12 months, including through assessment or open cases. The critical incident review process is a quality assurance process that examines practice,

policy, and training to make needed program improvements. The systemic review identifies areas, that if improved upon, may have prevented the death or severe injury of a child.

The Critical Incident Review Team meets quarterly and is chaired by the Division of Planning and Quality Improvement (DPQI). Team members are comprised of the BSS Commissioner and Deputy Commissioners; representatives from the offices of Field Support, Programs and Resource Development, and Planning and Research; the Director of Centralized Intake, the Director of the Division of Training, and the Institutional Investigative Unit (IIU) supervisor. In addition, the Social Services District Manager for any district having a history with the child or his/her family is included in the case review for that child.

The Critical Incident Review process begins when BSS is notified of a critical incident through the Centralized Intake assessment process. CPS assesses the allegations and takes appropriate action, based on policy, to ensure child safety. Once the assessment is completed, a three-person Field Review Team consisting of a regional program manager or designee, a policy specialist, and a specialist from DPQI, is assigned to complete a critical incident review.

The Field Review Team conducts a case record review of the family history with DHHR, including any prior abuse and/or neglect and interventions by the agency; services provided to the family, and the circumstances surrounding the critical incident. Interviews are conducted with Department staff, law enforcement, medical staff, and service providers. The DPQI Specialist presents the Field Review Team's findings at the quarterly Critical Incident Review Team meetings. A decision is made on each case as to whether the critical incident did or did not result from abuse and/or neglect as defined in state code and is evaluated for adherence to BSS policy and practice. The Critical Incident Review Team develops a Plan for Action to enhance case work practice and improve outcomes for children and families based on the findings and recommendations from the critical incident reviews. The information collected during the review process is aggregated, analyzed, and included in this annual report to the West Virginia Legislature.

Since 2016, the Critical Incident Review Team review process also includes families in which no other children resided in the home; however, the death was attributed to abuse and/or neglect. Prior to this policy change, cases were investigated for the safety of the children remaining in the home. This change increased the number of investigations for field staff, increased the number of critical incident reviews, and increased the number of children being reported.

In 2020, the Critical Incident Standard Operating Procedure was updated to include the review of all critical incidents involving any child in the custody of the Department. If a child is in a certified placement at the time of the critical incident, the investigation is completed by IIU.

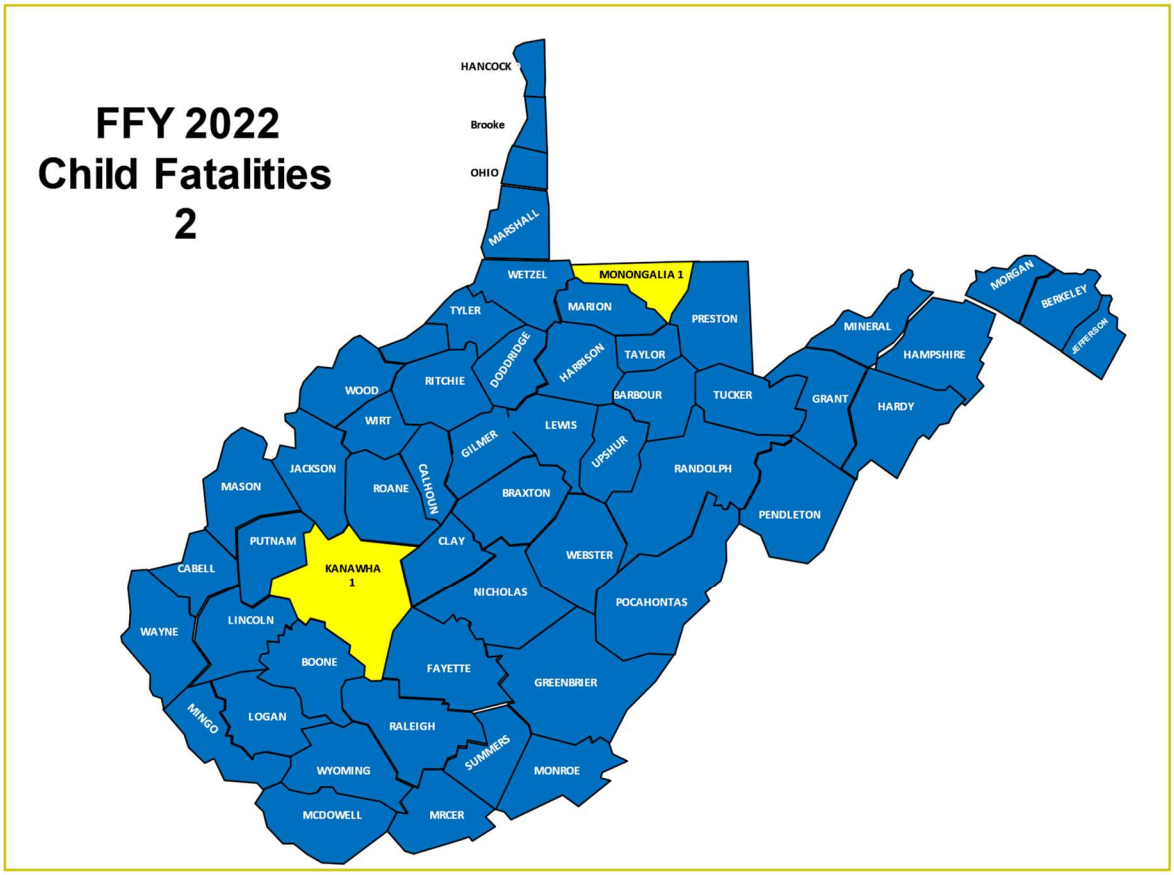
Child Fatalities

In FFY 2022, there were 18 fatalities of children known to BSS presented to the Critical Incident Review Team, following review by a Field Review Team. Two of the fatalities were determined to be a result of abuse and/or neglect. This is a decrease of four children compared to FFY 2021. The information below reflects the data collected from the internal Critical Incident Review Team for FFY 2022.

See **Appendix A** for a narrative of each child fatality for FFY 2022.

Critical Incidents FFY 2018	Critical Incidents FFY 2019	Critical Incidents FFY 2020	Critical Incidents FFY 2021	Critical Incidents FFY 2022
Fatality: 9	Fatality: 8	Fatality: 4	Fatality: 6	Fatality: 2

Map of Total Child Fatalities Due to Abuse and/or Neglect FFY 2022



Number of Victims in Abuse and Neglect Incidents by Known Cause of Fatality FFY 2022	
Lack of Supervision	2

Child Fatality – Demographics of Children, FFY 2022

Number of Victims in Fatal Incidents by Age	
Less Than 5 Years	2
5 to 10 Years	0

Number of Victims in Fatal Incidents by Race	
White	2

Number of Victims in Fatal Incidents by Gender	
Male	1
Female	1

Child Fatality – Maltreater Demographics, FFY 2022

Number of Maltreaters in Fatal Incidents by Age	
21-29 years	0
30-39 years	2
40-49	0

Number of Maltreaters in Fatal Incidents by Relationship	
Father	0
Mother	1
Foster Parent	1

Number of Maltreaters in Fatal Incidents by Race	
White	2

Number of Maltreaters in Fatal Incidents by Gender	
Male	0
Female	2

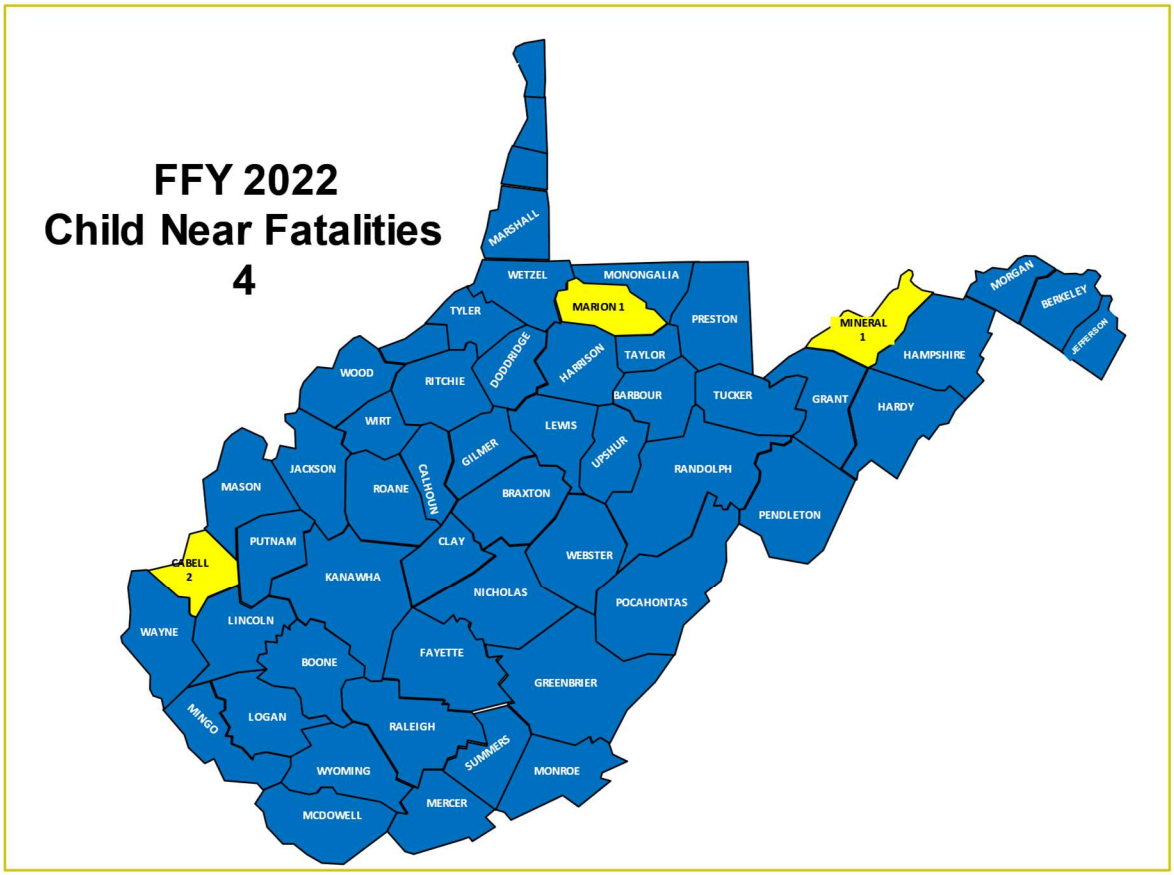
Child Near Fatalities

In FFY 2022, there were eight near fatalities of children known to BSS presented to the Critical Incident Review Team, following review by a Field Review Team. Of these, four children were determined to have been seriously injured due to abuse and/or neglect. This is an increase of one child compared to FFY 2021.

See **Appendix B** for a narrative of each child near fatality for FFY 2022.

Critical Incidents FFY 2018	Critical Incidents FFY 2019	Critical Incidents FFY 2020	Critical Incidents FFY 2021	Critical Incidents FFY 2022
Near Fatality: 5	Near Fatality: 8	Near Fatality: 5	Near Fatality: 3	Near Fatality: 4

Map of Total Child Near Fatalities Due to Abuse and/or Neglect FFY 2022



Number of Victims in Abuse and Neglect Incidents by Known Cause of Near Fatality, FFY 2022	
Lack of Supervision/Child Ingested Substance	2
Physical Injury	1
Lack of Supervision	1

Child Near Fatality – Demographics of Children, FFY 2022

Number of Victims in Near Fatal Incidents by Age	
Less than 5 Years	4
5 to 10 Years	0

Number of Victims in Near Fatal Incidents by Race	
White	1
African American	1
White/African American	2

Number of Victims in Near Fatal Incidents by Gender	
Male	2
Female	2

Child Near Fatality – Maltreater Demographics, FFY 2022

The data listed below reflects two cases with two maltreaters.

Number of Maltreaters in Near Fatal Incidents by Age	
20-29 years	5
30-39 years	1
40-49 years	

Number of Maltreaters in Near Fatal Incidents by Relationship	
Father	2
Mother	3
Guardian's Paramour	1

Number of Maltreaters in Near Fatal Incidents by Race	
White	3
African American	1
White/African American	2

Number of Maltreaters in Near Fatal Incidents by Gender	
Male	3
Female	3

Summary of 2022 Data

During FFY 2022, the State of West Virginia continued to experience the widespread and devastating impact of substance abuse. A report released in September 2022 by the U.S. Centers for Disease Control and Prevention's (CDC) National Vital Statistics System offers West Virginians a small glimmer of hope related to the ongoing drug epidemic the State has experienced in recent years. Data shows a decrease in overdose deaths from March 2021 through March 2022, which encompasses six months of FFY 2022. West Virginia was one of only six states in the nation to see a decrease in overdose deaths, dropping 3.63% during this period. While there is hope the State will continue to see a downward trend, the most recent data continues to show West Virginia as the state with the highest overdose death rate.

The State continues an array of initiatives and services to address issues related to substance abuse. In November 2022, DHHR issued a warning that 23 of the State's 55 counties were considered high risk for an increase in drug overdoses. Residents were encouraged to obtain naloxone, an opioid reversal drug, to help combat the increase. DHHR's Office of Drug Control Policy uses a predictive model that issues alerts based on overdose activities in neighboring states. Illicit use of fentanyl, a highly lethal opioid, has significantly contributed to overdose death rates in West Virginia, and surrounding areas, in recent years.

Overdose death rates are not the only area of concern caused by the ongoing substance abuse epidemic. Substance abuse and addiction have been a contributing factor to child abuse and neglect in West Virginia for several years, impacting thousands of children and families and taxing the State's child welfare resources. Substance abuse is frequently identified as a contributing factor to children entering foster care. It can be challenging to place children in the care of appropriate relatives, due to the increasing prevalence of substance abuse across generations. In November 2022, there were 6,369 children in foster care placement. The FFY 2020 Critical Incident Annual Report documented 6,935 children in foster care in the fall of 2020 and 6,884 in the fall of 2021. FFY 2022 would be the third consecutive year West Virginia has seen a decrease in the total number of children in foster care placements.

As indicated in the above data, six critical incident reviews during FFY 2022 concluded abuse and/or neglect was the cause of the fatality or severe injury of a child. These reviews further revealed substance abuse had an impact on each of these children, either at the time of the incident or historically by a caregiver.

Critical incidents occurring in FFY 2022 were primarily the result of a lack of supervision of the children by their caregiver(s). There was a direct lack of supervision for five of the six children included in this annual report. The sixth child was severely injured by physical violence; however, it is noted an additional finding of lack of supervision was also made. Both child fatalities were attributed to a lack of supervision. The FFY 2022 critical incident cases are noticeably different from what was reported in FFY 2021, when seven of the nine children died or were severely injured as a result of violence.

In FFY 2021, the father/male caregiver was identified as a maltreater in the majority of cases reviewed. During FFY 2022, the mother/female caregiver was predominantly identified as a maltreater in the majority of cases reviewed. There were five female maltreaters identified and three male maltreaters. FFY 2021 saw a shift in the maltreater age group to an older population, with maltreaters primarily falling between 30-39 years. During FFY 2022, a shift is once again noted, with the maltreater population primarily falling between 20-29 years of age. There is no

disparity in victim gender, as the number of male and female victims were the same for fatalities and near fatalities. Victims and maltreaters were most often white, which is consistent with reports for the past three years. The fatality and near fatality incidents occurred in five separate West Virginia counties.

Plan for Action

The BSS Plan for Action, based on the results of the critical incident reviews, is designed to increase awareness, support practice, and improve outcomes in child welfare cases. Initiatives that were continued and updated in FFY 2022 include:

- **Critical Incident Training for Staff to Increase Knowledge and Understanding**

  Critical incident training continues to be a mandatory training requirement for all new child welfare staff and must be completed within the first 18 months of employment. The training provides participants with statistical data on child fatalities in West Virginia and identifies trends in child welfare practices, factors related to child deaths, best practice standards, working with vulnerable children, supervisory consultation, safety planning, information gathering, co-sleeping, and substance abuse related child fatalities. Instructional methods for the training include lecture, small group activity, practice simulation, and group discussion. Updates are completed each January to include current state statistics and trends.

  During FFY 2022, BSS returned to face-to-face training following the lifting of COVID-19 pandemic restrictions. Newly hired staff receive initial critical incident training through in-person instruction. The refresher course continues to be updated each year with current data and trends. This course remains available online, with the expectation all child welfare staff will complete it annually.

- **Safe Sleep Initiative**

  BSS continues to focus on educating all parents of children under the age of one on safe sleep. DHHR's county offices continue to show safe sleep videos in their lobbies to help educate clients on safe sleep. The information provided can be reviewed at www.safesoundbabies.com. The *Our Babies: Safe and Sound* group, which educates West Virginia families about infant safety, works with DHHR's Office of Maternal, Child, and Family Health to ensure consistent and up-to-date messaging on safe sleep. Safe sleep information is especially targeted to parents with drug-affected infants due to their higher risk. Updated material was provided to the Statewide Child Fatality Review Team (Infant Mortality and Morbidity Workgroup) on safe sleep.

  The *Our Babies: Safe and Sound* project offers the following to their partners for education to further the efforts of Safe Sleep in West Virginia:

  a. Annual statewide competency training, a day-long session with national and state level presenters. This training is free and continuing education

units (CEUs) are provided for nurses, early childhood professionals, and social workers.
b. Quarterly peer topical calls.
c. An online training module, which reviews the research and latest American Academy of Pediatrics recommendations. This certified module is 1.5 hours, provides free CEUs, and can be viewed online at: www.safesoundbabies.com. Family childcare providers are required to complete this training.
d. Ongoing technical assistance and field updates.

Child welfare staff continue to assess sleeping arrangements of infants and to discuss safe sleep with their caregivers. Additionally, educational pamphlets regarding safe sleep practices are provided to parents during maltreatment assessments and in open child welfare cases.

During FFY 2022, CPS policy was updated to improve guidance and instruction to staff in addressing and discussing safe sleep practices with families and caregivers. The policy was implemented through release to staff in early 2022 and is available online for review at https://dhhr.wv.gov/bss/policy/Pages/Child-Welfare-Policy.aspx.

- **Drug-Affected Infant Policy**

Drug-affected infants are defined in the federal Comprehensive Addiction and Recovery Act (CARA) as those infants referred by medical staff, including hospital social workers, who are less than one year old, test positive for legal or illegal substances or prescribed medication, or suffer from withdrawal symptoms resulting from prenatal drug exposure or Fetal Alcohol Spectrum Disorder. BSS policy complies with federal requirements, outlined in the Child Abuse Prevention and Treatment Act (CAPTA), that every child identified as drug-affected would have a Plan of Safe Care. Not every infant identified as drug-affected is maltreated, and an assessment must be completed to make that determination.

If the assessment indicates a case should be opened, because maltreatment and/or an Impending Safety Threat has been identified, the Ongoing Assessment and Family Case Plan shall be the child's Plan of Safe Care. If the assessment determines there is a drug-affected infant, but no maltreatment finding or safety threats, the worker will open a case for "Plan of Safe Care Only", document the Plan of Safe Care in the Service Log, document other services put int place, and close the case immediately. In situations where BSS has knowledge of a drug affected infant, a referral to West Virginia Birth to Three is to be initiated and clearly documented.

In FFY 2022, the Bureau for Social Services prepared an Announcement of Funding Availability (AFA) to seek and secure an agency willing to take on the role of monitoring the plans. When an agency is secured, policy may need to be updated to reflect the changes.

- **Mandated Reporter Training**

  West Virginia Children's Justice Task Force has developed an online mandated reporter training which offers a certification for being trained as a mandated reporter. The course is available at www.handlewithcarewv.org. Several BSS staff participated in filming this training, which became available to child welfare staff in 2022. BSS has updated their virtual training for mandated reporters and the training has been provided to groups outside of the Bureau when requested. The mandated reporter curriculum has been provided to the Bureau's Regional Directors and shared with BSS Social Services District Managers for local organization and community training.

- **Supervisory Consultation**

  Each month a subject, policy, process, or trend is selected, with input from the Child Welfare Oversight team, to be presented during part of each supervisor's meeting with their staff. Each unit meeting is to have an agenda, a sign-in sheet, and produce minutes which clearly indicate coverage of the selected topic. Staff should consistently attend unit meetings and view them as an opportunity to learn, share, and connect with their peers. For staff unable to attend, the information is covered in their monthly conference with the supervisor and includes documentation of what was discussed. These documents are shared with the Social Services District Manager, who has the responsibility of ensuring these requirements are met. While all topics may not be specific to critical incidents, each topic is selected in effort to improve staff knowledge and casework practice which should thereby improve service delivery to West Virginia children and families and help to reduce the number of critical incidents.

  Throughout FFY 2022, BSS Commissioner Jeffrey Pack released weekly email messages to child welfare staff that included a variety of topics intended to support staff and their knowledge and efforts to serve children and families. The information from these weekly messages is also reviewed at monthly unit meetings.

Topics for monthly unit meetings in FFY 2022 included:

- Modifications to child welfare program booklets and expectations of use
- Multidisciplinary Treatment Teams
- Assessment Pathway
- Community Based Resources for Families
- Pathway to Children's Mental Health Services Policy
- Critical Incidents (including mandatory 2022 Critical Incident Refresher Training)
- Difference Between Adoption and Legal Guardianship
- Journey Placement Notebooks and Life Books
- Diligent Search
- Legal Guardianship, Successor Guardians, and Disruptions
- Transitioning Youth
- Assessing Safety and Well-Being of Children in Out-of-Home Placements

  Social Services Supervisor meetings are held every other month. These meetings include discussion of the monthly unit meeting topics, trends in practice, policy revisions, and ways to improve management skills. Peer reviews of casework

practice occur twice per year. The reviews are designed to educate supervisors on best practice(s) and to provide a platform for learning and sharing among peers. To provide oversight and further support this peer learning process, management meetings are held quarterly and include discussion of topics addressed in supervisor and unit meetings.

- **Reflective Supervision**

  To address issues surrounding worker retention and secondary trauma, BSS, in conjunction with Casey Family Programs, initiated the implementation of reflective supervision. The purpose of reflective supervision is to promote effective, trauma-informed decisions and build strong supervisory relationships. Reflective supervision relates to professional and personal development within one's discipline by attending to the emotional content of the work and how reactions to the content affect the work. Reflective supervision is regular, collaborative reflection between a supervisee and supervisor that builds on the supervisee's use of thoughts, feelings, and values within a service encounter. Reflective supervision is specifically designed to improve supervisory support for workers through relationship-focused, collaborative time between them. Unlike a more task-centered approach to supervision, reflective supervision meetings examine work-life balance, secondary trauma, and learning needs in a parallel process. The primary objectives of reflective supervision include the following:

  - To form a trusting relationship between supervisor and practitioner.
  - To establish consistent and predictable meetings and times.
  - To listen and remain emotionally present.
  - To teach, guide, nurture, and support staff.
  - To foster the reflective process to be internalized by the supervisee.
  - To explore the parallel process and allow time for personal reflection and attend to how reactions to the content affect the process.

  As part of the state's Child and Family Services Review Round 3 Program Improvement Plan, safety planning was incorporated into reflective supervision. A standard operating procedure was developed to guide supervisors in the monitoring of ongoing risk and safety assessments to ensure safety is being assessed for all children in the home. During FFY 2021, Casey Family Programs worked with eight districts throughout the state of West Virginia to provide additional training and support in utilizing reflective supervision. Two statewide trainings were held for Social Services Supervisors during FFY 2021 to teach and promote the reflective supervision model.

  During FFY 2022, BSS continued to work with, and receive support from, Casey Family Programs. Casey Family Programs continued consultation through the end of the implementation of key activities and strategies outlined in the Program Improvement Plan during November 2021. Following implementation, activities were to continue under contract. Individual districts were identified as areas to target, based on high turnover rates and the need for peer support. During FFY 2022, activities were temporarily on hold due to the retirement of the Casey Family Programs representative. A new representative was appointed, and an in-person meeting has been scheduled for December 2022.

- **Domestic Violence Training**

  BSS has continued to partner with the West Virginia Coalition Against Domestic Violence to provide training for child welfare staff. During FFY 2022, trainings progressed from being primarily virtual/online to a hybrid model that allowed a portion of the training to be offered in-person. There are four training phases: Phase 1 – Dynamics and Impacts of Domestic Violence; Phase 2 – Working with Families Experiencing Domestic Violence; Phase 3 – Working with Domestic Violence Offenders; and Phase 4 – Making the Connection, Domestic Violence and Co-Occurring Tactics of Control. The current schedule remains in place through June 2023 and is offered to individuals outside of BSS.

- **West Virginia Resilience Alliance**

  West Virginia Resilience Alliance has previously been included in the Plan for Action, but BSS made significant changes within the project during FFY 2021. West Virginia recognizes that child welfare staff interact with people who have experienced multiple traumas on a daily basis. Secondary traumatic stress (STS) is the emotional duress that results when an individual hears about the firsthand trauma experiences of another person. Given the nature of their work, child welfare staff and community-based providers are at very high risk of developing STS and can be at risk of experiencing trauma first-hand. In addition, the trauma and secondary trauma experienced by their clients and staff can affect organizations and the organizational culture. If left unaddressed, STS can have a negative impact on the ability of individuals and organizations to help children and families. Supervisors and administrators have the challenging task of developing and maintaining high-quality practice in a traumatogenic environment (modified from the National Child Traumatic Stress Network-NCTSN).

  BSS has made concerted efforts to address STS with its staff and to provide supportive counseling services. Efforts were hindered by staffing issues and COVID-19, which greatly impacted the ability to have meaningful in-person interactions with staff who were experiencing STS, often directly related to critical incidents. During FFY 2021, BSS began working with Marshall University's Center for Excellence to develop a process to address STS within the agency. The process will include assessment of the Bureau's needs for supervisor training and competency in recognizing and supporting staff who may be experiencing STS, teaching self-care, peer support groups and the development of a team within the BSS who will facilitate this process. A specific component of this collaboration is Crisis Intervention for Critical Incident Teams. Critical Incident Stress Management (CISM) is an intervention protocol developed specifically for dealing with traumatic events. It is a formal, highly structured, and professionally recognized process for helping those involved in a critical incident by allowing them to share their experiences, vent emotions, learn about stress reactions and symptoms, and providing referral for further help if required.

  In July 2022, the contract with Marshall University for these supportive services went into effect, and staff were hired. BSS continued to explore ways to expand and improve upon the traumatic response process. A schedule for self-care trainings, peer to peer support, and supervisory support was established, and will

carry into FFY 2023. BSS released the first Safety Culture Survey to agency staff in October 2022. Casey Family Programs will assist in aggregating data from the survey and targeting areas in need of greater support. BSS continued discussions with Marshall University specific to a critical incident response, similar to the multidisciplinary approach often used for first responders.

New Activities Initiated in 2022

- **Safety Culture/Safety Science**

  Agency efforts described above, under the topic of WV Resilience Alliance, led BSS to join the National Partnership for Child Safety (NPCS). Supported by Casey Family Programs and the Center for Innovation in Population Health at the University of Kentucky, NPCS is a quality improvement collaborative comprised of county, state, and tribal child serving agencies whose mission is to improve child safety and reduce child maltreatment and fatalities by strengthening families and promoting innovations in child protection. The growing membership includes 31 jurisdictions across the nation, committed to the use of safety science and shared data to support families and child welfare staff. Key concepts of the evidence-based approach include building a foundation for safety culture in child welfare, acknowledging high-risk activities and a determination to achieve consistently safe operations, promoting a blame-free environment in which individuals are able to report errors or near misses without fear of reprimanding/punishment, encouraging collaboration across ranks and disciplines to seek solutions, and committing resources to safety concerns.

  During FFY 2022, BSS staff were tasked with completing critical incident reviews, and members of the Critical Incident Review Team participated in training offered through NCPS and the University of Kentucky partners. Dr. Michael J. Cull spoke with staff about Safety Culture/Safety Science. Staff further participated in an in-depth training specific to the Safe Systems Improvement Tool (SSIT). The copyright for SSIT is held by the Praed Foundation to ensure that it remains free to use, with training and certification expected for appropriate use of the tool. SSIT is an information integration tool designed to support system improvement activities. The retrospective critical incident review tool centers on systems-level influences that contributed to casework practice in critical incidents. The output is structured and standardized, allowing for data aggregation for systems-level quality improvement to enhance safety and care of children and families. BSS staff completed training on SSIT during FFY 2022, and the tool will be used beginning FFY 2023 to gather and aggregate critical incident data.

Definitions

Abused Child: A child whose health or welfare is harmed or threatened by a parent, guardian, or custodian who knowingly or intentionally inflicts, attempts to inflict, or knowingly allows another person to inflict, physical injury or mental or emotional injury upon the child or another child in the home; sexual abuse or sexual exploitation; or the sale or attempted sale of a child by a parent, guardian, or custodian; domestic violence as defined in W. Va. Code §48-27-202; or human trafficking or attempted human trafficking, in violation of W. Va. Code §61-14-2d. In addition to its broader meaning, physical injury may include an injury to the child as a result of excessive corporal punishment (W. Va. Code §49-1-201).

Caregiver is Intoxicated (alcohol or other drugs): Report identifies a caregiver who is currently drunk or high on illegal drugs and unable to provide basic care and supervision to a child at that moment. In order to qualify as present danger, it must be evident in the report that a caregiver who is primarily responsible for childcare is unable to provide care for his/her child right now due to his/her level of intoxication. The state of the parent's/caregiver's condition is more important than the use of a substance (drinking compared to being drunk or using drugs as compared to being incapacitated by the drugs) and affects the child's safety.

Caretaker: The person responsible for the care of a child, including:

a) Parent, guardian, custodian, paramour of parent, or foster parent.
b) A relative or any other person with whom the child resides and who assumes care or supervision of the child, without reference to the length of time or continuity of such residence.
c) An employee or agent of any public or private facility providing care for a child, including an institution, hospital, healthcare facility, group home, mental health center, residential treatment center, shelter care facility, detention center, or childcare facility.
d) Any person providing care for a child, but with whom the child does not reside, without reference to the duration of the care. A person who assumes responsibility for the care or supervision of the child may assume such responsibility through verbal or written agreement, or implicitly through the willing assumption of the care-taking role.

Child: Any person under 18 years of age (W. Va. Code §49-1-202).

Child Fatality: The death of a person under the age of 18 that is a result of abuse or neglect, or both.

Child Maltreatment: A caregiver's behaviors and interactions with a child are consistent with the statutory definition of child abuse or neglect.

Child Near Fatality: An act that, as certified by a physician, places the child in serious or critical condition.

Comprehensive Addiction and Recovery Act (CARA): On July 22, 2016, President Obama signed into law the Comprehensive Addiction and Recovery Act (P.L. 114-198). This law establishes a comprehensive, coordinated balanced strategy through enhanced grant programs that expand prevention and education efforts while also promoting treatment and recovery. CARA has been subsequently amended.

Critical Incident: A reasonable suspicion that a fatality or near fatality was caused by abuse or neglect or when abuse or neglect has been determined to have led to a child's death or near death.

Critical Incident Review Team: A team of individuals defined by the Commissioner of the West Virginia Department of Health and Human Resources' Bureau for Social Services to review critical incidents for the purpose of improving the casework process to prevent future critical incidents.

Drug-Affected Infants: Infants referred by medical staff, including hospital social workers, who are less than one year old, test positive for legal or illegal substances or prescribed medication, or suffer from withdrawal symptoms resulting from prenatal drug exposure or Fetal Alcohol Spectrum Disorder.

Federal Fiscal Year (FFY): The federal budget or financial year for the period from October 1 through September 30. It is used by the federal government to report revenue and expenditures.

Known to the Bureau: A family with an open Child Protective Service (CPS) case or a Youth Service (YS) case in the last 12 months or whom CPS or YS has assessed within the last 12-months.

Maltreater: A person is considered to be a maltreater when a preponderance of credible evidence indicates that the conduct of the person falls within the boundaries of the statutory and operational definitions of abuse or neglect.

Neglected Child: A child whose physical or mental health is harmed or threatened by a present refusal, failure, or inability of the child's parent, guardian or custodian to supply the child with necessary food, clothing, shelter, supervision, medical care, or education, when such refusal, failure, or inability is not due primarily to a lack of financial means on the part of the parent, guardian or custodian; or, who is presently without necessary food, clothing, shelter, medical care, education, or supervision because of the disappearance or absence of the child's parent or guardian (W. Va. Code §49-1-201).

Substance Abuse: An element of the definition of child abuse or neglect in many states. Circumstances that are considered abuse or neglect in some states include the following:

- Prenatal exposure of a child to harm due to the mother's use of an illegal or legal drug or other substance.
- Manufacture of methamphetamine in the presence of a child.
- Selling, distributing, or giving illegal drugs or alcohol to a child.
- Use of a controlled substance by a caregiver that impairs the caregiver's ability to adequately care for the child.
- Infant born testing positive for a legal or illegal drug or prescribed medication or the infant is suffering from withdrawal from a legal or illegal drug or prescribed medication (including drugs that treat addiction), or Fetal Alcohol Spectrum Disorder.

Appendix A: Abuse and/or Neglect Cases Resulting in Child Fatality
FFY 2022

Child's Initials	County	Date of Incident	Gender	Age	Race/ Ethnicity	Type of Maltreatment	Brief Summary of Incident	Cause of Fatality
A.B.	Kanawha	10/17/21	Female	3 yrs., 5 mos.	White	Neglect: Failure or inability to supply necessary supervision	Medically fragile child left unattended; deceased for an extended period before mother was aware.	Lack of supervision
H.W.	Monongalia	7/15/22	Male	4 months	White	Neglect: Failure or inability to supply necessary supervision	Co-sleeping with a teenage foster sibling.	Lack of supervision

Appendix B: Abuse and/or Neglect Cases Resulting in Child Near Fatality
FFY 2022

Child's Initials	County	Date of Incident	Gender	Age	Race/ Ethnicity	Type of Maltreatment	Brief Summary of Incident	Cause of Injury
A.M	Cabell	11/9/21	Female	5 months	White Black/African American	Neglect: Failure or inability to provide necessary supervision	Infant was left laying on bed by impaired caregiver.	Lack of Supervision
C.L.	Marion	11/20/21	Female	2 years	White Black/African American	Neglect: Failure or inability to provide necessary supervision	Child ingested suboxone. Condition of the home a concern.	Child ingested Suboxone
D.P.	Cabell	1/25/22	Male	16 months	White Black/African American	Neglect: Failure or inability to provide necessary supervision	Child ingested fentanyl.	Child ingested fentanyl.
R.C.	Mineral	9/14/22	Male	3 years	White	Abuse: Physical injury	Legal guardian's paramour caused head trauma and respiratory distress, non-accidental trauma.	Physical Injury