STATE OF WEST VIRGINIA
DEPARTMENT OF HEALTH AND HUMAN RESOURCES

Bill J. Crouch
Cabinet Secretary

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Linda M. Watts
Commissioner

STANDARD OPERATING PROCEDURE

CRITICAL INCIDENT REVIEW
Revised May 2020

1.0 Purpose:

The Critical Incident Review process is a quality assurance process to look at practice, policy and training and to make needed program improvements. The review process will focus on children that are "known" to our Child Welfare System, this means any child or family that we have had prior contact with, either through Child Protective Services (CPS), a Youth Services (YS) Intake Assessment, or an open case within the last 12 months. The review process will look at practice, policy, and training to see if there are areas that, if improved, could have prevented the death or severe injury to the child. Recommendations will be made from the review team for a Plan of Action.

2.0 Definitions:

Annual Report: Report required by the Performance Evaluation Research Division (PERD) audit to be submitted to the West Virginia Legislature, Health and Human Resources Committee on an annual basis.

Critical Incident: A reasonable suspicion at Intake 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. This triggers the Critical Incident Review process.

Known to the Agency: A case known to the agency is defined as a family with an open CPS case or a YS case in the last 12 months or whom CPS or YS assessed within the last 12 months.

Plan for Action: A plan developed as a result of the reviews to improve practice.

3.0 Procedures:

3.1 Initiating the Field Review Process

The step-by-step process can be viewed in a flowchart format. **See Attachment A**.

1. A referral is made to Centralized Intake (CI) regarding a child fatality/near fatality.

2. CI staff performs an intake assessment. If the intake is deemed an IIU setting, the intake is forwarded to IIU for screening.
3. CI staff will check the appropriate Critical Incident box in the Family & Children's Tracking System (FACTS). (This will initiate an email alert to the appropriate personnel on the email list).
4. If the referral meets the definition for child abuse and/or neglect, then the case is assigned to the district for assessment.

5. If the referral is screened by centralized intake staff, field staff and policy staff need to be notified through the district notification process in addition to the Director of DPQI or designee and the Director of Children and Adult Services.

6. The screened intake will be reviewed by policy staff to ensure the decision to screen is accurate.
7. If it is determined by policy that the intake needs assigned to the district for assessment, the policy staff will notify the Director of Centralized Intake to accept and assign the intake.
8. The district or Institutional Investigative Unit is responsible for completion of the Critical Incident Form. **See Attachment B**.
9. The completed Critical Incident Form shall be submitted within **five working days** from the date of intake via email through the chain of command including the Social services Coordinator if applicable, the Community Services Manager, Regional Director, Social Services Program Manager, Deputy Commissioner over Field Operations, Commissioner, Director of Children and Adult Services (CAS), the Director of the Division of Planning and Quality Improvement (DPQI) or designee and the Director of Field Support (DFS).
10. If after initial contact with the family the district does not believe that the referral is a critical incident, the CSM will notify the RD and Program Manager who will notify the deputy commissioner over field operations. The Deputy Commissioner over Field Operations will make the decision if the case meets the definition of a critical incident and needs to be reviewed. If it is determined that the case should not be a critical incident, the team will notify the director of DPQI, or designee that the case will not be assigned for review.
11. If a critical incident review is indicated by a history in the last 12 months and the acceptance of the referral, the field review team will be determined by the Director of DPQI or designee, working with the program managers. The assignment will be made within **5 working days** of receiving the critical incident form. When sending out the assignment the Director of DQI or designee will cc the Director of Field Support.
12. The review team will conduct a review of the case with DPQI staff as the team lead.
13. If the assessment is not completed following policy requirements for FFA completion, the lead DPQI reviewer will notify appropriate staff using the communication protocol in section 3.5.
14. The DPQI lead will present the findings at the quarterly meetings using the approved PowerPoint Template as the media. **See Attachment C.**

3.2 Critical Incidents Involving the Institutional Investigative Unit (IIU)

Beginning October 1,2019, the critical incident review process will include the review of all child fatalities involving any child in the custody of the Department. This will include a child or children in an out of home placement setting, school setting, child-care setting and children who are on a home visit while in Department custody. These reviews will be handled by the Institutional Investigative Unit staff along with DPQI staff. The information gathered during these reviews will be presented at the quarterly critical incident review team meetings beginning in February 2020.

Reports of suspected child abuse or neglect in an out of home setting are assessed in a different manner than those in an intra-familial setting. The process used for IIU investigations is one that focuses on ensuring safety of the child/children, determination of whether the incident occurred, whether maltreatment (child abuse or neglect) occurred, the culpability of the agency/provider and areas of concern identified during the investigation that may indicate non-compliance.

The step by step process of the Institutional Investigative Unit (IIU) is as follows:

1. An allegation is received on an out of home setting, school setting or child-care setting.
2. The Institutional Investigative Unit (IIU) Supervisor shall be notified of the complaint as soon as it is received, and the referral is entered in FACTS.
3. The IIU Supervisor will review the intake and determine whether the information collected meets the statutory or operational definition of child abuse or neglect.
4. If the information indicates there is a reasonable cause to suspect that child abuse or neglect may have occurred, the report will be accepted for investigation.
5. The IIU Supervisor will identify the response time (14 days) and assign it to an IIU worker.
6. The assigned IIU worker will complete the assessment and investigation of the allegation within 60 days, unless supervisory approval is granted.
7. Following the IIU investigation, DPQI staff will review the critical incident following the current Critical Incident SOP.
8. Review findings will be presented at the quarterly critical incident team meeting using the approved power point.

3.2 A. IIU Procedural Process

A. The review will take place in the county of case origin as opposed to the county of placement.
B. The review will include a 12-month history for residential facilities and all history on foster home providers including all corrective action plans.
C. The CWC involved in the review will be from the child's home district as opposed to the county in which the critical incident occurred.
D. The IIU supervisor will not be involved in the interviews of IIU staff unless specifically requested by staff for purposes of support.
E. Interviews will minimally include: County supervisor, IIU staff person assigned to the case, county of origin CPS or YS workers involved in the case, and the licensing specialist.

F. The review team will review all records including the hard copy of the child's original record, FACTS records, medical records, and any other records pertaining to the child fatality.

3.3 Critical Incident Review Team Membership

The Critical Incident Review Team meeting will be chaired by the Director of DPQI, or designee and consist of the Commissioner of the Bureau for Children and Families (BCF), the Deputy Commissioner over Programs and Resource Development, the Deputy Commissioners over Field Operations and the Assistant Commissioner over the Office of Planning, Research and Evaluation (OPRE). Additional State level staff include; the Director of Training, the Director of CAS and the IIU Supervisor or designee. The staff representing field practice in each region includes the four Regional Directors, Director of Field Support and the four Regional Program Managers. The Community Services Manager for the District of the Critical Incident will participate by phone.

3.4 Procedure for Conducting the Field Review

A DPQI staff member will lead the Field Review Team. The Team will involve the CPS or YS worker, the CPS or YS Supervisor, and the Community Services Manager (CSM). The Field Review Team will perform a detailed review of the facts and circumstances surrounding the critical incident involving a child alleged to have been critically injured or died because of abuse and/or neglect. This includes, but is not limited to, a review of current CPS, child and family history of abuse and/or neglect, and a review of the department interventions and services from external providers. Interviews will be conducted with staff and external providers who have provided services or were a worker on the case in the last 12 months. A search of FACTS and **a review of the case file** is conducted to identify the CPS or YS history on the family. All Intake Assessments are reviewed to determine if the screening decision follows code and policy. All assessments are read to determine if the findings are correct and procedures for completing the assessment adhere to policy. Case plans and safety plans are reviewed to determine if the plans appropriately address the identified problems in the home. All case contacts are read to determine caseworker interaction with the family. The Field Review Team reviews all services to be sure requests were made in a timely manner and the provider delivered the requested services. All review findings and supporting data are entered on the approved PowerPoint Template. The findings are presented at the quarterly critical incident review team meeting by the DPQI review team lead.

3.5 Protocol for a Findings dispute:

If the finding for the critical incident report could create an unsafe situation for a child, follow the communication protocol below. If the finding is disputed but does not create a safety issue, the team will document the finding made by the staff and will document why they disagree with the finding in the power point. This will be discussed by the team at the Critical Incident Review Team meeting.

3.6 Communication Protocol for Situations that Require Immediate Action:

Communication about the need for an immediate action will be documented in an email and forwarded based on the following protocol**:**

DPQI lead to their Immediate Supervisor
DPQI lead to the Director of DPQI or designee

DPQI lead to other program managers within the DPQI Division.

If neither the supervisor, DPQI Director, designee or other DPQI Program Managers are available the team will notify the Director of Field Support. If it is not possible to put the information in an email due to the immediate nature of the situation, the lead reviewer is to make contact by phone and then put the information into an email as soon as possible. The email will then be forwarded to their immediate supervisor, DPQI director, or designee and Director of Field Support.

3.7 Procedure for Completing the PowerPoint Template

1. The review team will review all records in FACTS and will note any questions they have about the case focusing on the last 12 months.
2. If the review team determines that the case does not have a history in the last 12 months after a review of the case file, the DPQI staff will notify the Director of DPQI, or designee.
3. Once the case in FACTS has been reviewed and meets the criteria, the DPQI staff will coordinate a visit to the district to complete the review.
4. When the review team is on-site, they will review the hard case file for any additional information they may need.
5. Once the review of the record and FACTS has been completed the team will interview all pertinent staff. Pertinent staff include workers and supervisors that have been involved in the case in the last 12 months, service providers who have been involved in the case in the last 12 months, and law enforcement.
6. The review team leader will enter the information onto the appropriate power point slides after the review process is complete.
7. The power point will be sent to the review team members for approval prior to sending it to the Director of DPQI or designee to approve for the quarterly meeting.

4.0 Quarterly Meeting Procedure:

The Critical Incident Review Team will meet on a quarterly basis in February, May, August, and November of each year. Two days will be set aside for each of these meetings unless otherwise indicated, which will be on the 1st Wednesday and Thursday of the month. The Community Services Manager for the district case that is being reviewed will be required to participate in the review by phone.

The lead reviewer from DPQI will present the findings at the quarterly meetings. The Critical Incident Review Team will discuss each case and make recommendations for improvement. The team will determine if the fatality or near fatality was caused by abuse or neglect or if abuse or neglect has been determined to have led to a child's death or near death. The decision will be documented on the PowerPoint review tool for each child reviewed.

If additional information is needed to make a decision, the case will be pended to the next quarterly meeting and the regional program managers will be responsible for obtaining the additional information. Once the determination is made on the abuse and neglect

finding, the PowerPoint information will be updated to reflect the decision. DPQI will collect the information from the quarterly meetings for the annual report. If there is a conflict within the group on the determination of abuse or/or neglect, the CPS Policy Division will make the final determination.

Recommendations for enhancements to practice, policy and/or training will be listed at the end of each case on the PowerPoint and a plan for action will be developed and maintained from meeting to meeting. A plan for Action will be developed in order to address concerns from the reviews.
At the completion of the quarterly meeting, the Director of DPQI or designee will share the final power point with the district CSM, Regional Director, Deputy Commissioner over Field Operations, Director of Social Services and the Commissioner.

4.1 Case Review Schedule

Cases received in the months of October, November, and December will be reviewed at the February team meeting.
Cases received in the months of January, February, and March will be reviewed at the May team meeting.
Cases received in the months of April, May, and June will be reviewed at the August team meeting.
Cases received in the months of July, August, and September will be reviewed at the November team meeting.
The reason for this schedule is to allow the field staff time to complete their assessment prior to the Field Review.

5.0 Annual Report to the Legislature

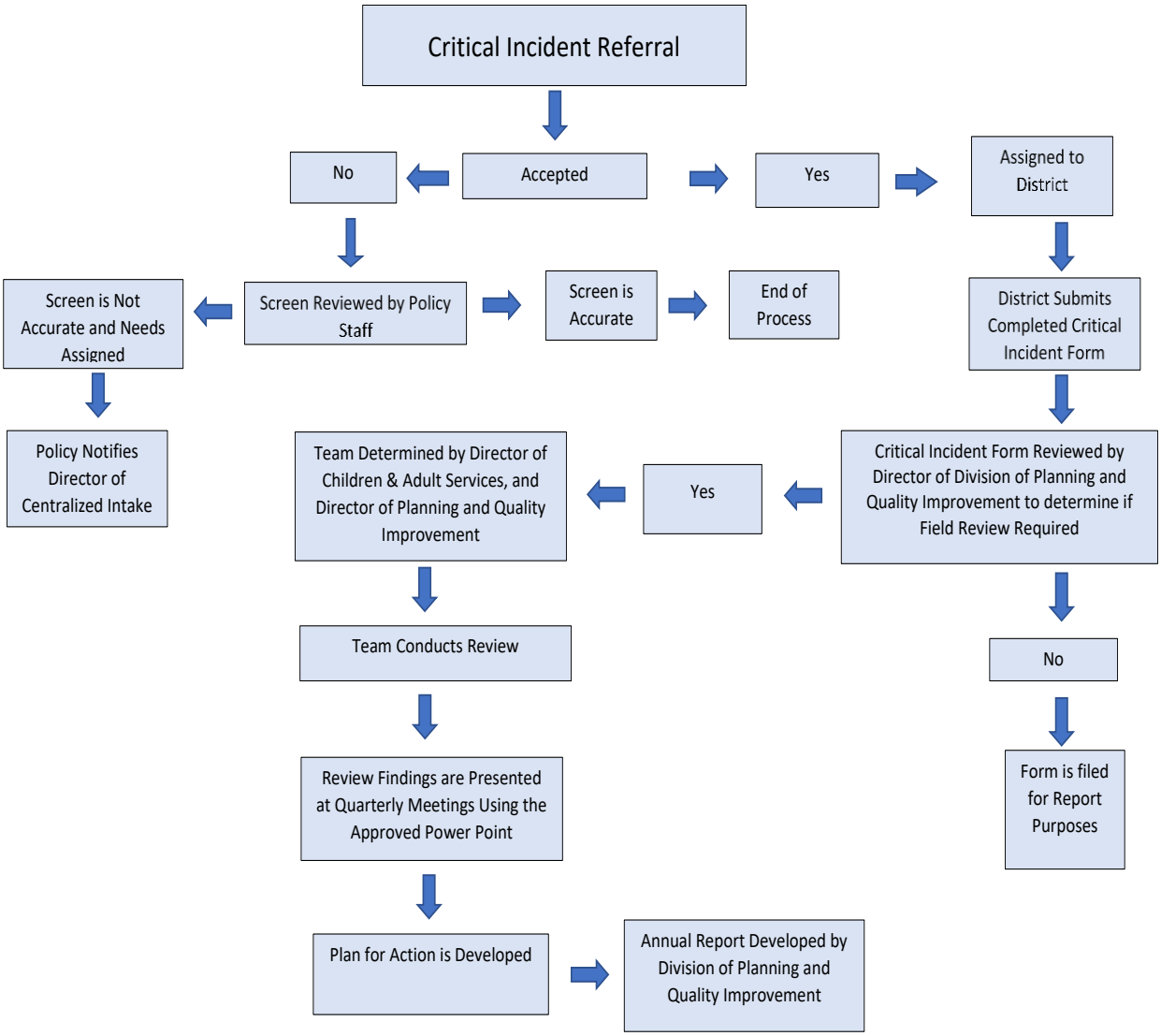
Annually on the first day of December, the review team will submit a report to the Commissioner of the Bureau for Children and Families to present to the state legislature. In order to get this report completed, everyone must meet timeframes in getting the cases reviewed and presented to the Review Team.

6.0 The Bureau for Children and Families is required to report all child fatalities to the Children's Bureau on an annual basis as part of our NCANDS report. To ensure accuracy of the report, the Director of DPQI, or designee will work with FACTS staff and the Program Managers for each region to ensure that all cases are accurate.

Facts staff will provide a list to the Director of DPQI, or designee of the cases being reported, the Director, or designee will review the case list and document discrepancies. Program managers will ensure that all cases that have been reviewed as part of a child fatality have accurate findings. Any child missing from the list that should be on the list will be reviewed to ensure the findings have been changed and are accurate. For cases not meeting the review criteria, the program managers will review the findings to ensure accuracy. The program managers will report their results to the director or designee who will verify the names with FACTS staff.

Since all fatalities are reported in NCANDS including those not known to the agency, the NCANDS numbers could be higher than those reported in the annual Critical Incident Report.

Attachment A: Critical Incident Referral Flow Chart



Attachment B: Critical Incident Report Form

Referral ID: enter numbers
Date of Incident: enter a date.
County: enter text.
Fatality: ☐
Near Fatality: ☐

Critical Incident Report Form

Check all that apply:

☐ A child of a family who has no history with CPS or Youth Services.

☐ A child who received CPS or Youth Services within the past 12 months including cases opened for services and cases assessed.

☐ A child of a family who has a previous history with CPS or Youth Services more than l2 months prior to the critical incident.

☐ A child in the custody of the Department.

Parent or Guardian

Name:	FACTS Client ID:	Current Address:
Click here to enter text.	Click here to enter text.	Click here to enter text.
Click here to enter text.	Click here to enter text.	Click here to enter text.

Deceased or severely injured child

Name: Click here to enter text.	DOB: Click here to enter text.	Facts ID#: Click here to enter text.
Name: Click here to enter text.	DOB: Click here to enter text.	Facts ID#: Click here to enter text.

Were other siblings in the home full or part time or facility at the time of fatality or injury? Yes ☐ No ☐

If yes, list below:

Name: Click here to enter text.	DOB: Click here to enter text.	Facts ID#: Click here to enter text.
Name: Click here to enter text.	DOB: Click here to enter text.	Facts ID#: Click here to enter

text.

Name: Click here to enter text. DOB: Click here to enter text. Facts ID#: Click here to enter text.

Name: Click here to enter text. DOB: Click here to enter text. Facts ID#: Click here to enter text.

Was action taken to assure the protection of other children in the home?

Explain:

Click here to enter text.

Nature of the family's involvement with CPS:

Date of CPS referral regarding fatality or near fatality: Click here to enter text.

CPS Screening Decision: Click here to enter text.

Manner of fatality or near fatality: Click here to enter text.

Dates of Notification:

Prosecuting Attorney: Click here to enter date.

Law Enforcement: Click here to enter date.

Medical Examiner: Click here to enter date.

Please list current and past referrals and/or case numbers in FACTS with dates and a brief description of outcome:

Date	**Intake Number**	**Allegations**	**Outcome of Intake-Substantiated/not substantiated or Open Case.**

Upon completion of the Detailed Critical Incident Report, it is to be forwarded through the Field Operations chain of command and include the Director of Field Support, Regional Program Manager, Director of Children and Adult Services and the Director of Planning and Quality Improvement within 5

working days of the date of the referral.

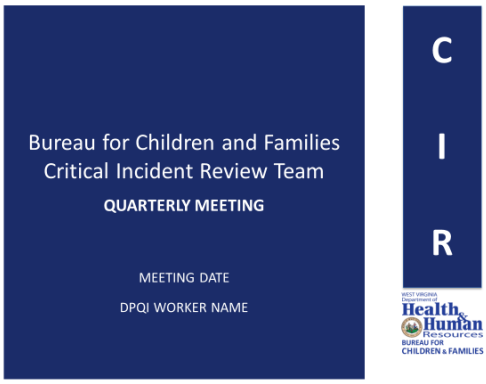
X

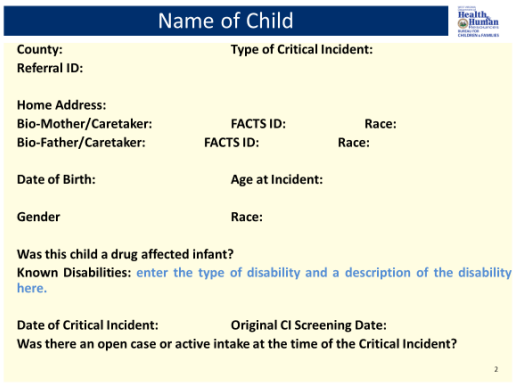
Signature of CPS Supervisor:

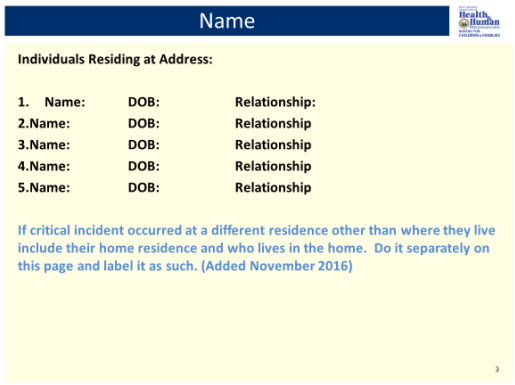
Print name here.

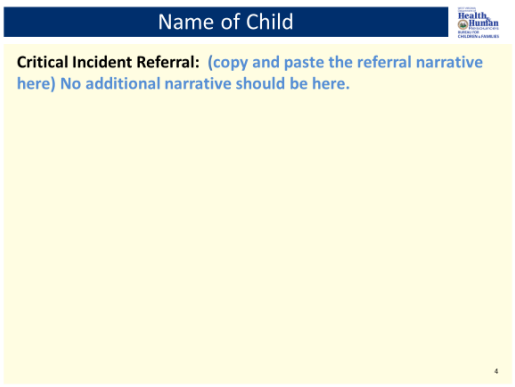
Critical Incident Report Form 05/2020

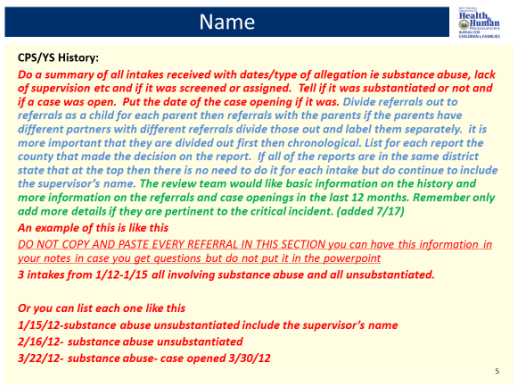
Attachment C: The approved PowerPoint Template used by the Critical Incident Review Team to present the finding at the quarterly meetings.











Name

Maltreater History:

Drug Abuse? **Yes** **No**

Allegations were not substantiated but police reports show that the mother was arrested for public intoxication.

Alcohol Abuse? **Yes** **No**

Domestic Violence? **Yes** **No**

if you do not agree with what was in the record put a narrative below the item like the example above

6

Name

Law Enforcement Report (if applicable):

Discuss your conversation with them and/or the police report in the record or no involvement at all etc. You should be talking to the police officer if they were involved in the case.

Medical Examiner Report (if applicable): not every case needs an autopsy and information about the autopsy maybe all that is needed. Document here if the review team feels there is a need for the autopsy or information from the medical examiner in order to make a decision on the critical incident being a result of abuse/neglect.(added 7/17)

7

Name

Review Team Findings: Be brief and get to the point this should be an over view of what you found not a huge narrative. Just address what impacts the critical incident. Do not list dates of face to face contact unless it impacts the assessment of the other children in the home during the critical incident or has an impact on this situation. This is not a case review in a traditional sense it is a review of the case to see if there was something we could have done differently to have prevented the critical incident. This gives us an idea of what we might need to improve in policy, training or reinforcement for staff to improve practice. (added November 2016)

This is actually what you found in the review that happened to the child to cause the critical incident. This is not your recommendations those go on page 10 . (added December 2018)

8

Name

Finding as documented in FFA: List each allegation and the findings as listed in Facts for this critical incident. This should be what is listed in FACTS only. I need to make sure that the allegations are consistent with the findings that the team makes. (added November 2016)

Does the Internal Review Team agree with the finding listed above: YES or NO

If your team disagrees with the findings above state why here. (added November 2016)

9

Name

Recommendations:

You can make recommendations here if there were things that were missed or if collaterals that should have been used were not. The team will add to this section but it is ok to make recommendations. Be objective on how you write this section. Does the team have ideas on what could have prevented this critical incident that we could do with staff? (Added November 2016)

10

State Critical Incident Team:

Death/Near Death - Result of Child Abuse/Neglect: YES or NO

This is completed by the Critical Incident Team at the meeting. (moved to this location November 2016)

State Critical Incident Team Recommendations:

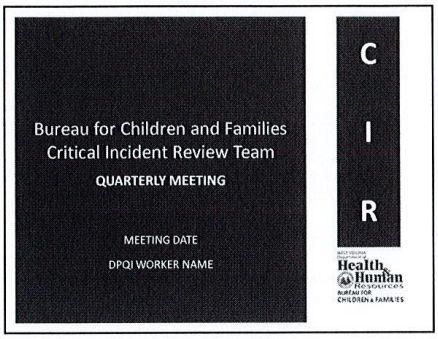
This is completed by the Critical Incident Team at the meeting. (moved to this location November 2016)

11

Attachment D: IIU Critical Incident Flowchart

Attachment E: The approved PowerPoint Template used by the Critical Incident Review Team to present the finding for IIU Critical Incidents at the quarterly meetings.

02/26/2020



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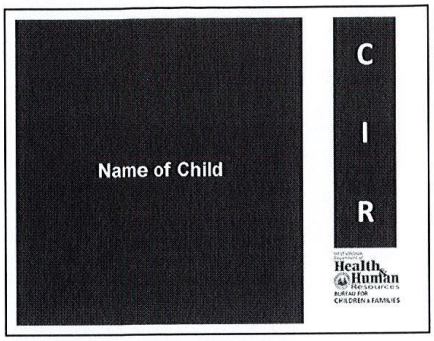

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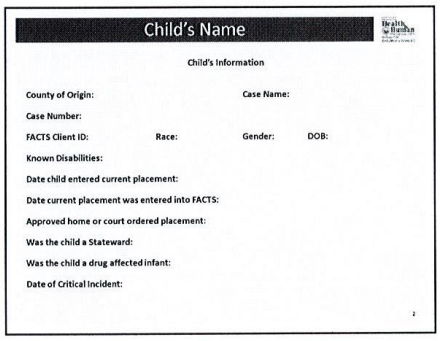

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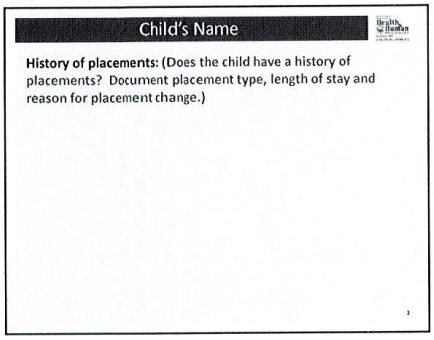

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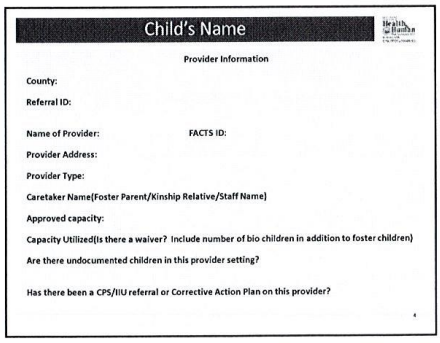

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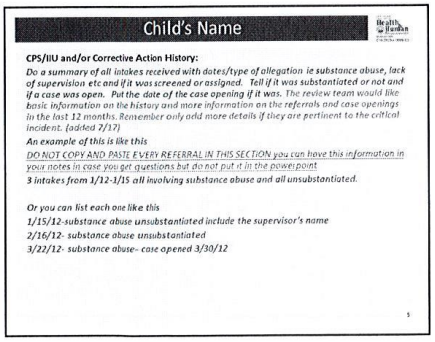

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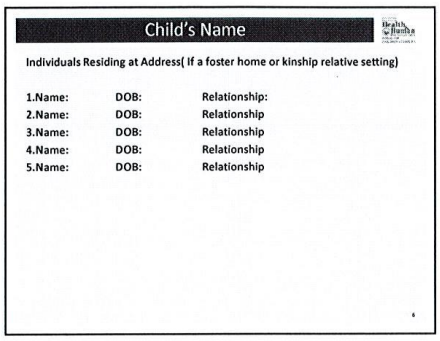
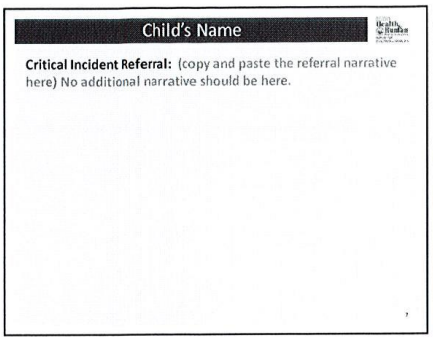
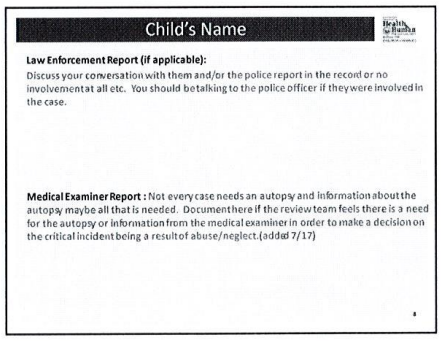

Child's Name
Individuals Residing at Address(If a foster home or kinship relative setting)
1.Name: DOB: Relationship:
2.Name: DOB: Relationship
3.Name: DOB: Relationship
4.Name: DOB: Relationship
5.Name: DOB: Relationship

6


Child's Name
Critical Incident Referral: (copy and paste the referral narrative here) No additional narrative should be here.

7


Child's Name
Law Enforcement Report (if applicable):
Discuss your conversation with them and/or the police report in the record or no involvement at all etc. You should be talking to the police officer if they were involved in the case.
Medical Examiner Report : Not every case needs an autopsy and information about the autopsy maybe all that is needed. Document here if the review team feels there is a need for the autopsy or information from the medical examiner in order to make a decision on the critical incident being a result of abuse/neglect.(added 7/17)

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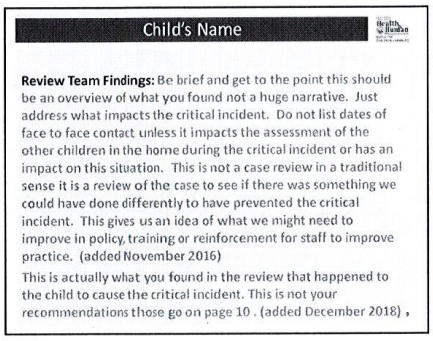
Child's Name
Review Team Findings: Be brief and get to the point this should be an overview of what you found not a huge narrative. Just address what impacts the critical incident. Do not list dates of face to face contact unless it impacts the assessment of the other children in the home during the critical incident or has an impact on this situation. This is not a case review in a traditional sense it is a review of the case to see if there was something we could have done differently to have prevented the critical incident. This gives us an idea of what we might need to improve in policy, training or reinforcement for staff to improve practice. (added November 2016)
This is actually what you found in the review that happened to the child to cause the critical incident. This is not your recommendations those go on page 10 . (added December 2018) ,

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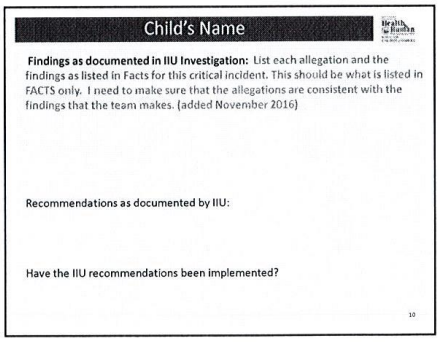
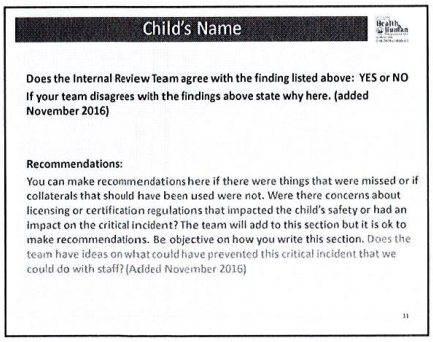

Child's Name
Findings as documented in IIU Investigation: List each allegation and the findings as listed in Facts for this critical incident. This should be what is listed in FACTS only. I need to make sure that the allegations are consistent with the findings that the team makes. (added November 2016)
Recommendations as documented by IIU:
Have the IIU recommendations been implemented?

10


Child's Name
Does the Internal Review Team agree with the finding listed above: YES or NO
If your team disagrees with the findings above state why here. (added November 2016)
Recommendations:
You can make recommendations here if there were things that were missed or if collaterals that should have been used were not. Were there concerns about licensing or certification regulations that impacted the child's safety or had an impact on the critical incident? The team will add to this section but it is ok to make recommendations. Be objective on how you write this section. Does the team have ideas on what could have prevented this critical incident that we could do with staff? (Added November 2016)

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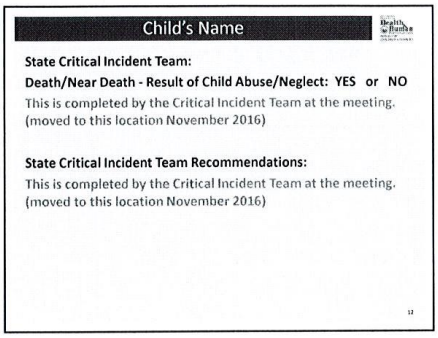
Child's Name
State Critical Incident Team:
Death/Near Death - Result of Child Abuse/Neglect: YES or NO
This is completed by the Critical Incident Team at the meeting.
(moved to this location November 2016)
State Critical Incident Team Recommendations:
This is completed by the Critical Incident Team at the meeting.
(moved to this location November 2016)
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