



CRITICAL INCIDENT ANNUAL REPORT

Child Fatalities and Near Fatalities Due to Abuse and Neglect

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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 Children and Families (Bureau or BCF).

The Legislative Audit Report

In the February 2013 Legislative Audit Report, the Performance Evaluation and Research Division (PERD) of the West Virginia Legislative Auditor's Office expressed concern over West Virginia having the highest and second highest incidence of child deaths related to abuse and neglect in the nation for six of the 12 years between 2000 and 2011. PERD also cited the annual Child Maltreatment Report produced by the U.S. Department of Health and Human Services, Administration for Children and Families (ACF), in which West Virginia has a higher recorded rate of deaths per 100,000 children than the national average for eight of the 12 years. The audit found that the information on child fatalities in West Virginia is not well documented; therefore, no statewide performance data were being gathered to determine the state's needs for training, policy, or field improvements that could reduce future child fatalities and near fatalities. In addition, the Legislature and the public were not made aware of the ongoing incidence of child fatalities and near fatalities due to abuse and neglect within the West Virginia child protective system.

The Fatality and Mortality Review Team - Child Fatality Review Panel and Report

A review of child fatalities is conducted by the West Virginia Supreme Court of Appeals and by the Fatality and Mortality Review Team. The West Virginia Supreme Court of Appeals analyzes the court system's performance and recommends changes that need to be made. The Fatality and Mortality Review Team is created under the West Virginia Department of Health and Human Resources, Bureau for Public Health and it is a multidisciplinary team that oversees and coordinates the examination, review and assessment of:

1. The deaths of all persons in West Virginia who die as a result of unintentional prescription or pharmaceutical drug overdoses;
2. The deaths of children under the age of eighteen years;
3. The deaths resulting from suspected domestic violence; and
4. The deaths of all infants and all women who die during pregnancy, at the time of birth or within one year of the birth of a child.

The Fatality and Mortality Review Team 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 eighteen;
3. A domestic violence fatality review panel to examine, analyze and review deaths resulting from suspected domestic violence; and
4. An infant and maternal mortality review panel to examine, analyze and review deaths of infants and women who die during pregnancy, at the time of birth or within one year of the birth of a child.

The Child Fatality Review Panel includes one CPS worker and the Director of the Office of Social Services within the West Virginia Department of Health and Human Resources, Bureau for Children and Families. The Child Fatality Review Panel examines, analyzes and reviews deaths of children under the age of eighteen. The Child Fatality Review Panel, in conjunction with the Fatality and Mortality Review Team, reviews and analyzes deaths, ascertains and documents trends, patterns and risk factors and provide statistical information and analysis regarding the causes of certain fatalities. The Child Fatality Review Panel and the Fatality and Mortality Review Team are required to provide an annual report with recommendations submitted to the Governor and the Legislature. West Virginia Code § 61-12A-1 et seq. and West Virginia Code of State Rules § 64-24-1 et seq.

The Critical Incident Review Team

In 2014, the Bureau established an internal child fatality review team to review incidents involving families who have a prior history within the Bureau. During FFY 2014, the team reviewed cases and collected data to develop a review process and to establish baseline data for making the determination on whether or not a child has been abused or neglected in order to address the trends in the data. In FFY 2015, the name of the team changed to the Critical Incident Review Team to encompass critical incidents involving both fatalities and near fatalities. The process and criteria developed by the review team is now used for the systematic review of critical incidents that have occurred in families known to the Bureau or that have come to its attention through the centralized intake assessment process.

The Critical Incident Review Team meets quarterly and is chaired by the Director of the Division of Planning and Quality Improvement (DPQI). Team members are comprised of the BCF Commissioner and Deputy Commissioners, the Regional Directors, and representatives from the Offices of Field Support, Programs and Resource Development, Planning and Research and the Offices of Field Operations. In addition, the Community Services Manager for any district having a history with the child or his/her family is included in the case review for that child. This team reviews all critical incidents resulting in a fatality or near fatality of a child with a known history with the Department in order to make improvements to the process in which critical incidents are reviewed with the intent of reducing the number of fatalities and near fatalities that were the result of abuse and neglect.

The Critical Incident Review process begins when the Bureau is notified of a critical incident through the centralized intake assessment. Child Protective Services assesses the case and takes appropriate actions based on policy. Once the assessment is completed, the incident is then assigned to a three-person Field Review Team which consists of a program manager who is a policy expert, a Child Protective Services policy specialist and a specialist from DPQI who leads the field review team.

The Field Review Team conducts a case record review of the family history of abuse and/or neglect and the Department's interventions and services provided to the family. Interviews are conducted with Department staff, law enforcement, medical staff and service providers. The DPQI Specialist presents their findings at the quarterly meetings of the Critical Incident Review Team. A decision is made on each case that the critical incident did or did not result from abuse or neglect as defined in state code and is evaluated for adherence to the Bureau's policy and practice. The Critical Incident Review Team develops a Plan for Action to enhance the case work practice and improve outcomes for children and families based on the findings and recommendations from the reviews.

The information collected during the review process is aggregated, analyzed, and included in this annual report to the West Virginia Legislature, as is required by the February 2013 Legislative Audit.

In 2016, policy was changed to expand the review process of the Critical Incident Review Team to include 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 from 2016 forward.

CHILD FATALITIES

In the federal fiscal year ending September 30, 2014, there were 17 fatal critical incidents resulting from abuse and/or neglect involving children of families that were known to the Bureau. "Known to the Bureau" is defined as having a prior Child Protective Services case or Youth Services case within the last 60 months or an assessment for either Child Protective Services or Youth Services within the last 12 months. Of those fatalities, one was a result of abuse, and seven were a result of neglect. Nine fatalities were attributed to both abuse and neglect.

In the federal fiscal year ending September 30, 2014, several initiatives were put into place as a result of the findings and recommendations of the Critical Incident Review Team. These activities were:

- A policy change requiring that any allegation of substance abuse in the home of a child under the age of one be assessed;
- A review by the Child Protective Services policy staff of all screened-out referrals to ensure policy compliance;
- A focus on better safety planning;
- Education for all staff working with families in DHHR county offices on safe sleep; and
- Updated Mandated Reporter Curriculum.

During federal fiscal year ending September 30, 2015, the Critical Incident Review Team determined there were seven fatalities due to abuse and neglect of children known to the Bureau. The activities that were put into place as a result of the team meetings were:

- Developed and implemented Critical Incident Training;
- Expanded Safe Sleep initiative;
- Updated the Drug Affected Infant Policy; and
- Developed and implemented Mandated Reporter Training.

As a result of the expansion in policy to accept the additional cases with no children in the home, a total of 12 cases were reviewed by the Critical Incident Review Team that would not have been reviewed in federal fiscal year 2015. In federal fiscal year ending September 30, 2016, the Critical Incident Review Team determined there were 13 fatalities due to abuse and neglect of children known to the Bureau. Of those cases, four were reported due to the policy change that would not have been reported in 2015.

During federal fiscal year ending September 2016, the Critical Incident Review Team determined there were 13 fatalities due to abuse and neglect of children known to the Bureau. The activities that were put into place as a result of the team meetings were:

Field support efforts including:

- West Virginia Resiliency Alliance;
- Collateral Desk Guide;
- Substance abuse training and

- Three Branch Institute.

Initiatives that were continued and updated from 2017 include:

- Critical Incident Training; and
- Safe Sleep Initiative;
- Drug Affected Infant Policy;
- Mandated Reporter Training; and
- Substance Abuse Training.

Initiatives that were continued and updated in 2018 include:

- Critical Incident Training;
- Safe Sleep Initiative;
- Drug Affected Infant Policy;
- Mandated Reporter Training;
- Substance Abuse Training; and
- Resiliency Services.

In addition to the continued initiatives, supervisory consultation was added in 2018 to help staff focus on practice issues that have been identified during the reviews.

In federal fiscal year 2018, there were 9 fatalities due to abuse and neglect of children known to the Bureau.

The information below is the data collected from our internal Critical Incident Review Team for FFY 2018.

See **Appendix A** for a narrative of each child fatality for FFY 2018.

Critical Incidents FFY 2014	Critical Incidents FFY 2015	Critical Incidents FFY 2016	Critical Incident FFY 2017	Critical Incident FFY2018
Fatality: 17	Fatality: 7	Fatality: 13	Fatality: 10	Fatality: 9

Map of Total Child Fatalities due to Abuse and/or Neglect, FFY 2018

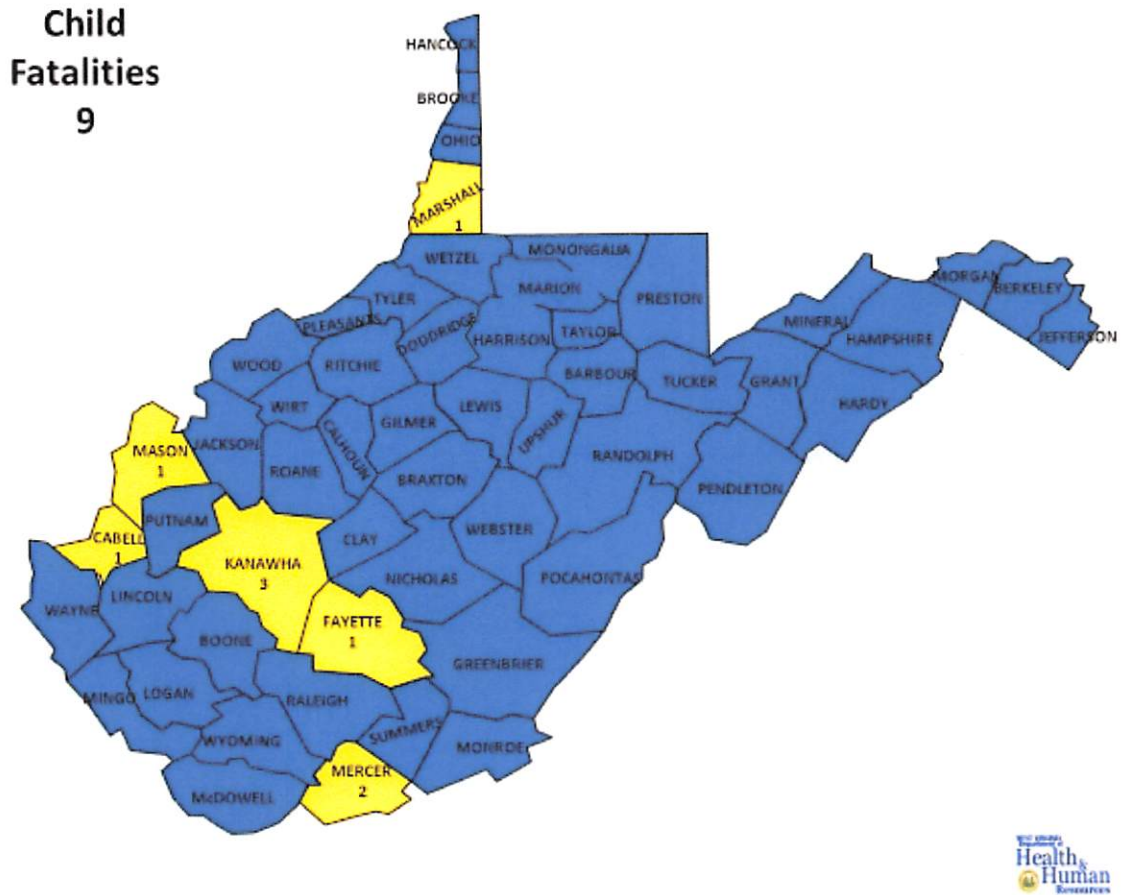


Figure 1: Child Fatalities 2018

Number of Victims in Abuse and Neglect Incidents by Known Cause of Fatality, FFY 2018	
Unsafe Sleep/Drug Use	1
Lack of Supervision/Struck by Car	1
Overdose/Lack of Supervision	1
Severe Trauma/Physical Abuse	4
Severe Trauma/Infant had drugs in system	2

Child Fatality – Demographics of Children, FFY 2018

Number of Victims in Fatal Incidents by Age	
14 years	1
2 years	2
1 year	1
Infant	5

Number of Victims in Fatal Incidents by Race	
White	9
African American	0

Number of Victims in Fatal Incidents by Gender	
Males	6
Females	3

Child Fatality – Maltreater Demographics, FFY 2018

In the cases below, the numbers do not add up to the 9 cases because in six cases there were two maltreaters and in one case, three maltreaters.

Number of Maltreaters in Fatal Incidents by Age	
20-29	9
30-45	8

Number of Maltreaters in Fatal Incidents by Relationship	
Mother	9
Father	4
Step-Father	1
Mother's Boyfriend	3

Number of Maltreaters in Fatal Incidents by Race	
White	17
African American	0
More than one race	0

Number of Maltreaters in Fatal Incidents by Gender	
Female	9
Male	8

CHILD NEAR FATALITIES

In FFY 2014, there were five children that were seriously injured due to abuse and/or neglect of families that were known to the Bureau.

In FFY 2015, there were seven children who were seriously injured due to abuse and/or neglect that were known to the Bureau. This is an increase of two children from FFY 2014 to FFY 2015.

In FFY 2016, there were nine children who were seriously injured due to abuse and/or neglect that were known to the Bureau. This is an increase of two children from FFY 2015 to FFY 2016.

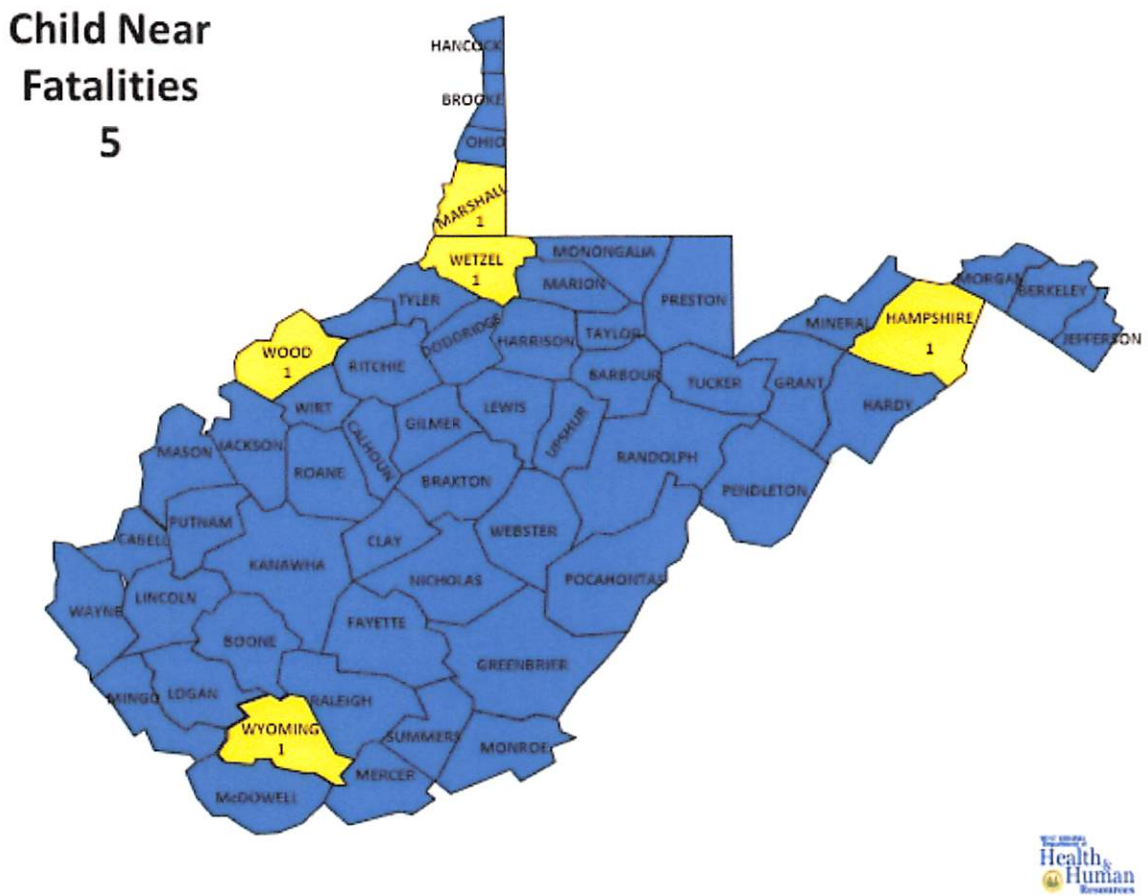
In FFY 2017, there were two children who were seriously injured due to abuse and/or neglect that were known to the Bureau. This is a decrease from all previous years of the critical incident review for near fatal incidents.

In FFY 2018 there were five children who were seriously injured due to abuse and/or neglect that were known to the Bureau. This is an increase of three children from FFY 2017.

See **Appendix B** for a narrative of each child near fatality for FFY 2018.

Critical Incidents FFY 2014	Critical Incidents FFY 2015	Critical Incidents FFY 2016	Critical Incidents FFY 2017	Critical Incidents FFY 2018
Near Fatality: 5	Near Fatality: 7	Near Fatality: 9	Near Fatality: 2	Near Fatality: 5

Map of Total Child Near Fatalities due to Abuse and/or Neglect, FFY 2018



Number of Victims in Abuse and Neglect Incidents by Known Cause of Near Fatality, FFY 2018	
Abuse/Severe Trauma	3
Car Accident/Drug Use by Caretaker	1
Overdose/Lack of Supervision	1

Child Near Fatality – Demographics of Children, FFY 2018

Number of Victims in Near Fatal Incidents by Age	
5 Years	1
1 year	1
Infants	3

Number of Victims in Near Fatal Incidents by Race	
White	4
African American	1

Number of Victims in Near Fatal Incidents by Gender	
Males	4
Female	1

Child Near Fatality – Maltreater Demographics, FFY 2018

In five of the cases, there was more than one maltreater.

Number of Maltreaters in Near Fatal Incidents by Age	
20-29	2
30-39	4
Number of Maltreaters in Near Fatal Incidents by Race	
White	6
African American	0
More than one race	0

Number of Maltreaters in Near Fatal Incidents by Relationship	
Mother	3
Father	2
Boyfriend	1
Number of Maltreaters in Near Fatal Incidents by Gender	
Female only	2
Male only	2
Both male and female	1

SUMMARY OF 2018 DATA

In 2018, the state of West Virginia continued to experience devastating drug use and saw a continued increase in foster care placements. In September of FFY 2017, 6,161 children were in foster care, as of September of FFY 2018, 6,683 children were in foster care. In 2018 we saw a difference in the type of fatalities and near fatalities from being predominately neglect in 2017 with ten of twelve critical incidents a result of neglect to four critical incidents in 2018 being a result of neglect. In 2018 out of 14 critical incident cases reviewed, nine were due to severe trauma.

Drug use continues to be a contributing factor in critical incidents in West Virginia out of the 14 critical incidents, 12 of the families either had a history of drug use or were actively using at the time of the child's death. Of the 14 children involved, six were born drug exposed. While there is no current data available on the drug use in West Virginia or which drugs are most prevalent, the Critical Incident Review Team saw a shift between children dying of neglect in 2017 and dying of several trauma in 2018 which could be related to the changes in the types of drug use. There could also be a difference

in the types of drug use that impact critical incidents based on the area of the state the child resides. The child fatalities are predominately in the southwestern part of the state.

In 2018 we continue to see that the maltreaters are the mother of the child, data on mother's boyfriends and fathers also remain consistent with 2017 data. Age groups and race for the maltreaters have also remained consistent with the 2017 report. In comparison to the 2017 report, females are most likely to be neglected and males are most likely to be abused resulting in a fatality or near fatality. Also, both maltreaters and victims are predominately white which is also consistent with the 2017 report.

In 2019 the Bureau will develop training for staff with local law enforcement that is based on the drugs that are most common in the areas in which they work. The team feels that this type of training would be more beneficial to staff and keep them current on the drugs being used and the signs of that drug use. Details of this initiative can be found in our Plan for Action in this report.

PLAN FOR ACTION

The Bureau has developed a Plan for Action based on the results of the Critical Incident Reviews starting in FFY 2015. The Plan for Action activities are designed to increase awareness, support practice, and improve outcomes in child welfare cases. In 2017, some of the activities in the previous plan have been updated and continue in addition to new activities that have been initiated.

I. Critical Incident Training for Staff to Increase Knowledge and Understanding

Critical incident training continues to be a mandatory training requirement for all child welfare staff. The training is updated each year in January after the completion of the annual report to provide staff current information and focus based on the review data.

II. Safe Sleep

The Bureau continues to focus on educating all parents of children under the age of one on safe sleep. The DHHR offices continue to show safe sleep videos in their office lobbies to help educate customers on safe sleep. The information provided can be reviewed at www.safesoundbabies.com. The group will also work with DHHR's Office of Maternal, Child, and Family Health to ensure consistent and up-to-date messaging on safe sleep. During the 2018 reviews the team has determined that safe sleep information is provided to the customers as required by policy but that we need to change our messaging to be more targeted to parents with drug affected infants as drug affected infants are at higher risk.

III. Drug-Affected Infant Policy

In September 2017, Child Protective Services Policy was updated as the result of the reauthorization through The Comprehensive Addiction and Recovery Act (CARA). Drug-affected Infants were redefined 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 a Fetal Alcohol Spectrum Disorder. Policy was also updated to comply with the requirement that every child identified as Drug-Affected would have a Plan of Safe Care.

IV. Mandated Reporter Training

Senate Bill 465 was passed in the 2018 legislative session modifying West Virginia's Mandated Reporting Statute. This bill amended West Virginia Code §49-2-803 to clarify that sexual abuse and sexual assault constitutes abuse of a child for reporting purposes; to reduce the time period in which a mandated reporter is required to report suspected abuse or neglect; to require mandated reporters to directly report known or suspected abuse or neglect; to eliminate certain broad reporting requirements applicable to any person over the age of 18; to clarify that minors are not mandated reporters; to eliminate certain exceptions to the reporting time limit; to eliminate particularized reporting requirements for education employees; and to eliminate provisions pertaining to conduct involving students or students and school personnel. Mandated reporter training was updated to reflect the new legislation and began dissemination in July 2018.

V. West Virginia Resiliency Alliance

The West Virginia Resiliency Alliance (WVRA) initiative was developed several years ago to assist staff for retention purposes, and now has been expanded to assist staff more specifically around trauma they are exposed to while doing their jobs. The resiliency services are available to staff and are continually being modified to meet the needs of staff who are involved in critical incidents. Efforts continue to be made to make staff aware of the services available to them and to encourage them to access those services.

NEW ACTIVITIES INITIATED IN 2018

I. Supervisory Consultation

On January 30, 2018, a memorandum was sent to the regional directors requiring each supervisor to have a monthly unit meeting with their staff. Each month a subject, policy, process or trend will be selected with input from the Child Welfare Oversight team to be presented during part of each supervisor's monthly unit meeting. 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 any staff unable to attend, the information will be covered with them in their monthly conference with the supervisor and include documentation of what was discussed. These documents are to be shared with the CSM who has the responsibility of ensuring these requirements are met.

Topics for monthly unit meetings:

December 2017: Collateral Contacts, Diligent Search

January 2018: Drug Affected Infant policy-CAS Policy 17-6

February 2018: Foster care planning, transitional planning for older children, out of state placements, Kinship/relative Provider letter, Right to Be Heard for foster parents, Placement activities with Kinship homes, and MDTs.

March 2018: Worker preparation for the Family Functioning Assessment (FFA) (CPS Policy 4.3-4.6), initial family contact, information collection.

April 2018: (CPS Policy 4.31-4.35 and 4.37) FFA and infant guardianship proceedings, FFA with domestic violence, FFA and allegations during divorce proceedings.

May 2018: (WV Code §49-4-111) Removal of child from a foster home; foster care arrangement termination; notice of child's availability for placement; adoption; sibling placement. (CPS Policy, Policy 7.11.1) Placement of a child whose siblings are already in foster care, (CPS Policy 2.1.4 Sibling placements, 5.1.2 sibling visitation, 4.5 sibling placement).

June 2018: (WV Code §49-4-405) MDTs and including school officials in MDTs. Protocols established by the state superintendent of schools.

July 2018: Diligent Search policy number 2.6.1 and Foster Care Policy 2.4.2 Kinship/Relative Placement and Relative Foster/Adoptive Family.

August 2018: Normalcy for Foster Children and Prudent Parenting Foster Care Policy 5.22 and 5.22.1.

September 2018: Referrals to Birth to Three, Foster Care Policy 3.2.3 Birth to Three Programs, CPS Policy Section 4.24 Birth to Three Program Referrals, CPS Policy 4.40; Family Functioning Assessments Involving Substance Use or Abuse (Drug-Affected Infants).

Items that have been identified during the 2018 critical incident reviews that will be included in the supervisory unit meeting in 2019 include the following:

- Focusing on securing collaterals during the initial assessment.

- Looking at the history of a case and using that information as part of the assessment.

- Making sure staff use resources available to them to maintain contact with families and ensuring customers that move is referred to staff in their new location.

- Including fathers in-service planning.

- Ensuring that services are available around the work schedules of parents involved in open cases.

II. Substance Abuse Training:

In April of 2018, staff from DHHR's Bureau for Behavioral Health and Health Facilities (BBHFF) and Bureau for Children and Families (BCF) partnered to provide statewide employee trainings on substance use disorder (SUD). The trainings were supported by the West Virginia Association of Alcoholism and Drug Abuse Counselors and DHHR's Office of Human Resources Management.

SUD staff trainings were provided in DHHR county offices in the four BCF regions of the state: Harrison (April 16), Kanawha (April 19), Mercer (April 20), and Berkeley (April 27).

Topics included the effects of SUD on the brain; signs of disease and co-occurring disorders; pros and cons of medication-assisted treatment; SUD and pregnant women, youth and families; American Society of Addiction Medicine levels of care; medical marijuana;

legislative updates; and SUD resources for families. There were also panel discussions with individuals in recovery.

Training details:

Date: April 16, 2018

Location: Harrison Co. DHHR

Time: AM session 9:00-12:00 Substance Abuse Basics

Time: PM Session 1:00-4:00 Substance Use Disorder Advanced

Date: April 19, 2018

Location: Kanawha Co. DHHR

Time: AM session 9:00-12:00 Substance Abuse Basics

Time: PM session 1:00-4:00 Substance Use Disorder Advanced

Date: April 20, 2018

Location: Mercer Co. DHHR

Time: AM session 9:00-12:00 Substance Abuse Basics

Time: PM session 1:00-4:00 Substance Use Disorder Advanced

Date: April 27, 2018

Location: Berkeley Co. DHHR

Time: AM session 9:00-12:00 Substance Abuse Basics

Time: PM session 1:00-4:00 Substance Use Disorder Advanced

AM - Substance Abuse: The Basics

- Is Addiction a disease? Signs of a SUD problem. How drugs effect the structure and function of the brain. Signs of disease progression and Co-occurring Disorders.
- Medication Assisted Treatment: pros and cons, counseling and supportive TX with MAT and outcomes with and without the "AT."

SUD with pregnant women, youth, families

Clients in recovery – the good side of SUD

PM – Substance Use Disorder Advanced

General Addiction Information brief review

- ASAM levels of care: different types of treatment, does treatment = a bed?
- Triggers for addicts, signs of disease progression, Co-occurring Disorders
- How can you avoid enabling without being heartless?
- Street drugs & drugs of abuse in WV information

SUD with pregnant women

- Effects on the baby in utero, NAS and interpreting a Finnegan
- Effects of MAT meds on breast milk / breast feeding, long-term effects on drug-affected babies

SUD with youth

- *Resources* for use with Youth SUD, co-occurring problems and how can you tell symptoms of a co-occurring problem versus symptoms of SUD itself?

SUD with families

- Resources

Medication Assisted Treatment

- Medication Assisted Treatment: pros and cons, counseling and supportive TX with MAT and outcomes with and without the "AT."
- Legislative changes

Marijuana

- Is medical marijuana, well ... medical?

Clients in recovery – the good side of SUD

Panel Discussion with Recovering People: The Solution (live or video)

An all-staff meeting was held in the Marion/Monongalia District on February 23, 2018 at the Marion County DHHR office. This meeting consisted of a presentation by Deputy Chris Garner of the Doddridge County Sheriff's Department. Deputy Garner is a K-9 officer and focuses on drug eradication. In addition to being a K-9 officer, Deputy Garner is a certified EMT with the Doddridge County Ambulance Authority and a certified fire fighter with the West Union Volunteer Fire Department. Deputy Garner has more than 20 years as a first responder. He has spent time as an EMT in Monongalia County as well.

This presentation was an overview of the drug epidemic in north central WV. Deputy Garner provided an overview of the different classifications of drugs, talked briefly about the most commonly seen drugs, showed videos of individuals under the influence of Flakka and the effects of huffing, and a music video by Theory of a Deadman of their song Rx which shows all aspects of drug addiction. He also demonstrated various field sobriety tests.

Deputy Garner explained how to tell if someone is under the influence of various substances, including physical signs and behavioral actions. Deputy Garner provided information on what to look for in client's homes for staff who do home visits that are indicators of drug use and manufacturing. Community Services Manager, Jondrea Nicholson, of Monongalia and Marion counties, explained what to do in the event a worker feels a client in the office is under the influence.

Deputy Garner had various substances (marijuana, methamphetamine, heroin, cocaine) in baggies which were in a lock box that he allowed staff to view under his supervision following the presentation. He also provided staff with photos of various paraphernalia and substances of how they typically appear in society.

BCF Deputy Commissioners plan to develop similar interactive trainings for Bureau staff statewide.

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; or sexual abuse or sexual exploitation; or the sale or attempted sale of a child by a parent, guardian or custodian; and domestic violence. In addition to its broader meaning, physical injury may include an injury to the child as a result of excessive corporal punishment. (*WV 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 right now. 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/caregiver's condition is more important than the use of a substance (drinking compared to being drunk), uses drugs as compared to being incapacitated by the drugs, and if accurate 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, health care facility, group home, mental health center, residential treatment center, shelter care facility, detention center, or child care 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 less than 18 years of age. (*WV Code §49-1-202*)

Child Abuse Prevention and Treatment Act (CAPTA): CAPTA is one of the key pieces of legislation that guides child protection. CAPTA, in its original inception, was signed into law on January 31, 1974 (P.L. 93-247). It was reauthorized in 1978, 1984, 1988, 1992, 1996, and 2003, and with each reauthorization, amendments have been made to CAPTA that have expanded and refined the scope of the law.

CAPTA was most recently reauthorized on December 20, 2010, by the CAPTA Reauthorization Act of 2010 (P.L. 111-320). The amendment in 2010 added a requirement for states to report child fatalities of children who were known to the agency, defined as having been assessed in the last 12 months or who have received family preservation services in the last 60 months.

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

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

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.

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 Children and Families to review critical incidents for the purpose of improving the casework process to prevent future critical incidents.

Crohn's Disease: Crohn's disease is a relapsing inflammatory bowel disease (IBD) that mainly affects the gastrointestinal (GI) tract. It can result in abdominal pain, fever, bowel obstruction, diarrhea, and even the passage of blood in stool.

Drug Affected Infants: A child reported by a medical professional, including a hospital social worker, indicating that the infant was 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.

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.

Glycogen Storage Disease: Glycogen storage disease (GSD) is a rare condition that changes the way the body uses and stores glycogen, a form of sugar or glucose.

Known to the Bureau: Refers to a child with an open Child Protective Services or Youth Services case within the last 60 months or who was assessed by Child Protective Services or Youth Services within the last 12 months.

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

Mediport: A mediport is a port placed under the skin to provide medications.

National Governor's Association (NGA): NGA—the bipartisan organization of the nation's governors—promotes visionary state leadership, shares best practices and speaks with a collective voice on national policy.

Near Child Fatality: Any medical condition of the child which is certified by the attending physician to be life-threatening.

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 provide 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. (*WV Code §49-1-201*)

Opana: An opioid pain medication used to treat moderate to severe pain.

Oxymorphone: An opioid pain medication used to treat moderate to severe pain.

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; and
- 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.

West Virginia Birth to Three: A statewide system of services and supports for children under age three who have a delay in their development, or may be at risk of having a delay, and their family. The West Virginia Department of Health and Human Resources, through the Bureau for Public Health's Office of Maternal, Child and Family Health, West Virginia Birth to Three, as the lead agency for Part C of the Individuals with Disabilities Education Act (IDEA), assures that family-centered, community-based services are available to all eligible children and families.

Appendix A: Abuse and/or Neglect Cases Resulting in Child Fatality FFY 2018

Child's Initials	County	Date of Incident	Gender	Age	Race Ethnicity	Type of Maltreatment	Brief Summary of Incident	Cause of Fatality
F.S.	Cabell	11/22/17	Male	4 months	White	Physical Abuse	The child was severely shaken and had fractured ribs. There are pending charges.	Shaken baby and severe trauma.
L.L.	Kanawha	5/5/18	Male	2 months	White	Neglect	Mother was co-sleeping with infant under the influence and the child was asphyxiated.	Co-sleeping/ Unsafe sleep.
*B.W.	Mason	5/30/18	Male	2 months	White	Neglect	Child was not checked on for over ten hours after being put to bed. Parental use of illegal substances.	Failure to check on a two-month-old infant for ten hours.
M.R.	Fayette	6/20/18	Female	1 year	White	Physical Abuse	Child was severely shaken and suffered significant brain injury.	Shaken baby/severe head trauma.

*This case was missed for regular review. It should have been reviewed by the Critical Incident Team and included in the report. The Deputy Commissioners reviewed the case and made a determination that the death was due to abuse and neglect. That determination was included in the report.

Child's Initials	County	Date of Incident	Gender	Age	Race Ethnicity	Type of Maltreatment	Brief Summary of Incident	Cause of Fatality
L.H.	Kanawha	6/23/18	Female	8 months	White	Physical Abuse	Multiple severe traumas. At autopsy the child had methamphetamine in her system.	Severe trauma.
J.G.	Mercer	8/8/18	Male	2 years	White	Physical Abuse	Child had severe trauma both parents have been charged.	Severe trauma.
A.N.	Kanawha	9/2/18	Female	4 months	White	Physical Abuse	Child had severe head trauma and other trauma. At autopsy the child was found to have methamphetamine in her system.	Severe trauma.
M.S.	Marshall	9/2/18	Male	14 years	White	Neglect	Child died of an overdose after doing drugs with his step-father.	Overdose.
A.K.	Mercer	9/13/18	Male	2 Years	White	Neglect	Father failed to supervise the child who was hit by a car.	Multiple injuries due to being hit by a car.

**Appendix B: Abuse and/or Neglect Cases Resulting in Child Near Fatality
FFY 2018**

Child's Initials	County	Date of Incident	Gender	Age	Race/ Ethnicity	Type of Maltreatment	Brief Summary of Incident	Cause of injury
J.S.	Wyoming	11/9/17	Female	7 Months	White	Abuse	Severe head trauma/ shaken baby; it is unknown if the mother or the mother's boyfriend is responsible for the trauma.	Severe Head Trauma.
D.S.	Marshall	12/18/17	Male	5 Years	African American	Neglect	Child got access to his mother's prescription medication and overdosed.	Overdose.
B.I.	Hampshire	12/25/17	Male	1 year	White	Neglect	Mother was driving under the influence of drugs and alcohol and wrecked resulting in severe injury to the child. The child was not properly restrained in the vehicle.	Car Wreck.
B.J.	Wood	3/5/18	Male	2 months	White	Physical Abuse	Severe head trauma/ shaken baby by the father. Father has been charged in relation to the injuries.	Severe head trauma.
X.L.	Wetzel	4/4/18	Male	2 months	White	Physical Abuse	Severe head trauma/ shaken baby by the father.	Severe head trauma.