CRITICAL INCIDENT ANNUAL REPORT

Child Fatalities and Near Fatalities Due to Abuse/Neglect

WEST VIRGINIA DEPARTMENT OF HUMAN SERVICES

Office of Quality Initiatives

Division of Planning and Quality Improvement
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Executive Summary

The West Virginia Department of Human Services (DoHS), formerly 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 DoHS'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 the West Virginia Department of Health (DH), Bureau for Public Health (BPH). 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 electronic records. West Virginia Statewide Automated Child Welfare Information System (SACWIS), known as the Families and Children Tracking System (FACTS) was utilized at the onset of FFY 2023. In January 2023, the use of a Comprehensive Child Welfare Information System (CCWIS), known as West Virginia People's Access to Help (WV PATH) was implemented. Additional information about abused and neglected children with no prior history with CPS is obtained from DH'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 Quality Initiatives, Field Support, Field Operations, and Programs and Policy; the Director of Centralized Intake, the Director of the Division of Professional Development, the Director of Division of Planning and Quality Improvement, 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 DoHS, 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 workers and supervisors who have worked with the family, law enforcement, medical staff, and service providers. The Field Review Team's findings are presented at Critical Incident Review Team meetings. A decision is made on each case as to whether the critical incident was a result of 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 casework 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.

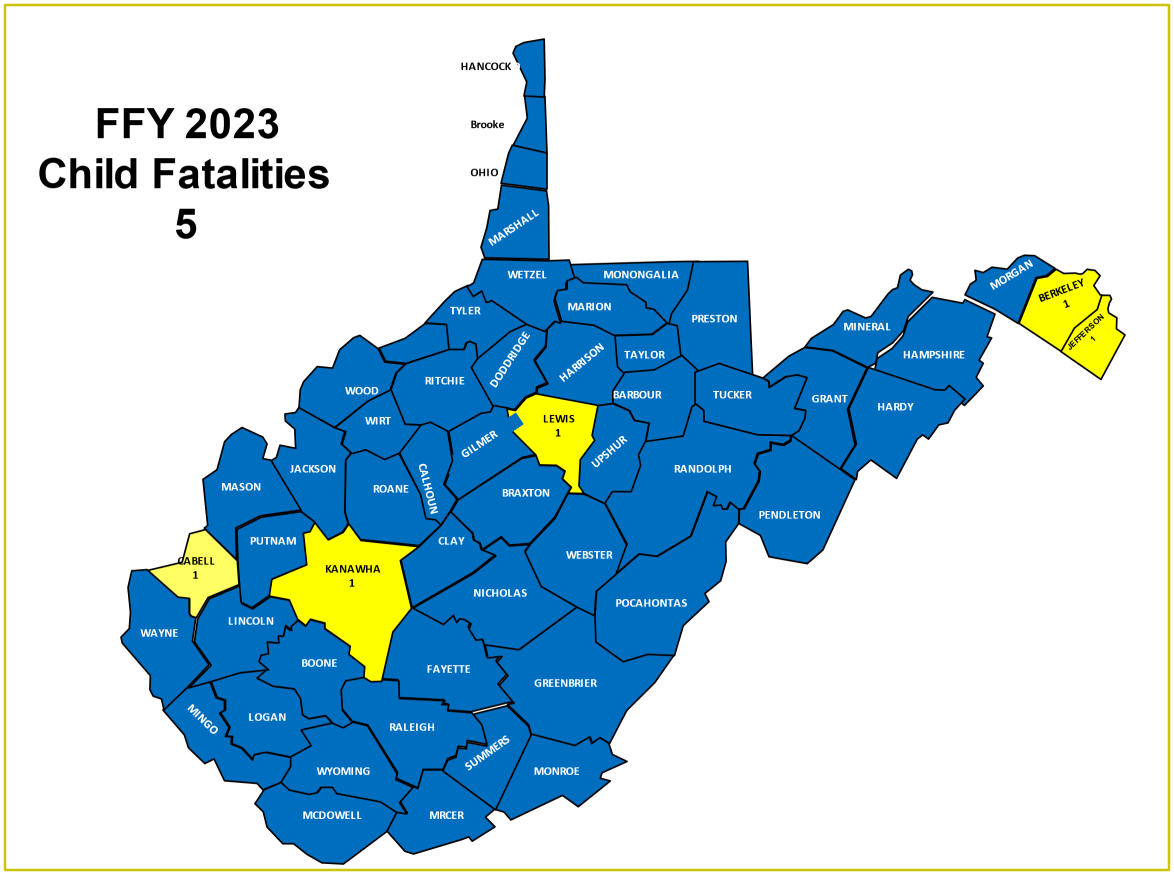
In 2020, the Critical Incident Standard Operating Procedure was updated to include the review of all critical incidents involving any child in the custody of the Department. If a child is in a certified placement at the time of the critical incident, the investigation is completed by IIU.

Child Fatalities

In FFY 2023, there were 16 fatalities of children known to BSS presented to the Critical Incident Review Team, following review by a Field Review Team. Five of the fatalities were determined to be a result of abuse and/or neglect. This is an increase of three children compared to FFY 2022. The information below reflects the data collected from the internal Critical Incident Review Team for FFY 2023.

Critical Incidents FFY 2019	Critical Incidents FFY 2020	Critical Incidents FFY 2021	Critical Incidents FFY 2022	Critical Incidents FFY 2023
Fatality: 8	Fatality: 4	Fatality: 6	Fatality: 2	Fatality: 5

Map of Total Child Fatalities Due to Abuse and/or Neglect FFY 2023



Number of Victims in Abuse and Neglect Incidents by Known Cause of Fatality FFY 2023	
Lack of Supervision/Drowning	1
Physical Abuse	2
Medical Neglect	2

Child Fatality – Demographics of Children, FFY 2023

Number of Victims in Fatal Incidents by Age	
Less Than 5 Years	5

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

Number of Victims in Fatal Incidents by Gender	
Male	2
Female	3

Child Fatality – Maltreater Demographics, FFY 2023

The data listed below reflects two cases with two maltreaters.

Number of Maltreaters in Fatal Incidents by Age	
20-29 years	3
30-39 years	2
40-49	2

Number of Maltreaters in Fatal Incidents by Relationship	
Father	2
Mother	3
Grandparent	2

Number of Maltreaters in Fatal Incidents by Race	
White	6
Black/African American	1

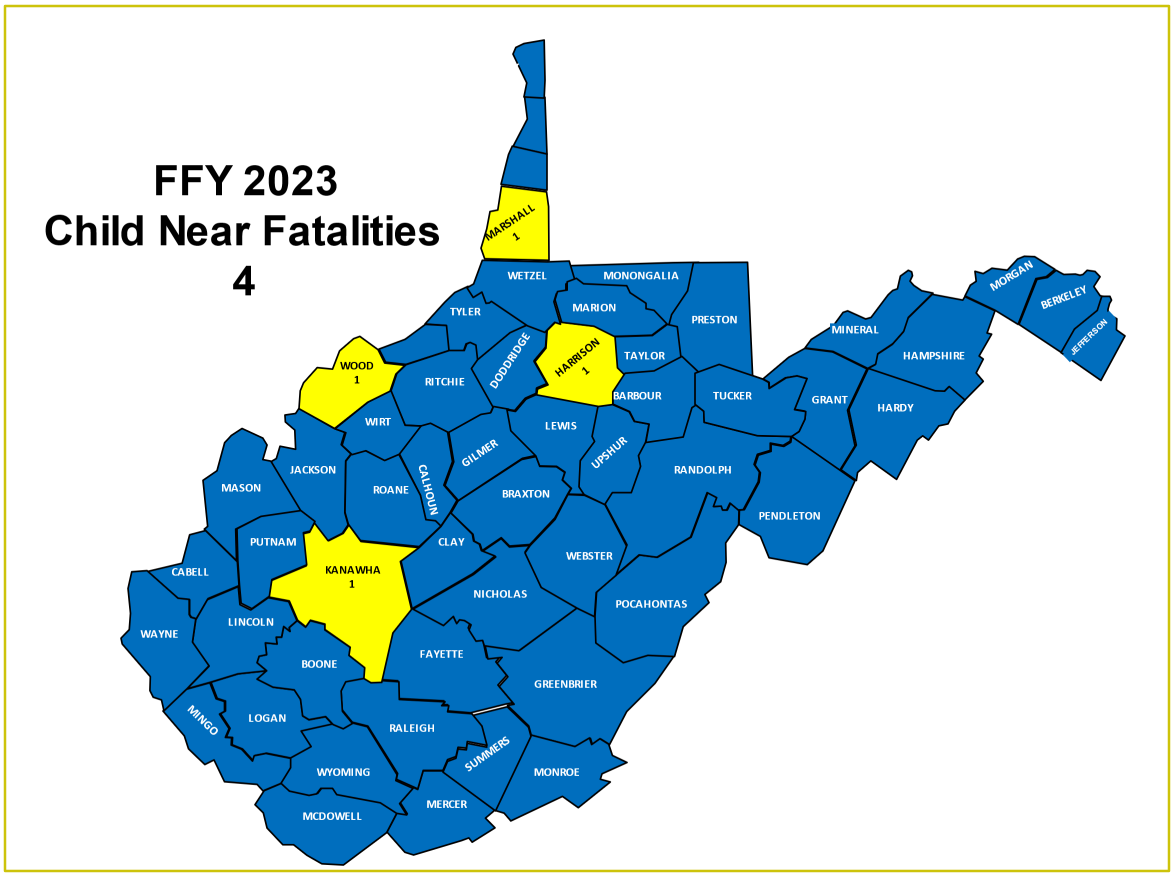
Number of Maltreaters in Fatal Incidents by Gender	
Male	2
Female	5

Child Near Fatalities

In FFY 2023, there were five 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 the same number of children determined to have been seriously injured due to abuse and/or neglect in FFY 2022.

Critical Incidents FFY 2019	Critical Incidents FFY 2020	Critical Incidents FFY 2021	Critical Incidents FFY 2022	Critical Incidents FFY 2023
Near Fatality: 8	Near Fatality: 5	Near Fatality: 3	Near Fatality: 4	Near Fatality: 4

Map of Total Child Near Fatalities Due to Abuse and/or Neglect FFY 2023



Number of Victims in Abuse and Neglect Incidents by Known Cause of Near Fatality, FFY 2023

Lack of Supervision/Child Ingested Substance	2
Physical Injury/Lack of Supervision	1
Physical Injury/Lack of medical care	1

Child Near Fatality – Demographics of Children, FFY 2023

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

Number of Victims in Near Fatal Incidents by Race	
White	4

Number of Victims in Near Fatal Incidents by Gender	
Male	3
Female	1

Child Near Fatality – Maltreater Demographics, FFY 2023

The data listed below reflects four cases with two maltreaters.

Number of Maltreaters in Near Fatal Incidents by Age	
20-29 years	3
30-39 years	3
50-60 years	2

Number of Maltreaters in Near Fatal Incidents by Relationship	
Father	4
Mother	3
Father's Paramour	1

Number of Maltreaters in Near Fatal Incidents by Race	
White	8

Number of Maltreaters in Near Fatal Incidents by Gender	
Male	4
Female	4

Summary of 2023 Data

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 lack of supervision for each of the six children included in the FFY 2022 annual report. Data from FFY 2023 critical incident reviews suggests a lack of adequate supervision continues to contribute to the death or significant injury of children. Of the nine fatalities and near fatalities determined to be the result of abuse and/or neglect in FFY 2023, four children were determined to not have been sufficiently supervised, leading to death by drowning, ingestion of harmful illicit substances, and/or physical injury. Critical incident reviews completed in FFY 2023 revealed two fatalities and one near fatality were the result of children with unmet medical needs. Two of these children had significant health care needs that required an increased level of care, which was not sufficiently provided and resulted in their death. The third child suffered non-accidental physical injury and did not receive timely medical care to address their medical needs. Data from FFY 2023 reviews further reveals physical injury by caregivers was a contributing factor in the death or significant injury of four children. It should be noted that there were co-occurring findings of maltreatment related to critical incidents for several of the identified victims.

In FFY 2021, the father/male caregiver was identified as a maltreater in the majority of cases reviewed, and in FFY 2022, the mother/female caregiver was predominantly identified as the maltreater. In FFY 2023, there is no disparity between the mother and father, with six mothers and six fathers being identified as maltreaters. It is noted that in two of the cases examined a caregiver other than a parent was identified as a maltreater, two grandmothers and a paramour of a father. When considering this information, the female gender surpasses the male gender as an identified maltreater, with nine females overall and six males. There were six identified maltreaters falling between the ages of 20 to 29 years, and five individuals falling between the ages of 30 to 39 years. Some cases reviewed during FFY 2023 involved grandparents as caregivers and/or as adoptive parents. As a result, there were two maltreaters noted in the age range of 40 to 49 years and two between the ages of 50 to 60 years. It is noted that FFY 2022 data showed the maltreater population to have shifted out of the youngest category into the range of 30 to 39 years. While maltreaters over the age of 40 years are not the predominantly identified group, this is the second year in a row to reflect an increase in the age of maltreaters. Maltreaters were most often white, with only one of the 15 identified maltreaters being black/African American. This data is consistent with annual reports from the last several years.

There is no significant disparity in gender for victims reported during FFY 2023, with five males and four females identified. This is consistent with data from the previous year, which reflected equal numbers of male and female victims. All nine of the identified victims were under the age of five years, with seven of them being identified under the age of one and half years. It is noted that all victims reported in FFY 2022 were also under the age of five years. Victims were most often white, with only one of the nine identified victims being black/African American. This data is consistent with the annual reports for the last several years.

One child fatality and one near fatality were located within Kanawha County. The remaining seven of the nine critical incidents were all reported from individual counties, including: Lewis, Jefferson, Cabell, Berkeley, Harrison, Marshall, and Wood counties.

Plan for Action

The BSS Plan for Action, based on the results of critical incident reviews, is designed to increase awareness, support practice, and improve outcomes in child welfare cases.

Historically Initiated Activities

During previous fiscal years, BSS recognized the need to address trends that were identified as emerging through data and information obtained in the critical incident review process. The FFY 2022 Critical Incident Report included a Plan for Action that described initiatives and activities that are considered achieved, as they have been successfully implemented as an ongoing practice. This section will include information about those initiatives, which are no longer reflected as an activity in the Plan for Action.

Critical incident training for BSS staff is a mandatory training requirement for all new child welfare staff, completed within the first 18 months of employment. The training is updated on a yearly basis to include statistical data and trends for child fatalities and near fatalities in West Virginia. It further includes guidance and training on best practice standards. A refresher course is available online, with the expectation that all child welfare staff will complete it annually.

Training is available to mandated reporters in the form of an online course now offered through West Virginia Children's Justice Task Force. The course is available at www.handlewithcarewv.org and offers certification for participants. BSS maintains a mandated reporter training curriculum that is available to small groups outside of the Bureau, when requested. This training has been shared with the regional and district managers for local organization and community training, when needed.

BSS continues to partner with West Virginia Coalition Against Domestic Violence to provide training for child welfare staff. 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.

There were no fatalities or near fatalities involving maltreatment related to safe sleep practices identified in FFY 2023. BSS continues to focus on educating parents of children under the age of one year on safe sleep practices. The *Our Babies: Safe and Sound* group, which educates West Virginia families about infant safety, works with the Office of Maternal, Child, and Family Health to ensure consistent and up-to-date messaging is provided. Information can be viewed at www.safesoundbabies.com. Child welfare staff continue to assess sleeping arrangements of infants, and to discuss safe sleep practices with their caregivers. Educational pamphlets are provided to caregivers 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.

Plan for Action Activities

This section will describe activities and initiatives implemented prior to FFY 2023 that were continued and updated throughout the fiscal year.

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 in 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.

During FFY 2023, BSS and Office of Maternal, Child, and Family Health began discussion for a memorandum of understanding for Office of Maternal, Child, and Family Health staff to oversee the Plan of Safe Care plans. It should be noted that none of the aforementioned fatalities or near fatalities were a direct result of the child victim's exposure to substances in utero.

BSS recognizes that child welfare staff interact with people who have experienced multiple traumas on a regular basis. Secondary traumatic stress, the emotional duress that can result from being exposed to the trauma experiences of another person, is something child welfare staff are at high risk of developing. Trauma, and secondary trauma, experienced by clients and staff can affect organizations and organizational culture. If left unaddressed, it can have a negative impact on the ability of individuals and organizations to help children and families.

BSS continues to make concerted efforts to address job related stress and trauma, and to provide supportive services. During FFY 2023, BSS contracted with Marshall University Center of Excellence for Recovery, to develop and implement a trauma sensitive workplace program specifically to address critical and crisis events and workplace trauma. The Trauma Sensitive Workplace (TSW) team completed Transformational Collaborative Outcomes Management (TCOM) certification, Trauma 101 training, Secondary Trauma training, Vicarious Trauma training, and Peer Support Training. The team further attended intensive training for Critical Incident Stress Management. The TSW team released a Safety Culture assessment to BSS staff at the onset of FFY 2023, along with additional assessments for Secondary/Vicarious Trauma and Self-Care. The plan is to release the assessments on an annual basis. The University of Kentucky gathered result information, to assure anonymity for staff. During FFY 2023, the TSW team developed a training and coaching curriculum and began piloting the training. After completion of the pilot group, training and coaching were rolled out to applicable

BSS staff. Survey results were used to support training in individual districts. By the end of FFY 2023, 422 BSS staff had participated in Protecting the Protectors training, with the course offered in all districts across the state. Course evaluations returned an 85% positive rating given by participants. FFY 2023 activities included the development of a second training, Weathering the Storm, with anticipation of it being rolled out at the onset of FFY 2024. Additional TSW team activities included developing a Peer Support manual and Peer Support network and special training activities for peer leaders. Peer Support groups were held in many districts across the state. The TSW team was further tasked with creating a Critical Incident Team, utilizing state partners, to respond face-to-face to all critical incidents and tracking all Crisis Event Responses. Many districts throughout the state benefited from the support of the TSW team following a traumatic event in their office.

During FFY 2023, West Virginia continued membership with 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 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 trained in the use of the Safe Systems Improvement Tool (SSIT) and implemented use of the tool during FFY 2023 critical incident reviews. BSS received training and technical assistance through NPCS related to the use of SSIT in the form of bi-monthly meetings specific to West Virginia's implementation and use of SSIT. BSS staff were further offered the opportunity to participate in a variety of peer leader and support groups available within NPCS in an effort to support critical incident review and best practices. In April 2023, Dr. Michael J. Cull presented information related to Safety Culture/Safety Science to BSS management staff.

New Activities Initiated in 2023

As described in the FFY 2022 Critical Incident Annual Report, BSS staff that participate in the critical incident review process, as a field review team member or a member of the Critical Incident Review Team, received in-depth training offered through the National Partnership for Child Safety in the use of the Safe Systems Improvement Tool (SSIT). SSIT is an information integration tool designed to support system improvement activities. The retrospective critical incident review tool centers on systems-level influences that contribute to casework practice in critical incidents. The output is structured and standardized, allowing for data aggregation for systems-level quality improvement to enhance the safety and care of children and families. BSS staff completed SSIT training during FFY 2022 and implemented use of the tool in critical incident reviews during FFY 2023. BSS is using the tool to gather and aggregate critical incident data, in order to identify trends that reflect agency strengths as well as areas needing improvement.

After implementing the use of SSIT in critical incident reviews, the Critical Incident Review Team determined the Standard Operating Procedure (SOP) for critical incident assessments should be updated to reflect the new tool and process. A workgroup was formed, and met throughout part of FFY 2023, to examine BSS policies and directives related to critical incident assessments and the review process that is completed when a family is known to the agency. The workgroup created a SOP that offers support to field staff completing critical incident assessments. The revised SOP also provides guidance for members of the field review team. In the revised SOP, the critical incident review process will begin earlier in the assessment process. Rather than wait until district staff have finalized the critical incident assessment, the appointed field review team members will initiate the review prior to approval. The field review team will continue to be comprised of a policy specialist, a field staff/support specialist, and a quality assurance specialist. This team of specialists will be able to assist district staff in determining if sufficient information has been gathered and documented to support if maltreatment has or has not occurred. The field review team will use information gathered through interviews and document reviews to complete the SSIT and will provide timely feedback at a district level of areas identified as strengths or needing improvement. A summary of each case will be presented to the Critical Incident Review Team, as well as aggregated data obtained from each SSIT completed in all critical incident reviews. This will allow for the identification of improvement opportunities at a systemic level. The revised SOP and use of SSIT is intended to ensure a more thorough critical incident review, that includes a system approach, and a better analysis of data. The data collected will aid BSS in identifying trends, which will result in future Plan for Action initiatives.

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 §61-14-2b. 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 present 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 2023

Child's Initials	County	Date of Incident	Gender	Age	Race/ Ethnicity	Type of Maltreatment	Brief Summary of Incident	Cause of Fatality
S.C.	Kanawha	12/06/22	Male	15 months	Black/African American	Neglect: Failure or inability to supply necessary supervisio n	Child left unattended in a bathtub, experienced delayed drowning.	Lack of supervision
L.S.	Lewis	12/30/22	Female	3 months	White	Abuse: Physical Injury	Child was stabbed.	Physical injury/homicide
J.F.	Jefferson	02/12/23	Male	37 days	White	Abuse: Physical Injury	Infant experienced non-accidental trauma resulting in brain bleed.	Physical injury
I.B.	Cabell	04/19/23	Female	4 years	White	Neglect: Failure or inability to supply necessary medical care.	Child had diagnosed medical conditions that were not properly treated.	Medical neglect
M.H.	Berkeley	08/29/23	Female	18 months	White	Neglect: Failure or inability to supply necessary medical care.	Child had diagnosed medical conditions that were not properly treated.	Medical neglect

Appendix B: Abuse and/or Neglect Cases Resulting in Child Near Fatality
FFY 2023

Child's Initials	County	Date of Incident	Gender	Age	Race/ Ethnicity	Type of Maltreatment	Brief Summary of Incident	Cause of Injury
A.F.	Harrison	01/11/23	Male	1 year	White	Neglect: Failure or inability to provide necessary supervisio n; Abuse: Mental or Emotional Injury	Child ingested harmful illicit substance. Caregivers were abusing substances.	Lack of Supervision
B.S.	Marshall	01/23/23	Male	4 months	White	Abuse: Physical Injury; Neglect: Failure or inability to provide necessary medical care	Child experienced non-accidental trauma, caregivers did not seek timely medical intervention	Physical Abuse
P.L.	Wood	04/14/23	Female	4 years	White	Abuse: Physical Injury; Neglect: Failure or inability to supply necessary supervision	Child experienced non-accidental trauma, brain bleed.	Physical Abuse/Lack of Supervision
T.R.	Kanawha	04/19/23	Male	14 months	White	Neglect: Failure or inability to provide necessary supervisio n	Child ingested harmful illicit substance.	Lack of supervision