CRITICAL INCIDENT ANNUAL REPORT

Child Fatalities and Near Fatalities Due to Abuse and Neglect

WEST VIRGINIA Department of Health & Human Resources
BUREAU FOR CHILDREN & FAMILIES

Office of Planning and Quality Improvement

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EXECUTIVE SUMMARY

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

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. The West Virginia Child Fatality Review Team and the Infant Mortality Review Team are facilitated by the Commissioner of DHHR's Bureau for Public Health. The West Virginia Child Fatality Review Team reviews all deaths of children under the age of 18 and the Infant Mortality Review Team examines, analyzes and reviews the deaths of infants and women who die during pregnancy or at the time of birth, and children who die within one year of birth. West Virginia Code §61-12A-1, et seq. authorized 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 eighteen 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.
4. An Infant and Maternal Mortality Review Panel to identify infant and maternal death cases, determine preventability of deaths and provide statistical analysis regarding the causes of infant and maternal fatalities.

The Child Fatality Review Panel includes one CPS worker and the Director of the Office of Social Service in BCF.

Since 2000, the Bureau 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 (October 1 to September 30). When there is a Child Protective Services history, case level information, known as the Child File, is collected by NCANDS directly from the West Virginia Statewide Automated Child Welfare Information System (SACWIS) known as the Family and Children Tracking System (FACTS). Additional information about abused and neglected children with no prior history with Child Protective Services is obtained from DHHR's Office of the Chief Medical Examiner by Bureau staff and submitted to NCANDS in the Agency File. The February 2013 Legislative Audit conveyed the federal Child Maltreatment Report does not address individual state trends, prevention strategies, near fatal incidents of child abuse and neglect, or policy related needs. This report is compiled to gather and analyze this information.

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 as to 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 Division of Planning and Quality Improvement (DPQI). Team members include 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 staff assess the case and take 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 or designee 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 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 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, 2015, there were seven fatalities resulting from abuse and/or neglect involving children of families that were known to the Bureau. "Known to the Bureau" is defined as a family with an open CPS case or a Youth Services case in the last 12 months or whom CPS or YS assessed within the last 12 months. (Changed to reflect definition in the Critical Incident Standard Operating Procedure.)

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, 2015, several initiatives were put into place as a result of the findings and recommendations of the Critical Incident Review Team. The activities that were put into place as a result of the team meeting 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 2019, there were 8 fatalities due to abuse and neglect of children known to the Bureau. This is a decrease of one child from the FFY 2018 data.

The information below is the data collected from our internal Critical Incident Review Team for FFY 2019.

See **Appendix A** for a narrative of each child fatality for FFY 2019.

Critical Incidents FFY 2015	Critical Incidents FFY 2016	Critical Incidents FFY 2017	Critical Incidents FFY 2018	Critical Incidents FFY 2019
Fatality: 7	Fatality: 13	Fatality: 10	Fatality: 9	Fatality: 8

Map of Total Child Fatalities Due to Abuse and/or Neglect, FFY 2019

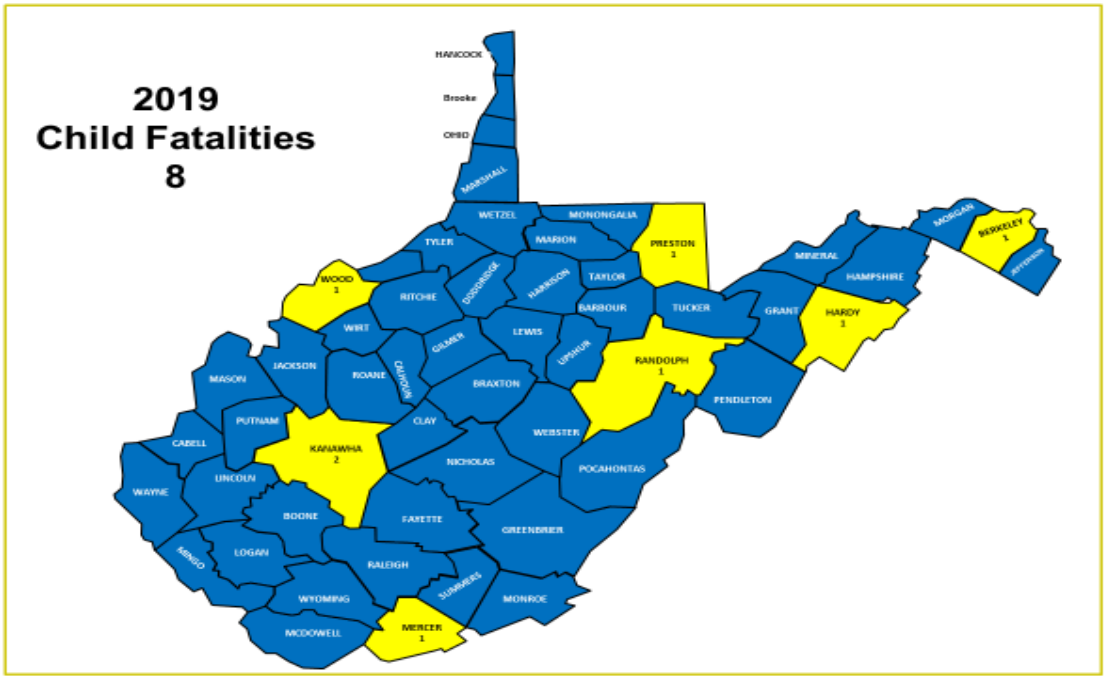


Figure 1: Child Fatalities 2019

Number of Victims in Abuse and Neglect Incidents by Known Cause of Fatality, FFY 2019	
Malnutrition/Dehydration	1
Lack of Supervision/Aspiration	1
Methamphetamine Intoxication/Overdose/Lack of Supervision	2
Severe Trauma/Physical Abuse/Violent Shaking	2
Lack of Supervision/Respiratory Disfunction	1
Lack of Supervision/Cardiac Arrest	1

Child Fatality – Demographics of Children, FFY 2019

Number of Victims in Fatal Incidents by Age	
13-20 months	4
Infant	4

Number of Victims in Fatal Incidents by Race	
African American	1
White	7

Number of Victims in Fatal Incidents by Gender	
Females	2
Males	6

Child Fatality – Maltreater Demographics, FFY 2019

In the cases below, the numbers do not add up to 8 cases because in six cases there were two maltreaters.

Number of Maltreaters in Fatal Incidents by Age	
18-20	4
21-29	7
30-45	3

Number of Maltreaters in Fatal Incidents by Relationship	
Mother	6
Father	5
Babysitter	2
Mother's Boyfriend	1

Number of Maltreaters in Fatal Incidents by Race	
White	13
African American	1
More than one race	0

Number of Maltreaters in Fatal Incidents by Gender	
Female	7
Male	7

Child Near Fatalities

A child near fatality is any medical condition of the child which is certified by the attending physician to be life-threatening. For purposes of this report, the incidents of child near fatalities are events determined to be caused by abuse and/or neglect.

In FFY 2015, there were seven children who were seriously injured due to abuse and/or neglect 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 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 known to the Bureau. This is a decrease from all previous years of the critical incident review for near fatal incidents.

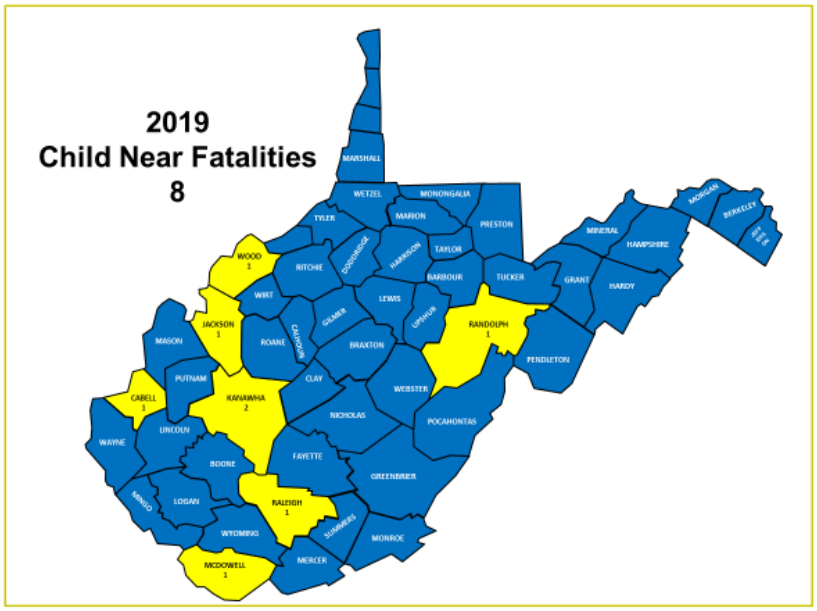
In FFY 2018, there were five children who were seriously injured due to abuse and/or neglect known to the Bureau. This is an increase of three children from FFY 2017.

In FFY 2019, there were eight children who were seriously injured due to abuse and/or neglect known to the agency. This is an increase of three children from FFY 2018.

See **Appendix B** for a narrative of each child near fatality for FFY 2019.

Critical Incidents FFY 2015	Critical Incidents FFY 2016	Critical Incidents FFY 2017	Critical Incidents FFY 2018	Critical Incidents FFY 2019
Near Fatality: 7	Near Fatality: 9	Near Fatality: 2	Near Fatality: 5	Near Fatality: 8

Map of Total Child Near Fatalities Due to Abuse and/or Neglect, FFY 2019



Number of Victims in Abuse and Neglect Incidents by Known Cause of Near Fatality, FFY 2019	
Physical Abuse/Severe Trauma	6
Failure to Supply Proper Medical Care	1
Drug Exposure/Lack of Supervision	1

Child Near Fatality – Demographics of Children, FFY 2019

Number of Victims in Near Fatal Incidents by Age	
2-3 years	4
Infants	4

Number of Victims in Near Fatal Incidents by Race	
African American	1
White	7

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

Child Near Fatality – Maltreater Demographics, FFY 2019

In the cases below, the numbers do not add up to 8 cases because in six cases there were two maltreaters.

Number of Maltreaters in Near Fatal Incidents by Age	
20-29	13
30-39	1

Number of Maltreaters in Near Fatal Incidents by Relationship	
Mother	5
Father	5
Boyfriend	2
Girlfriend	1
Stepfather	1

Number of Maltreaters in Near Fatal Incidents by Race	
White	14
African American	0
Moore than one race	0

Number of Maltreaters in Near Fatal Incidents by Gender	
Female only	1
Male only	2
Both male and female	5

SUMMARY OF 2019 DATA

The state of West Virginia continues to experience devastating drug use. According to DHHR's Health Statistics Center, it is estimated that the final 2018 overdose deaths will be approximately 952 deaths. (This figure is calculated using reported deaths, historical data on pending records and causes of death, and the total number of pending records which remain unclassified as

to the cause of death.) To date, DHHR's Health Statistics Center has recorded 888 overdose deaths for 2018 with a number of deaths still pending a cause of death determination, and a majority expected to be classified as drug overdose deaths.

Although there are many societal factors that contribute to child abuse and neglect resulting in critical incidents in West Virginia, the co-occurrence between substance use disorders and child maltreatment related behaviors by caregivers is the most prevalent factor. Addiction places ever increasing demands on the limited child welfare resources of the state and impacts children directly through caregiver abuse and neglect.

West Virginia saw a continued increase in foster care placements. In September of FFY 2018, 6,683 children were in foster care. As of September, of FFY 2019, 6,977 children were in foster care. In 2019, the type of fatalities and near fatalities changed from being predominately severe trauma in 2018, with nine of the 14 cases reviewed being due to severe trauma, to being equally distributed in 2019. In 2019, of the 16 cases reviewed, eight critical incidents were due to neglect and eight of the critical incidents were due to severe trauma.

Drug use continues to be a contributing factor in critical incidents in West Virginia. Of the 16 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 16 children involved, four were born drug exposed. The Critical Incident Review Team continues to see a correlation between drug use and critical incident occurrences. This could indicate a difference in the types of drug use that impact critical incidents based on the area of the state in which the child resides. The child fatalities in 2019 were split with four in the northeastern part of the state and four in the southern part of the state, while the near fatalities were predominately in the southern part of the state. Also notable is that in all eight child fatality cases reviewed, there was a history of substance use by the caregivers. However, in the near fatality cases reviewed, seven of the eight had a domestic violence history, with four of those eight also having a substance use history among caregivers.

In 2019, DHHR continued to see that the child's mother was the predominant maltreater; data on the father figures also remain consistent with 2018 data. In 2019, the maltreater age group was primarily 20-29, while the race for the maltreaters remained consistent with the 2018 report. In comparison to the 2018 report, the majority of the victims of abuse were females, while the majority of the males were victims of neglect resulting in a fatality or near fatality. Also, both maltreaters and victims were predominately white, which is also consistent with the 2018 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 2019, some of the activities in the previous plan have been updated and continue in addition to newly initiated activities.

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

Critical incident training continues to be a mandatory training requirement for all new child welfare staff. The training is updated each year in January after the completion of the annual report to provide staff current information and areas of focus based on the review data. The current training was updated in February 2019 to reflect the updated critical incident information

including the number of fatalities and near fatalities in the state of West Virginia, where in the state they occurred, the presence of substance use and maltreater patterns.

II. Safe Sleep

The Bureau continues to focus on educating all parents of children under the age of one on safe sleep. 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 Our Babies: Safe and Sound group also works 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 Child Fatality Review Team determined that safe sleep information is provided to the customers as required by policy but that the Bureau needs to change the message to be more targeted to parents with drug-affected infants as these infants are at higher risk. This information continues to be provided to customers.

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

a. An Annual Statewide Competency training with national and state level presenters; this day-long session is free and Continuing Education Units (CEUs) are provided for nurses, early childhood professionals, and social workers.
b. Quarterly peer topical calls.
c. An online training module, which reviews the research and latest American Academy of Pediatrics recommendations. This certified module is 1.5 hours, provides free CEUs, and can be viewed at www.safesoundbabies.com. Family childcare providers are required to complete this training. The project is in the process of developing a new module for release in early 2020. This module is certified through CAMC Health, Education and Research Institute.
d. Ongoing technical assistance and field updates.

III. Drug-Affected Infant Policy

In September 2017, Child Protective Services Policy was updated due to 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. Bureau policy was also updated to comply with the requirement that every child identified as drug-affected would have a Plan of Safe Care. The policy was updated in 2019 to include the following information: If the assessment determines that there is a drug-affected infant but there is no maltreatment finding and no safety concerns or impending dangers identified, the Plan of Safe Care document will be uploaded, services entered on the service log and the case will be closed immediately.

IV. Mandated Reporter Training

Senate Bill 465 was passed during 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. The Mandated Reporter Training continues to be offered both as a blackboard course and a face-to-face training. The face-to-face training has been provided at four Handle with Care conferences this year by the Director of Centralized Intake. Two occurred in Charleston, one in Buckhannon and one in Elkins. The training was also offered in Flatwoods as part of the statewide School Nurses Conference by the Director of Centralized Intake. In July and August 2019, the curriculum was provided to the Regional Directors for community training if requested.

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 exposure. The resiliency services are available to staff when requested and are continually being modified to meet the needs of staff who are involved in critical incidents. Efforts continue to make staff aware of the services available to them and to encourage them to access those services.

VI. 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 Community Services Manager (CSM) who has the responsibility of ensuring these requirements are met.

Topics for monthly unit meetings in FFY 2019 that have an impact on Critical Incident:

November 2018: Documentation of Client Contacts at Family Functioning Assessment. (FFA).

December 2018: Foster Care Policy - 5.6.3 Medicaid Home and Community Based Intellectual/Developmental Disabilities Waiver (medley) Standard Operating Procedure, Special Project, BCF WV Intellectual/Developmental Disabilities Waiver Program, Policy Manual Handbook Intellectual and Developmental Disabilities Waiver Brochure and application, Bureau for Medical Services Policy Chapter 513 Intellectual and Developmental Disabilities Waiver Sections 513.6 to 513.7.2

January 2019: 4.8 Temporary Protection Plans, 4.13 Safety Analysis and Safety Planning, 4.14 In-Home Safety Plan, 4.16 Safety Services, 4.17 Out of Home Safety Plan, 5.8.3 Safety Management Responsibilities, 5.9 Ongoing Safety Management, 5.10 Continuing Formal Evaluation of Child Safety Drug-Affected Infant policy-CAS Policy 17-6

March 2019: Interview protocol, 4.3 CPS Social Worker Preparation, 4.4 Initial Family Contact, 4.6 Information Collection

April 2019: Foster Care Policy 3.6, Foster Care Policy 2.6.1, Diligent Search

June 2019: Case planning

August 2019: CPS Policy Section 3.19 Trafficked Children and Youth, Section 5.15 SafeKids Pix Identification Card Program, Section 5.20 Runaway, Missing or Abducted Children

September 2019: Relative/Kinship Placements

NEW ACTIVITIES INITIATED IN 2019

I. Reflective Supervision

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

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

In June 2019, the Bureau for Children and Families along with Casey Family Programs began training supervisors and managers on the reflective supervision process. A standard operating procedure has been developed and mandatory ongoing trainings for new and tenured supervisors and managers are being held.

II. Family Treatment Court

West Virginia is addressing the lack of services to address addiction through the implementation of a Family Treatment Court pilot program. Family Treatment Courts' main purpose is to enhance the overall wellbeing of the entire family. During the initial milestones, the Family Treatment Courts will focus on the participants' addiction and preparing them to properly care for their children when sober. While in foster care/kinship care, the needs of the children will be met by the Bureau for Children and Families. As the participant progresses through the milestones, safe family reunification and the skills to do so are to be provided to all.

As discussed in the 2019 data summary, all eight of the child fatality cases reviewed this year included substance use by one or both caregivers. As stated above, the main purpose of the Family Treatment Court is to have a positive impact on the overall wellbeing of the family and directly target addiction. The Family Treatment Court Program has the potential to have a direct impact on the fatality or near fatality of a vulnerable child or children whose caregiver suffers from addiction or substance use issues. One of the major components of this program is court oversight. The court will monitor the progress of the participants on a regular basis ensuring compliance with the program, positive change and safety of the children. This court oversight and additional family support could have a dramatic effect on the number of children who die as a direct or indirect result of the addition or substance use issues of their parent or caregiver.

Pursuant to West Virginia Code §62-15B-1, participation in Family Treatment Court (FTC) is voluntary, post-adjudication, and with a written agreement by and between the adult respondent, and the Bureau for Children and Families with concurrence of the Court. Family Treatment Court programs will be as inclusive as resources and community support will allow. Family Treatment Courts will adhere to the following criteria when making decisions on accepting participants to FTC:

- Target Population, Objective Eligibility, and Exclusion Criteria
- Standardized Systematic Referral, Screening, and Assessment Process
- Use of Valid and Reliable Screening and Assessment Instruments
- Valid, Reliable, and Developmentally Appropriate Assessments for Children
- Identification and Resolution of Barriers to Treatment and Reunification Services

The Family Treatment Court will collect and review data to monitor participant progress, engage in a process of continuous quality improvement, monitor adherence to best practice standards, and evaluate outcomes using scientifically valid and reliable procedures. The Family Treatment Court will establish performance measures for shared accountability across systems, encourage data quality, and foster the exchange of data and evaluation results with multiple stakeholders. The Family Treatment Court will use this information to improve policies and practices in addition to monitoring the strengths and limitations of various service components.

Pursuant to West Virginia Code §62-15B-1(f), the Local Family Drug Treatment Court Advisory Committee shall include the following individuals or their designees: the Family Treatment Court Judge, who shall serve as chair, the Prosecuting Attorney of the County, the Public Defender or a member of the county bar who represents individuals in child abuse and neglect case, the Community Services Manager of BCF, a Court Appointed Special Advocate (CASA) as applicable, and any such other person or persons the chair deems appropriate. This advisory committee shall be staffed by the local Family Treatment Court Case Coordinator with the FTC-Child Protective Service Worker (CPSW).

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. (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 immediate basic care and supervision to a child. 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 immediate care for his/her child 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 <u>if accurate affects</u> 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 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 less than 18 years of age. (W. Va. 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): Beginning on July 22, 2016, CARA 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: Is defined as a family with an open CPS case or a Youth Services case in the last 12 months or whom CPS or Youth Services assessed 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): Bipartisan organization of the nation's governors that 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. (W. Va. 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 Use Disorder: 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 2019

Child's Initials	County	Date of Incident	Gender	Age	Race/Ethnicity	Type of Maltreatment	Brief Summary of Incident	Cause of Fatality
D.S.	Wood	10/19/18	Male	1 month	African American	Neglect	Child was taken to ER in Cardiac Arrest. Home conditions deplorable. No adequate sleeping spaces.	Neglect. Cause of death not able to be determined. Cardiac Arrest.
B.L.	Preston	11/10/18	Female	13 months	White	Physical Abuse	Child was in the home of babysitter. She suffered multiple injuries.	Physical abuse/violent shaking
J.M.	Mercer	11/08/18	Male	20 months	White	Neglect	Child was severely malnourished and dehydrated. Both parents have been charged with child neglect resulting in death.	Malnutrition/ dehydration
*D.R.	Kanawha	3/4/18	Female	1 month	White	Abuse	Child found not breathing due to co-sleeping.	Following autopsy, it was determined that the child died as a result of Methamphetamine intoxication.

*This is a case in which the child died in 2018. The case was reviewed and determined not to be due to Abuse/Neglect. The autopsy revealed that the child had meth in his system and the cause of death was determined to be Methamphetamine intoxication. Therefore, the information surrounding this death is being added to the report.

Child's Initials	County	Date of Incident	Gender	Age	Race/ Ethnicity	Type of Maltreatment	Brief Summary of Incident	Cause of Fatality
D.W.	Hardy	9/18/19	Male	17 months	White	Physical Abuse	Child suffered multiple fractures, acute head injury, cardiorespiratory arrest and numerous retinal hemorrhages. Mother and paramour have been arrested on counts of child abuse causing death.	Severe physical trauma
D. H.	Berkeley	4/19/19	Male	3 months	White	Neglect	The parents were engaged in a verbal altercation and left the child to cry for an extended period-of-time. The child was born pre-mature.	Respiratory dysfunction
A.P.	Randolph	7/22/19	Male	3 months	White	Neglect	The parents propped a bottle in the child's mouth and left him alone for 2 hours. During that time the child vomited and aspirated.	Aspiration
S.W.	Kanawha	9/1/9	Male	18 months	White	Physical Abuse/Neglect	Medication in the home was left within reach of the toddler.	Overdose

Appendix B: Abuse and/or Neglect Cases Resulting in Child Near Fatality
FFY 2019

Child's Initials	County	Date of Incident	Gender	Age	Race/ Ethnicity	Type of Maltreatment	Brief Summary of Incident	Cause of injury
R.H.	Jackson	10/6/18	Female	6 months	White	Physical Abuse	Child was violently shaken and choked by the father. He has been arrested and incarcerated in relation to the abuse.	Severe physical abuse
K.H.	Wood	2/10/19	Male	2 years	White	Neglect	Child suffered a head injury which resulted in a stroke. Mom's boyfriend has been charged with child neglect resulting in injury.	Head trauma
J.B.	Raleigh	1/19/19	Male	3 months	White	Physical Abuse	Infant child was shaken and thrown to the floor. Both parents are incarcerated in relation to the injuries.	Severe physical abuse
M.H.	Cabell	3/31/19	Male	2 1/2 years	African American	Physical Abuse	Severe head trauma/physical abuse by the caretaker who has been charged in relation to the injuries.	Severe head trauma
C.D.	McDowell	5/8/19	Female	2 years	White	Physical Abuse	Severe head trauma/shaken baby.	Severe head trauma
E.K.	Kanawha	9/17/19	Female	10 months	White	Neglect	Child tested positive for Fentanyl.	Drug exposure
K.S.	Kanawha	9/11/19	Male	2 years	White	Neglect	Child had a seizure due to pneumonia and being given adult medication.	Failure to supply proper medical care
S.F.	Randolph	8/28/19	Female	57 days	White	Physical Abuse	Child suffered multiple injuries including bruises, lacerations, rib fractures, contusions and hemorrhages on her brain and sexual abuse. The father is currently incarcerated.	Severe physical and sexual trauma