REPORT ON CHILD FATALITIES AND NEAR FATALITIES DUE TO ABUSE OR NEGLECT IN WEST VIRGINIA

FFY2015

October 1, 2014-September 30, 2015

First Annual Report

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West Virginia Department of Health and Human Resources
Bureau for Children & Families
February 2016

WEST VIRGINIA
Department of
Health & Human Resources

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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. *(49-1-201)*

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.

CAPTA: The Child Abuse Prevention and Treatment Act (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.

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 child care 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.

Child: Any person less than 18 years of age. *(49-1-202)*

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

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

Drug Affected Infants: Infants born and identified as affected by illegal substance abuse having withdrawal symptoms resulting from prenatal drug exposure, or an infant diagnosed as having Fetal Alcohol Spectrum Disorder.

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

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 Agency: 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.

Near Fatality: A severe childhood injury or condition caused by abuse or neglect which results in the child receiving critical care for at least 24 hours.

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. *(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 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.

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 Department of Health and Human Resources, through the Bureau for Public Health and the 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.

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 State Code. Incidents of abuse and neglect are investigated by Child Protective Services (CPS) located within the Bureau for Children and Families.

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 on-going 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 in West Virginia is conducted by several entities in West Virginia: the Supreme Court of Appeals of West Virginia which is an independent branch of state government, 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 Bureau for Public Health within the Department of Health and Human Resources. 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 State Code 61-12A-2 establishes both the West Virginia Child Fatality Review Team and the Infant Mortality Review Team and sets forth the requirements of these teams. By state code, both of these teams review and analyze all deaths, ascertain and document the trends, patterns and risk factors and provide statistical information and

analysis regarding the causes of certain fatalities. Both teams are required to provide an annual report with recommendations, which goes to the Governor.

Since 2000, the Bureau for Children and Families (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 the 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; nor does it identify policy related needs. This report is to fulfill the needs of gathering and analyzing 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 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 Commissioner and Deputy Commissioners for the Bureau for Children and Families, the Regional Directors, and representatives from the Offices of Field Support, Programs and Resource Development, Planning and Research and the Offices of Field Operations. 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. One 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. To insure an objective review, the members are selected from staff who do not work in the region where the critical incident occurred.

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, the child's family, law enforcement, medical staff and service providers. The Field Teams present 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 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 for the reviews.

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

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 who 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 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 our county offices on safe sleep; and
- Updated Mandated Reporter Curriculum.

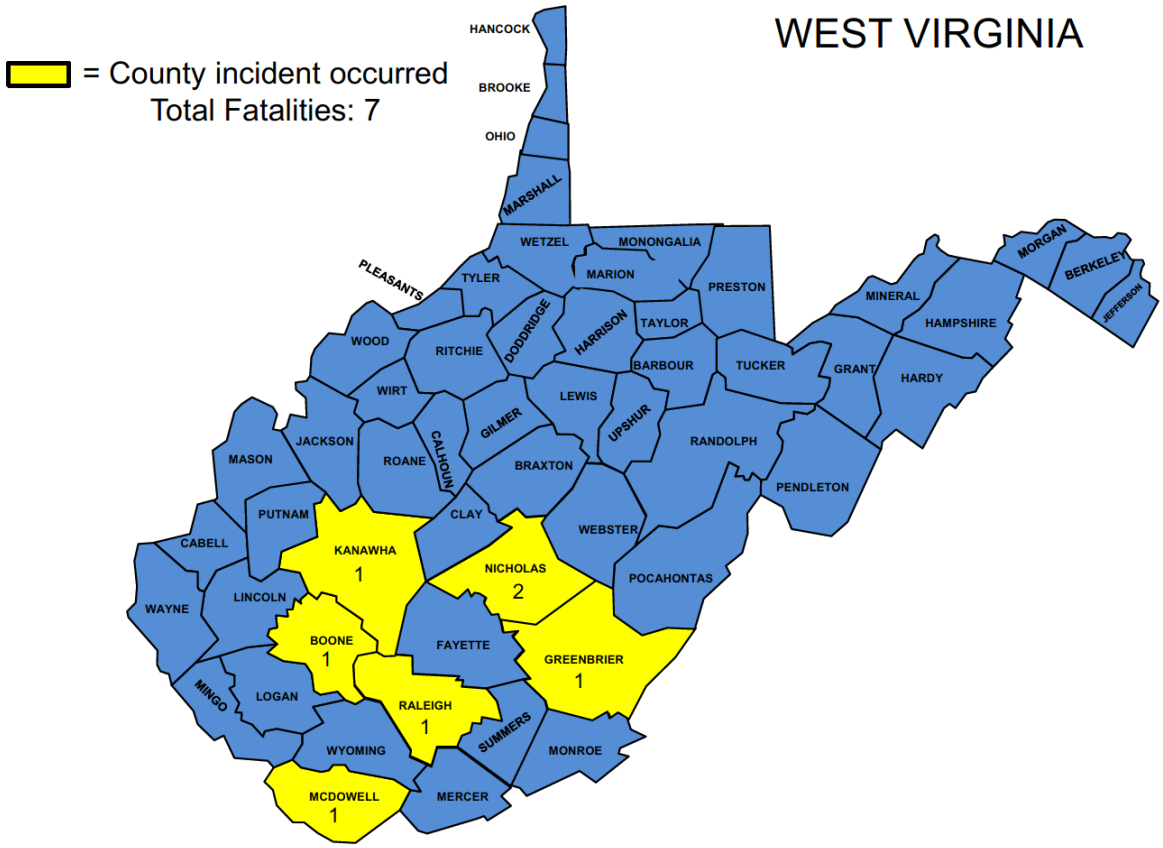
During federal fiscal year ending September 30, 2015, the Critical Incident Review Team determined there were seven fatalities due to abuse and neglect of children known to the Department.

The information below is the data collected from our internal Critical Incident Review Team for FFY 2015.

See **Appendix A** for a narrative of each child fatality for FFY 2015.

Critical Incidents FFY 2014	Critical Incidents FFY 2015
Fatality: 17	Fatality: 7

Map of Total Child Fatalities due to Abuse and/or Neglect, FFY 2015



Number of Victims in Abuse and Neglect Incidents by Known Cause of Fatality, FFY 2015	
Unsafe Sleep/Drug Use	3
Physical Injury/Medical Neglect	3
Physical Injury/Inappropriate Caregiver	1

Child Fatality – Demographics of Children, FFY 2015

Number of Victims in Fatal Incidents by Age	
	#
6 Years	1
2 Years	1
Infant	5

Number of Victims in Fatal Incidents by Race	
	#
White	6
Two or More Races	1

Number of Victims in Fatal Incidents by Gender	
	#
Males	4
Females	3

Child Fatality – Maltreater Demographics, FFY 2015

In one case, there were twins with one maltreater. In four of the cases, there was more than one person that contributed to the fatality.

Number of Maltreaters in Fatal Incidents by Age	
	#
16-19	0
20-29	3
30-39	4
40-49	2

Number of Maltreaters in Fatal Incidents by Relationship	
	#
Mother	5
Father	2
Babysitter	1
No Relation	1

Number of Maltreaters in Fatal Incidents by Race	
	#
White	9
Two or More Races	0

Number of Maltreaters in Fatal Incidents by Gender	
	#
Male	3
Female	6

CHILD NEAR FATALITIES

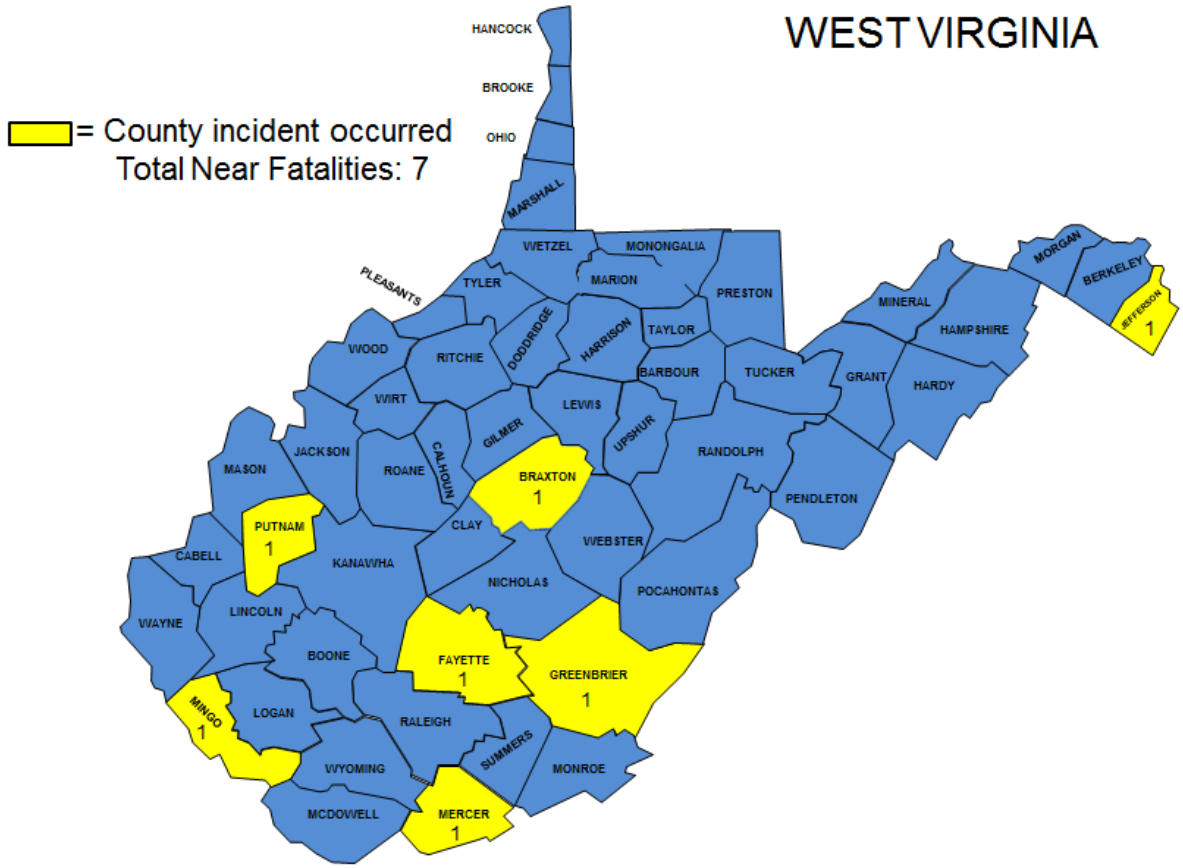
In FFY 2014, there were five children that were seriously injured due to abuse and/or neglect of families that were known to the Bureau.

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.

See **Appendix B** for a narrative of each child near fatality for FFY 2015.

Critical Incidents FFY 2014	Critical Incidents FFY 2015
Near Fatality: 5	Near Fatality: 7

Map of Total Child Near Fatalities due to Abuse and/or Neglect, FFY 2015



Number of Victims in Abuse and Neglect Incidents by Known Cause of Near Fatality, FFY 2015	
Shaken Baby	2
Drug Use Resulting in Injury	1
Shaken Baby/Medical Neglect	1
Physical Injury and Medical Neglect	2
Lack of Supervision Resulting in Injury	1

Child Near Fatality – Demographics of Children, FFY 2015

Number of Victims in Near Fatal Incidents by Age	
	#
6 Years	2
2 Years	1
Infant	4

Number of Victims in Near Fatal Incidents by Race	
	#
White	7
Two or More Races	0

Number of Victims in Near Fatal Incidents by Gender	
	#
Males	4
Females	3

Child Near Fatality – Maltreater Demographics, FFY 2015

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

Number of Maltreaters in Near Fatal Incidents by Age	
	#
16-19	2
20-29	7
30-39	2
40-49	2
50+	2

Number of Maltreaters in Near Fatal Incidents by Relationship	
	#
Mother	6
Father	3
Boyfriend	2
Step-Father	1
Grandparent	1

Number of Maltreaters in Near Fatal Incidents by Race	
	#
White	13
Two or More Races	0

Number of Maltreaters in Near Fatal Incidents by Gender	
	#
Male	6
Female	7

PLAN FOR ACTION

The Bureau for Children and Families has developed a Plan for Action based on the results of the Critical Incident Reviews for FFY 2015. The Plan for Action activities are designed to increase awareness, support practice, and improve outcomes in child welfare cases.

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

Nationwide, unsafe sleep combined with drug use has been identified as one of the top contributing factors involved in critical incidents. Unsafe sleep and drug abuse were found to be factors in three fatalities that were reviewed. A plan was developed around the issues identified in the reviews including better safety planning; better assessments around drug use specifically when there are small children in the home, more frequent contact with children in cases. The training also incorporated a section on self-care for our staff and tips on how they can take care of themselves when assessing a critical incident.

The training started in October 2015 and was completed in December 2015. The training is mandatory for all social service staff and will be incorporated into new worker training for all staff hired in the future. The training will be continuously updated to reflect the findings of the on-going Critical Incident Reviews as part of the continuous quality improvement program. As a result of this training, we are supporting our staff through better safety planning, better risk identification and increased awareness of the issues that have resulted in a fatality or near fatality.

See **Appendix C** for Critical Incident Syllabus.
See **Appendix D** for Critical Incident Response.

II. Safe Sleep

During the Critical Incident Reviews and nationwide, unsafe sleep combined with drug use has been identified as one of the top contributing factors involved in critical incidents. In order to address this issue, the Bureau for Children and Families has partnered with Team for West Virginia's Children, using federal funding to enhance their Safe Sleep campaign. During 2015, Team for West Virginia's Children expanded their campaign to distribute safe sleep videos to birthing hospitals in the state. As part of the campaign, the hospital agrees to require parents to watch the video prior to taking the child

home from the hospital. The plan is to expand the campaign in 2016 to all hospitals in the state.

The Bureau is also playing the Safe Sleep video in all DHHR district office lobbies across the state and has provided all staff making home visits with Safe Sleep flyers to provide to families of small children. A Safe Sleep Assessment Tool is being developed to use during home visits with implementation planned for the spring of 2016.

All of these actions are an effort to educate anyone who is caring for an infant, as well as Department staff, of the dangers of unsafe sleep and to reinforce safe sleep habits with infants to reduce the number of fatalities and near fatalities.

See **Appendix E** for Safe Sleep flyer.
See **Appendix F** for Boppy Pillow flyer.

III. Drug Affected Infant Policy Update

In September 2015, the Bureau updated the Child Protective Services Policy to include the following sections:

3.19 Reports Involving Caregiver Substance Abuse

Caregiver substance abuse in and of itself does not constitute child maltreatment; however, caregiver substance abuse is often present when child maltreatment occurs. When a report is received alleging caregiver substance abuse, and a thorough interview is conducted with the reporter in order to determine if there is reason to suspect that the child is abused or neglected in any way, or subject to conditions or circumstances that would likely result in abuse or neglect due to **any** use or abuse of substances (legal or illegal) by the parents, **the report must be accepted and assigned**.

3.20 Reports Involving Drug-affected Infants or Infants/Children suffering from Fetal Alcohol Spectrum Disorder

The Child Abuse Prevention and Treatment Act (CAPTA) is a key piece of federal legislation that guides Child Protective Services. This legislation requires that Child Protective Services and other community service providers address the needs of newborn infants who have been identified as being affected by illegal drug abuse or are experiencing withdrawal symptoms resulting from prenatal drug exposure. Health care providers who are involved in the delivery or care of such infants are required to make a report to child protective services.

All newborns are extremely vulnerable as 100% of their livelihood is dependent upon their care givers. Infants who test positive for prescribed, non-prescribed or illegal drugs; present withdrawal symptoms; or are diagnosed with fetal alcohol spectrum disorder are even more vulnerable due to their medical condition. When a child is born with prescribed or non-prescribed drugs in their system, it is often impossible to know based upon the intake assessment if the parent is actively involved in a treatment program or if the parent is abusing the prescribed drugs, such as suboxone or methadone, and unable to properly care for a newborn.

Substance abuse may be identified at various stages throughout a Child Protective Services case process and can affect safety in various ways. Child Protective Services will focus on infants born with ***effects*** of illegal substances as well as infants suffering from fetal alcohol spectrum disorder. All allegations of substance use or abuse in which there is a young child in the home will be assessed by Child Protective Services.

4.40 Family Functioning Assessments Involving Drug-affected Infants and/or Infants/Children suffering from Fetal Alcohol Spectrum Disorder

Substance abuse may be identified at various stages throughout a Child Protective Services case process and can affect safety in various ways. However, the purpose of this section will focus on infants born with ***effects*** of illegal substances as well as infants suffering from fetal alcohol spectrum disorder.

• Once the referral is assigned to the district, the Child Protective Services Worker will review the family's available records and history of past involvement with the Department of Health and Human Resources. This includes other adults that would be considered caregivers and residing in the household.

• The Child Protective Services Worker will conduct a face-to-face interview with the family based on the assigned time frame.

• The Child Protective Services Worker should obtain identifying information about the father. Hospital Staff should be asked if paternity declaration was established.

• The Child Protective Services Worker should thoroughly assess the family, gathering information from the parents, and other pertinent collaterals. Suggested collaterals are, but should not be limited to, hospital staff, social worker, pediatrician, drug counselors, therapist and teachers. Both the mother and child(ren)'s hospital records should be obtained. This could include

toxicology reports and withdrawal scores of the infant and nurses/doctors progress notes. Infants whose mothers self-report drug use and/or test positive for drugs while pregnant should be identified as a "Drug Affected Infant," and a protection plan or safety plan initiated before the child(ren) is discharged from the hospital after consultation with a supervisor.

• It is important for the worker to obtain information about the parent's interaction with the infant and any relevant statements the parents revealed to staff about the ability to properly care for the child(ren).

• Upon the child(ren)'s discharge from the hospital, the Child Protective Services Worker should visit the family's home assessing the total home environment and what safety concerns, if any, are in the home. The Child Protective Services Worker should assess the parent's preparedness for the child(ren) as evidenced by the presence of adequate baby supplies. Sleeping arrangements and what intentions/beliefs the parents have regarding sleeping arrangements should also be discussed with all caregivers.

• Child Protective Services Worker should assess the parent's ability to parent the infant and any other children in the home identifying any safety concerns in the home.

• During the assessment process, it is important to assess the caretakers/parents ability to parent the child(ren), and if the caretakers/parents have made strides to correct the substance abuse issues. This could include what methods of treatment intervention the parent chose and compliance with those treatments.

In situations where the mother has been prescribed medication due to a physical illness, it is very important for the Child Protective Services Worker to:

• Obtain documentation from the prescribing physician about the mother's illness and maintenance of the medication.

• Obtain records from the obstetrician to determine the mother's cooperation with pre-natal appointments and to determine if the mother consulted about the effects of the medications. This will help to determine if the mother did what was in the best interest of her child.

• It is important to assess if the mother has taken the medication as advised by a physician.

For example: A mother is in a severe car wreck while pregnant and has several surgeries due to injuries. She takes medication as prescribed by her physician. Upon delivery, a safety plan/protection plan ***may not*** *need to be*

developed. A full assessment should be completed to determine her ability to parent is not compromised.

In situations where the Department has knowledge of drug affected/exposed infants, a referral to **West Virginia Birth to Three** must be initiated and clearly documented. This is regardless of a maltreatment finding of whether the case will be opened.

The purpose of the policy change was to assist staff in the assessment of infants who are exposed to drugs and provide more clarification to improve the practice of taking, accepting, and completing the intake assessment.

IV. Mandated Reporter Training

The mandated reporter training curriculum was updated in 2015 to include Centralized Intake as the Bureau's practice in making a referral for Child Protective Services. As a part of the Bureau's reviews, it was discovered that a mandated reporter had not made a report on a child that should have been made. The training was provided to the facility three different times on March 25, 2015, in order to reach all staff. This training is available and can be provided to any mandated reporter when requested or when the Bureau determines that there is a need.

Appendix A: Abuse and/or Neglect Cases Resulting in Child Fatality
FFY 2015

Child's Name	County	Date of Incident	Gender	Age	Race/ Ethnicity	Type of Maltreatment	Brief Summary of Incident	Cause of Fatality
Z. M.	Raleigh	10/13/2014	M	1 month	White	Abuse and Neglect	Child fatality was a result of unsafe sleep and drug use by caretakers, both the mother and father, resulting in asphyxiation. Child Protective Services was in the process of assessing the family based on a referral received at the time of the child's birth alleging substance abuse by the mother.	Unsafe Sleep/Drug Use
J.Y.	Greenbrier	02/10/2015	M	6 years	White	Abuse and Neglect	Child fatality is due to sodium poisoning, dehydration, malnourishment and a subdural hematoma causing hypoxic encephalopathy damage to the brain and spinal cord from inadequate oxygen. The child died from both abuse and neglect. Child Protective Services was assessing the family at the time of the fatality based on a report alleging physical abuse and neglect.	Physical Injury/Medical Neglect

Child's Name	County	Date of Incident	Gender	Age	Race/ Ethnicity	Type of Maltreatment	Brief Summary of Incident	Cause of Fatality
R. G.	McDowell	05/19/2015	M	1 month	White	Abuse and Neglect	Child fatality due to unsafe sleep and drug use by caretakers, both mother and father, resulting in asphyxiation. Child Protective Services had previous reports on the father with other children, but there was no history on this mother or this child other than the referral for the fatality.	Unsafe Sleep/Drug Use
G. A.	Kanawha	05/30/2015	M	2 years	Bi-Racial	Abuse and Neglect	Child fatality as a result of abuse by a caretaker (acquaintance to the mother) and neglect by the mother of the child who did not ensure an appropriate caregiver. Child was abused with multiple traumas. Child Protective Services had 4 referrals dating back to 2005, but the allegations were not substantiated. The most recent referral received by Child Protective Services was on May 8, 2015, alleging neglect by the mother for leaving the children with an inappropriate caregiver, which was active at the time of the child's death.	Physical Injury/ Inappropriate Caregiver

Child's Name	County	Date of Incident	Gender	Age	Race/ Ethnicity	Type of Maltreatment	Brief Summary of Incident	Cause of Fatality
P. A.	Boone	06/19/2015	F	1 month	White	Abuse and Neglect	Child fatality due to unsafe sleep and drug use by mother resulting in asphyxiation. Child Protective Services was assessing this family at the time of the fatality due to a referral alleging substance use by the mother at the time of the child's birth.	Unsafe Sleep/Drug Use
F. W. P.	Nicholas	04/26/2015	F	minutes	White	Abuse	Child fatality due to mother's use of drugs during pregnancy, and child born premature with complications of the drug use. The child was a twin, and the sibling also died as a result of the drug use. Child Protective Services had a history of seven referrals starting in 2007, until the case opened in 2014; all referrals centered around neglect and drug use. There was an open case at the time of the death with a termination of parental rights on two older children.	Drug Use Resulting in Fatality

Child's Name	County	Date of Incident	Gender	Age	Race/ Ethnicity	Type of Maltreatment	Brief Summary of Incident	Cause of Fatality
H. W.P.	Nicholas	04/26/2016	F	hours	White	Abuse	Child fatality due to mother's use of drugs during pregnancy, and child born premature with complications of the drug use. The child was a twin, and the sibling also died as a result of the drug use. Child Protective Services had a history of seven referrals starting in 2007, until the case opened in 2014; all referrals centered around neglect and drug use. There was an open case at the time of the death with a termination of parental rights on two older children.	Drug Use Resulting in Fatality

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

FFY 2015

Below is the summary of cases involving near fatalities. Due to confidentiality, the names of the children cannot be disclosed. Only the names of children involved in a fatality can be disclosed based on CAPTA requirements.

County of Incident	Date of Incident	Gender	Age	Race/Ethnicity	Type of Maltreatment	Brief Summary of Incident	Cause of Near Fatality
Fayette	10/01/2014	F	1 year	White	Neglect	Child was severely injured by drinking Drano as a result of a lack of supervision by the mother and her boyfriend. The child received injuries to the mouth, esophagus, and internal stomach. Child Protective Services had an open case at the time of the time of the critical incident based on inappropriate living conditions and neglect due to substance abuse. On October 1, 2014, the referral for the critical incident was received and substantiated for neglect.	Lack of Supervision Resulting in Injury

County of Incident	Date of Incident	Gender	Age	Race/Ethnicity	Type of Maltreatment	Brief Summary of Incident	Cause of Near Fatality
Mercer	10/15/2014	M	3 Years	White	Abuse and Neglect	Child was severely injured as a result of abuse. The child presented with multiple facial injuries, left black eye, and marks to his back. The child also presented with thermal burns around his mouth and bruising in various stages of healing. The child was diagnosed with a radial fracture upon release from the hospital. Child Protective Services had 4 referrals on this family dating back to 2007 alleging substance use, inadequate physical care and physical abuse with no substantiations. Child Protective Services received one referral that did not meet the definition of abuse or neglect. On October 15, 2014, the critical incident referral was received for abuse and neglect and substantiated. The mother's boyfriend, the mother and the grandmother were identified as the maltreaters for both physical abuse and neglect for failing to seek medical attention for the child.	Physical Injury and Medical Neglect
Putnam	10/29/2014	F	4 months	White	Abuse and Neglect	Child was severely injured as a result of abuse. The child had a swollen head, fever, and skull fracture. Abuse was substantiated on the father. Child Protective Services received 3 referrals from 2013 until the critical incident referral was received on October 29, 2014, and was substantiated. The prior referrals alleging emotional and psychological abuse and neglect were unsubstantiated. The mother and grandmother were substantiated for neglect for not obtaining medical treatment.	Shaken Baby/Medical Neglect
Mingo	02/16/2015	F	2 months	White	Abuse	Child was severely injured as a result of shaking by the father. In August of 2014, Child Protective Services received a referral alleging domestic violence which was unsubstantiated. On February 16, 2015, the critical incident referral was received and substantiated as abuse by the father.	Shaken Baby

County of Incident	Date of Incident	Gender	Age	Race/Ethnicity	Type of Maltreatment	Brief Summary of Incident	Cause of Near Fatality
Greenbrier	03/05/2015	M	8 months	White	Abuse	Child was severely injured as a result of abuse. The child had a bilateral subdural hematoma and a posterior hematoma, shaken baby syndrome. The child had a spiral fracture and bruising and was diagnosed with traumatic brain injury. Child Protective Services received 5 referrals from 2007 until September 2014 alleging inadequate housing, physical abuse, sexual abuse and lack of supervision. On September 29, 2014, the critical incident referral was received and substantiated for abuse. The mother and father have been identified as the maltreaters.	Shaken Baby
Braxton	03/11/2015	F	3 years	White	Abuse and Neglect	Child was severely injured as a result of physical abuse, non-accidental trauma, bruising, head trauma, retinal hemorrhage, subdural hematoma, and neglect as a result of inadequate treatment of a serious illness/disease. Child Protective Services received 5 referrals on this family from 2001 until the critical incident on March 11, 2015. The referrals alleged medical neglect, emotional and psychological abuse, inadequate physical care and neglect. On March 11, 2015, the critical incident report was received and substantiated for abuse and neglect on the mother, step-father and grandmother.	Physical Injury and Medical Neglect

County of Incident	Date of Incident	Gender	Age	Race/Ethnicity	Type of Maltreatment	Brief Summary of Incident	Cause of Near Fatality
Jefferson	06/27/2015	M	Birth	White	Neglect	The child was born prematurely at 26 weeks and was a twin. The child's umbilical cord tested positive for opiate metabolites, morphine, hydrocodone, oxymorphone and oxycodone at birth, and the child remains hospitalized due to medical complications of premature birth and drug exposure. Child Protective Services received 6 referrals on this family from 2009 until the critical incident report received in July 2015. The referrals alleged sexual abuse, lack of supervision, inadequate clothing, dangerous shelter, drug use and physical abuse. On July 1, 2015, the critical incident referral was received and substantiated on the mother for neglect and drug use causing injury.	Drug Use Resulting in Injury

Appendix C: Critical Incident Syllabus

Critical Incident Syllabus

Course Description:

The Critical Incident course is designed to promote awareness among workers about child fatalities and near fatalities, thus resulting in improved outcomes.

Learning Outcomes:

Workers completing this course should be able to:

- Demonstrate an understanding of risk factors associated with critical incidents.
- Understand the importance of a thorough assessment of the situation, the family and the home.
- Understand the importance of having a solid knowledge of child development.
- Explain and understand the dangers of un-safe sleep and co-sleeping.
- Demonstrate the ability to create safety plans specific to small children.
- Recognize the indicators and symptoms of secondary trauma to our social services staff.

Classroom Procedures and Protocols:

This is an in-service training that all social service workers are required to attend within their first year of employment.

Workers are expected to actively participate in all discussions and activities.

Appendix D: Critical Incident Response

WV RESILIENCE Alliance

Procedures and Practice Manual

Name of WVRA Procedure/Practice: WV RESILIENCE Alliance (WVRA) Critical Incident Response (WVRAPP2)

Desired Outcome: To provide a trauma-informed, child welfare best practice response to critical incidents experienced by West Virginia's child welfare professional staff.

Date Procedure/Practice Implemented: January 2016

WVRA Procedure/Practice:

a. **The WVRA critical incident response will utilize the SAFER-R - Crisis Response - Model (see insert #1 below).**
b. **The Summary Matrix of the 'tiered' levels of critical incident response (see Insert #2 below) will guide the format and structure of the WVRA critical incident response.**
c. **The PROCESS to trigger, implement and complete the WVRA Critical Incident(CI) Response is:**
    1. **CSM determines CI need and initiates request.**
    2. **CSM (or designee) contacts their RD and Deputy Commissioner for consultation.**
    3. **The RD/Deputy Commissioner authorizes the CI intervention and contacts the WVRA Regional Facilitator with directions to intervene.**
    4. **At the conclusion of the intervention, the Facilitator(s) will complete an informal evaluation of the intervention with the CI participants.**

5. **At the conclusion of the intervention, the Facilitator(s) will provide appropriate feedback to the CSM/RD/Deputy Commissioner regarding the intervention.**
6. **At the conclusion of the intervention, the Facilitator(s) will engage in a trauma-informed processing of the intervention with the other WVRA Facilitators.**
7. **At the conclusion of the intervention, the Facilitator(s) will provide a formal written evaluation of the intervention to the RD/Deputy Commissioner. This evaluation will include assessment of the value, benefits and/or suggested changes to the intervention process and format. It will also recommend any further, trauma-informed assistance which the Facilitator(s) may assess to be necessary to stabilize and "normalize" the trauma-affected staff.**

WVRA CI Response Insert #1 – SAFER-R - Crisis Response - Model

STABILIZATION (Introduction; Meet Basic Needs; Mitigate Acute Stressors)

ACKNOWLEDGEMENT - A. Event B. Reactions

FACILITATION of UNDERSTANDING; NORMALIZATION

ENCOURAGE EFFECTIVE COPING (Mechanisms of Action)

RECOVERY or REFERRAL (Facilitate Access to Continued Care)

1. **STABILIZE**

The first part of the stabilization process involves introductions. It would be best if there were already a rapport between the individual who has been involved in the event and the one helping with the intervention. Following the introductions, see that basic needs are met within an environment of safety.

2. **ACKNOWLEDGE**

Acknowledgement of the event includes listening to the who, what, and when, of the event "story." Try not to focus on the "why" and "how" of the event. These tend to lead to judgment statements. Stay with the facts.

Acknowledgement of reactions involves listening to the responses and reactions of the one involved with the event.

3. **FACILITATE UNDERSTANDING**

This step involves encouraging the expression of difficult emotions, and helping them understand the impact of the critical event. It is a time to paraphrase the content of what is being said. It is a time for normalization; it is an opportunity to share events they have been through that will elicit reactions and emotions. It is a time to attribute reactions and emotions to the situation, and not to personal weakness.

4. **ENCOURAGE EFFECTIVE COPING**

Here is the time to identify personal stress management tools. These management techniques might include time management, nutritional techniques, avoiding known stressors, relaxation response training, physical exercise, and catharsis. Also identify external support/coping resources.

5. **RECOVERY or REFERRAL - Assess the person's ability to safely function. Make referrals as needed.**

THE SAFER-R MODEL of CRISIS INTERVENTION WITH INDIVIDUALS (George S. Everly, Jr., Ph.D., C.T.S, 2001)

Remarks:

- **Let the individual know this is "guided conversation." It is not psychotherapy nor is it a substitute for psychotherapy.**
- **Let the individual know that the discussion is confidential and not part of an investigation, rather it is for the individual.**
- **Let the individual know reports are not made to their supervisor, only suggestions to better help the individual and their unit.**
- **Let the individual know that the WV Resilience Alliance facilitator is available as needed.**
- **Let the individual know that Resilience Alliance training is available.**
- **Let the individual know you desire to create a safe place (emotionally) for them.**

Introduction:

- **Facilitator introduction**
- **State purpose and goal**
- **Set the rules**
- **Confidentiality**
- **Not investigation**
- **Offer additional support**

Exploration:

- **Observe for Secondary Traumatic Stress (STS) indicators (physical, mental, social, and spiritual, etc.).**

Information:

- **Accept and summarize their exploration**
- **Normalize experience and reactions**
- **Discuss coping skills**
- **Promote self- care**
- **Employee Assistance Program**
- **Other**

WVRA CI Response Insert #2 – The Summary Matrix of the 'tiered' levels of critical incident response

Summary Matrix
Critical Incident Response by WV RESILENCE Alliance

Trauma 'Tier"	Assessment of Impacted Staff	Degree of Severity of Trauma	WV RESILENCE Alliance Response
Mild	A single or a few child welfare staff have experienced a traumatic event that is noticeably and negatively affecting their child welfare 'best practice.'	Although the individual staff is currently 'traumatized,' they are functioning and have coping mechanisms, which can be 'recovered.'	The Regional WV RESILIENCE Alliance Facilitator will respond to the traumatized staff either one-on-one or in a small group format utilizing the S.A.F.E.R. intervention model. The facilitator will assess the level of residual trauma following the intervention and make recommendation for further trauma-informed assistance to the CSM/RD.
Moderate	A small group, specified group, or unit has experienced trauma that is significantly and negatively affecting their child welfare 'best practice.'	The individuals/staff obviously 'traumatized' and the trauma is negatively affecting their effective functioning as child welfare professionals. They need help to 'recover' their job 'mastery' and 'efficacy.'	The Regional WV RESILENCE Alliance Facilitator and other Facilitators, as needed, will respond to the traumatized staff either in a small or large group format utilizing the S.A.F.E.R intervention model. The Facilitator(s) will assess the level or residual trauma following the intervention(s) and make recommendation for further trauma-informed assistance to the CSM/RD.
Critical	A large specified group or unit(s) or an entire office/region has experienced trauma that is significantly, critically and negatively affecting their child welfare 'best practice.'	The groups, units, offices, and/or regions are obviously and significantly 'traumatized' and the trauma is negatively affecting their effective functioning as child welfare professionals. They need intensive help to 'recover' their job 'mastery' and 'efficacy.'	The four Regional WV RESILIENCE Alliance Facilitators will plan and implement large group intervention(s) utilizing the S.A.F.E.R. intervention model. The Facilitators will assess the level of residual trauma following the intervention(s) and make recommendation for further trauma-informed assistance to the CSM/RD.

Appendix E: Safe Sleep Flyer

Say YES to Safe Sleep

- Baby always sleeps alone on his or her back in a crib or bassinet
- Baby sleeps in a smoke-free room
- Baby has on only a diaper, sleeper and light blanket
- Crib is clear of toys, heavy blankets, bumper pads and pillows
- Baby's mattress is firm and fits close to the sides
- Crib is in good shape and meets Consumer Product Safety Commission guidelines

For video + more information visit:

SafeSoundBabies.com

Our Babies: safe&sound

The West Virginia Children's Trust Fund

TEAM for West Virginia Children

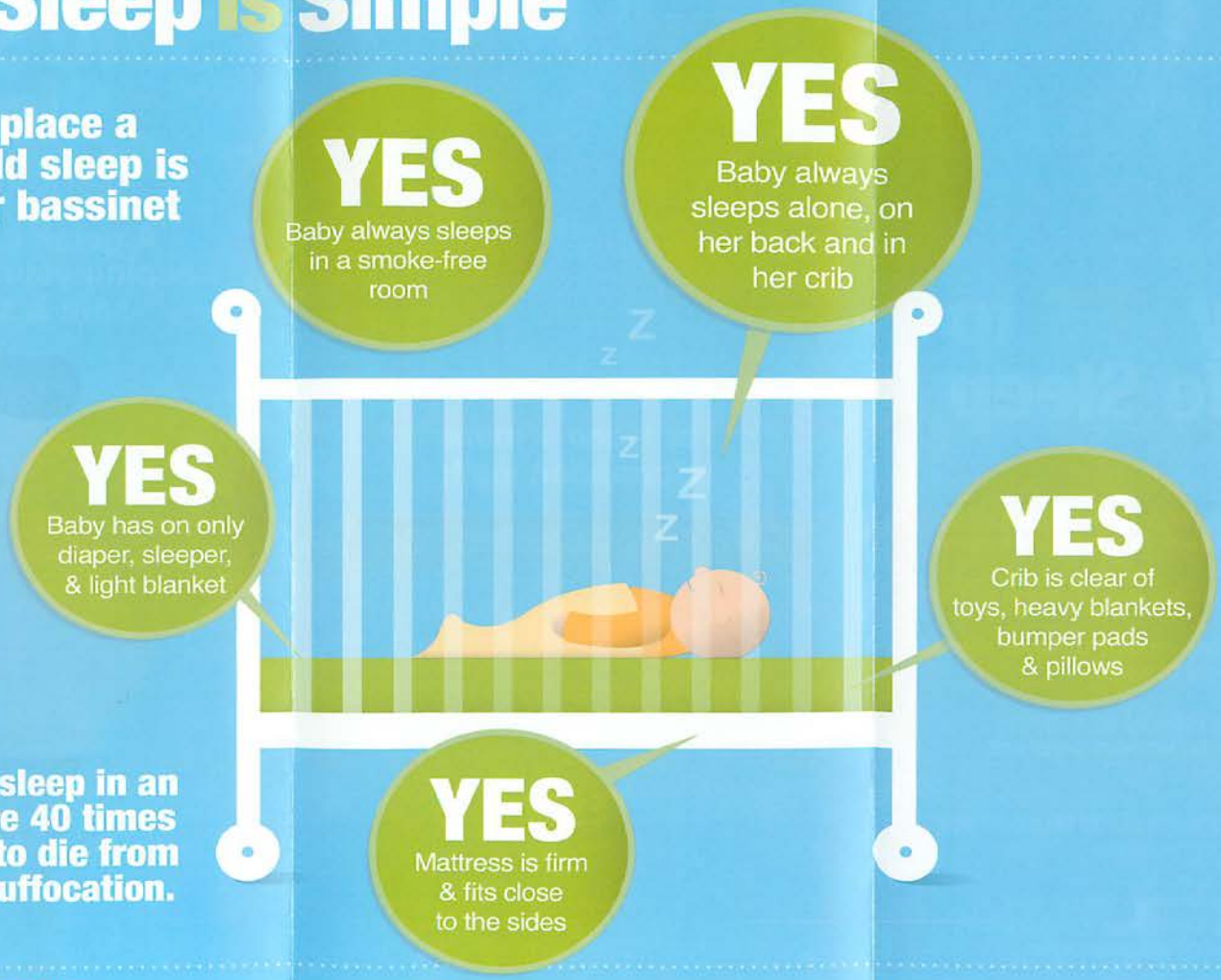
This program is being presented with financial assistance as a grant to the TEAM for West Virginia Children from the WV Department of Health and Human Resources.

Safe Sleep is Simple

A quick guide to keeping your new baby safe & sound

Safe Sleep is Simple

The ONLY place a baby should sleep is in a crib or bassinet



Babies who sleep in an adult bed are 40 times more likely to die from accidental suffocation.

TEAM for West Virginia Children

SafeSoundBabies.com

Our Babies: safe&sound

Appendix F: Boppy Pillow Flyer

Keep Your Infant Safe

Don't let your baby sleep with a nursing pillow.

Crescent-shaped infant and nursing pillows are versatile and popular. They make it easier to feed babies by reducing strain on the arms, shoulder and neck.

However, crescent-shaped pillows such as the well-known Boppy™ should NEVER be used as sleep aids or placed in a baby's crib. The Boppy™ pillow is tagged with a warning and the symbol plainly cautioning against the use of the product for sleeping babies.

Additionally, the Boppy™ website specifically states: "We do not recommend using any of the Boppy™ pillow products for babies while sleeping."

Recent child fatalities have been linked to crescent-shaped infant pillows. Deaths involved children who were sleeping propped up on the pillow. One involved a child who was put to sleep in a crib near a crescent-shaped pillow. In each case, the cause of death was unexplained, and the fatalities were ruled to be the result of Sudden Infant Death Syndrome (SIDS). Research review teams found it significant that each case involved the improper use of a crescent-shaped pillow in the infant's sleeping environment.

Below are a few tips that can help keep your infant safe:

- Babies should be given a sleep surface that is flat, firm and free of blankets, quilts, toys, stuffed animals and pillows of any kind.
- Never lay your baby on top of a pillow to sleep or prop your baby's head or neck up with pillows or soft items like rolled-up towels.
- Use a crib that meets current safety standards. See www.cpsc.gov
- Babies left to sleep should be placed on their backs, not on their tummies.

WEST VIRGINIA Department of Health & Human Resources

Visit www.dhhr.wv.gov for more information.

February 2016