

# **WEST VIRGINIA LEGISLATURE**

**2024 REGULAR SESSION**

**Committee Substitute**

**for**

**Senate Bill 474**

BY SENATORS WOELFEL, TAKUBO, AND DEEDS

[Originating in the Committee on Health and Human  
Resources; reported January 26, 2024]



1 A BILL to amend the Code of West Virginia, 1931, as amended, by adding thereto a new article,  
2 designated §61-12B-1, §61-12B-2, §61-12B-3, §61-12B-4, and §61-12B-5, all relating to  
3 critical incident reporting; creating a Critical Incident Review Team; setting forth duties of  
4 the Critical Incident Review Team; requiring reporting of the Critical Incident Review  
5 Team; setting forth date of report; providing Critical Incident Review Team with access to  
6 information; and setting forth confidentiality.

*Be it enacted by the Legislature of West Virginia:*

**ARTICLE 12B. CRITICAL INCIDENT REVIEW TEAM.**

**§61-12B-1. Critical Incident Review Team.**

1 (a) The Critical Incident Review Team is created under the Department of Human  
2 Services and is a multidisciplinary team created to oversee and coordinate the examination,  
3 review, and assessment of:

4 (1) The death or near death of a child in the custody of the Department of Human Services;  
5 (2) The death or near death of a child who is a member of a family known or with a prior  
6 history with the Department of Human Services. A known case is defined as an open Child  
7 Protective Services case or youth services case in the last 12 months, or a case whom Child  
8 Protective Services, youth services, or a contracted vendor has assessed within the last 12  
9 months; and

10 (3) The deaths or near deaths of a child whose identity is brought to the attention of the  
11 Department of Human Services through a centralized intake report, regardless of whether the  
12 report was accepted for an investigation.

13 (b) The Critical Incident Review Team shall consist of the following members:

14 (1) The Commissioner of the Bureau for Social Services, or his or her designee, who is to  
15 serve as the chairperson and who is responsible for calling and coordinating quarterly meetings  
16 of the Critical Incident Review Team;

17 (2) The Director of the Division of Planning and Quality Improvement;

- 18           (3) The Deputy Commissioner of the Bureau for Social Services;  
19           (4) Representatives from the Offices of Field Support, Programs and Resource  
20 Development, Planning and Research, and the Offices of Field Operations;  
21           (5) The social services manager for any district having a history with the child or his or her  
22 family that is the subject of the critical incident review;  
23           (6) The Foster Care Ombudsman, or his or her designee; and  
24           (7) A representative of the West Virginia Supreme Court of Appeals, Division of Children  
25 Services.  
26           (c) Each member shall serve without additional compensation and may not be reimbursed  
27 for any expenses incurred in the discharge of his or her duties under the provisions of this article.  
28           (d) The Critical Incident Review Team has the ability to seek guidance and opinion  
29 regarding any matter under review from outside experts in any related field. At any such time, the  
30 Critical Incident Review Team shall require that all appropriate privacy requirements required in  
31 this article are in place.

**§61-12B-2. Responsibilities of the Critical Incident Review Team.**

- 1           The Critical Incident Review Team shall:  
2           (1) Review and analyze all deaths and near deaths as required by this article;  
3           (2) Ascertain and document the trends, patterns, and risk factors associated with the  
4 deaths and near deaths evaluated;  
5           (3) Provide statistical information and analysis regarding the causes of certain deaths and  
6 near deaths;  
7           (4) Establish standard procedures for the handling of the critical incident review;  
8           (5) Establish processes and protocols for the review and analysis of deaths and near  
9 deaths of those who were not suffering from mortal diseases shortly before death;  
10           (6) Establish processes and protocols to ensure confidentiality of records obtained by the  
11 Critical Incident Review Team; and

12           (7) Seek additional expert guidance as necessary to complete a review of any death or  
13 near death evaluated.

**§61-12B-3. Reporting of the Critical Incident Review Team.**

1           (a) The Critical Incident Review Team shall submit an initial report on December 1, 2024,  
2 to the Legislative Oversight Commission on Health and Human Resources and the report shall  
3 be submitted December 1 annually thereafter.

4           (b) The report is to include statistical information concerning cases reviewed during the  
5 year, trends and patterns concerning these cases, and the team's recommendations to reduce  
6 the number of deaths and near deaths that occur in this state.

7           (c) The Critical Incident Review Team may provide reporting to child residential facilities  
8 to inform their internal peer review activities. Such information shall be deemed confidential and  
9 shall be used only for peer review purposes.

**§61-12B-4. Access to information; other agencies of government required to cooperate.**

1           (a) Notwithstanding any other provision of this code to the contrary, the Critical Incident  
2 Review Team may request information and records as necessary to carry out its responsibilities.  
3 Records and information that may be requested under this section include:

- 4           (1) Medical, dental, and mental health records;  
5           (2) Substance abuse records to the extent allowed by federal law;  
6           (3) Information and records maintained by any state, federal, or local government agency,  
7 except as provided in §61-12B-2 of this code.

8           (b) State, county, and local government agencies shall provide the Critical Incident Review  
9 Team with any information requested in writing by the team.

**§61-12B-5. Confidentiality.**

1           (a) Proceedings, records, and opinions of the Critical Incident Review Team established  
2 pursuant to this article are confidential and are not subject to discovery, subpoena, or the  
3 introduction into evidence in any civil or criminal proceeding. This section does not limit or restrict

4 the right to discover or use in any civil or criminal proceeding anything that is available from  
5 another source and entirely independent of the proceedings of the team.

6 (b) Members of the Critical Incident Review Team may not be questioned in any civil or  
7 criminal proceeding regarding information presented or opinions formed as a result of a meeting  
8 of the team. This subsection does not prevent a member of a team from testifying to information  
9 obtained independently of the team which is public information.

10 (c) Proceedings, records, and opinions of the Critical Incident Review Team established  
11 by the team are exempt from disclosure under the Freedom of Information Act as provided in  
12 §29B-1-1 et seq. of this code.

13 (d) Notwithstanding any other provision to the contrary, the Critical Incident Review Team  
14 shall prepare a compilation of data to be shared, on an annual basis or more often as requested  
15 or needed, with the Centers for Disease Control and Prevention to study child deaths or near  
16 deaths.

17 (e) Information shall be maintained by the Critical Incident Review Team in a confidential  
18 manner compliant with the Health Insurance Portability and Accountability Act of 1996.