

90 Day Report of the Critical Incident Review Team Required By W. Va Code §61-12B-5

The information contained within this report reflects the views and recommendations of the Critical Incident Review Team, a multi-disciplinary body established under W. Va. Code §61-12B-1 *et seq.*, only and does not necessarily reflect the views, opinions, or recommendations of the Department of Human Services.

The Critical Incident Review Team (CIRT) is mandated by House Bill 2880, of the West Virginia Legislative Session 2025. Under W. Va. Code §61-12b-1, *et seq.*, CIRT is charged with reviewing fatalities and near fatalities involving children involved in the child welfare system. Specifically, CIRT must review: (1) the fatality or near fatality of a child in the custody of the Department of Human Services (DoHS); (2) the fatality or near fatality of a child who has a known case with DoHS or who is the immediate family member or member of a household with a known case with DoHS; and (3) the fatality or near fatality of a child whose identity has been brought to the attention of DoHS through a centralized intake report.

CIRT reviewed a total of 20 cases between May and July. The dates of the reviews occurred:

- May 4, 2026
- June 8, 2026
- July 13, 2026

Of the 20 critical incident referrals (16 fatalities and 4 near fatalities) reviewed:

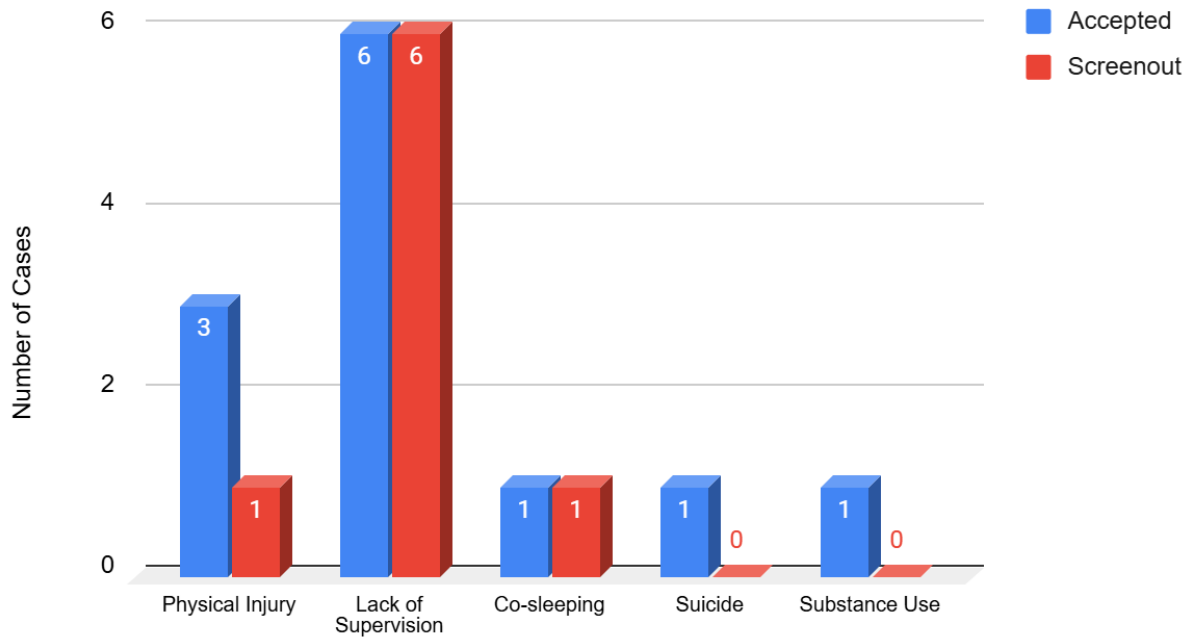
- 12 referrals were accepted for assessment
 - Of the 12 accepted referrals, 5 were determined to be the result of abuse or neglect:
 - 2 findings of neglect due to lack of supervision
 - 2 findings of physical abuse
 - 1 finding of medical neglect
- 8 were screened out, and not referred for investigation

Of the 16 fatalities reviewed:

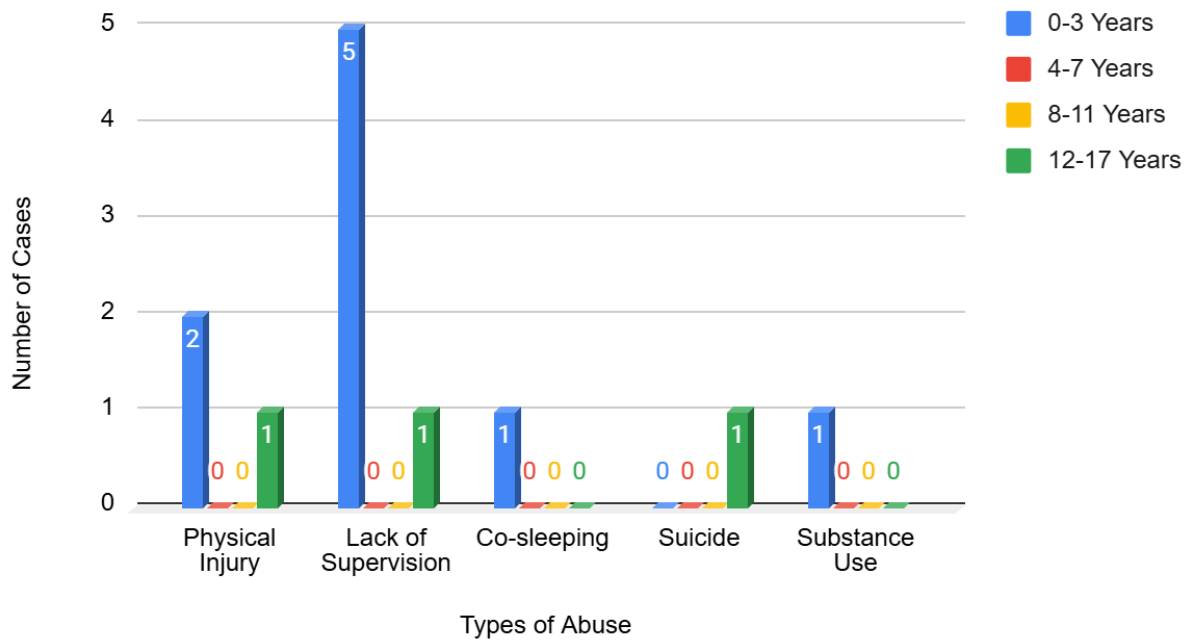
- 4 had open cases/assessments;
 - 1 child was in custody in a kinship/relative placement.

Of the four near fatalities reviewed, none had open cases or assessments, and no children were in custody.

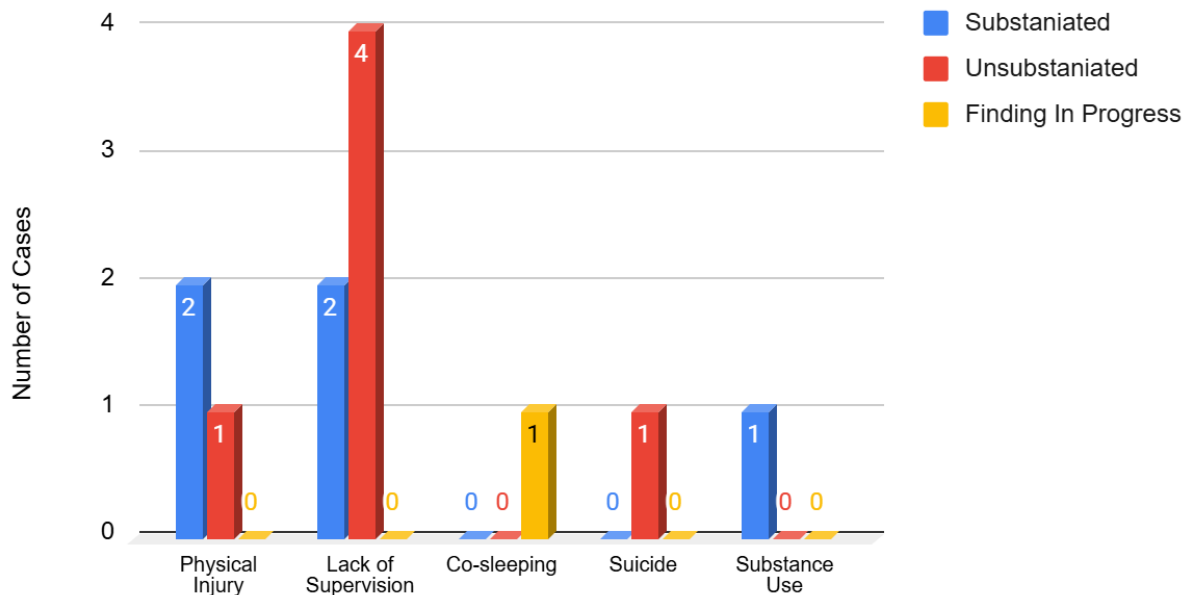
Critical Incidents April 1 2026 - June 30, 2026



Accepted Referrals by Age Group April 1, 2026 - June 30, 2026



Accepted Referrals Substantiated/Unsubstantiated April 1,2026 - June 30, 2026



A total of eight critical incident referrals were screened out, meaning they did not meet the statutory threshold for a formal child protective services investigation.

Breakdown of the Demographics of Screened Out Referrals:

Teenagers (16–17 years old): four cases

Infants (Under 1 year old): three cases

Young children (6 years old): one case

Screened Out Referral Breakdown:

- 1.) A 16-year-old male youth, race unavailable, who was with a relative, was involved in an accident in which the driver lost control in a curve and went down an embankment. The youth was not wearing a seatbelt. The youth was believed to be in and out of the vehicle as it rolled several times. This referral was screened out as it does not rise to the level of child abuse under West Virginia Code Chapter 49.
- 2.) A 17-year-old male youth, race unavailable, who was with friends, began drinking and using marijuana. While with a friend, the youth borrowed a friend's gun and went into another room and shot himself. The youth did not leave any notes, and there were no indications that the suicide was planned. This referral was screened

out as it does not rise to the level of child abuse under West Virginia Code Chapter 49.

- 3.) A less than one-year-old male infant, race unavailable, was co-sleeping with the mother and was found in the mother's arm with the infant's face in the mother's chest and armpit area. The father administered CPR and attempted to clean the infant's nose to remove mucous and blood from the infant's nose. There was no indication that the mother was under the influence. The reporter advised that the home was spotless, and there weren't any indicators for abuse or neglect. This referral was screened out as it does not rise to the level of child abuse under West Virginia Code Chapter 49.
- 4.) A 17-year-old male youth, whose race was unavailable, was with friends in an abandoned parking lot. The other youths with him began drinking alcohol. Two unknown individuals walked up to the driver's seat, where the 17-year-old was sitting, and demanded money and alcohol. The unknown individuals had an AR-15 style firearm and pointed it into the vehicle. The 17-year-old youth was struck by bullets three times. The 17-year-old youth's friends drove the youth to the hospital, where he was pronounced deceased. This referral was screened out as the particular facts reported did not rise to the level of child abuse under West Virginia Code Chapter 49.
- 5.) A White 17-year-old male was driving home after being at a friend's home when the youth hit the back of a tractor-trailer head-on. Law enforcement believed the youth fell asleep while driving. This referral was screened out as it does not rise to the level of child abuse under West Virginia Code Chapter 49.
- 6.) A less-than-one-year-old male, whose race was unavailable, was co-sleeping after becoming fussy while in the infant's crib next to the parents' bed. No blanket or pillow was near the infant, and the home temperature was 76 degrees. The mother found the infant unresponsive. 911 was called. This referral was screened out as it does not rise to the level of child abuse under West Virginia Code Chapter 49.
- 7.) A female infant, whose race was unavailable, born at 22 weeks of gestation with no indication of substance abuse by the mother, died shortly after birth. This referral was screened out as it does not rise to the level of child abuse under West Virginia Code Chapter 49.
- 8.) A White 6-year-old male child died from injuries sustained while racing a dirt bike at a local county fairgrounds. This child was wearing all safety racing gear, and the

estimated speed was 10 miles per hour. This referral was screened out as it does not rise to the level of child abuse under West Virginia Code Chapter 49.

Critical Incidents Reviewed May 4, 2026, June 8, 2026, and July 13, 2026

Breakdown of the 12 Accepted Critical Incidents Accepted for Review:

- 5 cases were substantiated, meaning abuse or neglect was confirmed;
- 6 cases were unsubstantiated, meaning the investigation determined the incidents did not meet the definition of child abuse or neglect under W.Va. Code Chapter 49; and
- 1 case remains in progress, meaning the investigation is ongoing and the final determination is pending.

The data reflects that infants under one year of age represent the highest risk demographic. This age group accounted for over half of all accepted referrals and is the majority of substantiated findings.

Accepted Referral Breakdown of the 12 Accepted Critical Incidents:

- 1.) A White male infant, born drug-affected with a low birth weight and medical issues, died shortly after birth. This case was substantiated and closed, as there are no other children in the home.
- 2.) A White male infant less than one year of age was transported to the hospital by the father. The child had no pulse and no respiration. The infant survived, however, and has been hospitalized. A CAT scan was performed to reveal a brain bleed. Maltreatment was substantiated against the father for the infliction of nonaccidental trauma.
- 3.) A White female youth aged 16 was found deceased on the parents' property. There is an ongoing criminal investigation, and the cause of death has not been revealed at this time. Maltreatment was substantiated. The remaining children were removed from their home.
- 4.) A White male infant less than one year of age died from exposure to fentanyl. The child had previously been removed from the parents at birth, as part of an open CPS case prior to the infant's death. The infant's removal from the parents was due to substance use and being born drug affected. The child was placed in a kinship placement as part of the civil abuse and neglect case with the court.

Despite the infant's removal from the parents, the kinship placement allowed the biological mother to care for the infant whereby the infant was ultimately exposed to fentanyl. Three adults have been arrested as a result of the infant's death. Maltreatment was substantiated. There were no other children in the home.

- 5.) A White female infant less than one year of age showed signs of overdosing, and Narcan was administered and the child survived. The family has had two prior CPS referrals, and the case remains open. The parents were referred to informal services. Maltreatment was substantiated.
- 6.) A White male child aged three was transported by EMS after having a headache and became unresponsive during transport, requiring manual ventilation due to depressed respiration. The child survived, but he tested positive for THC. Maltreatment was unsubstantiated.
- 7.) A 12-year-old White male child was riding an electric scooter with a friend. The child rode in front of a motorcycle going in the same direction. The motorcycle knocked the child into oncoming traffic going the opposite direction, and the child was struck by an oncoming vehicle. The child passed away from the injuries. Maltreatment was not substantiated.
- 8.) A White male child age 16 passed from a self-inflicted gunshot wound. Allegations of verbal and physical abuse were included in the referral, as well as allegations of substance abuse by the father. Maltreatment was not substantiated.
- 9.) A White female infant less than one year of age became unresponsive and was not breathing. She was transported to the hospital where she was intubated, but she subsequently passed away. Law Enforcement was involved and spoke with the attending Pathologist who identified some abnormalities during the autopsy and indicated that further testing, as well as examination by a specialist, was required. The Pathologist stated there was bruising on various parts of the infant's body and that she had posterior rib fractures. There are no other children in the home. Maltreatment was not substantiated. At such time when the medical examiner report is received, if abuse is identified as the cause of death, the finding will be changed to reflect such.
- 10.) A White female infant less than one year of age was found silent and not breathing by the mother. The mother administered CPR, and the infant was transported to the hospital by EMS. After a thorough medical evaluation and testing, physicians determined there was no physical injury and that the child being found

unresponsive could have been a “Brief Resolved Unexplained Event (BRUE).” Maltreatment was not substantiated.

- 11.) A one-year-old White female was playing on the top bunk of a bunk bed, fell to the floor, and passed away as a result of her injuries. Maltreatment was not substantiated.
- 12.) A male infant less than one year of age, whose race was unavailable, was co-sleeping and passed away. The home was reportedly in deplorable condition. The parents have been charged criminally, and there is an ongoing criminal investigation. The cause of death has not been revealed at this time, and the initial assessment remains open as a result. No finding regarding whether there was maltreatment has been made as the assessment is still open, pending the cause of death being determined and released. Once the cause of death is determined by the State Medical Examiner, CPS will be able to conclude its investigation.

CIRT Recommendations

All statutorily identified members of the CIRT should actively participate in the reviews. Each statutorily required member plays a vital role on this team, and all member perspectives and contributions are equally significant to this process and purpose. Recommendations are team-based unless otherwise cited as an individual member's recommendation that was not agreed upon by the overall team.

After reviewing the 20 referrals and all corresponding documentation, and taking previous reviews into account, the team discussed several recommendations for moving forward as a state.

- For the Bureau for Social Services (BSS) Division of Professional Development to establish and require refresher training for child welfare staff on substance use investigations and drug-affected infant referrals.
- For the Office of Drug Control Policy (ODCP) to develop or improve educational materials related to the safe storage of MAT medications, THC-edibles, and other substances that are causing poisoning deaths. These educational materials could be distributed by physicians prescribing these medications or the facilities dispensing them.
- For the Office of Maternal, Child, and Family Health to develop more detailed and evidence-based information and resources specifically related to safe sleep practices and the intersection of safe sleep with issues related to drug-affected infants. Leverage information from the National Partnership for Child Safety

(NPCS) and Casey Family Programs, the nation's largest operating foundation focused on safely reducing the need for foster care while improving child safety and well-being.

- Collaborate with hospitals, midwives, and OBGYNs to make sure this information is delivered to parents in a timely and adequate manner leaving with newborns and during the term of pregnancy to increase the prevention of SUIDs or death resulting from co-sleeping.
- The BSS Training Unit should develop additional policies and procedures to guide and inform field investigation practice as it relates to substance use in homes where children under the age of three reside, given the correlation between early childhood and substance use-related critical incidents.
- For the Bureau of Behavioral Health (BBH) to develop a comprehensive, statewide initiative to integrate mobile crisis response teams within school systems and systematically map available resources to expand access to pediatric mental health services. This recommendation is based on the pattern related to child/teen suicides that the team has reviewed throughout the first year of the CIRT's establishment.
- As an immediate step, the Secretary of the DoHS is directing a member of BBH to serve as an active member in the Critical Incident Review Team meetings to provide invaluable expertise in identifying the behavioral health needs of families affected by critical incidents. Their involvement will increase the team's capacity to identify behavioral health issues and to determine obstacles to families' access to services after critical incidents.
- As a longer-term solution, for the Legislature to add a member of BBH as a statutory member of the CIRT.
- For the Legislature to add an epidemiologist from the Office of Epidemiology and Prevention Services as a statutory member of CIRT to provide epidemiological analyses as required by the CIRT statute and to identify epidemiological patterns and trends in the data presented by cases reviewed by CIRT.