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**WEST VIRGINIA CODE CHAPTER 61**  
**ARTICLE 12B**

WV Legislature

**§61-12B-1. Purpose.**

The Critical Incident Review Team is created under the Department of Human Services for the purpose of reviewing fatalities and near fatalities involving children involved in the child welfare system and making recommendations to identify effective prevention and intervention processes to decrease preventable child fatalities and near fatalities in the child welfare system.

WV Legislature

**§61-12B-2. Definitions.**

As used in this article:

"Epidemiological analysis" means an analysis of demographic factors related to the child's fatality or near fatality including, but not limited to, an analysis of the following factors: the date of birth of the child; the sex of the child; the county of the child's residence; the race/ethnicity of the child; the date the child suffered the fatality or near fatality; the type of maltreatment; the cause of the fatality or near fatality; whether the agency had any contact, and if so, how many times, with the child or a member of the child's family or household before the fatality or near fatality; and maltreater demographic information.

"Known case" means any Child Protective Services case or youth services case in the Comprehensive Child Welfare Information System or a case assessed by Child Protective Services, youth services, or a contracted vendor;

"Near fatality" means any medical condition of the child which is certified by the attending physician to be life threatening. It shall also include incidents that have been found to have created a substantial risk of death or serious bodily injury to the child.

**§61-12B-3. Creation of the Critical Incident Review Team and composition of members.**

(a) The Critical Incident Review Team is created under the Office of the Inspector General and is a multidisciplinary team created to oversee and coordinate the examination, review, and assessment of:

(1) The fatality or near fatality of a child in the custody of the Department of Human Services;

(2) The fatality or near fatality of a child who has a known case with the Department of Human Services or who is the immediate family member or a member of a household of a person with a known case with the Department of Human Services; and

(3) The fatality or near fatality of a child whose identity has been brought to the attention of the Department of Human Services through a centralized intake report, regardless of whether the report was accepted for an investigation.

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

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

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

(3) The Deputy Commissioner of the Bureau for Social Services;

(4) A representative from the Office of Field Support, Programs and Resource Development, Planning and Research, or the Office of Field Operations;

(5) The social services manager for any district having a history with the child or his or her family or any household member that is the subject of the critical incident review;

(6) The Foster Care Ombudsman, or his or her designee;

(7) A representative of the West Virginia Supreme Court of Appeals, Division of Children Services;

(8) A representative from the Prosecuting Attorney's Institute;

(9) The Superintendent of the West Virginia State Police or his or her designee;

(10) A member of the West Virginia Senate, appointed by the President of the Senate, who shall serve as an ex officio member; and

(11) A member of the West Virginia House of Delegates, appointed by the Speaker of the

House, who shall serve as an ex officio member.

(c) Each member shall serve without additional compensation and may not be reimbursed for any expenses incurred in the discharge of his or her duties under the provisions of this article.

(d) The Critical Incident Review Team may seek guidance and opinion regarding any matter under review from outside experts in any related field. At any such time, the Critical Incident Review Team shall require that all appropriate privacy requirements required in this article are in place.

**§61-12B-4. Responsibilities of the Critical Incident Review Team.**

(a) The Critical Incident Review Team shall:

- (1) The team shall meet at least quarterly: *Provided*, That in the event of a fatality or near fatality, the team shall meet within 45 days of such fatality or near fatality to conduct the review required by this article;
- (2) Review and analyze all fatalities and near fatalities as required by this article;
- (3) Ascertain and document the trends, patterns, and risk factors associated with the fatalities and near fatalities evaluated;
- (4) Provide statistical information and an epidemiological analysis regarding the causes of fatalities and near fatalities as specified in this article;
- (5) Establish standard procedures for the handling of the critical incident review;
- (6) Establish processes and protocols for the review and analysis of fatalities and near fatalities of those who were not suffering from mortal diseases shortly before fatality;
- (7) Establish processes and protocols to ensure confidentiality of records obtained by the Critical Incident Review Team; and
- (8) Seek additional expert guidance as necessary to complete a review of any fatality or near fatality evaluated.

(b) The team is prohibited from the following:

- (1) Contacting a witness or witnesses to take testimony from individuals involved in the investigation of a fatality; or
- (2) Otherwise take any action which impedes an ongoing law enforcement investigation.

**§61-12B-5. Reporting of the Critical Incident Review Team.**

(a)(1) The Critical Incident Review Team shall submit an initial report within 75 days of the fatality or near fatality to the Legislative Oversight Commission on Health and Human Resources Accountability with updated reports every 90 days.

(2) Any initial reports submitted mid-year and any other updated reports to be made shall be compiled into a final report to be submitted to the Legislative Oversight Commission on Health and Human Resources Accountability which shall be submitted no later than December 1 each year.

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

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

**§61-12B-6. Access to information; other agencies of government required to cooperate.**

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

- (1) Medical, dental, and mental health records;
- (2) Substance abuse records to the extent allowed by federal law; and
- (3) Information and records maintained by any state, federal, or local government agency.

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

**§61-12B-7. Confidentiality.**

(a) Proceedings and records of the Critical Incident Review Team established pursuant to this article are confidential and are not subject to discovery, subpoena, or the introduction into evidence in any civil or criminal proceeding. This section does not limit or restrict the right to discover or use in any civil or criminal proceeding anything that is available from another source and entirely independent of the proceedings of the team.

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

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

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

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