



# West Virginia Fatality and Mortality Review Team

## Annual Report 2020

Child Fatality Review Panel CY 2016

Domestic Violence Fatality Review Panel CY 2015

Infant and Maternal Mortality Review Panel

Maternal Deaths CY 2015 & Infant Deaths CY 2014

Unintentional Pharmaceutical Drug Overdose Review Panel

**December 1, 2022**

West Virginia Fatality and Mortality Review Team  
Annual Report 2020



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The following report is filed in compliance with W. Va. Code §61-12A-1, *et seq.*, known as the Fatality and Mortality Review Team which is created under the West Virginia Department of Health and Human Resources, Bureau for Public Health.

All individuals listed were in office at time of report distribution.

# TABLE OF CONTENTS

<b>Introduction .....</b>	<b>5</b>
<b>Child Fatality Review Panel.....</b>	<b>6</b>
Overview .....	6
Membership.....	6
Types of Deaths Reviewed.....	6
Case Review Process .....	6
<b><u>Calendar Year 2016</u></b>	
Findings.....	7
Demographics .....	8
Manner of Death.....	9
Cause of Death.....	10
Distribution of Deaths for Various Categories .....	11
Infant Deaths.....	12
Demographics Infants.....	12
Manner of Death in Infants .....	14
Cause of Death in Infants .....	14
Motor Vehicle Deaths .....	17
Suicide Deaths .....	20
Homicide Deaths .....	23
Recommendations Based on 2016 Data Review .....	25
<b>Domestic Violence Fatality Review Panel.....</b>	<b>30</b>
Overview .....	30
Membership.....	30
Types of Deaths Reviewed.....	30
Case Review Process .....	31
<b><u>Calendar Year 2015</u></b>	
Findings.....	32
Demographics .....	32
Manner of Death.....	33
Cause of Death.....	34
Distribution of Deaths for Various Categories .....	35
Data Limitations.....	38
2015 DVFRP Recommendations.....	38
<b>Infant and Maternal Mortality Review Panel .....</b>	<b>40</b>
Overview .....	40
Responsibilities for the Infant and Maternal Mortality Review Panel .....	40
Definitions .....	40
Case Identification of Maternal Deaths .....	41
Case Identification of Infant Deaths .....	42

**Maternal Deaths 2015**

Manner of Death..... 42  
Cause of Death ..... 43  
Maternal Age..... 43  
Maternal Education ..... 43  
Maternal Prenatal Care ..... 44  
Time of Death..... 44  
Maternal Insurance Coverage ..... 45  
Maternal Marital Status ..... 45  
Recommendations to Date: Maternal Deaths ..... 46

**Infant Deaths 2014**

Manner of Death..... 46  
Cause of Death ..... 47  
Infant Race..... 47  
Infant Age at Time of Death..... 48  
Maternal Prenatal Care ..... 48  
Insurance Coverage ..... 49  
Recommendations to Date: Infant Deaths ..... 49

**Unintentional Pharmaceutical Drug Overdose Fatality Review Panel .... 51**

Overview..... 51  
Membership..... 51  
Findings ..... 52

# INTRODUCTION

The following report is filed in compliance with W. Va. Code §61-12A-1, *et seq.*, by the Fatality and Mortality Review Team (FMRT) of the West Virginia Department of Health and Human Resources (DHHR), Bureau for Public Health.

W. Va. Code §61-12A-1, *et seq.* establishes standard procedures for the formation and conduction of business of the FMRT. The FMRT is a multidisciplinary team created to oversee and coordinate the examination, review, and assessment of special cases of death where other than natural causes are suspected.

The FMRT consists of four members which includes the Chief Medical Examiner (chairperson), Commissioner of the Bureau for Public Health (or designee), Superintendent of the West Virginia State Police (or designee) and a prosecuting attorney appointed by the Governor. To carry out the purpose of the team, four Advisory Panels were established and set up as follows:

- A Child Fatality Review Panel (CFRP) created to examine, analyze, and review deaths of children under the age of 18 years;
- A Domestic Violence Fatality Review Panel (DVFRP) created to examine, analyze, and review deaths resulting from suspected domestic violence;
- An Infant and Maternal Mortality Review Panel (IMMRP) created 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 the birth of a child; and
- An Unintentional Pharmaceutical Drug Overdose Review Panel (UPDORP) created to examine, analyze, and review deaths from unintentional prescription or pharmaceutical drug overdoses.

The FMRT is required to submit an annual report to the Governor and to the Legislative Oversight Committee on Health and Human Resources Accountability concerning its activities and the activities of the Advisory Panels including statistical information concerning cases reviewed during the year, trends and patterns concerning these cases and the panel's recommendations to reduce the number of fatalities and mortalities that occur in West Virginia.

Cases subject to review by the panels are prepared for review at different points in time. Each of the review panels has different timelines, caseloads, investigative approaches and processes that comprise the panel work. As such, the panels are currently working on different schedules and calendar year reviews.

This report embodies the findings of the CFRP for the calendar year 2016 which may differ from information reported by DHHR's West Virginia Health Statistics Center, and DVFRP for the calendar year 2015. The IMMRP data reporting includes maternal deaths for 2015 and infant deaths for 2014. At the time of this report, UPDORP has not been activated.

# CHILD FATALITY REVIEW PANEL

## **Overview**

The CFRP is responsible for reviewing the facts and circumstances surrounding deaths of all children, under the age of 18, who were residents of the State of West Virginia at the time of their death.

The CFRP is required to provide statistical data and analysis concerning the causes of child fatalities in West Virginia, promote public awareness of the prevalence and causes of child fatalities, as well as include recommendations for their reduction. The fundamental objective of the CFRP is to prevent future deaths of children by providing necessary tools and information to expectant parents, parents, grandparents, families, appropriate agencies, and the general public. CFRP recommendations are designed to make the needed changes in actions and policies to protect children, while holding perpetrators responsible for their actions, and reducing the overall number of child fatalities that occur in the state.

## **Membership**

According to statute, CFRP operates under the auspices of the OCME, with the state Chief Medical Examiner acting as the chair of the panel and the coordinator housed within that office as well. Other mandated members of the panel include:

- Two prosecuting attorneys or their designees;
- State Superintendent of the West Virginia State Police or his or her designee;
- One law enforcement official other than a member of the State Police;
- One Child Protective Services (CPS) worker currently employed in investigating reports of child abuse or neglect;
- One physician specializing in the practice of pediatric or family medicine;
- One social worker who may be employed in the area of public health;
- Director of the Office of Maternal, Child, and Family Health (OMCFH) of DHHR's Bureau for Public Health or his or her designee;
- One representative of the Sudden Infant Death Syndrome Program in OMCFH;
- Director of the Division of Children's Mental Health Services of DHHR's Bureau for Behavioral Health or his or her designee;
- Director of the Office of Social Services in DHHR's Bureau for Children and Families [now Bureau for Social Services] or his or her designee
- Superintendent of the West Virginia Department of Education or his or her designee;
- Director of Division of Juvenile Services or his or her designee; and
- President of the West Virginia Association of School Nurses or his or her designee.

## **Types of Deaths Reviewed**

The CFRP reviews all preventable death cases of any person under the age of 18. The majority of cases the panel reviews fit into the categories of accident, homicide, suicide, or undetermined. The deaths that occur attributable to natural disease typically are not selected for a panel review unless information reveals potential for the death to have been prevented.

## **Case Review Process**

Initial screening of all fatalities is completed by the DHHR's Bureau for Public Health (BPH) and the OCME to determine if they meet the definition of a preventable child fatality. OCME investigators, pathologists, and the CFRP Coordinator review all potential cases and make a

determination of the child's resident status based on all the information available at the time the case is first presented to the OCME. Typically, with this method of determination, it is rare that a case is overlooked. In an attempt to combat this issue, a list of all child fatalities is obtained from DHHR's West Virginia Health Statistics Center and serves as a way to catch any child deaths that may have been missed initially.

The CFRP Coordinator maintains a running list of all identified child fatalities to be reviewed by the panel. The panel only reviews closed cases and does not attempt to reopen the investigation of those deaths. The CFRP's definition of closed cases are those where the offender is dead, has been convicted in a death, or there is a determination of no further legal action. For the reasons previously mentioned, most cases are reviewed approximately two years following the actual event.

Case reviews are conducted in confidential meetings. All panel members and invited guests are required to sign an agreement to abide by the confidentiality standards specified in the FMRT statute.

Prior to case review by the CFRP, a request for records is sent to all agencies that were identified as having relevant information. The collected information typically includes demographic information, autopsy reports, criminal and civil court histories of the victim and offender, Child Protective Services (CPS) information, media reports, information regarding the use of legal or advocacy services, and the details of the incident including those occurring both prior to and following the death.

The CFRP members present a summary of the information collected for each case reviewed during the monthly meeting. This is followed by a panel discussion, which aims to address the following matters for each incident:

- What were the hazardous events that led up to the fatality?
- Were there any opportunities to prevent the fatality?
- Is training or education needed as it relates to specific areas or occupations?
- How does the incident relate to other reviewed incidents?
- Are there policies relevant to the incident that need to be reviewed or changed?
- Are there lessons or educational messages to be derived from this incident?

As part of the review, CFRP identifies which systems, if any, the victim or the offender, or both, had contact with prior to, during, or after the death. This information helps the panel identify possible recommendations for improvement to system responses to incidents. This method of constructing system recommendations does not in any way have the intention to place blame on any individual or organization. To further support this objective, the recommendations made throughout the year are assembled and presented as wide-ranging proposals for systemic improvements as opposed to case specific ones. The panel believes that these recommendations can be used to improve system responses across an array of agencies and service providers to drastically reduce or eliminate preventable child deaths in West Virginia.

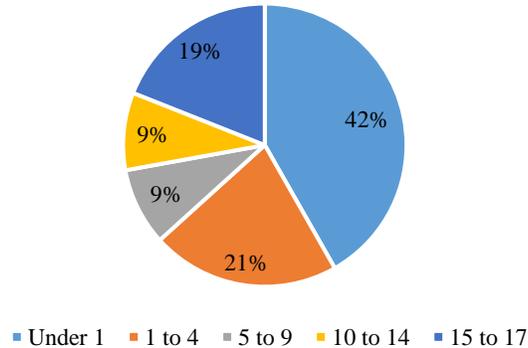
## **Findings**

In 2016, the CFRP had 79 recorded preventable deaths. The information presented within this report will provide insight into the reasons children are dying and provide recommendations as to the preventative measures that can be taken to reduce this number in the future.

## Demographics

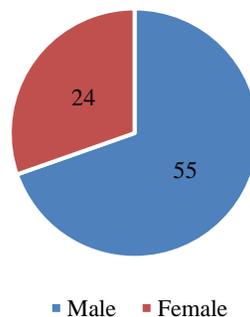
Figure 1 illustrates the distribution of child deaths by age with the percentages for each group. In 2016, the majority of deaths reviewed were among infants under one year of age. Of the 79 preventable deaths reviewed by the CFRP, 33 were infants. An infant death is defined as the death of a child prior to their first birthday. Young children aged one to four accounted for 17 total deaths. Children aged five to nine accounted for seven deaths. There were seven deaths in adolescents aged 10 to 14. Teens aged 15 through 17 numbered 15 deaths.

**Figure 1: Total Deaths By Age Group**



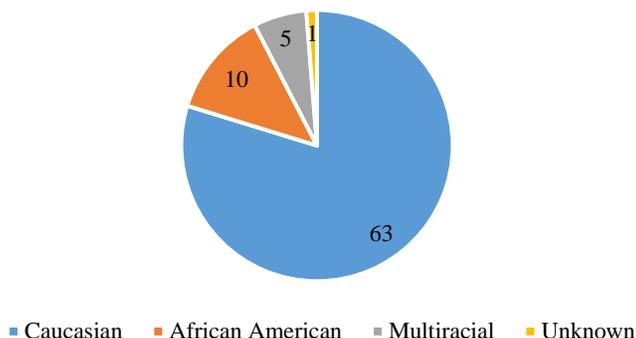
In Figure 2, the child deaths are separated by gender. There were 55 male child deaths and 24 female child deaths that occurred during 2016. This difference between male and female mortality is said to occur from birth and continue throughout life. Research shows the human male is more vulnerable than the female. At the time of birth, a male newborn is said to be about four to six weeks behind a female newborn physiologically. Also, the excess of fatal accidents involving males is attributed to the fact that they have a pattern of poor motor skills and cognitive regulation, which leads to a misjudgment of risk [1].

**Figure 2: Deaths By Sex**



The distribution of child deaths in West Virginia as related to race is shown in Figure 3. The data show that 63 of the 79 deaths were Caucasian children. This is followed by 10 African American child deaths, five deaths of children identifying with two or more races, and one child of unknown race.

**Figure 3: Deaths By Race**



**Manner of Death**

The data is broken down into five manner of death types: natural, accident, suicide, homicide, and undetermined. For 2016, there were no deaths from complications of a natural disease that could have been prevented if properly taken care of. The remaining categories of death that were reviewed result from damage involving the structure and/or function of the body initiated by an external agent or force. These causes could be due to an accident (i.e., motor vehicle, drowning, fire, etc.) or intentional (i.e., suicide or homicide). Other deaths were ruled undetermined that could be either accidental or intentional.

The majority of preventable deaths, 34 of 79, in children from birth to age 17 were due to undetermined causes shown in Figure 4. This was followed by accidental deaths comprising 30 of 79. Suicides accounted for four of 79, and homicide deaths were 11 of 79.

**Figure 4: 2016 Deaths By Manner**

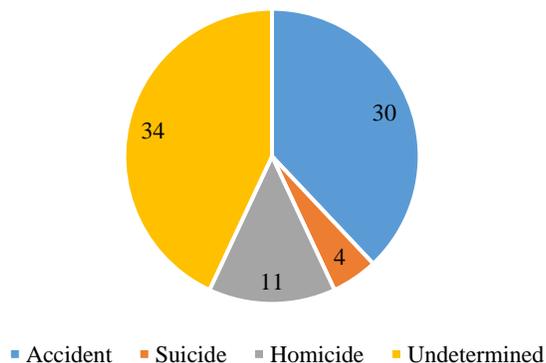


Figure 5 shows the manner of death by age group. Infants under age one comprised 27 of the 34 undetermined deaths. Overall, infants under age one had the highest number of deaths for all age groups with 33 of the 79 preventable deaths. Young children aged 1-4 had the second highest number of deaths with 17 of the 79.

**Figure 5: Manner of Death By Age Group**

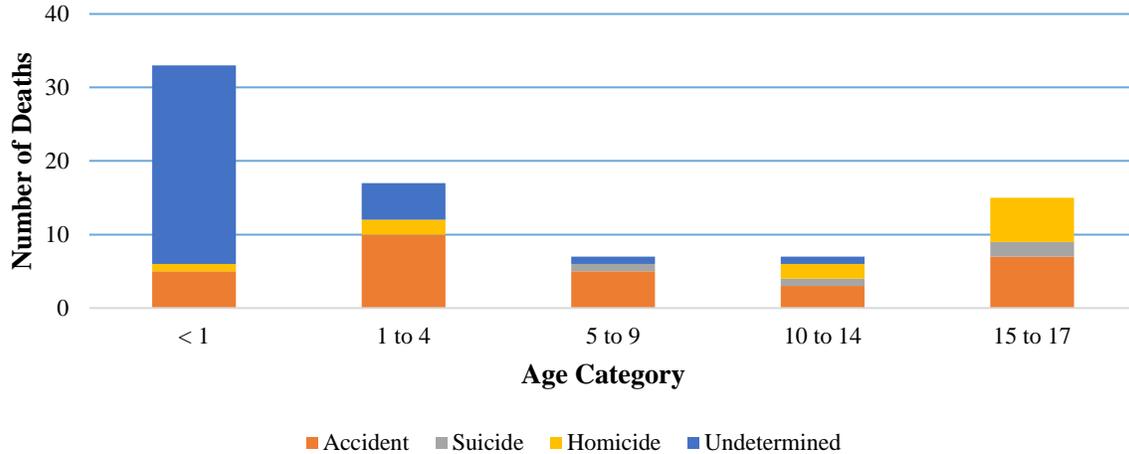
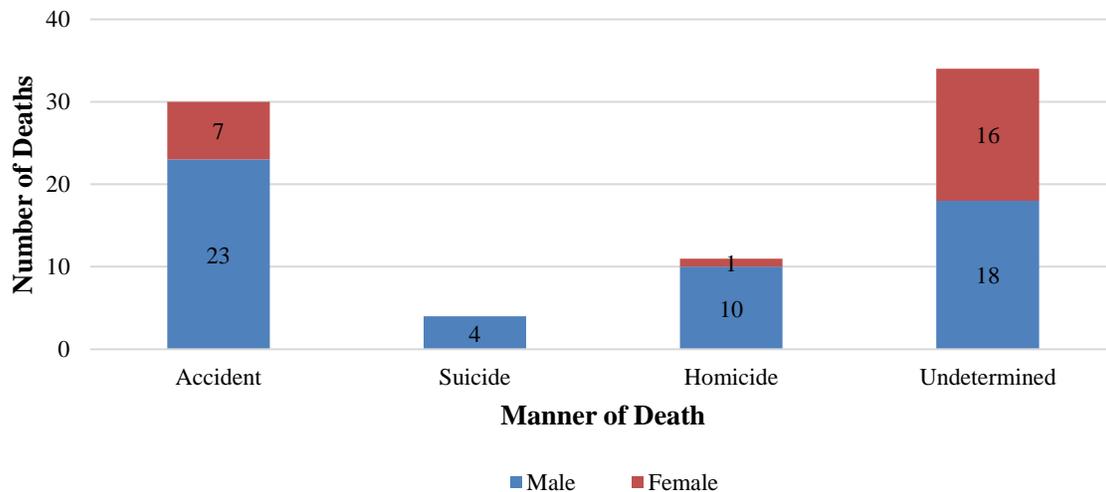


Figure 6 shows 2016 deaths by manner of death and gender of the child. More male children died overall than female children. The data show males were more often the victims of homicide when compared to females. The incidence of a male completing suicide was also higher as there were no suicides completed by a female. It also shows that slightly more male infants died as a result of undetermined deaths when compared to females. Looking at the accidental deaths, males had more than three times the number of deaths of females for 2016.

**Figure 6: Deaths By Manner and Sex**



**Cause of Death**

Each manner of death has subdivisions or categories termed causes, which give a more detailed explanation as to why the death occurred. The top three causes of death overall were unknown (could not be determined) followed by assault or weapon (homicide) and third was tied between drowning (accident) and motor vehicle (accident). Unknown deaths accounted for 30 of the 79 total child deaths, which is 37.9% overall. Homicide deaths were responsible for 13.9% or 11 of the 79 deaths. Table 1 shows a detailed list of all preventable causes of death by manner for all age groups that occurred in 2016.

Table 1: Causes of Death By Manner and Age Group						
Manner	Cause	<1	1 to 4	5 to 9	10 to 14	15 to 17
Accident	Motor Vehicle	1	2	1	1	5
	Fire, Burn, or Electrocution	-	1	2	1	-
	Drowning	-	7	1	1	1
	Unintentional Asphyxia	4	-	-	-	-
	Poisoning, Overdose, or Acute Intoxication	-	-	-	-	1
	Other Injury	-	-	1	-	-
Suicide	Assault or Weapon	-	-	1	1	2
Homicide	Assault or Weapon	1	2	-	2	6
Undetermined	Fire, Burn, or Electrocution	-	2	1	-	-
	Poisoning, Overdose, or Acute Intoxication	1	-	-	-	-
	Unknown	26	3	-	1	-

### Distribution of Deaths for Various Categories

Figure 7 shows all preventable deaths that occurred for each month in 2016. There were two months tied for the most child deaths, June and July. The month with the fewest total deaths was May.

Figure 7: 2016 Child Deaths By Month

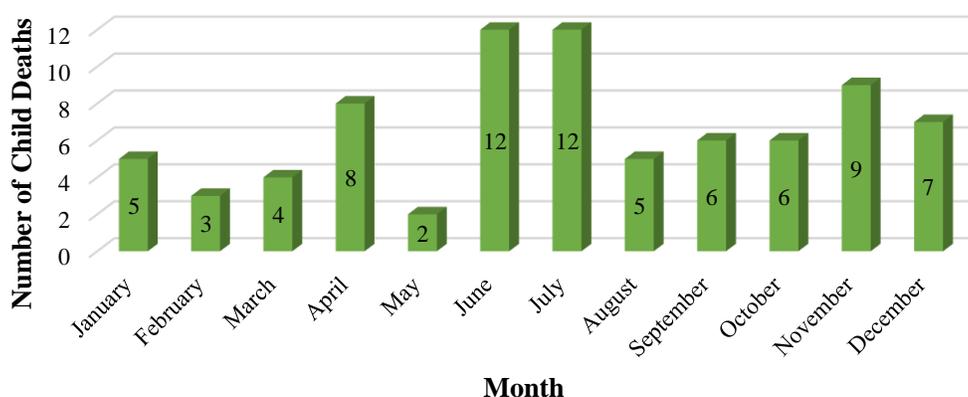
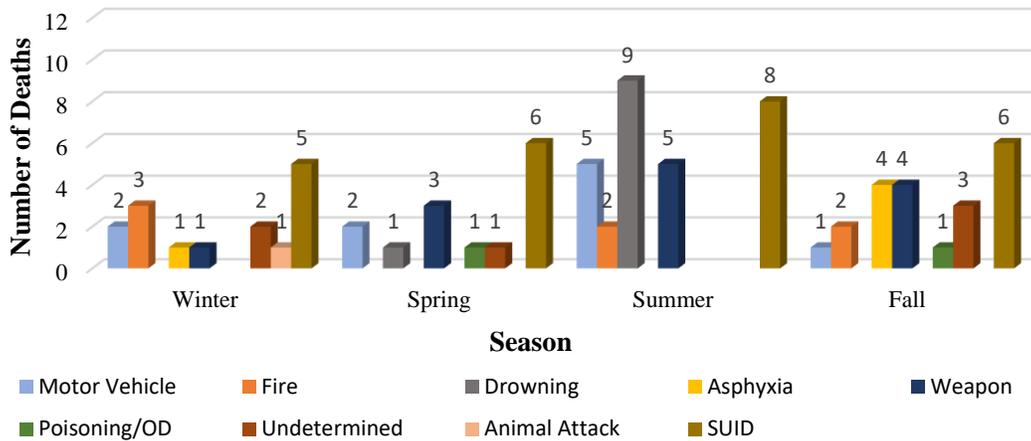


Figure 8 shows preventable causes of death by season.<sup>a</sup> The data shows that most motor vehicle accidents occurred in summer. Most drowning deaths also occurred during the summer. This is expected given that summer is the most popular time for children to go swimming. There was one death during the spring due to drowning. It is important to mention that the increase in drowning deaths for the year was related to the June 2016 flooding that hit West Virginia. The flooding was the result of eight to 10 inches of rain falling over a 12–24-hour period. This flood was noted as being among the deadliest to hit the state. Four of the nine summer drowning deaths were the direct result of the flood. According to information from the Centers for Disease Control and Prevention (CDC), about one in five children aged 14 and younger dies from drowning each year

<sup>a</sup>For the purposes of this report, the seasons are as follows: Winter-Dec., Jan., Feb.; Spring-Mar., Apr., May; Summer-Jun., Jul., Aug.; and Fall-Sept., Oct., Nov.

[2]. Correspondingly, for every one child who dies from drowning, there are another five who are taken to the emergency department to receive care for non-fatal submersion injuries [2].

**Figure 8: Deaths By Cause Per Season**



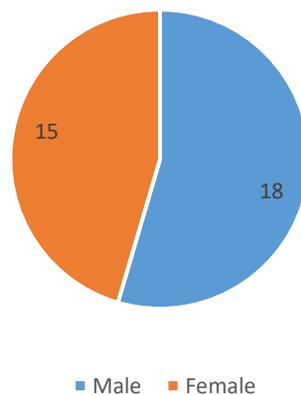
**Infant Deaths**

An infant death is the death of a child any time after their birth but prior to reaching their first birthday. In 2016, there were 33 preventable infant deaths reviewed by the CFRP. The age category with the most preventable deaths in 2016 was infants. Infant mortality is characteristically used as an indicator of overall health of a society [3].

**Demographics**

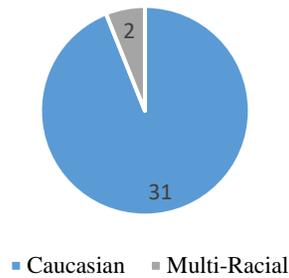
Figure 9 shows the infant deaths in West Virginia divided into the category of gender. It shows that 18 male infants and 15 female infants died in 2016. This displays that 55% of infant deaths were in males and 45% were in females.

**Figure 9: Infant Deaths By Gender**



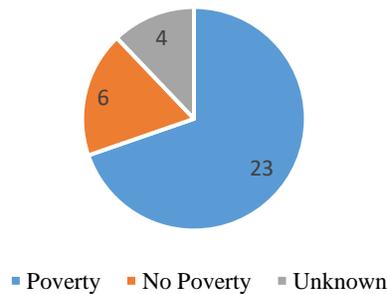
Infant deaths by race are shown in Figure 10. This figure shows that most of the deaths (31) occurred in Caucasian infants. There were zero African American infants, and two multiracial infants.

**Figure 10: Infant Deaths By Race**



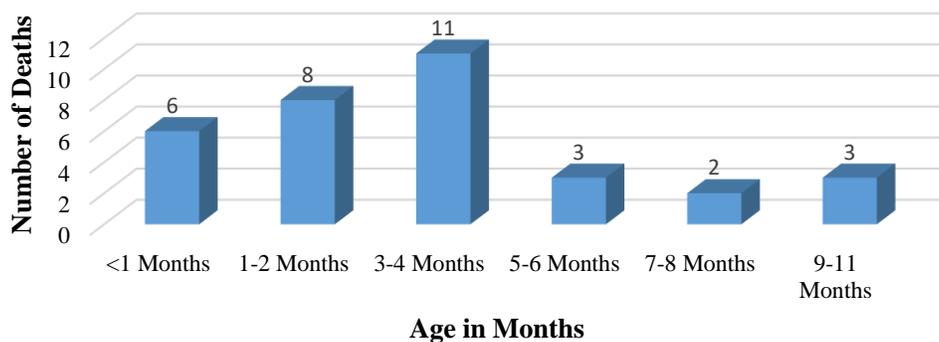
The poverty status<sup>b</sup> of infants who died of preventable deaths in West Virginia in 2016 provides a figure that indicates a possible correlation. Figure 11 shows the 33 deaths by poverty status of the parents at the time of the infant’s death. There were 23 of the 33 infants who were considered to be in poverty. This accounts for 70% of all preventable infant deaths. In West Virginia, the infants in poverty were more likely than their non-poverty counterparts to die from a preventable death. A report by He *et al.* states the high infant mortality rate in the United States has some association with disparities in socioeconomic status [4]. A family’s financial situation can affect factors such as nutrition, food security, education, and health care [4].

**Figure 11: Preventable Infant Deaths By Poverty Status**



Infant deaths per age category in months are shown in Figure 12. This figure shows the number of deaths was increasing from birth to about four months with a peak in deaths for the 3-4-month-old infants. After that, the number of deaths falls but does have some fluctuation.

**Figure 12: Infant Deaths By Age In Months**



<sup>b</sup> Poverty status is determined by family receiving Medicaid at time of infant’s death.

### **Manner of Death in Infants**

The data on preventable death for infants is divided into three manner of death categories: accident, homicide, and undetermined. Figure 13 shows there were 27 deaths deemed undetermined, five deemed accidents, and one deemed homicide.

**Figure 13: Manner of Death In Infants**

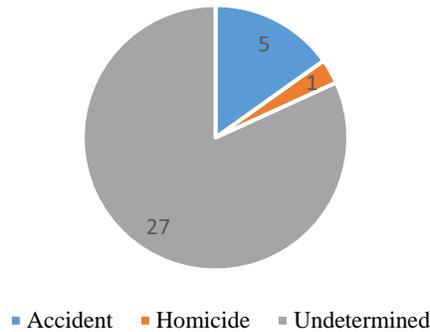
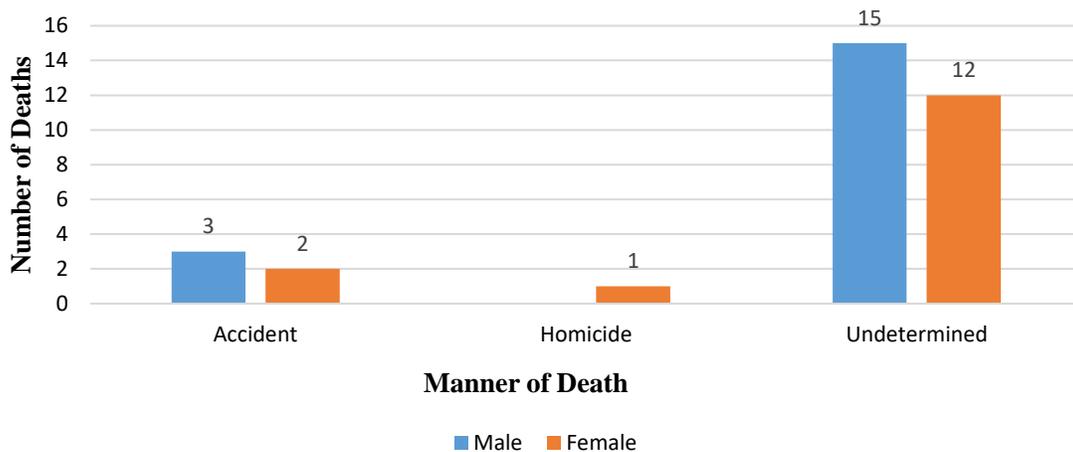


Figure 14 shows the manners of death for infants by the gender of the infant. This figure shows that overall male infants died at higher numbers than female infants. Male infants accounted for the most undetermined and accidental deaths. The homicide was a female infant.

**Figure 14: Infant Manner of Death By Gender**



### **Causes of Death In Infants**

The leading cause of preventable death in West Virginia infants in 2016 was unknown (undetermined). Most of those deaths were attributed to an unsafe sleep environment. The sleep-related deaths are coded differently than they were in the last 20-30 years. In the past, most deaths were labeled as Sudden Infant Death Syndrome (SIDS) deaths even when there was evidence of unsafe sleep conditions; whereas now, they can be labeled differently depending on findings during investigation such as Sudden Unexplained Infant Death (SUID), undetermined/unknown cause, asphyxia, or suffocation. SUID is a general category under which all sudden unexpected deaths in infants fall, including SIDS. To further differentiate between the two terms, SUID is an infant death that does not have a specific cause but has associated risk factors that may have contributed to the death, whereas SIDS is the cause of death after the

autopsy, death scene investigation, and medical history rules out all other possible causes and contributing risk factors.

There were 23 sleep-related deaths that occurred in 2016 in the state. It is important to look at the way these deaths were recorded to better understand the information within this report. The manner of death for 19 of 23 sleep-related deaths was undetermined. The causes for those same deaths were listed as 18 SUID and one undetermined. The remaining four of 23 sleep-related deaths had the manner of death as accident with the causes of death being listed as asphyxia for two, one as suffocation, and one as smothering.

The 23 unsafe sleep-related deaths are divided out into four main categories: co-sleeping, unsafe sleep surface, unsafe sleep position, and unsafe bedding. Figure 15 shows this information separated into the categories previously mentioned. It is important to mention that some of the co-sleeping deaths had other contributing factors such as unsafe sleep position and unsafe sleep surface, which are not reflected in the values shown. Co-sleeping or sharing a sleeping surface with an adult, child, or pet accounted for 11 of the 23 total sleep-related deaths. There were five deaths that were attributed to an unsafe sleeping position, meaning the infant was not on their back. Unsafe sleeping surface was a risk factor in five of the deaths. An unsafe sleeping surface is any surface that is not designed for an infant such as a couch. There were two deaths caused by unsafe bedding, meaning too many covers or blankets with the infant.

**Figure 15: 2016 Unsafe Sleep-Related Deaths**

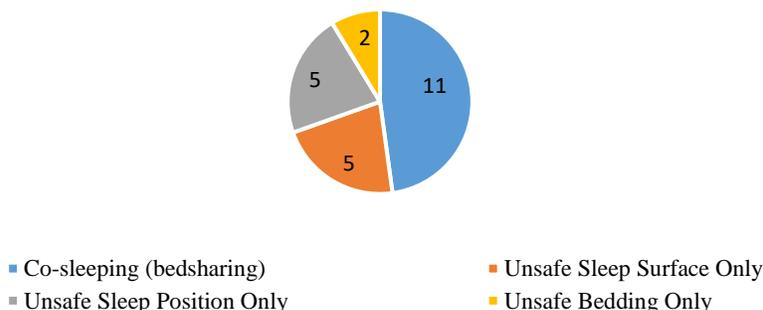


Figure 16 shows whether a crib or port-a-crib was in the home for infant use. The data shows that 15 of 23 had a crib in the home for infant use. Only two of 23 infants were known to not have a crib available. There were six infants in which it was unknown if a crib was available or not. This is an important factor to consider since 11 of the 23 sleep-related deaths were contributed to co-sleeping.

**Figure 16: Availability of Crib/Port-a-Crib for Infant Use**

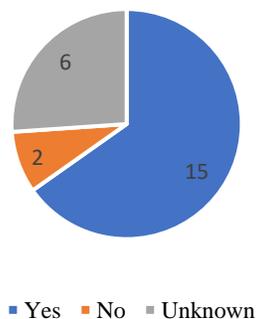
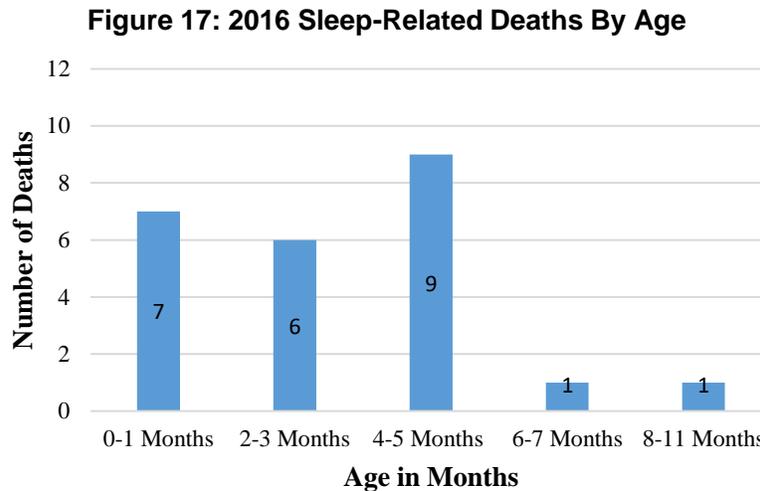
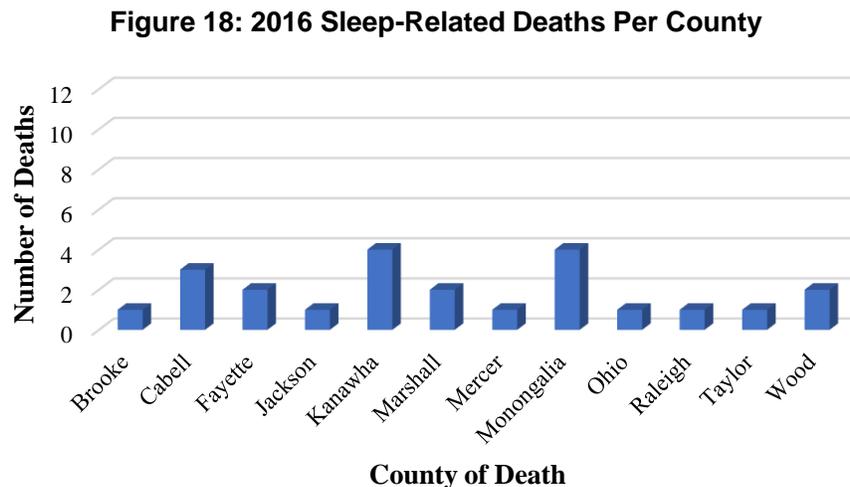


Figure 17 shows the unsafe sleeping deaths by age in months. According to the numbers for 2016, infants ranging in age from birth to five-months old were the most likely to die from unsafe sleep practices. This number reduced to one death in the next two age categories of six- to seven-months old and the eight- to 11-months old.



Looking at the sleep-related deaths by county in Figure 18, the deaths took place in 12 of the 55 counties. The data show that the most unsafe sleep-related deaths occurred in Kanawha and Monongalia counties where there were four deaths each in 2016. There were three deaths in Cabell County. Fayette, Marshall, and Wood counties had two unsafe sleep-related deaths each and the remaining six counties all had one death each.



Another interesting statistic is the secondhand smoke exposure in the sleep-related deaths as smoking is also a risk factor in SUID deaths. Figure 19 shows that nine of the 23 infants who died were exposed to secondhand smoke. There were nine of 23 infants that lived in non-smoking homes and the remaining five had an unknown status. This is an important risk to consider; the CDC states infants who are exposed to secondhand smoke after birth are at a greater risk for sudden, unexplained death because the chemicals in secondhand smoke appear to affect the brain in ways that interfere with the regulation of the infants' breathing [5].

**Figure 19: Secondhand Smoke Exposure In Sleep-Related Deaths**

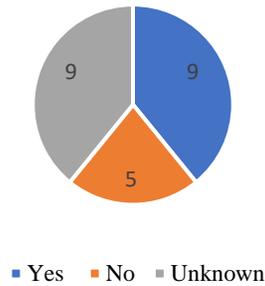
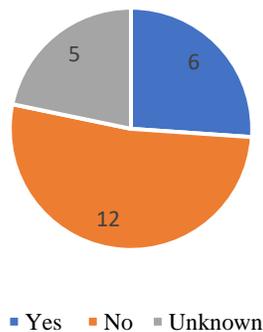


Figure 20 shows the sleep related deaths involving the child being placed to sleep with a pacifier. According to the data for 2016, 12 of 23 infants did not use a pacifier during sleep. There were six infants who did use a pacifier and the pacifier usage is unknown for the remaining five infants. Research has shown that through a currently indeterminate mechanism, pacifiers used at sleep time may reduce the risk of SIDS by as much as 90% [6]. In the Chicago Infant Mortality Study, it was found that pacifier use was associated with a reduced risk of SIDS. The data indicated that pacifier use may offer some additional protection for infants who sleep in high-risk environments such as those who sleep in the prone or side position, those who bedshare, or those who have soft bedding present in their sleeping environment [6]. This was consistent with the findings of a population-based, case-control study in a demographically diverse population that was conducted by Li *et al.*, 2006, but it has been noted that larger sample sizes need to be used for data to be statistically significant [6].

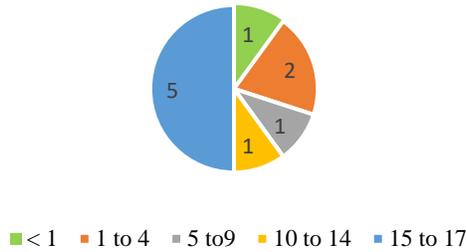
**Figure 20: Sleep-Related Deaths By Pacifier Usage**



### **Motor Vehicle Deaths**

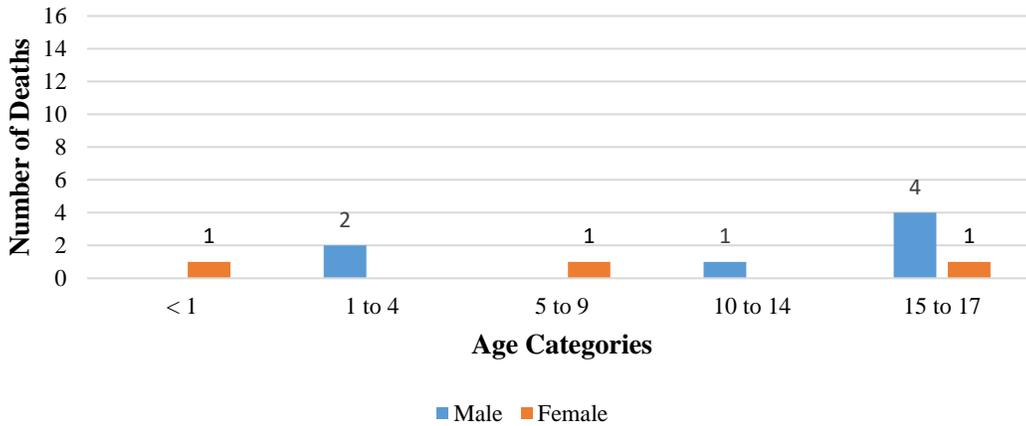
In 2016, a total of 10 children ages birth to 17 died in West Virginia as a result of a motor vehicle accident as either the driver, passenger, or pedestrian. Figure 21 shows the deaths by the age categories. This clearly shows that exactly half (five of 10) of the motor vehicle accident deaths that were reviewed occurred in teens aged 15-17. This was followed by children aged one to four with two deaths. All other age categories had one child death each. The data follow the statistics regarding motor vehicle accidents, which state that the risk of motor vehicle crashes is higher among 16–19-year-old children than among any other age group [7].

**Figure 21: 2016 Motor Vehicle Deaths By Age**



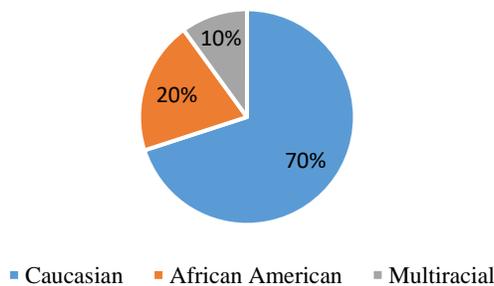
The number of deaths by gender and age category is shown in Figure 22. For teens aged 15-17 and children aged one to four, and 10 to 14 there were more deaths in males than females. In children aged five to 9 and under one, females outnumbered males.

**Figure 22: 2016 Motor Vehicle Deaths By Age and Gender**



Regarding the motor vehicle deaths by race in Figure 23, Caucasian children represent a majority of the deaths at 70% of the children who died in motor vehicle accidents in 2016. African American children account for 20% and multiracial children account for 10%.

**Figure 23: 2016 Motor Vehicle Deaths By Race**



The breakdown of motor vehicle deaths by type of vehicle involved is presented in Figure 24. Three deaths involved a car and two deaths each involved a sport utility vehicle (SUV) and a go-kart. The remaining categories of truck, all-terrain vehicle (ATV), and motorcycle had one death each.

**Figure 24: Death By Type of Vehicle**

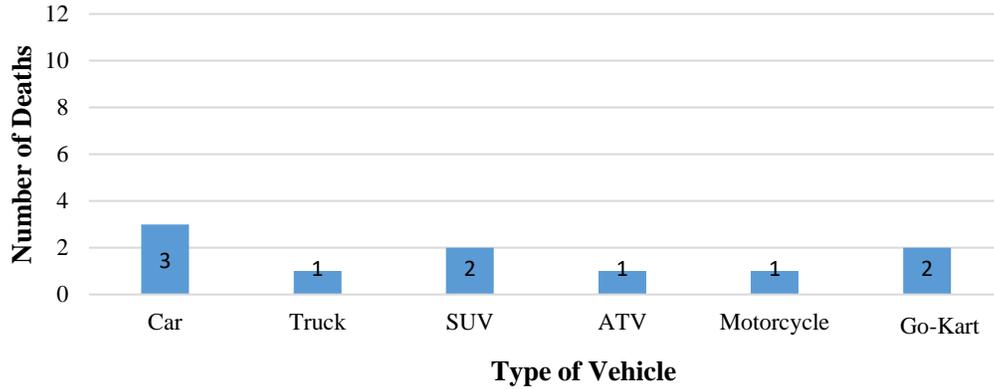


Figure 25 shows the majority of children who died were drivers at the time of their death. This number includes children who were driving a go-kart or ATV. With respect to the passenger locations, one child was in the backseat and the other child had an unknown passenger position. There were two children who were pedestrians at the time of their death.

**Figure 25: Position of Child**

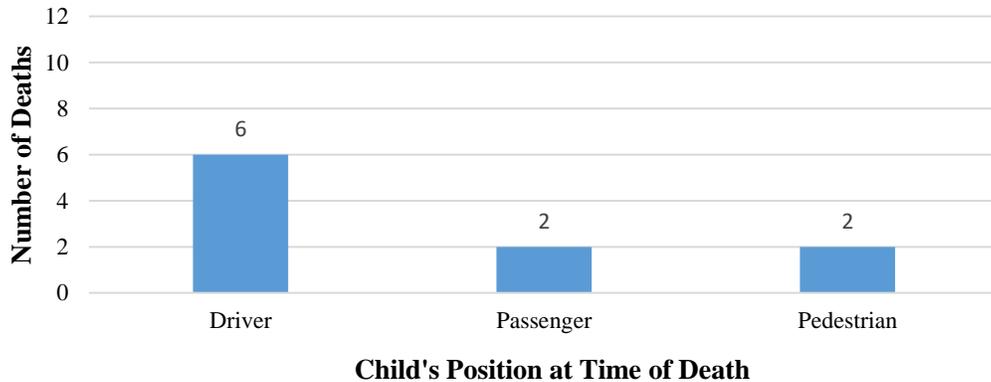


Figure 26 shows the party responsible for causing the motor vehicle accident that resulted in the death of a child. The figure shows that a majority of the deaths (seven of 10) were caused by the child. There were two deaths in which the accident was caused by the child's driver and one death was caused by the other driver. Of the two deaths that were caused by the child's driver, one was the biological parent and one was the grandparent of the child.

**Figure 26: Person Responsible for Accident**

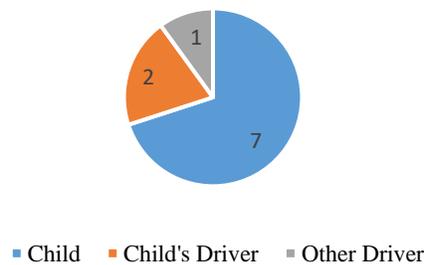


Figure 27 contains the locations in which the fatal incidents occurred. In 2016, the fatal incidents occurred in six different locations. The majority of the motor vehicle accidents (40%) occurred on the highway, which was followed by 20% occurring on city streets. There was one death each for residential street, rural road, intersection, and off road.

**Figure 27: Location of Incident**



With motor vehicle accidents accounting for 10 childhood deaths in West Virginia for 2016, it is important to look at some of the risk factors the fatalities shared. Running a red light was the contributing factor in three accidents and speeding was a contributing factor in one of the accidents. Driving while under the influence of drugs or alcohol was a factor in two of the accidents. Driver inexperience was listed as a contributing factor in three of the accidents in which the child was the driver causing said accident. When looking at safety measures, there were three accidents in which a seatbelt was present but was not used. Also, there were three accidents in which the child needed a helmet but was not wearing one.

**Suicide Deaths**

Suicide accounted for four childhood deaths for West Virginia in 2016. The suicide deaths of children reviewed were comprised of those ranging in age from nine through 17 years old. Data indicate that for every successful suicide, there were 25 attempts [7]. Overall, females are three times more likely than males to attempt suicide; however, males are four times more likely to die by suicide [8].

In West Virginia, four children completed suicide in 2016. Figure 28 shows the suicides divided into different age categories. The age categories shown here follow the same age categories used throughout the rest of the report. These data show that half of the suicide deaths (two of four) occurred in teens aged 15-17. There was one suicide in children aged 10-14 and one suicide in the five to nine age range. It is important to note that all the suicide deaths occurred in males.

**Figure 28: Suicide Deaths By Age**

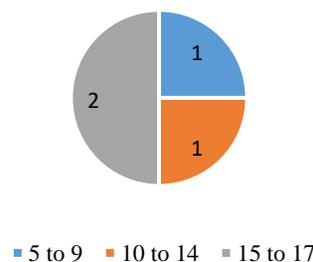


Figure 29 shows the suicide deaths by cause. There were two suicides completed by using a weapon and two were completed by asphyxia. No suicide deaths were attributed to an overdose for 2016. Both weapon suicides were completed using a firearm. Nationwide, firearm deaths account for half of all suicides [8].

**Figure 29: Suicide Deaths By Cause**

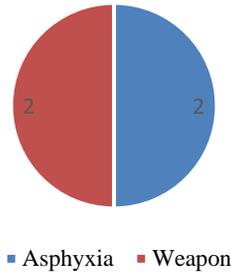
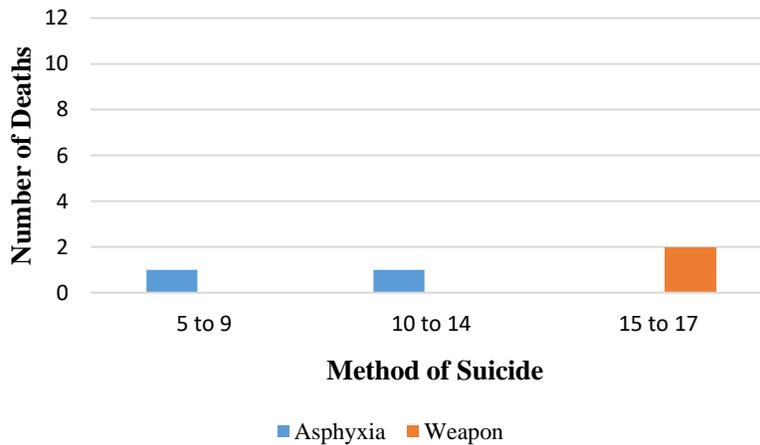


Figure 30 shows suicide deaths by cause separated into age categories. This allows a visualization of which types of death were most common for each group. With respect to the asphyxia deaths, both were completed using a belt.

**Figure 30: Suicide Cause By Age**



The weapon deaths that occurred all used a firearm and those can be broken out by the type of firearm used during the suicide. Figure 31 shows a handgun accounted for one death and a shotgun accounted for the other suicide.

**Figure 31: Type of Firearm Used in Suicides**

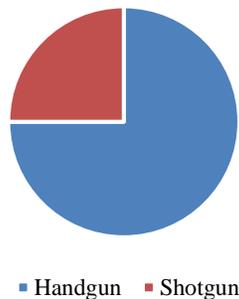
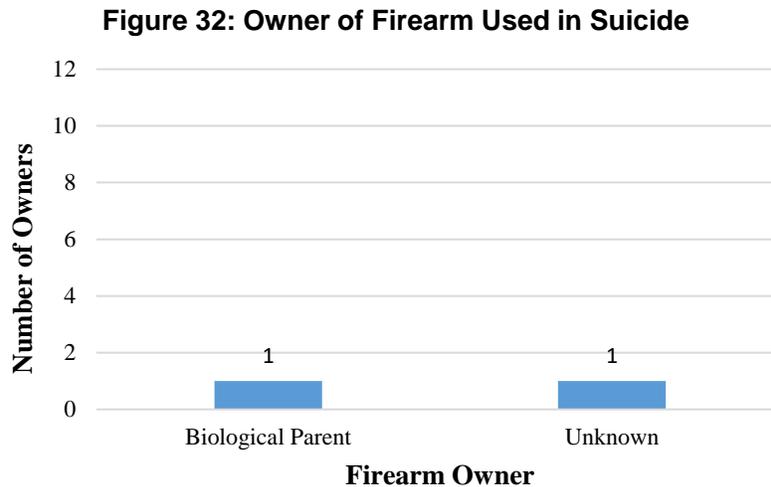


Figure 32 shows the owner of the fatal firearm used by the child. This information shows that half of the firearms were owned by the biological parent of the child. There was one death in which the biological parent was the owner of the firearm and one death where the owner of the firearm was unknown.



The common factor in a majority of the firearm deaths was that little to no safety features were used. Table 2 shows this information and displays whether the safety feature was used (yes) or not (no) in each of the two firearm deaths.

<b>Table 2: Firearm Safety Features</b>			
	<b>Yes</b>	<b>No</b>	<b>Unknown</b>
Trigger Lock	0	2	0
External Safety	1	1	0
Loaded Chamber Indicator	0	2	0
Magazine Disconnect	0	2	0
Minimum Pull Trigger	0	2	0
Locked Storage Cabinet	0	2	0
Stored with Ammunition	0	1	1
Stored Loaded	1	0	1

Looking at suicide deaths overall, there were some common risk factors involved in the deaths, which are relevant to suicide prevention. It is important to keep in mind that there could be multiple risk factors for each case, so these numbers will add up to more than four. None of the children left a suicide note. Table 3 shows the warning signs that the child showed that could have possibly been used as points of intervention.

<b>Table 3: Possible Warning Signs</b>	
Child Talked About Suicide	1
Prior Suicide Threats Made	3
Prior Suicide Attempts	2
History of Running Away	1

Another important issue to examine when dealing with suicide is the events that took place at the time surrounding the suicide. These events are considered personal crises and could be either acute or cumulative with their effect on the child’s despondency. Those factors are shown in Table 4.

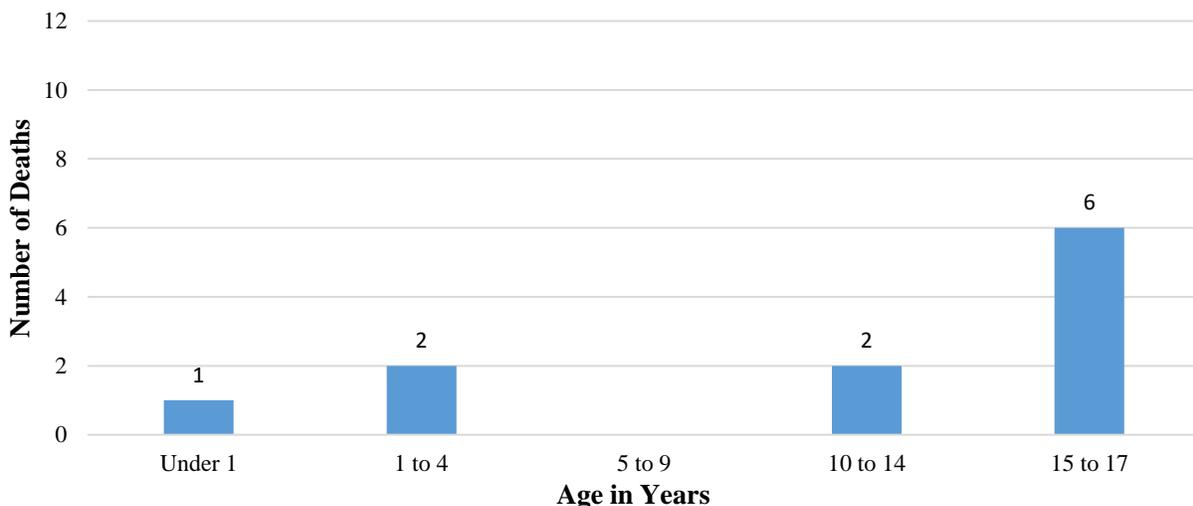
<b>Table 4: Personal Crisis Prior to Death</b>	
Parents’ divorce/separation	2
Argument with parents/caregivers	3
Bullying as victim	2
School failure	1
Physical abuse/assault	1
Drug/alcohol use	1
Failed romantic interest	1

CPS involvement was a factor that was examined as well. All four of the children who completed suicide had a CPS history of child maltreatment as the victim. Two of those four children had been placed outside the home at some point prior to their death. Mental health was another factor that was considered. There was one child receiving mental health services at the time of their death.

**Homicide Deaths**

Homicide accounted for 11 childhood deaths for West Virginia in 2016. The homicide deaths of children reviewed were comprised of those ranging in age from under one through 16 years old. Figure 33 shows the homicides divided into different age categories. The age categories shown here follow the same age categories used throughout the rest of the report. These data show that more than half of the homicide deaths (six of 11) occurred in teens aged 15-17. There were two homicides in each of the one to four and 10–14-year-old age group. One homicide occurred in the under one category and no homicides occurred in the five to nine age range. Looking at the sex of the homicide deaths, 10 occurred in male children and one occurred in a female child.

**Figure 33: Homicide Deaths By Age**



Homicide deaths by race are shown in Figure 34. This figure shows that a majority of the deaths (six of 11) occurred in Caucasian children followed by four deaths in African American children. There was one homicide that occurred in the multiracial category.

**Figure 34: Homicide Deaths By Race**

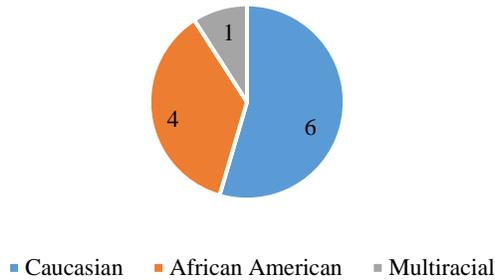


Figure 35 shows the homicide deaths by weapon type. Most of the deaths (six of 11) occurred due to the use of a firearm. Three deaths occurred due to the use of a person's body part. One death occurred from the use of a sharp instrument and one death occurred due to an unknown weapon.

**Figure 35: Homicide Deaths By Weapon Type**

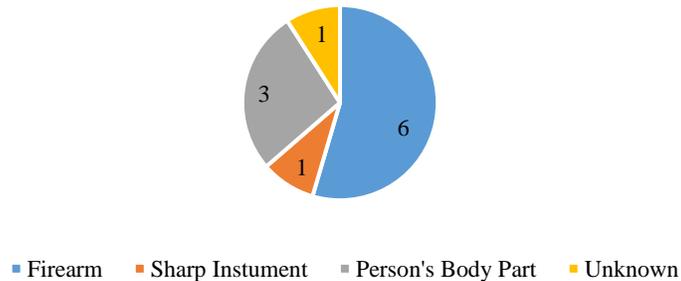


Figure 36 shows the firearm deaths by the type of firearm used in the homicide. More than half of the firearm homicide deaths or four of six included a handgun. One included a shotgun and the remaining one included a hunting rifle.

**Figure 36: Firearm Homicides By Firearm Type**



The breakdown of homicide deaths by perpetrator are shown in Figure 37. Four of the 11 homicides were committed by a friend or acquaintance of the child. There were two deaths each caused by a biological parent and mother’s partner. One homicide was caused by a sibling of the child, one caused by a stranger, and one was caused by an unknown perpetrator.

**Figure 37: Homicide Deaths By Perpetrator**

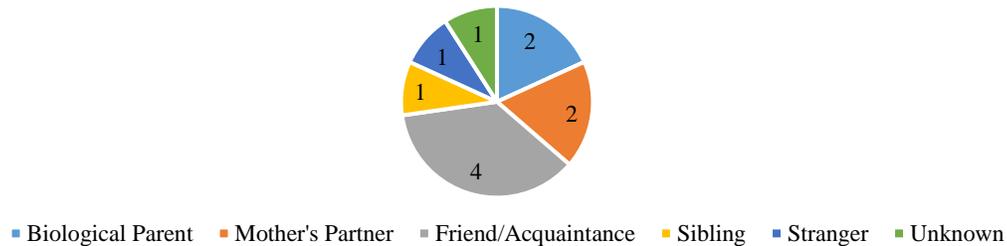
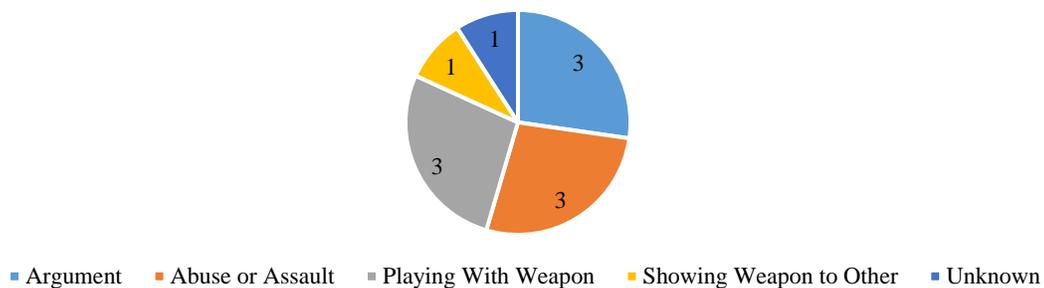


Figure 38 shows the activity at the time of or immediately prior to the homicide taking place. There were three homicides each in the categories of argument, abuse, or assault, and playing with the weapon. There was one death in which the weapon used was being shown to others. There was one death in which the activity at the time of or immediately prior to the homicide was unknown.

**Figure 38: Activity at Time of Homicide**



**Recommendations Based on 2016 Data Review**

*Note: Due to the retrospective nature of the CFRP, some of the recommendations listed may already be in the implementation process at time of report dissemination.*

**Infant Deaths**

1. Recommend expanding the current Safe Sleep Campaign to include an emphasis on always keeping the child in their own crib, alone, and on their backs. Increase education to parents, providers, and social service providers so anyone around an infant knows the current safe sleep information. Ensure that the hazards associated with co-sleeping are well known. Also, make it a point to let parents know an infant death CAN happen even if they only plan to co-sleep one time. Expand information to be provided as part of training by DHHR’s Birth to Three to include special needs children and the importance of not co-sleeping. Make sure that safe sleep messaging is adapted for teens parents as well.
2. Recommend a ban on the sale of bumper pads in the state.

3. Recommend enactment of felony legislation for anyone who causes the death of their child while under the influence of substances. This could be verified by requiring an instant drug screen to all parents during the child death scene investigation.
4. Recommend medical professionals order further testing in instances when an infant does not meet developmental milestones to rule out possible abuse as opposed to waiting to see if the issue corrects itself.

#### Substance Use Disorder (SUD)

1. Recommend changing the current CPS screening policy on drugs to include drugs that are prescribed to the parent if levels are found to be above the therapeutic range.
2. Recommend changing the current CPS policy so a baby does not have to be a neonatal abstinence syndrome (NAS) baby to have a case opened. Any positive drug screen should result in an intake. Don't allow drug exposed infants to go home with parents still using drugs.
3. Recommend initiation of a requirement for hospitals to notify CPS when a child is born to a mother who has had a positive drug screen, and that hospitals are aware of pregnant women with a history of drug abuse.
4. Recommend expanding programs meant to support mothers while treating them for drug abuse. Included in this program should be help with parenting skills as well as training for CPS workers to be more aware of substances parents are prescribed for treatment and how they affect them.
5. Recommend reinforcing the importance of prenatal care to expectant mothers. Include in the education the importance of abstaining from drug, tobacco, and alcohol use during pregnancy. Reinforce the dangers of using these substances during pregnancy.
6. Recommend instituting provider education to school personnel on overdose and the trauma caused to the children who witness it. Make sure there is full utilization and expansion of the Handle with Care Program.
7. Recommend increasing the number of drug treatment facilities available for youth. Additionally, provide a program to work with families while the child is in treatment, so the child is not returning to a dysfunctional family. Make sure appropriate therapy is provided.
8. Recommend implementation of additional plans on disposal of medications found in the homes.
9. Recommend that parents be charged criminally the first time they are found to be providing drugs to their child or using substances with their child.

#### Automobile Safety

1. Recommend increasing safe driving education within school systems for children which would include seatbelt safety and the importance of always using a seatbelt.
2. Recommend creating an updated safe driving video including the newer hazards that face teen drivers. Include real-life stories to make the video feel more relatable for teens.
3. Recommend increasing car seat education programs to make sure parents know the correct size for the child, proper installation, and proper placement in the car.
4. Recommend the Don't Drink and Drive Campaign be expanded to Driving Under the Influence, which would also include substance abuse.
5. Recommend increasing awareness for parents about installing applications on their child's phone to prevent texting while driving.

#### Suicide Prevention

1. Recommend increasing the amount of child suicide prevention education. Suicide prevention in school systems needs to increase to include fact sheets on what to look for regarding child suicide risk. This should be available to everyone, especially parents, educators, and anyone who is in close contact with children.

2. Recommend implementation and/or expansion of an anti-bullying campaign. This needs to include providing support against the stigma/bias against LGBTQ persons.
3. Recommend increasing education on symptoms of depression and drug use, which are correlated with suicide risk.
4. Recommend increasing training for parent monitoring of social media. Make sure that everyone is aware that any suicidal ideation should be reported to a trusted adult. Promote the available options so parents can help their child seek therapy or therapeutic medication.
5. Recommend a campaign on educating adults on the importance of preventing unsupervised access to means of committing suicide. This includes education on methods of ensuring that guns are safely stored in a locked area and unloaded.
6. Recommend a statute that allows emergency department personnel to report the names of suicide attempt victims to Prevent Suicide WV so that victim and family support services could be offered.
7. Recommend giving licensed physicians the ability to call in a child advocate to help commit a child for psychiatric evaluation in instances where the parents do not consent.
8. Recommend that schools be required to provide supportive follow up to student body and personnel when a child completes suicide.

#### Fire Safety

1. Recommend increasing fire safety prevention and education to school-aged children.
2. Recommend a campaign to make the public aware of the free smoke detectors that are available through the West Virginia Fire Marshal and American Red Cross.
3. Recommend educating the public on the importance of purchasing only electrical appliances, especially heaters, that contain an Underwriters Laboratories "UL" label.

#### Water Safety

1. Recommend a water safety campaign enhancing the message to parents and other adults regarding leaving children unattended near water, including the bathtub.
2. Recommend program to increase awareness of the importance of using life vests. Also, advise children that if they do not know how to swim, they should not horseplay around the water.
3. Recommend that all pools in the state have lifeguard stands that are elevated for visibility purposes.
4. Recommend teaching the importance of placing locks above child's height when barring access to a pool.

#### ATV/Motorcycle Safety

1. Recommend an amendment of the current laws to add side-by-sides to the laws regarding ATVs.
2. Recommend increased dissemination of information on the importance of wearing a helmet and not driving on paved roads. Include information on how to check for proper helmet size for a child.
3. Recommend a required license for an ATV and a required operator's course and make stricter age limits. Hold parents responsible for children operating ATVs and utility task vehicles (UTVs).

#### Hunting Safety

1. Recommend additional hunting education campaigns and ensure campaigns are created to reach the target population.
2. Recommend reviewing and strengthening laws regarding gun purchases for children and increasing education on the importance of keeping guns in a locked safe.

### CPS Recommendations

1. Recommend a shift to make CPS behavioral-based instead of compliance-based because compliance does not guarantee changed behavior.
2. Recommend creation of a poster project to remind providers of their mandated reporting status.
3. Recommend changing the intake process to ensure that multiple people look at an incident report as it comes in instead of leaving it up to one person. The more eyes that see the incident, the more likely it is that a case will not be overlooked.
4. Recommend improving the practice of screening in/out referrals. Possibly implement a rule that on the third referral, a case is opened for investigation.
5. Recommend CPS assessment of every household with an infant under one year old that is investigated.

### Miscellaneous

1. Recommend creating a campaign to teach CPR to all parents before they leave the hospital.
2. Recommend expanding services of free counseling/bereavement counseling to those in need after the death of a child.
3. Recommend linking the Child Abuse Registry, DHHR's Office of Vital Statistics, and health care provider information to ensure that if there is a pregnancy in someone known to be a child abuse offender, all are notified to watch for the baby to be born and notify CPS.
4. Recommend that an incident report be filed by law enforcement when attending a child death scene.
5. Recommend a statute that homeschooled children be regularly monitored by professionals to prevent abuse.
6. Recommend a requirement that all family court placements have background checks.
7. Recommend a public service announcement for "Camp Good Grief" and other grief programs for children so that grieving children can get the help they need following the loss of a loved one.
8. Recommend uniform use of Skylar's Law (re: Amber Alert System) throughout the entire state.
9. Recommend that law enforcement treat all child death investigations as if they were homicide investigations.
10. Recommend a campaign to make sure that mothers with type 1 diabetes are aware of the dangers of breastfeeding and hypoglycemia.

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# DOMESTIC VIOLENCE FATALITY REVIEW PANEL

## **Overview**

The West Virginia Domestic Violence Fatality Review Panel (DVFRP), a part of the FMRT, is a statutory body enabled by the West Virginia Legislature under W. Va. Code §61-12A-1. Panel coordination and staff services are housed in DHHR's Office of the Chief Medical Examiner (OCME). The DVFRP is responsible for reviewing facts and circumstances surrounding all deaths that occurred in West Virginia of victims or suspected victims of domestic violence, including suicides, for those 18 years of age or older.

The DVFRP is required to provide statistical data and analysis concerning the causes of domestic violence fatalities in West Virginia, promote public awareness of the incidence and causes of domestic violence fatalities, as well as include recommendations for their reduction. The fundamental objective of the DVFRP is to prevent future homicides and suicides by providing necessary tools to families, individuals, and appropriate agencies. DVFRP recommendations are intended to protect victims and hold perpetrators accountable for their crime to reduce the number of domestic violence related deaths occurring in the state.

## **Membership**

According to law, the DVFRP operates under the auspices of the OCME, with the State Chief Medical Examiner acting as the chair of the panel. The coordinator is housed within that office as well. Other mandated members of the panel include:

- Four prosecuting attorneys or their designees;
- State Superintendent of the West Virginia State Police or his/her designee;
- One county law enforcement official;
- One municipality police officer;
- One physician, resident, or nurse practitioner specializing in the practice of family medicine or emergency medicine;
- One physician, resident, or nurse practitioner specializing in the practice of obstetrics and gynecology;
- One adult protective service worker currently employed in investigating reports of adult abuse or neglect;
- One social worker who may be employed in medical social work;
- Commissioner of DHHR's Bureau for Behavioral Health or his/her designee;
- Commissioner of DHHR's Bureau for Social Services or his/her designee;
- One domestic violence advocate from a licensed domestic violence program;
- A representative of the West Virginia Coalition Against Domestic Violence;
- Commissioner of the West Virginia Division of Corrections and Rehabilitation or his/her designee; and
- Director of Office of Epidemiology and Prevention Services in DHHR's Bureau for Public Health or his/her designee.

## **Types of Deaths Reviewed**

The DVFRP reviews cases where the manner of death is classified by the OCME as homicide, suicide, undetermined, or accident. The majority of cases the panel reviews falls into the following categories:

- Homicide committed by current or former intimate partner, current or former roommate, or family member following an act of domestic violence, sexual violence, or stalking, with or without a prior domestic violence history;
- Homicide of perpetrator following an act of domestic violence, sexual violence, or stalking incident to include those caused by officer-involved shootings or bystander intervention;
- Suicide committed by a victim following an act of domestic violence, sexual violence, or stalking; and
- Suicide committed by a perpetrator following an act of domestic violence, sexual violence, or stalking.

### **Case Review Process**

Initial screening of all fatalities is completed by the OCME to determine if they meet the definition for domestic violence. OCME investigators, pathologists and the Fatality and Mortality Review Program (FMRP) Coordinator review all potential cases and make a determination of the domestic violence status based on information available at the time the case is first presented to the OCME. With this method of determination, it is possible some domestic violence cases may be overlooked as vital information is missing at the time of the initial review. In an attempt to identify domestic violence issues, an internet search is performed on West Virginia homicides and undetermined deaths, which sometimes results in the identification of additional domestic violence incidents.

The FMRP Coordinator maintains a running list of all identified domestic violence fatalities which is reviewed by the entire DVFRP. The panel only reviews closed cases and does not attempt to reopen the investigation of those deaths. Closed cases are considered those where the offender is dead, has been convicted in a death, or there is a determination of no further legal action. Consequently, most cases are reviewed approximately two years following the actual event. Case reviews are conducted in confidential meetings. All panel members and invited guests are required to sign an agreement to abide by the confidentiality standards specified in the FMRT statutes.

Prior to case review by the DVFRP, a request for records is sent to all agencies identified as having relevant information. Collected information typically includes demographic information, autopsy reports, criminal and civil court histories of the victim and offender, other known history of intimate partner violence, media reports, information regarding the use of legal or advocacy services, and the details of the incident including those occurring both prior to and following the death.

DVFRP members present a summary of the information collected for each case reviewed during the monthly meeting. This is followed by a panel discussion, which aims to address the following matters for each incident:

- Was the fatality the result of a domestic incident as defined by the state statute?
- What were the perilous events that led up to the fatality?
- Were there any opportunities to prevent the fatality?
- Is training or education needed as it relates to specific areas or occupations?
- How does the incident relate to other reviewed incidents?
- Are there policies relevant to the incident that need to be reviewed or changed?
- Are there lessons or educational messages to be derived from this incident?

As part of the review, the DVFRP identifies which systems, if any, the victim and/or the offender had contact with prior to, during, or after the death. This information helps the panel identify

possible recommendations for improvement to system responses to domestic violence. This method of constructing system recommendations does not in any way have the intention to place blame on any individual or organization. To further support this prerogative, recommendations made throughout the year are assembled and presented as wide-ranging proposals for systemic improvements as opposed to case specific ones. It is with optimism that the panel believes that these recommendations can be used to improve system responses across an array of agencies and service providers to reduce or eliminate domestic violence deaths in West Virginia.

## **Findings**

For 2015, there were 146 possible domestic violence cases identified for panel review. After the panel completed review of those cases, 87 were determined to be deaths resulting from domestic violence.

The National Coalition Against Domestic Violence (NCADV) defines domestic violence as the willful intimidation, physical assault, battery, sexual assault, and/or other abusive behavior as part of a systematic pattern of power and control perpetuated by one intimate partner against another [1]. This violence could include behaviors such as stalking, intimidation, threats, physical violence, sexual violence, emotional abuse, psychological abuse, or economic deprivation [1]. The DVFRP does not limit the definition of domestic violence to intimate partners only. The definition includes family members as well as roommates sharing a dwelling.

## **Demographics**

In 2015, a majority of the domestic violence deaths reviewed by the panel were males. Figure 1 shows the percentage of deaths that were male compared to the percentage of deaths that were female. Of the deaths reviewed, 54 of the 87 were males while 33 of the 87 were females. Data for West Virginia differ from what is generally seen nationally as current data show a higher rate of males. Nationally, the NCADV shows that on average one in three women and one in four men have been abused by an intimate partner [1].

**Figure 1: Domestic Violence Deaths By Sex**

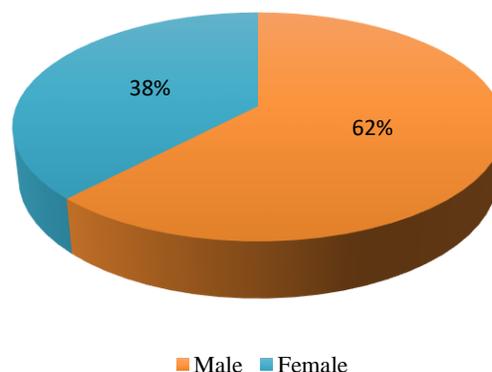


Figure 2 shows the domestic violence deaths by age. Age groups used were 10-year increments. The ages of domestic violence victims in West Virginia ranged from the youngest being 19 years old to the oldest being 87 years old. The 40- to 49-year-old age category had the most deaths recorded for 2015. It is important to note that all deaths occurred in Caucasian individuals.

**Figure 2: Deaths By Age Group**

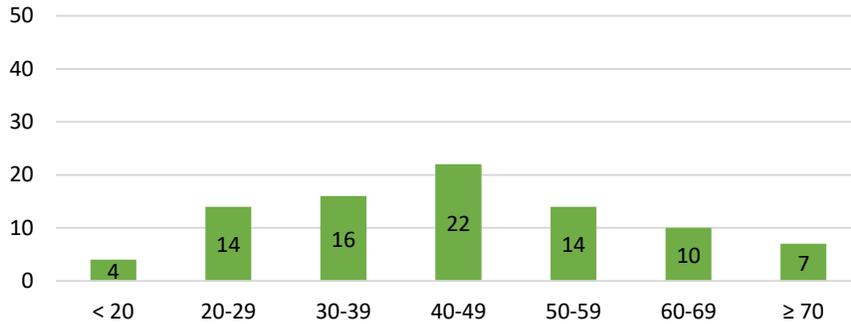
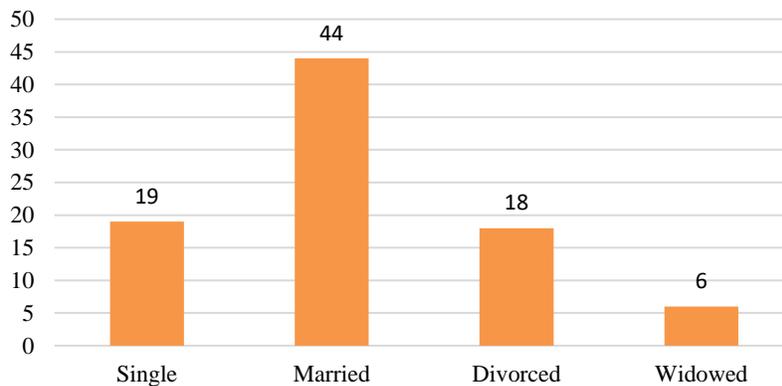


Figure 3 shows deaths distributed by marital status. It is important to note that a marital status of single denotes that the individuals were not married at the time of death but could have been in a relationship. This information shows that a majority of the reviewed deaths (50%) were among married couples. This was followed by single (22%) and divorced (21%) individuals who died as a result of domestic violence. Widowed individuals (7%) were the least likely to die from domestic violence-related deaths. There were 13 of 44 married deaths that occurred in individuals who were recently separated or in the process of a divorce. For all other marital status categories, there were eight individuals who were planning to break up or going through a recent break up at the time of their death. National data states that women are most vulnerable to violence when separated from their intimate partner or during divorce [2].

**Figure 3: Deaths By Marital Status**



### **Manner of Death**

Manner of death is broken into four categories: accident, suicide, homicide, and undetermined. Figure 4 shows that most of the domestic violence deaths that were reviewed in West Virginia in 2015 were suicides. Forty-five of the 87 reviewed deaths, or 52%, were determined to be suicides. This was followed closely by homicides at 37% with 32 reviewed deaths falling within that category. There were eight deaths (9%) that were ruled as undetermined. Two of the deaths (2%) were determined to be natural; however, the natural disease processes were exacerbated by neglect and therefore included.

**Figure 4: Deaths By Manner**

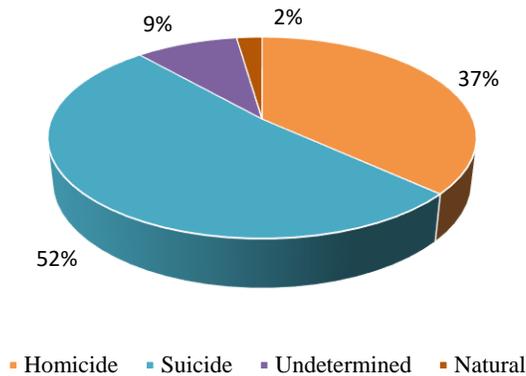
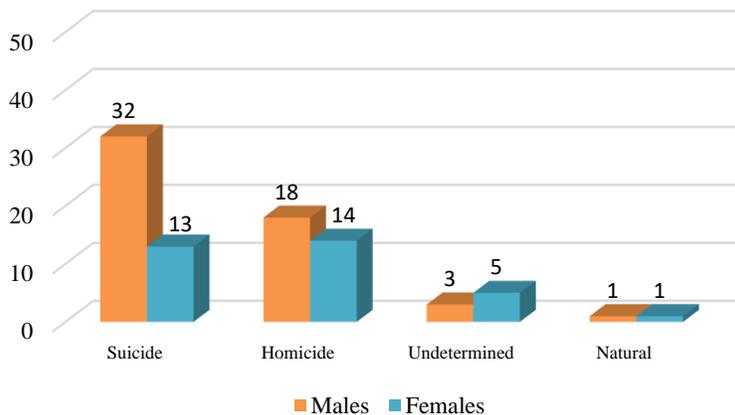


Figure 5 shows the manner of death by gender. The data show that males are most likely to commit suicide when related to domestic violence deaths. Male suicides were about 2.5 times as likely as females and accounted for 71% or 32 reviewed suicide deaths. Female suicides accounted for 29% or 13 of the deaths reviewed. The number of homicide deaths were similar between the two sexes. Male homicides accounted for 56% or 18 deaths and female homicides accounted for 44% or 14 deaths. Females accounted for a majority of undetermined deaths. There were three males (37.5%) and five females (62.5%). Overall, the natural deaths were the least likely to occur as there were only two deaths determined to be of natural causes and one was male, and one was female.

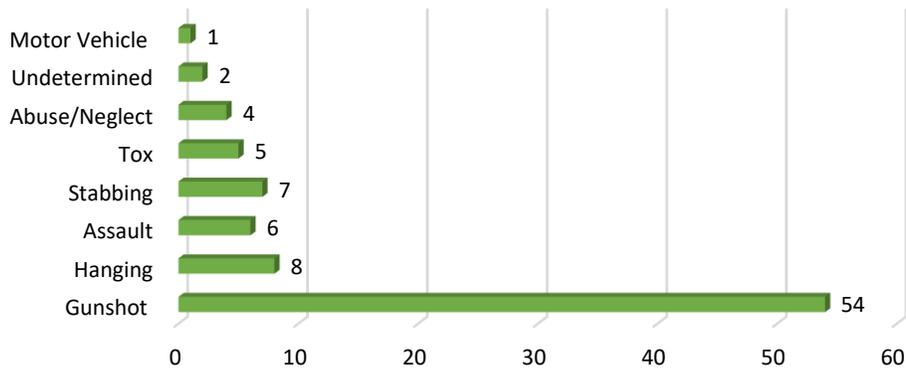
**Figure 5: Manner of Death By Sex**



**Cause of Death**

Within each manner of death, there are subdivisions termed causes which give a more detailed explanation as to why the death occurred. There were eight causes for reviewed domestic violence-related deaths that occurred in West Virginia in 2015, as seen in Figure 6. The most prevalent cause of death was gunshot wounds, which accounted for 54 of the 87 reviewed deaths. Statistics from the NCADV state that the presence of a gun in domestic violence situations increases the risk of homicide by 500% [1].

**Figure 6: Cause of Death**



**Distribution of Deaths for Various Categories**

Figure 7 shows the domestic violence related deaths that occurred in West Virginia in 2015 by county of residence. The counties included in the figure have three or more deaths. Most deaths occurred in Kanawha County with 13 reported deaths, followed by Mercer County, which had five. Counties that had four reported deaths each are Berkeley, Marion, and Raleigh. Counties that had three reported deaths each are Fayette, Greenbrier, Harrison, Preston, Summers, and Wood. Boone, Braxton, Brooke, Hampshire, Logan, Mingo, Monongalia, Monroe, and Pocahontas all had two deaths. The counties that had one death reported were Barbour, Cabell, Clay, Hardy, Jackson, Jefferson, Lewis, Marshall, Mason, McDowell, Morgan, Nicholas, Putnam, Randolph, Roane, Wayne, and Wyoming. The remaining 18 counties did not have any reported domestic violence related deaths in 2015. These numbers are raw numbers for the reported deaths per county and did not take into account the population size of each county.

**Figure 7: Number of Deaths Per County**

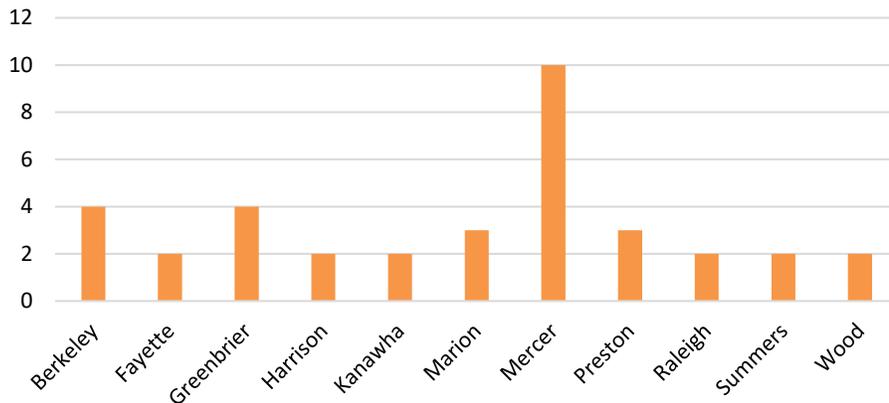


Figure 8 shows the number of domestic violence deaths in which there was a known domestic violence history between the perpetrator and the victim. This shows that 36%, or 31 of the 87 deaths reviewed, had a prior domestic violence history. There were 64%, or 56 of 87 reviewed deaths, with no known or reported domestic violence history.

**Figure 8: History of Domestic Violence**

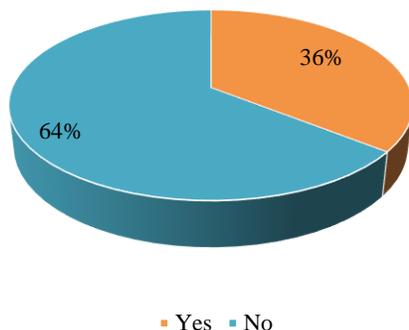


Figure 9 shows the number of victims who had an active domestic violence protection order against their significant other or the perpetrator at the time of their death. This number includes three suicides in which the current or former partner had a domestic violence petition (DVP) against the individual completing suicide.

**Figure 9: Active DVP at Time of Death**

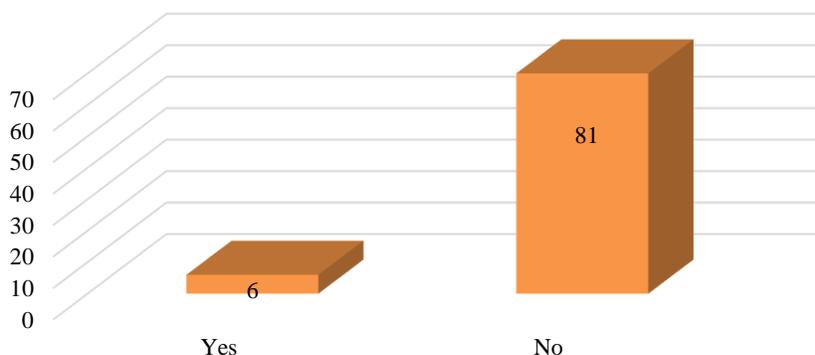
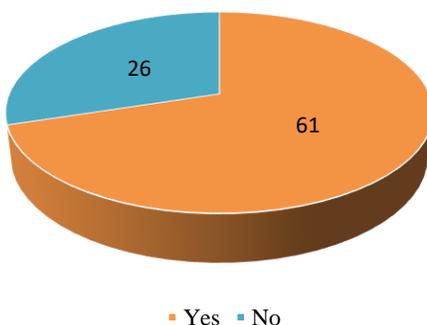


Figure 10 shows the number of people who were involved in an argument or fight prior to their death. For 2015, 61 of the 87 people were known to have an argument at the time immediately preceding their death.

**Figure 10: Involved In Argument Prior To Death**



Another possible correlation is the number of domestic violence related decedents who were known to have a mental illness. Figure 11 shows that 34 of the 87 reviewed deaths, had diagnosed mental health issues. Mental illnesses identified ranged from depression, anxiety, post-traumatic stress disorder (PTSD), to bipolar disorder.

**Figure 11: Victim Had Mental Health Issues**

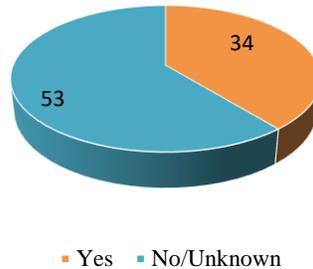


Figure 12 shows the substance abuse status of the domestic violence decedents. A little more than half, or 45 people, were not known to use either drugs or alcohol at any time prior to their deaths. There were 23 people who were known to use only alcohol, 16 people used only drugs, and three people were known to use both alcohol and drugs. The drugs ranged from prescribed medications to illegal substances such as heroin, methamphetamine, and cocaine.

**Figure 12: Known Substance Abuse History**

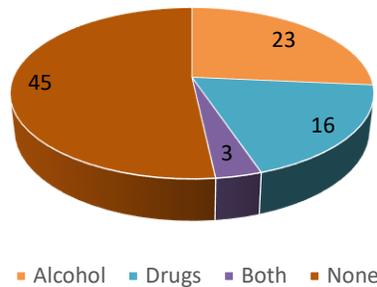
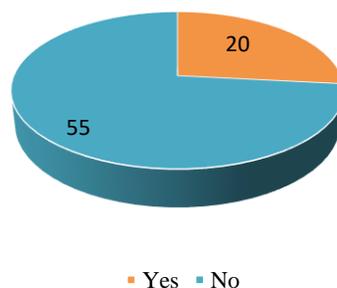


Figure 13 shows a very important statistic related to domestic violence related fatalities. The figure shows the number of deaths that had children present. About 18% of the deaths had children present at the time of the fatal incident. Sixteen of the 87 deaths reviewed had at least one child present. This is a major issue, as research has shown that children who experience childhood trauma, including domestic violence, are at a greater risk of tobacco use, substance abuse, obesity, cancer, heart disease, depression, and unintended pregnancy [3].

**Figure 13: Child Present at Time of Death**



## **Data Limitations**

Domestic violence fatalities reviewed by the DVFRP were determined to meet the definition of domestic violence set forth in the W. Va. Code. Some fatalities reviewed may have had elements of domestic violence identified in the victims' lives, but it could not be determined that domestic violence was directly linked to the cause of death. This accounts for the discrepancy between the 146 cases reviewed and the 87 cases determined to be domestic violence deaths as a result of review.

## **2015 DVFRP Recommendations**

*Note: Due to the retrospective nature of the DVFRP, some of the recommendations listed may already be in the implementation process at time of report dissemination.*

1. The DVFRP recommends a centralized coordinator who would work to ensure that law enforcement response is consistent and conducted in accordance with West Virginia laws and Legislative rules. This includes one office to be established to coordinate the response statewide. This would be an office that could communicate and collaborate with all the systems and disciplines by employing a person(s) who would coordinate training and best practices based on the best examples from around the state and across the nation. By creating a collaborative environment that includes the West Virginia Coalition Against Domestic Violence, the West Virginia Foundation for Rape Information Services, the DVFRP, all STOP Teams, all Sexual Assault Response Teams, and Title IX offices, a victim could expect the same comprehensive response anywhere in West Virginia.
2. The DVFRP recommends that a representative from the West Virginia Department of Veterans Affairs be added to the panel to participate in reviews. The panel believes that this would help with gathering information about past military service of perpetrators and victims.
3. The DVFRP recommends that it be granted access to the Domestic Violence Offender Registry as it would help the panel gather more information on victims and perpetrators.
4. The DVFRP recommends an updated domestic violence awareness campaign, which would include exploitation of the elderly.
5. The DVFRP recommends the implementation of lethality training for the regional jails. The panel believes that this would allow intervention to be made at a point that could potentially save a life.
6. The DVFRP recommends increasing training for law enforcement in order to increase awareness of domestic violence and elder abuse. The panel believes that law enforcement generally views domestic violence as being between intimate partners but that is only a portion of the actual domestic violence cases.
7. The DVFRP recommends continuation and expansion of the Kanawha County Pilot Project with the magistrate court where one judge handles all cases of a domestic violence offender. This allows the judge to see the entire history of the offender and make sure that sentences are appropriate to the crimes committed.
8. The DVFRP recommends that prosecuting attorneys include no access to firearms as a standard condition of bond. The panel believes that the limitation of access to firearms for offenders could potentially reduce the number of firearm related deaths.
9. The DVFRP recommends that more services be offered to families of victims. This would include access to scene cleanup as well as grief counseling free of charge. The panel believes that there are a limited number of these types of services currently available in the state.
10. The DVFRP recommends that a change be made to current Adult Protective Services policies to include contacting law enforcement when there is a reasonable suspicion of abuse, neglect, or exploitation even in cases that are not substantiated during their assessment.
11. The DVFRP recommends expanding "Mental Health First Aid" to help first responders and other bystanders to identify, understand, and respond to signs of mental illnesses or

substance abuse disorders. It would give individuals the skills needed to reach out and provide initial help and support to someone in need and possibly help save lives.

12. The DVFRP recommends strengthening law enforcement training regarding calls for checking on the welfare of individuals to make sure they look more in-depth at the scene and screen for possible domestic violence issues to assure investigation occurs as opposed to taking the word of an individual that “everything is fine.”
13. The DVFRP recommends creating a public service announcement about reaching out for help if someone is threatening suicide or harm to themselves or others.
14. The DVFRP recommends increasing the number of child exchange centers available as well as increasing the usage of such services in domestic violence situations.
15. The DVFRP recommends no domestic violence charge should be dismissed based solely on the fact that the victim does not show up to court. This includes making sure that prosecutors ask for continuation in domestic violence protective order cases as opposed to dropping charges. This could involve training to law enforcement and all court personnel to have understanding and empathy for the victim while understanding that it is harder to leave as well as safer not to leave in some cases. This could be integrated into Dangerousness and Lethality Assessment training. Also, making sure that the lethality assessment is fully utilized and included in police reports along with all prior domestic violence history. There should be training given to anyone using the lethality assessment to make sure that they are using trauma informed interview techniques.
16. The DVFRP recommends expanding the Buddy-to-Buddy volunteer veteran’s program. This would allow more veterans to reach out for help if needed as well as give other veterans the opportunity to volunteer their time to help a fellow in need.
17. The DVFRP recommends making the domestic violence registry public to allow the public access to search individuals convicted of such crimes much like is available with pedophiles.

## **References**

1. National Coalition Against Domestic Violence. Domestic Violence National Statistics. Accessed online at: [www.ncadv.org](http://www.ncadv.org)
2. Callie Marie Rennison (1101). Intimate Partner Violence and Age of Victim, 1993-1999. Bureau of Justice Statistics Special Report. Washington DC: U.S. Department of Justice. NCJ #187635. Estimates are provided from the National Crime Victimization Survey, which defines an intimate partner as a current or former spouse, girlfriend, or boyfriend. Violent acts include murder, rape, sexual assault, robbery, aggravated assault, and simple assault.
3. Felitti, V.J., et al. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The Adverse Childhood Experiences (ACE) Study. American Journal of Preventative Medicine, 14(4): 248-58. Centers for Disease Control and Prevention and the Kaiser Permanente’s Health Appraisal Clinic, San Diego, CA. Available at <http://www.cdc.gov/NCCDPHP/ACE/index.htm>.

# INFANT AND MATERNAL MORTALITY REVIEW PANEL

## **Overview**

The Legislature found that there was a need for a process to study the causes of infant and maternal deaths. Comprehensive studies indicate that these mortalities are more complex than they initially appear on death certificates and believe that more extensive studies will enable development of a plan to reduce these deaths in the future. Thus, an additional multi-year report was added by legislation passed in 2020, now codified at W. Va. Code §61-12A-2.

The Infant and Maternal Mortality Review process is a method of understanding the diverse factors and issues that contribute to preventable deaths and identifying and implementing interventions to address these problems. The knowledge gained from the reviews may be used to enhance services, influence public health policy, and direct planning efforts intended to lower mortality rates.

## **Responsibilities of the Infant and Maternal Mortality Review Panel (IMMRP)**

The responsibilities of the IMMRP are as follows: (1) identify infant and maternal death cases; (2) review medical records and other relevant data; (3) determine preventability of deaths; (4) establish trends, patterns and risk factors and develop recommendations for the prevention of infant and maternal deaths; (5) provide statistical analysis regarding the causes of infant and maternal fatalities; (6) disseminate findings and make recommendations to policymakers, health care providers and facilities; and (7) promote public awareness of the incidence and causes of infant and maternal fatalities, including recommendations for their reduction.

The IMMRP submits an annual report to the FMRT and the West Virginia Legislature concerning its activities and the incidence of infant and maternal fatalities within West Virginia. The report is to include statistics setting forth the number of infant and maternal fatalities, identifiable trends in infant and maternal fatalities in the state, including possible causes, if any, and recommendations to reduce the number of preventable infant and maternal fatalities in the state.

## **Definitions**

**Infant Death:** Death of a live born infant in the first year of life.

**Infant Mortality Rate:** Number of infant deaths divided by the number of live births (rate reported per 1,000).

**Live Birth:** The complete expulsion or extraction from its mother of a product of human conception, irrespective of the duration of pregnancy, which, after such expulsion or extraction, breathes or shows any evidence of life such as beating of the heart, pulsation of the umbilical cord or definite movement of voluntary muscles, whether or not the umbilical cord has been cut or the placenta is attached.

**Maternal Death:** Death of a woman during pregnancy, at the time of birth or within one year of the birth of a child from any cause related to or aggravated by pregnancy or its management, but not from accidental or incidental causes.

In 1986, the CDC and the American College of Obstetricians and Gynecologists (ACOG) collaborated to issue a statement recommending the use of two enhanced surveillance definitions

as an approach to identify deaths more accurately among women in which pregnancy was a contributing factor.

**Pregnancy-Associated Death (ACOG/CDC):** The death of a woman while pregnant or within one year of termination of pregnancy, irrespective of cause.

**Pregnancy-Related Death (ACOG/CDC):** The death of a woman while pregnant or within one year of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by her pregnancy or its management, but not from accidental or incidental causes.

Pregnancy-related deaths are caused by:

- Complications of the pregnancy itself
- Chain of events initiated by the pregnancy
- Aggravation of an unrelated condition or event by the physiologic effects of pregnancy

**Pregnancy-Related Maternal Mortality Rate:** Number of maternal deaths related to or aggravated by pregnancy divided by the number of live births (rate reported per 100,000).

**Review:** The process by which all facts and circumstances about a deceased infant who has died in the first year of life or a woman who has died during pregnancy, at the time of birth, or within one year of giving birth, are known, and discussed among members of the IMMRP.

**Unexpected Death:** The death of an infant who has died in the first year of life; or, a woman who has died during pregnancy, at the time of birth or within one year of the birth of a child, whose immediate death is not anticipated.

**Unexplained Death:** The cause and manner of death of an infant who has died in the first year of life; or, a woman who has died during pregnancy, at the time of birth or within one year of the birth of a child, that cannot be determined after an autopsy and thorough investigation of the circumstances surrounding the death.

### **Case Identification of Maternal Deaths**

Maternal deaths are identified by linking death certificates for women aged 10-50 years with birth certificates and fetal death certificates. Additional maternal deaths are identified by ICD 10 diagnostic codes O00–O99 – pregnancy, childbirth and the puerperium. All maternal deaths occurring within 365 days of pregnancy conclusion are designated as pregnancy-associated and further investigated.

Cases for review are limited to women of childbearing age who were residents of West Virginia at the time of their death. West Virginia residents who died in other jurisdictions are counted in the DHHR's official West Virginia Health Statistics Center reports, but they are included in the case reviews only when additional information is available due to the difficulty in obtaining records across jurisdictions.

A Nurse Reviewer reviews death and birth certificates for all pregnancy-associated deaths. Once cases are identified as potentially pregnancy-related, medical records are obtained from all health care facilities providing care before, during and after the pregnancy conclusion. Hospital records at the time of death and autopsy reports are included when applicable. Medical records are de-identified, and a summary of events is developed. These documents are sent to all members

prior to the meeting. Information is entered into a CDC database known as the Maternal Mortality Review Information Application (MMRIA, or “Maria”). MMRIA is a standardized data collection tool to assist in understanding the causes of maternal mortality and eliminating preventable pregnancy-related deaths.

The IMMRP reviews all pregnancy-associated deaths to determine if they are pregnancy-related. The Panel determines whether the maternal death was preventable, possibly preventable, or not preventable. Opportunities for prevention and recommendations are determined through IMMRP discussion.

### **Case Identification of Infant Deaths**

Infant deaths are identified by linking birth and death certificates for infants in the first year of life. Due to perinatal influences of the mother’s health and maternal risk factors, maternal medical information obtained during pregnancy is also reviewed.

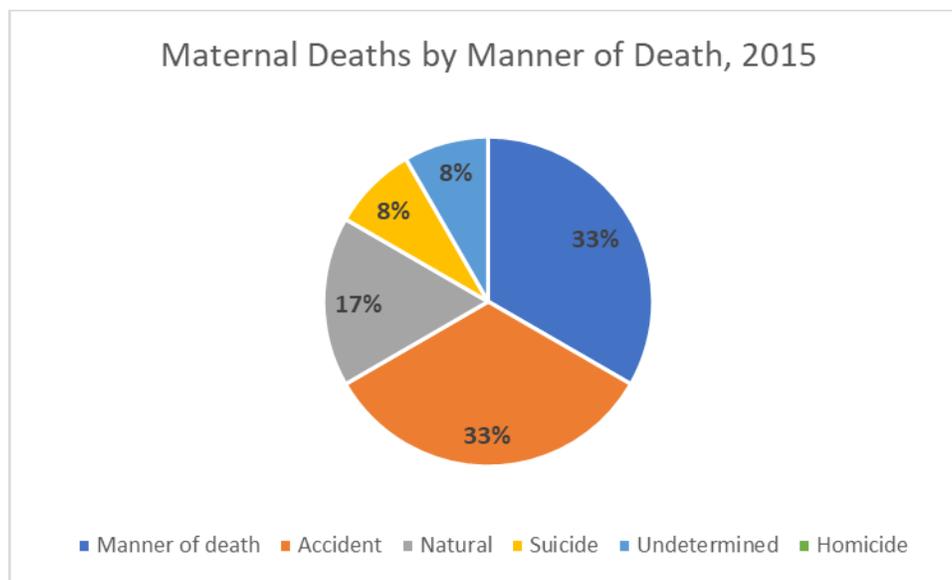
Case reviews are limited to live born infants who were residents of West Virginia at the time of their death. Infants who died in other jurisdictions are counted in DHHR’s official West Virginia Health Statistic Center reports but are only included in case reviews when additional information is available due to the difficulty in obtaining records from other jurisdictions.

## **Maternal Deaths 2015**

### **Manner of Death**

In 2015, there were 12 pregnancy-associated maternal deaths of which three were determined to be pregnancy-related. The manner of death was listed as: four (33%) accident, four (33%) natural, two (17%) suicide, one (8%) homicide, and one (8%) undetermined death.

The rate of pregnancy-related maternal mortality in 2015 was 15.2 per 100,000 (calculated as three maternal deaths divided by 19,788 residence births – based upon 2015 DHHR – West Virginia Health Statistics Center data.

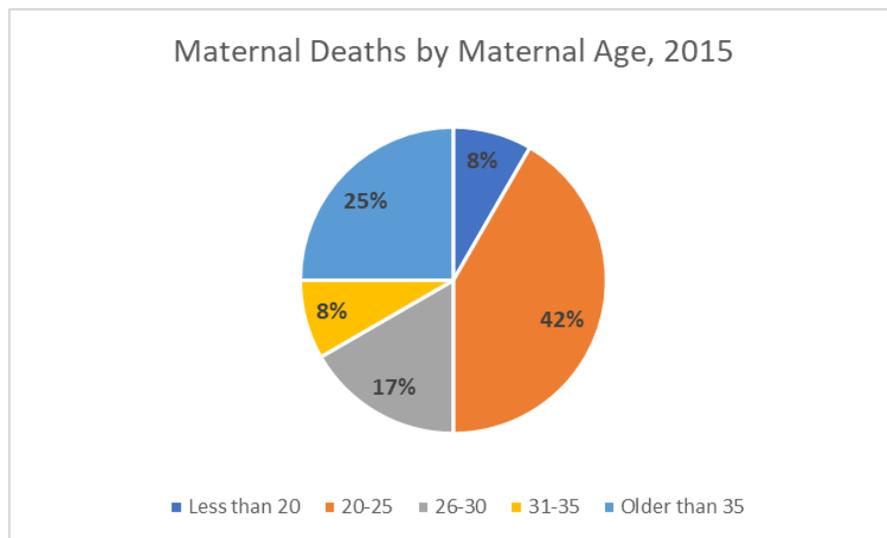


### **Cause of Death**

In 2015, there were 12 pregnancy-associated maternal deaths. Drug abuse was the cause of four deaths. Four deaths were natural with causes of spontaneous brain stem hemorrhage, septic shock due to septic pulmonary emboli as a consequence of presumed infective endocarditis, methicillin resistant staphylococcus aureus sepsis due to infection endocarditis and complications of pre-eclampsia with acute fatty liver. Two deaths were the result of asphyxia due to hanging. One death was the result of a gunshot wound by homicide. The remaining death was undetermined.

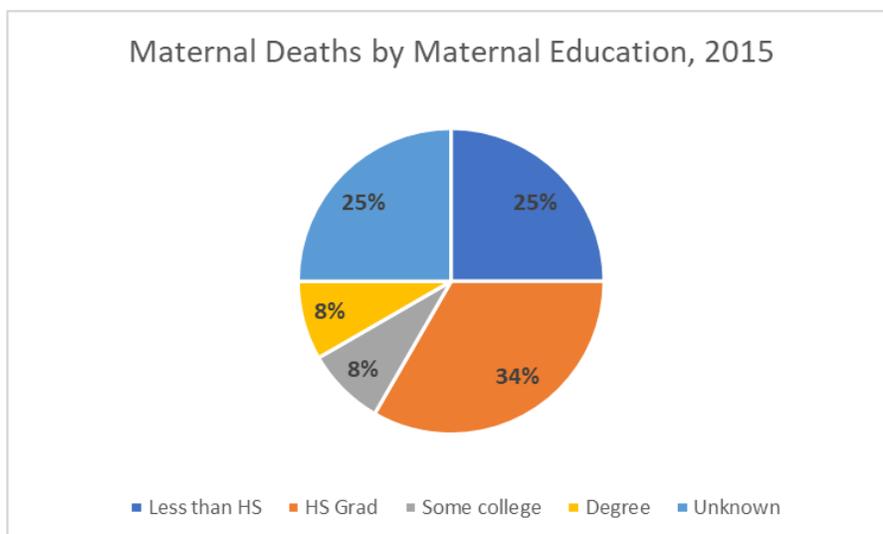
### **Maternal Age**

In 2015, of the 12 pregnancy-associated maternal deaths, one was less than 20 years of age, five were 20-25 years of age, two were 26-30 years of age, one was 31-35 years of age, and three were older than 35 years of age.



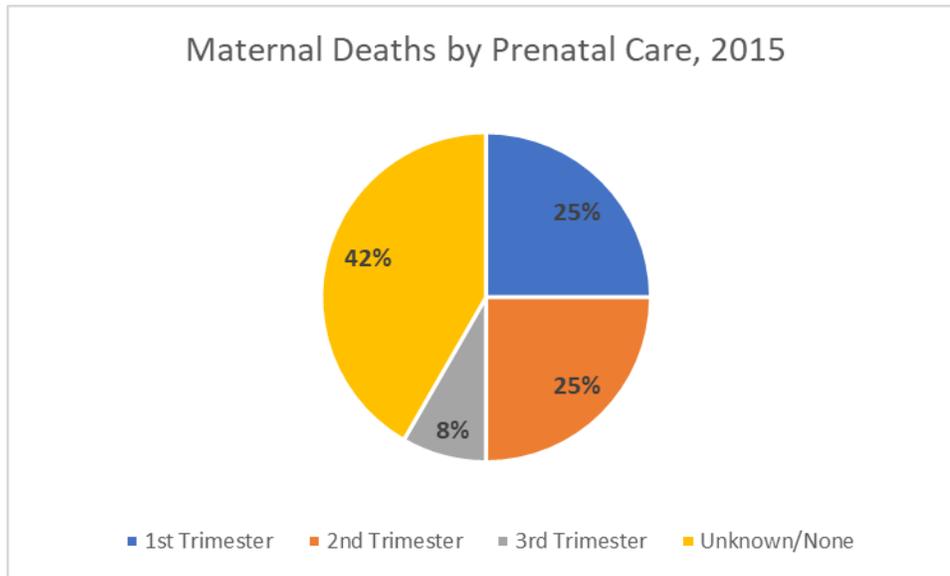
### **Maternal Education**

In 2015, of the 12 pregnancy-associated maternal deaths, three had less than a high school education, four had at least a 12th grade education, one had some college, one had a college degree, and for three education was unknown.



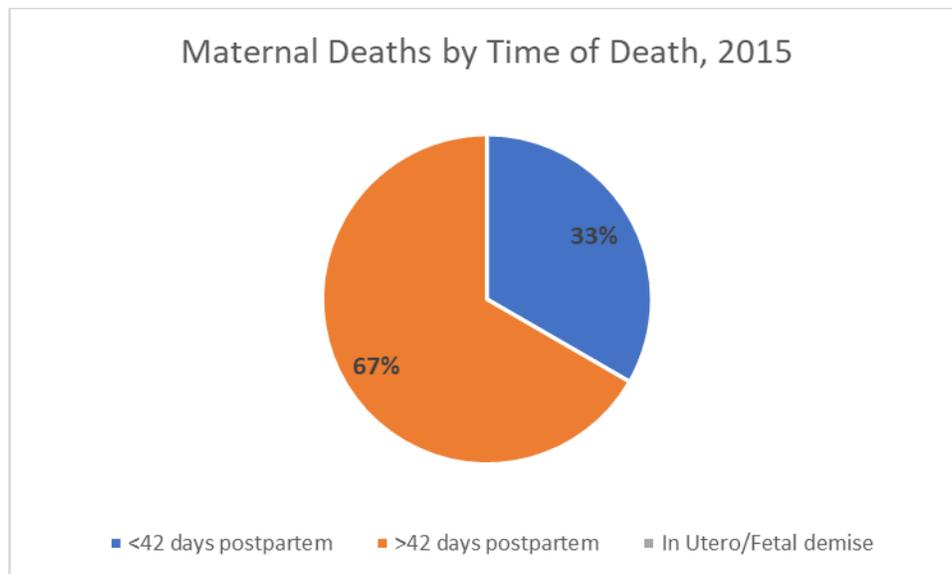
### **Maternal Prenatal Care**

In 2015, of the 12 pregnancy-associated maternal deaths, three began prenatal care in the first trimester, three began prenatal care during the second trimester, one began prenatal care during the third trimester, and five had unknown prenatal care.



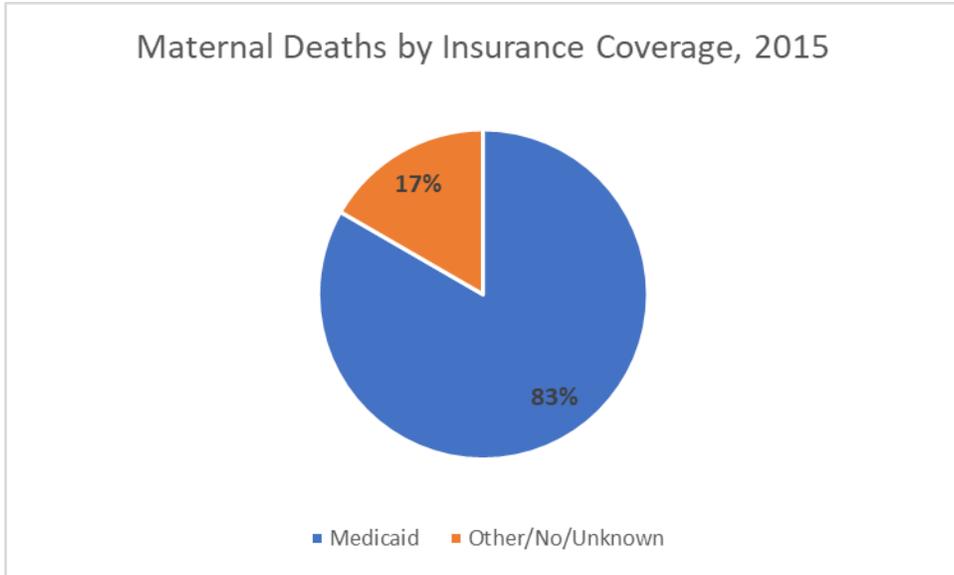
### **Time of Death**

In 2015, of the 12 pregnancy-associated maternal deaths four deaths, of which three were pregnancy-related, occurred less than 42 days postpartum, and eight deaths occurred greater than 42 days postpartum.



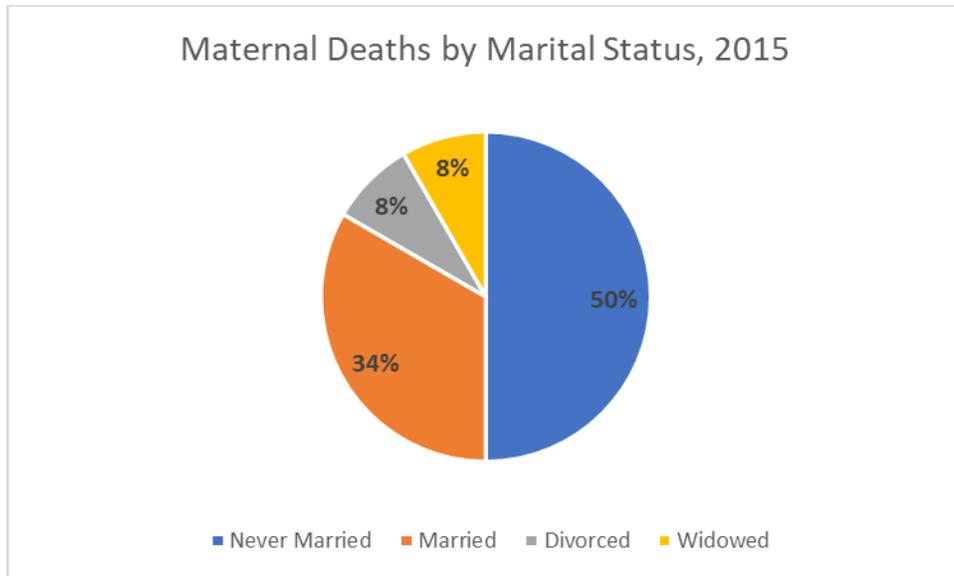
**Maternal Insurance Coverage**

In 2015, Medicaid was the primary insurance coverage for ten of the 12 pregnancy-associated maternal deaths, two deaths were either covered by other insurance or had no/unknown insurance coverage.



**Maternal Marital Status**

In 2015, six of the 12 maternal deaths had never been married, four were married, one was divorced, and one was widowed.



## **Recommendations to Date: Maternal Deaths**

*Note: Due to the retrospective nature of the IMMRP, some of the recommendations listed may already be in the implementation process at time of report dissemination.*

After review of cases, the following recommendations have been made by the IMMRP:

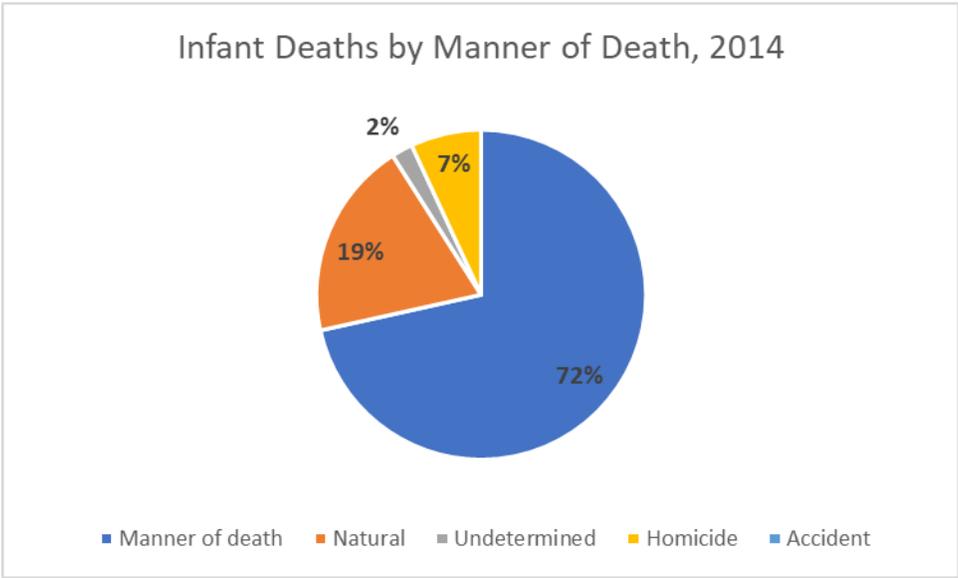
- Education to be provided on the use of vacuum delivery.
- All Maternal Mortality cases be referred to DHHR's Office of the Chief Medical Examiner (OCME) for determination regarding the need for an autopsy.
- Promote screening for postpartum depression prior to maternal discharge from hospital.
- Posters to promote screening and help for postpartum depression.
- Identify and/or promote drug treatment programs in jails; promote seamless referral system for continued treatment for continued treatment post-incarceration.
- Assess if West Virginia prisons provide substance use disorder (SUD) treatment on site.
- Identify and promote available drug treatment/mental health services.
- Review hospitals' criteria for admission of individuals with suicidal ideations (direct admits).
- Additional law enforcement investigation of maternal deaths due to suspected overdoses.
- Add Narcan to the Medicaid Pharmacy Formulary for pregnant women and during postpartum for up to one year after the delivery period.
- Developing a tool to educate on sex during pregnancy.
- Consider offering long-acting reversible contraception (LARC) at all medication-assisted treatment (MAT) offices for easy accessibility to decrease pregnancy in unstable patients. Improve the system to help postpartum mothers get LARC with minimal barriers.
- Provide options for infant and maternal cases to be received in hard copy or electronic versions.
- DHHR's State Health Officer and Commissioner for the Bureau for Public Health to recommend the IMMRP laws be modified to permit cases be identifiable and additional details be shared with IMMRP members.
- IMMRP members receive cases in advance of meeting to have adequate time to review cases and be able to indicate specific cases they would like to discuss by sending an email.
- Obtain out-of-state records for infants who are delivered or expired out of state and mothers who expired out-of-state.
- Request the Governor advocate with out-of-state governmental entities to commit to improved inter-jurisdictional data sharing.

## **Infant Deaths 2014**

### **Manner of Death**

For calendar year 2014, 144 infant deaths were reviewed by the IMMRP. The manner of death was listed as: 103 (72%) natural, 28 (19%) undetermined, three (2%) homicide, and ten (7%) accident.

The infant mortality rate for West Virginia in 2014 was 7.1 infant deaths per 1,000 live births (calculated as 144 infant deaths by 20,303 resident births - 2014 DHHR – West Virginia Health Statistics Center data). In 2014, the CDC reported the U.S. infant mortality rate as 5.7 infant deaths per 1,000 live births.

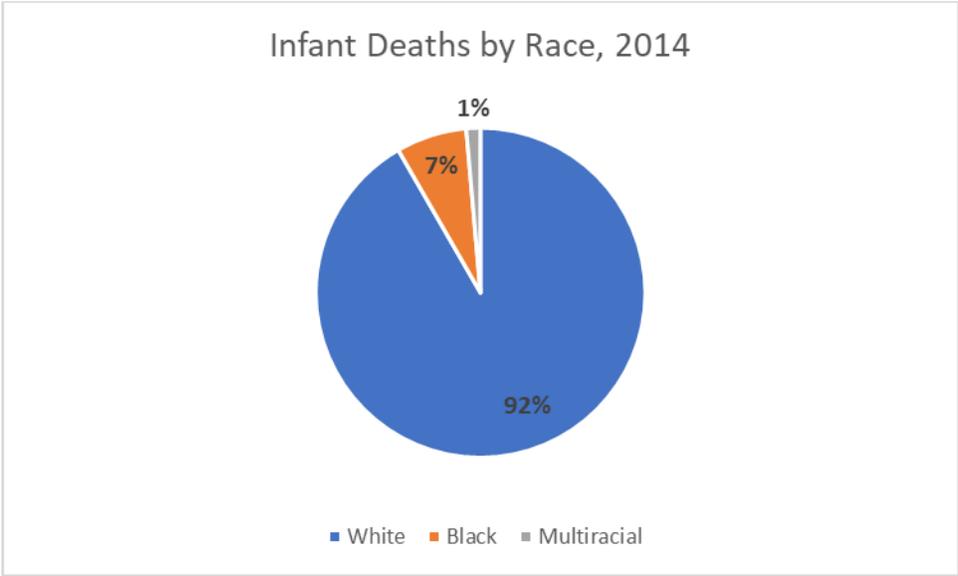


**Cause of Death**

In 2014, of the 144 infant deaths, 48 deaths were due to prematurity, 31 deaths were due to birth defects, 35 deaths were due to Sudden Unexplained Infant Deaths (SUID), 23 deaths were medical related, two were due to accidents, three were due to homicide, and the remaining two deaths were either unknown, no information, undetermined or pending.

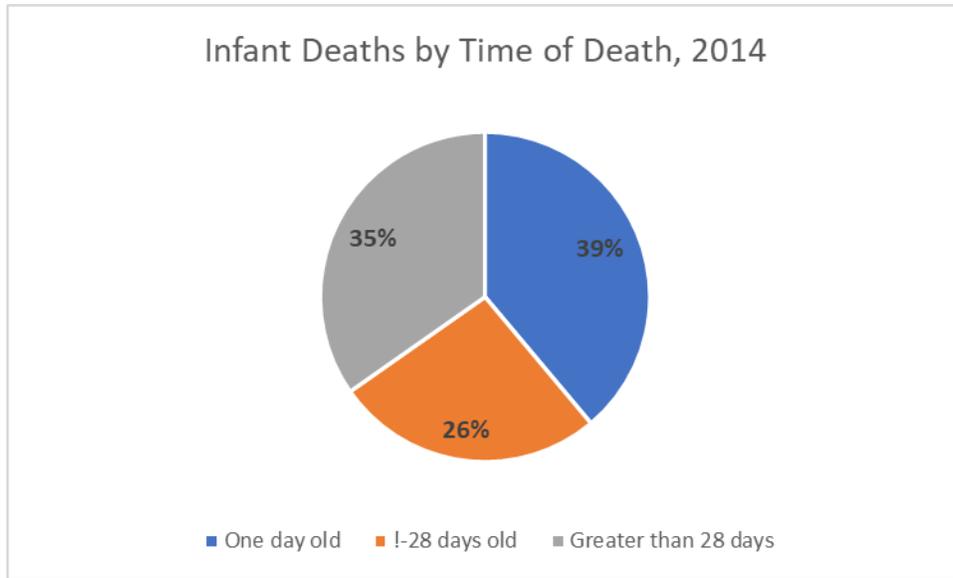
**Infant Race**

In 2014, 132 of the 144 deaths were white, ten were black, and two were multiracial.



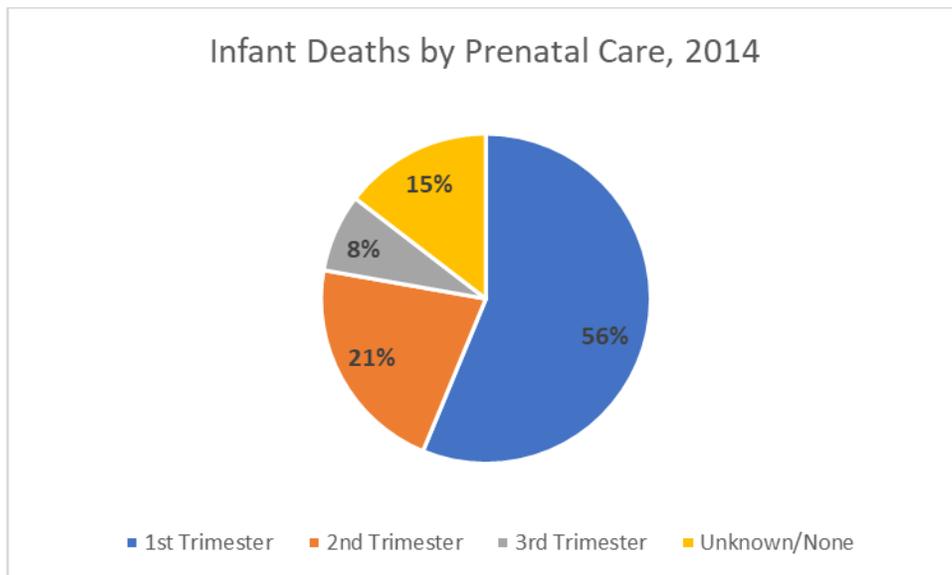
**Infant Age at Time of Death**

In 2014, 56 of the 144 deaths were less than one day old, 38 were 1-28 days old, and 50 were greater than 28 days old.



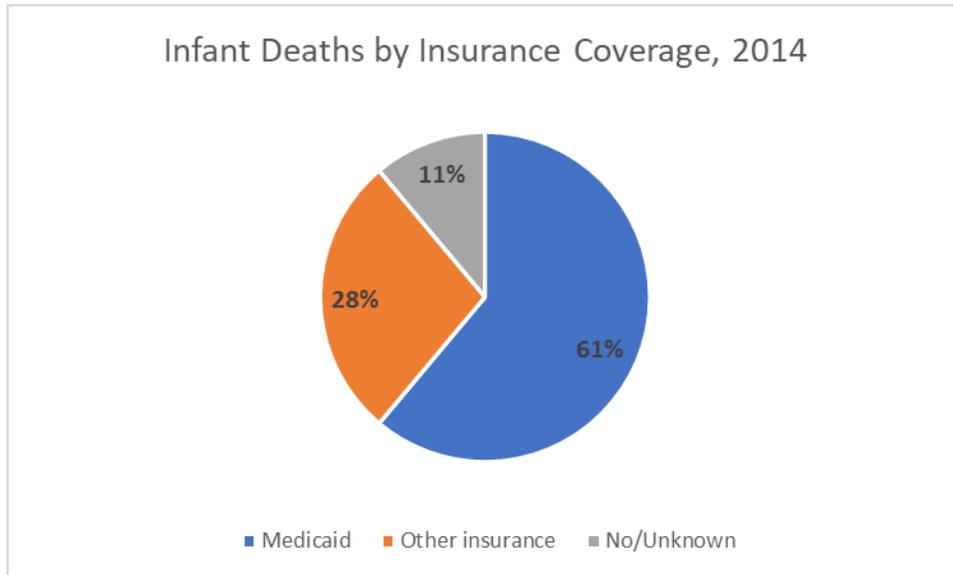
**Maternal Prenatal Care**

In 2014, 81 of the 144 infant deaths began prenatal care in the first trimester, 31 began prenatal care during the second trimester, 11 began prenatal care in the third trimester, nine had no prenatal care, and the remaining 12 had unknown prenatal care.



## **Insurance Coverage**

In 2014, Medicaid was the primary medical coverage in 88 of the 144 infant deaths while 40 were covered by other insurance, and 16 deaths had no/unknown insurance coverage.



## **Recommendations to Date: Infant Deaths**

*Note: Due to the retrospective nature of the IMMRP, some of the recommendations listed may already be in the implementation process at time of report dissemination.*

After review of cases, the following recommendations were noted:

- Consult with CPS about changing protocols to keep cases involving mothers that use drugs open and follow-up after the infant is taken home.
- Facilities keep cord tissue for one week after delivery at all West Virginia birthing facilities.
- Drug screening of all infants born in West Virginia.
- All pulse oximetry results will be added to the Birth Score.
- Notify physicians and/or hospitals of infants and mothers who experienced a poor outcome due to medical practice issues or provide education and training to hospital staff.
- Extend invitations to representatives from Level I and Level II birthing hospitals to join the IMMRP.
- Infants with a failed Critical Congenital Heart Disease (CCHD) not be discharged without an echocardiogram or transferred to another hospital that can perform an echocardiogram.
- Policy be developed to refer all preterm labor cases to facilities equipped to handle premature infants.
- Maternal mortality cases be able to request CPS information.
- Educate homeless shelters regarding safe sleeping environments for infants.
- Promotion of safe sleep messaging particularly with fathers and other infant caregivers. Review with pediatricians and obstetrics safe sleep messaging with new/expectant parents.
- Additional training on APGAR scoring and timing of death.
- Public service announcement regarding safe sleep guidelines.

- Training Level I and Level II hospitals on when to call a higher-level bedside neonatal intensive care unit (NICU) support and developing a NICU telehealth program for smaller community hospitals.
- CPS safety plans with safe sleep, in-home teaching.
- Infant is rooming in with mother at facility after delivery, stress safe sleep guidelines, train staff to recognize impaired caretakers to ascertain who may be committing criminal activity on hospital property and empower staff to call security.
- Early intervention in the home for support and education, quick follow-up for concerns of neglect.
- CPS or other early intervention home visit within a week of delivery and close follow-up to assure safety.
- Training for Level I hospital staff, pediatricians and emergency departments on APGARs, intubation, when to call for appropriate transfer to higher level of care for mother or for NICU team to be present for impending birth.
- Follow protocol when suspicious deaths are referred to the DHHR's Medical Examiner so the scene can be visited, and the family interviewed in a timely manner.
- Creating a subcommittee regarding sleep related deaths.
- Proposed Physician Consultant to review infant cases to promote identification of trends and possible interventions to reduce infant mortalities and assist DHHR's Office of Maternal, Child and Family Health.
- Information that mothers receive is explained at the mother's level of understanding in verbal, written, and video formats.
- Provide options for infant and maternal cases to be received in hard copy or electronic versions.
- DHHR's State Health Officer and Commissioner of the Bureau for Public Health to recommend the IMMRP law be modified to permit cases be identifiable and additional details be shared with IMMRP members.
- IMMRP members receive cases in advance of meeting to have adequate time to review cases and be able to indicate specific cases they would like to discuss by sending an email.
- Obtain out-of-state records for infants who are delivered or expired out-of-state and mothers who expired out of state.
- Request the Governor to advocate with out-of-state governmental entities to commit to improved inter-jurisdictional data sharing.

# UNINTENTIONAL PHARMACEUTICAL DRUG OVERDOSE FATALITY REVIEW PANEL

## **Overview**

The Unintentional Pharmaceutical Drug Overdose Fatality Review Panel (UPDORP) is responsible for reviewing and analyzing all deaths occurring within the State of West Virginia where the cause of death was determined to be due to unintentional pharmaceutical drug overdose, specifically excluding the death of persons suffering from a mortal disease or instances where the manner of the overdose death was suicide.

The UPDORP is required to ascertain and document trends, patterns and risk factors related to unintentional pharmaceutical drug overdose fatalities in the state which includes patterns related to the sale and distribution of pharmaceutical prescriptions by those otherwise licensed to provide said prescription. The fundamental objective of the UPDORP is to develop and implement standards for the uniform and consistent reporting of unintentional pharmaceutical drug overdose deaths by law enforcement or other emergency service responders and provide statistical information and analysis regarding the cause of unintentional pharmaceutical drug overdose fatalities.

## **Membership**

According to legislative rule, UPDORP operates under the auspices of DHHR's Office of the Chief Medical Examiner (OCME), with the state Chief Medical Examiner (or designee) acting as the chair of the panel responsible for calling and coordinating all meetings. Other mandated members of the panel include:

- Director of the West Virginia Board of Pharmacy (or designee);
- Commissioner of DHHR's Bureau for Public Health (or designee);
- Director of DHHR's Division of Vital Statistics (or designee);
- Superintendent of the West Virginia State Police (or designee);
- One physician nominated by the West Virginia State Medical Association;
- One registered nurse nominated by the West Virginia Nurses Association;
- One doctor of osteopathy nominated by the West Virginia Society of Osteopathic Medicine;
- One licensed physician or doctor of osteopathy who practices pain management as a principal part of his or her practice;
- One doctor of pharmacy with a background in prescription drug abuse and diversion selected by the West Virginia Pharmacists Association;
- One licensed counselor selected by the West Virginia Association of Alcoholism and Drug Abuse Counselors;
- One representative of the United States Drug Enforcement Administration;
- One prosecuting attorney selected by the West Virginia Prosecuting Attorneys Institute;
- A person who is considered an expert in bioethics training;
- One licensed dentist recommended by the West Virginia Dental Association; and
- Any additional persons the chairperson of the panel determines is needed in the review and consideration of a particular case.

**Findings**

Even though the DVFRP, CFRP and IMMRP have continued to operate within the scope of the law, as of this report, UPDORP has not been activated.