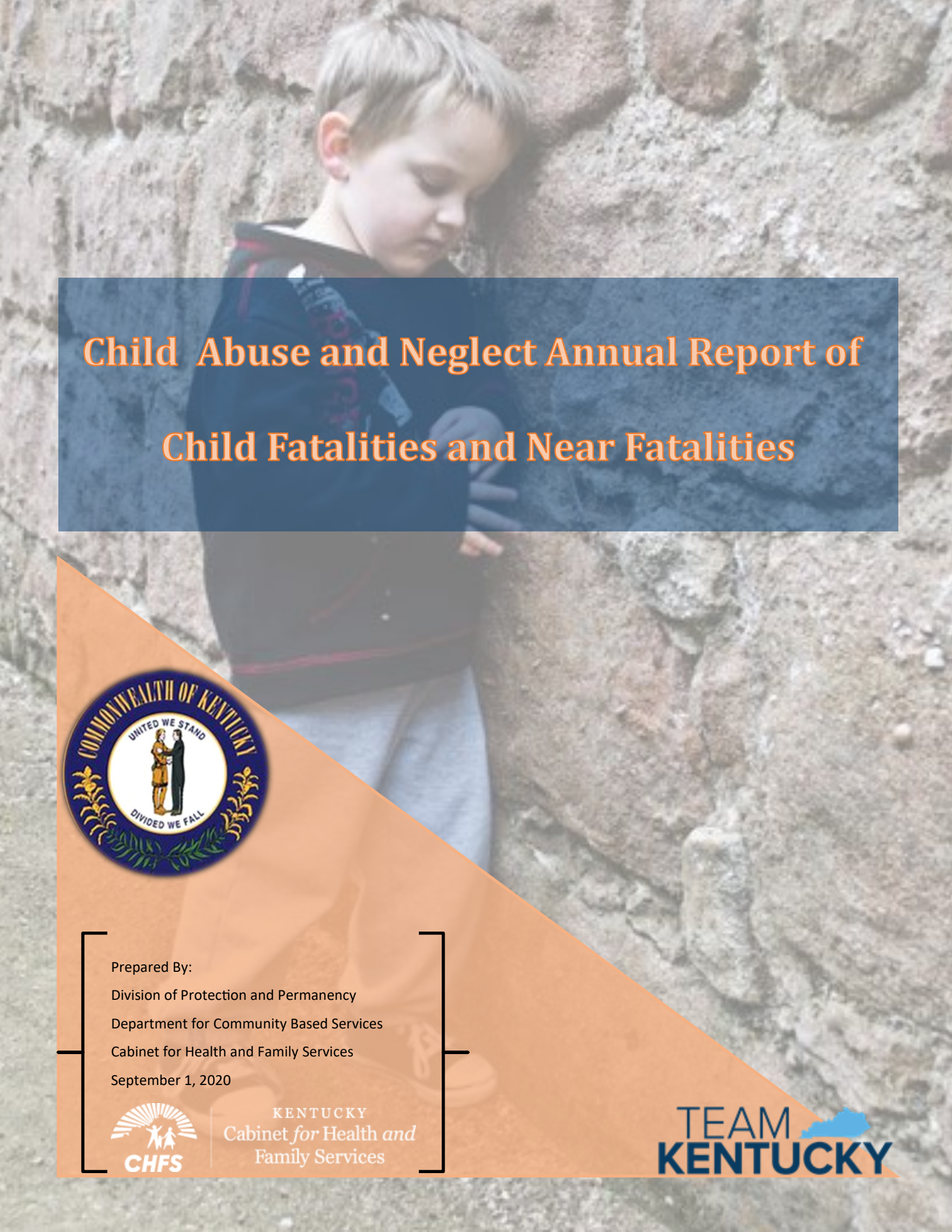


Child Abuse and Neglect Annual Report of Child Fatalities and Near Fatalities

Prepared By:

Division of Protection and Permanency

Department for Community Based Services

Cabinet for Health and Family Services

September 1, 2020

CHFS

KENTUCKY
Cabinet *for* Health *and*
Family Services

TEAM KENTUCKY

Table of Contents

Section I: Comparative Referral Data	3
Section II: Child Demographics	6
Section III: Perpetrator and Maltreatment Demographics	7
Section IV: Prior Involvement with Families of Fatality/Near Fatality(F/NF) Victims	11
Section V: Program Improvement Efforts	13

In accordance with KRS 620.050(12)(c), the Cabinet for Health and Family Services (CHFS/cabinet), Department for Community Based Services (DCBS/ department) submits this annual report of child abuse and neglect fatalities and near fatalities. A near fatality is defined by KRS 600.020(40) as, "an injury that, as certified by a physician, places a child in serious or critical condition." This report provides insights into the demographics of the children who were the victims of abusive or neglectful deaths and near deaths, as well as the circumstances around these events.

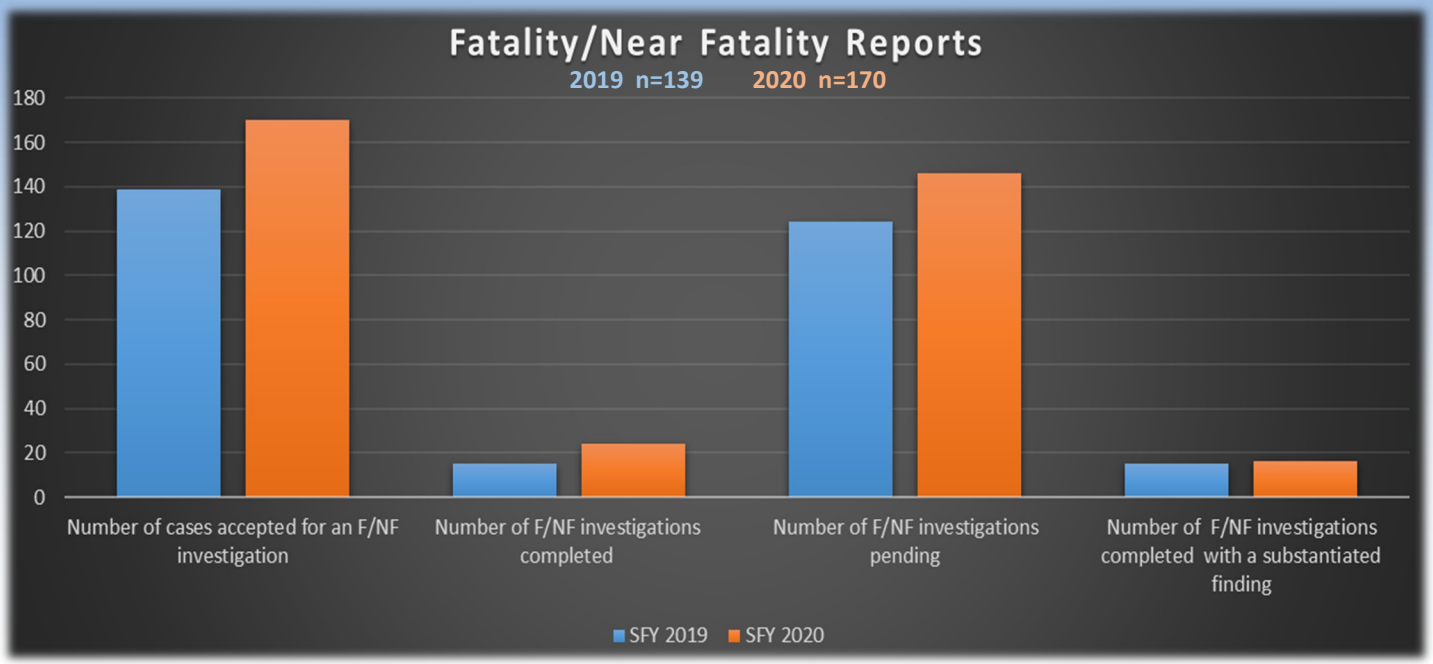
The report is organized into five sections. Historical data in this report spans five state fiscal years and includes only child abuse and neglect fatalities and near fatalities.

"Childhood should be carefree, playing in the sun; not living a nightmare in the darkness of the soul."

-Dave Pelzer, A Child Called "IT"

Section I:

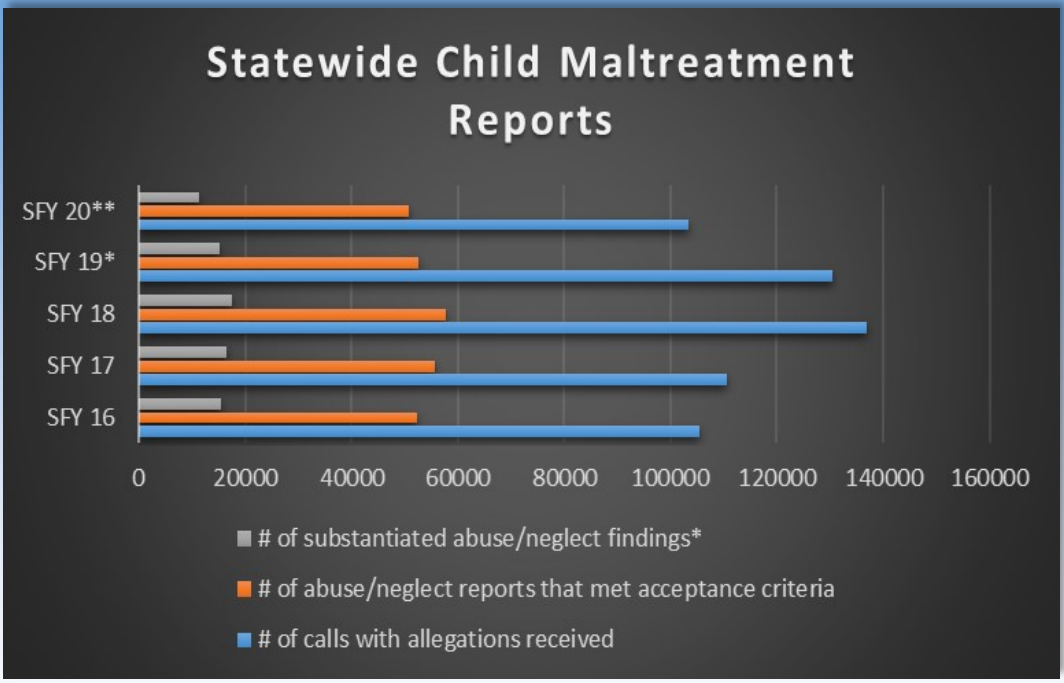
Comparative Referral Data

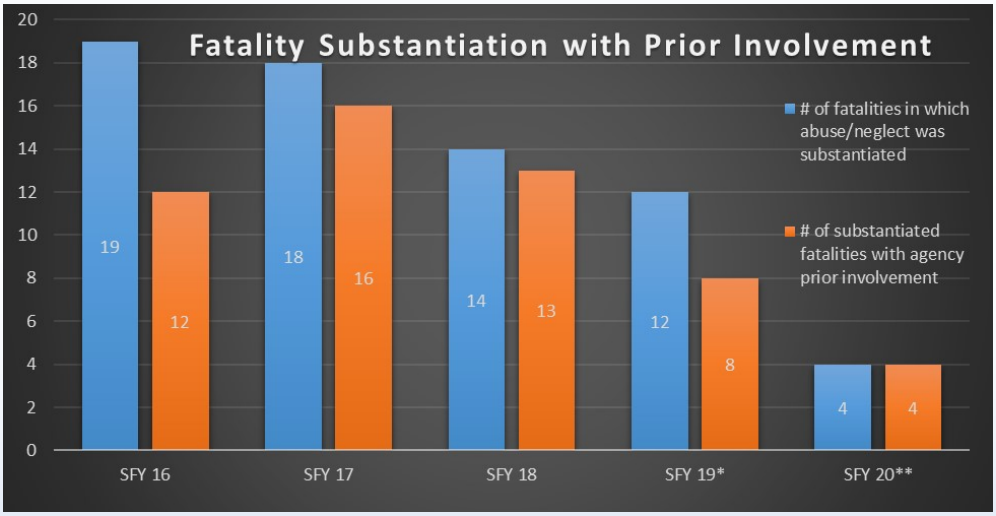


DCBS has seen an 18% percent increase in fatality and near fatality (F/NF) reports in state fiscal year (SFY) 2020 compared to SFY 2019. Despite an increase in reports, there has been a 37% increase in completed investigations for SFY 2020 compared to the previous fiscal year. The graph above illustrates data from all completed investigations at the time of this report. The data indicates no significant increase in the number of substantiated findings. Additionally, there continues to be a large number of pending investigations at the time of this report. The timing of the report submission does not lend itself to a large number of completed reports for the most recent state fiscal year.

The work required in fatality/near fatality investigations is more involved when compared to other types of investigations. These are conducted jointly with law enforcement and require records collection and collaboration with other agencies, such as a forensic medical team and the medical examiners office, in order to reach a finding. This can cause delays in finalizing the investigation.

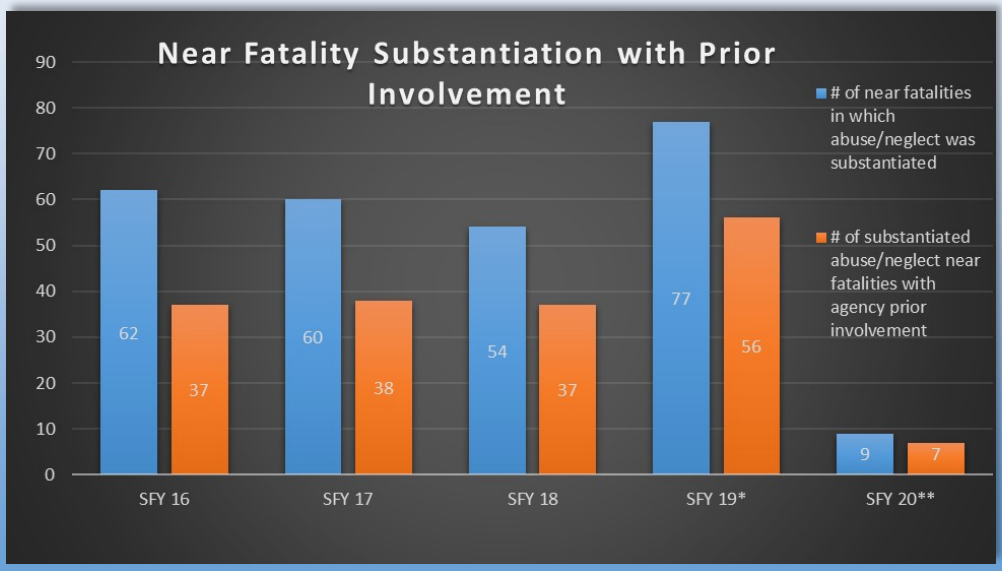
The data indicates a significant increase in total reports received in SFY 18. This increase is reflected in corresponding increases in reports that met acceptance criteria and substantiated referrals in that same time period. However, there was not a corresponding increase in substantiated fatalities and near fatalities during that time period. The total number of reports received have decreased in SFY 19 and 20.





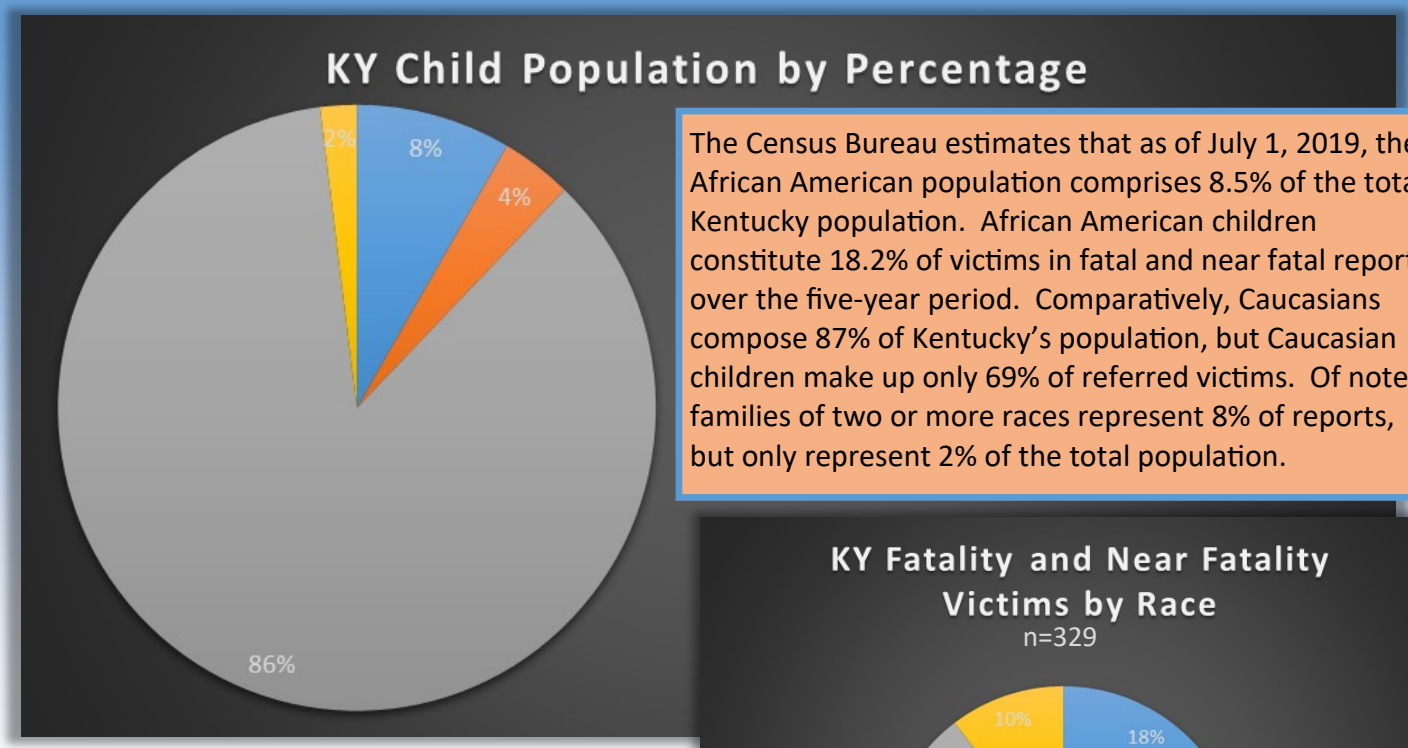
There was an increase in substantiated near fatalities in SFY 19. It is unknown, based on limited data for SFY 20, if this was an aberration specific to SFY 19 or if this is part of a continuing trend. Of significant note, 77% of substantiated fatalities and 64% of substantiated near fatalities over a five-year period have had prior agency involvement. This does not differentiate between the nature of the prior involvement.

(Please see the related information in Section 4.)

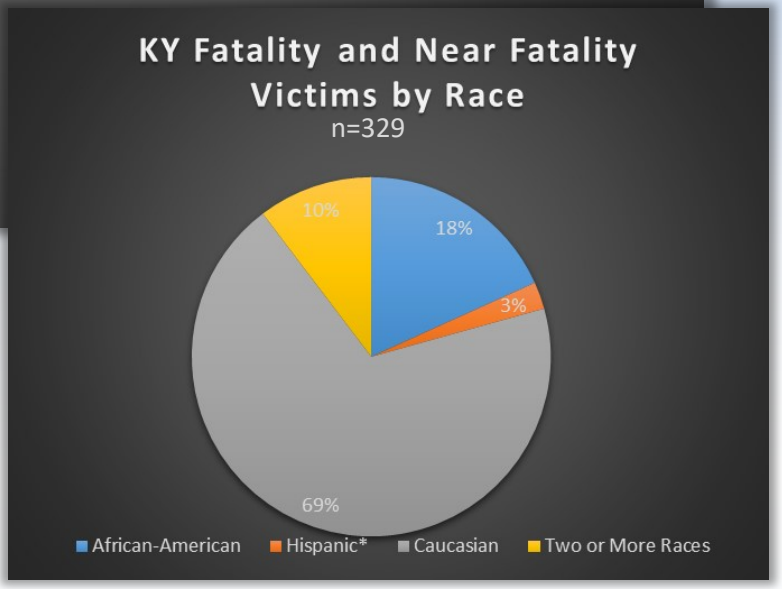


* Indicates adjustment to the number of substantiations from prior year's report due to completed investigations

**Indicates incomplete data for investigations



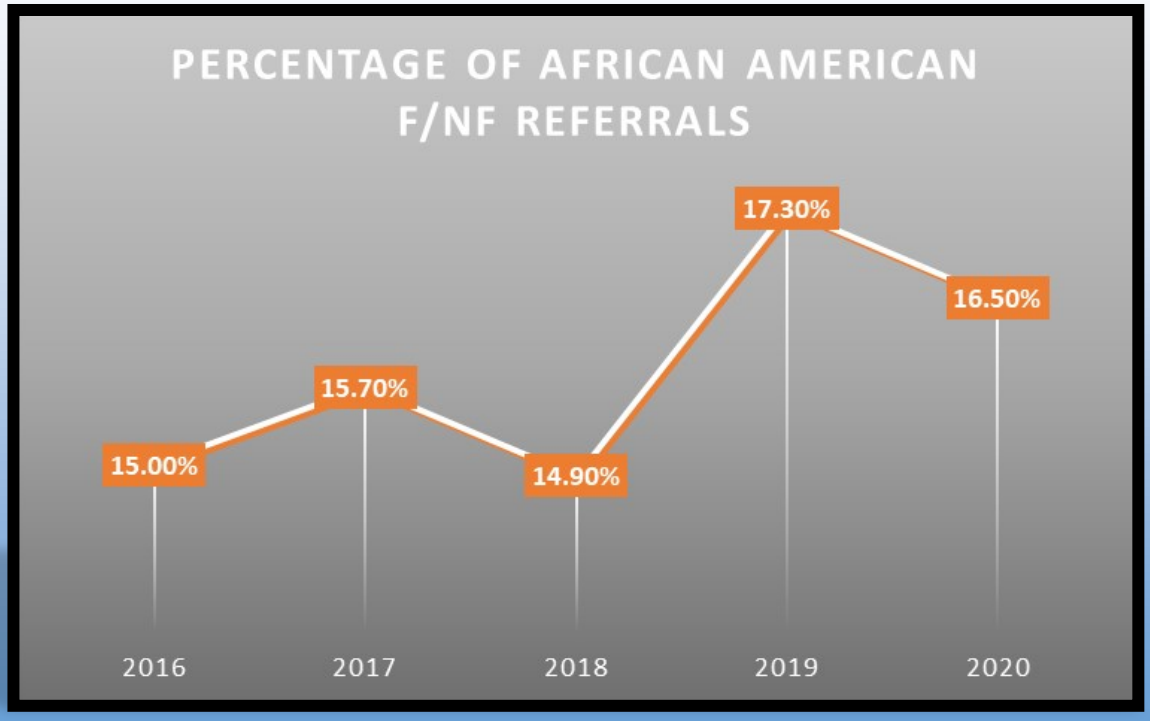
The Census Bureau estimates that as of July 1, 2019, the African American population comprises 8.5% of the total Kentucky population. African American children constitute 18.2% of victims in fatal and near fatal reports over the five-year period. Comparatively, Caucasians compose 87% of Kentucky's population, but Caucasian children make up only 69% of referred victims. Of note, families of two or more races represent 8% of reports, but only represent 2% of the total population.



"Anyone who does anything to help a child is a hero to me."

— Fred Rogers, television personality

The African-American population consistently makes up 15% or greater of all fatal/near fatal reports received annually. The data available does not address other demographic variables, such as residency in urban or rural areas affected by disparities.



Section II:

Child Demographics

Race of Victim by Age

< 1
Caucasian = 31.31%
African American = 9.12%
Bi-racial = 5.47%

1
Caucasian = 9.73%
African American = 2.13%
Bi-racial = 1.82%

2
Caucasian = 7.6%
African American = 2.13%
Bi-racial = 0.91%

3
Caucasian = 6.08%
African American = 1.52%
Bi-racial = 0.91%
Hispanic = 0%

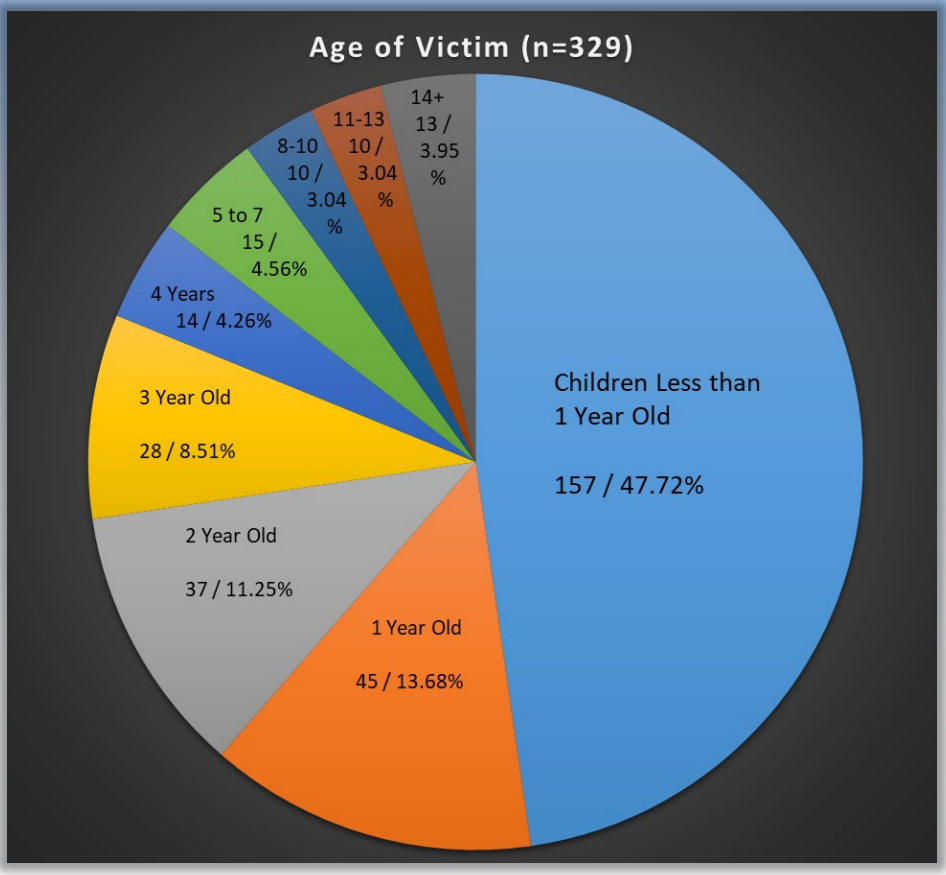
4
Caucasian = 3.34%
African American = 0.91%
Bi-racial = 0%

5-7
Caucasian = 3.04%
African American = 1.22%
Bi-racial = 0.30%

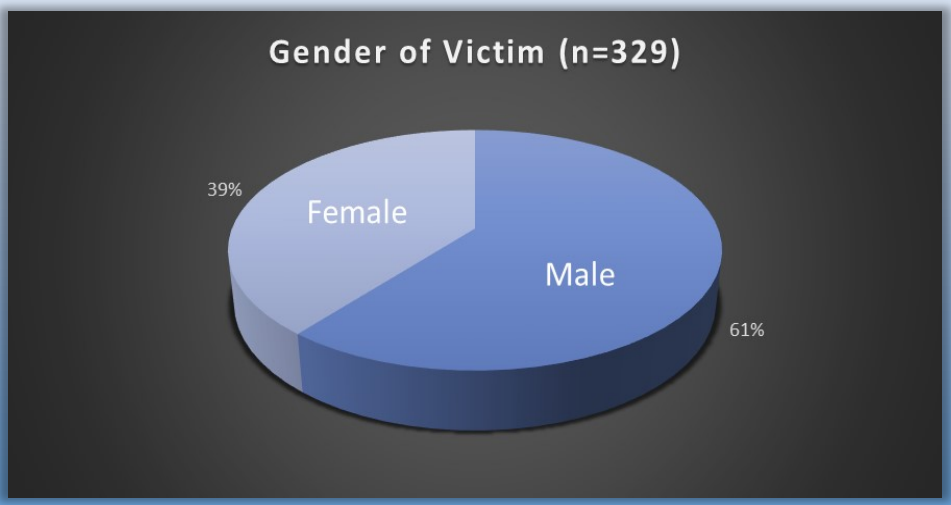
8-10
Caucasian = 2.43%
African American = 0.30%
Bi-racial = 0.30%

11-13
Caucasian = 2.01%
African American = 0.61%
Bi-racial = 0.30%

14+
Caucasian = 3.34%
African American = 0.30%
Bi-racial = 0.30%

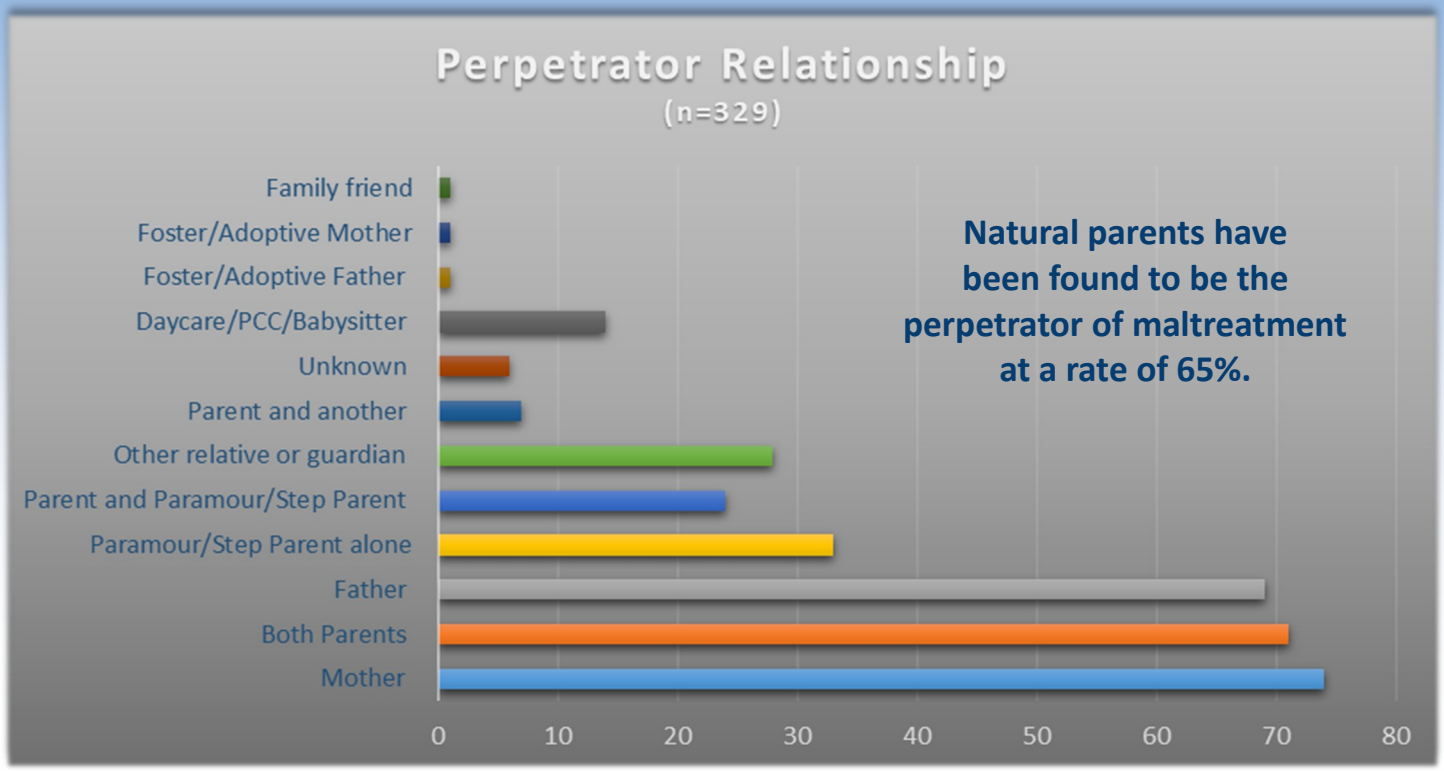


- Male children represent 60.79% of the children with substantiated fatal and near fatal maltreatment.
- Nearly half of all victims are under the age of one. 72.64% of all victims are two years old or younger, and 85.41% are four years old or younger.



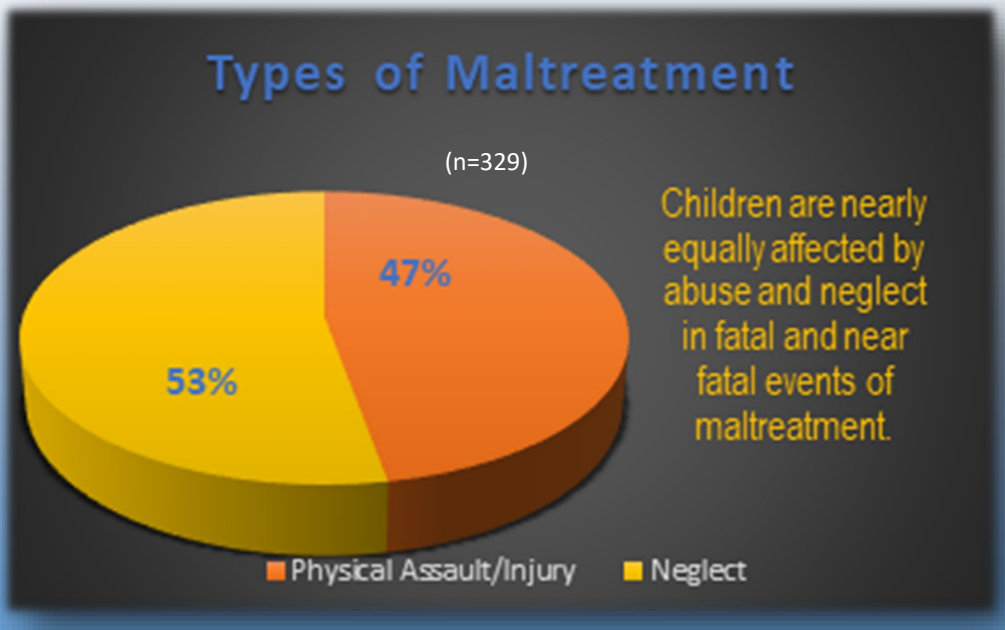
Section III:

Perpetrator and Maltreatment Demographics



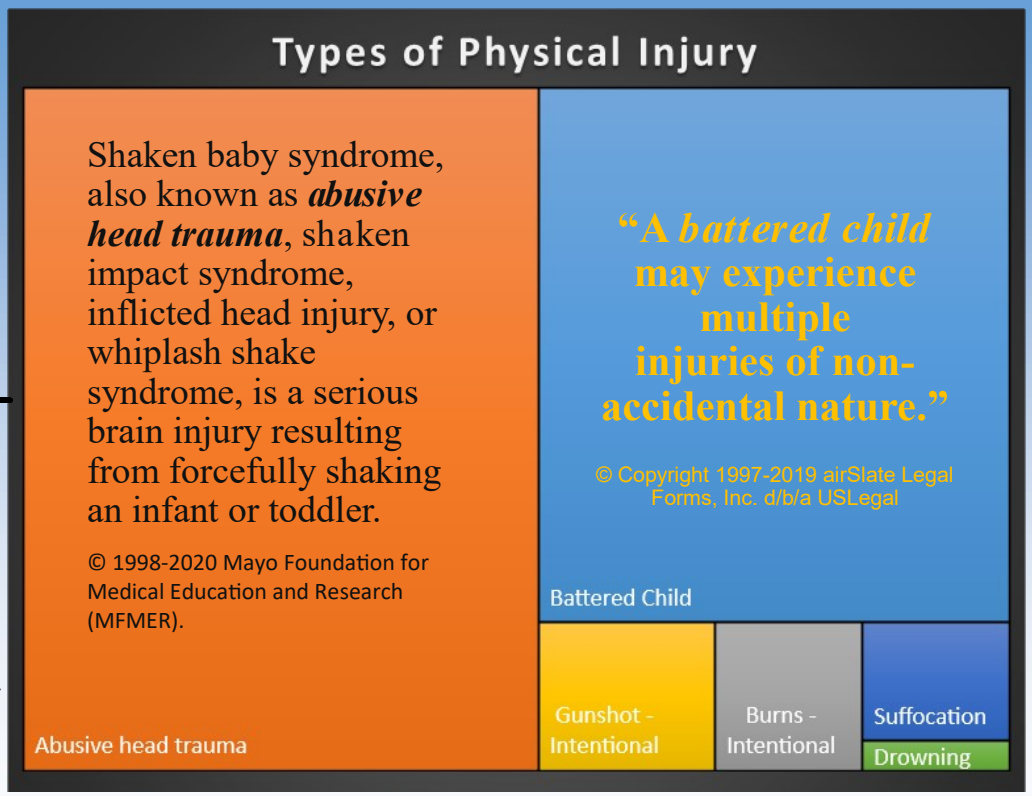
"Abuse manipulates and twists a child's natural sense of trust and love."

-Laura Dennis, Allies in Healing



89.68% of physical abuse injuries are abusive head trauma and battered child.

The majority of these injuries are sustained by children four years of age and under.



Parents who experience any or all of the following may be more likely to forcefully shake a baby and cause shaken baby syndrome:

⇒ Unrealistic expectations of babies

⇒ Young or single parenthood

⇒ Stress

⇒ Domestic violence

⇒ Alcohol or substance abuse

⇒ Unstable family situations

⇒ Depression

⇒ A history of mistreatment as a child

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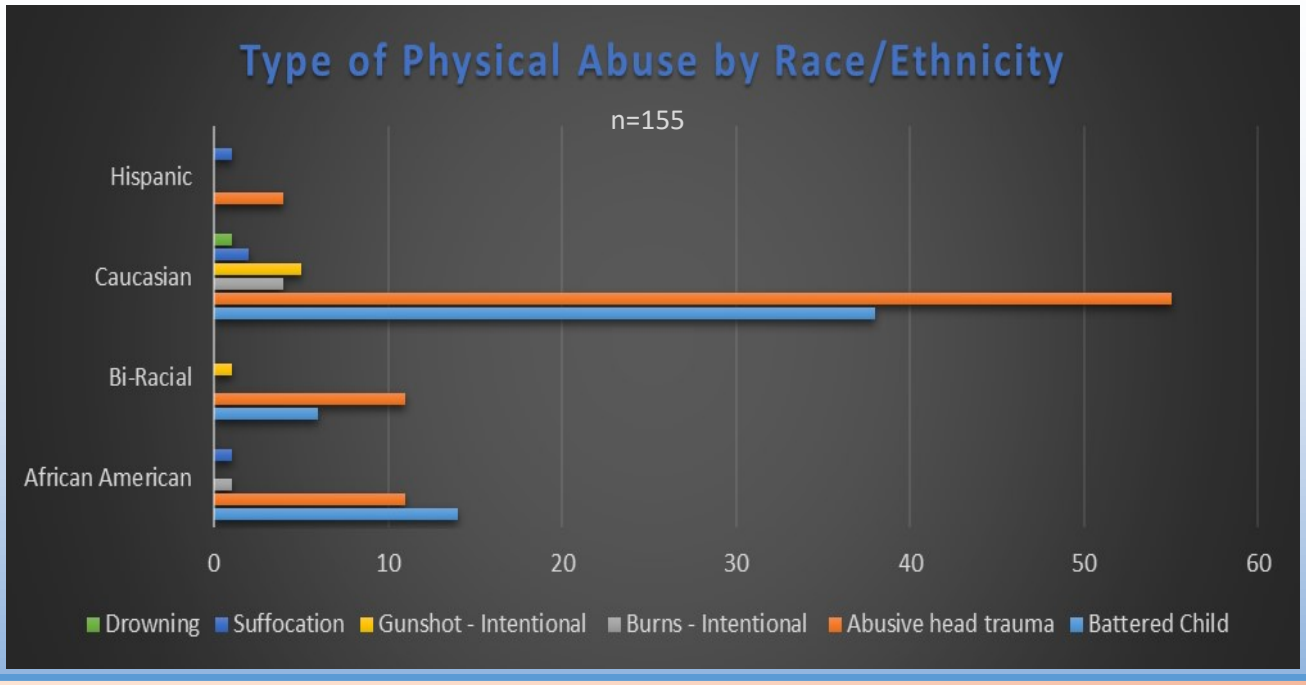
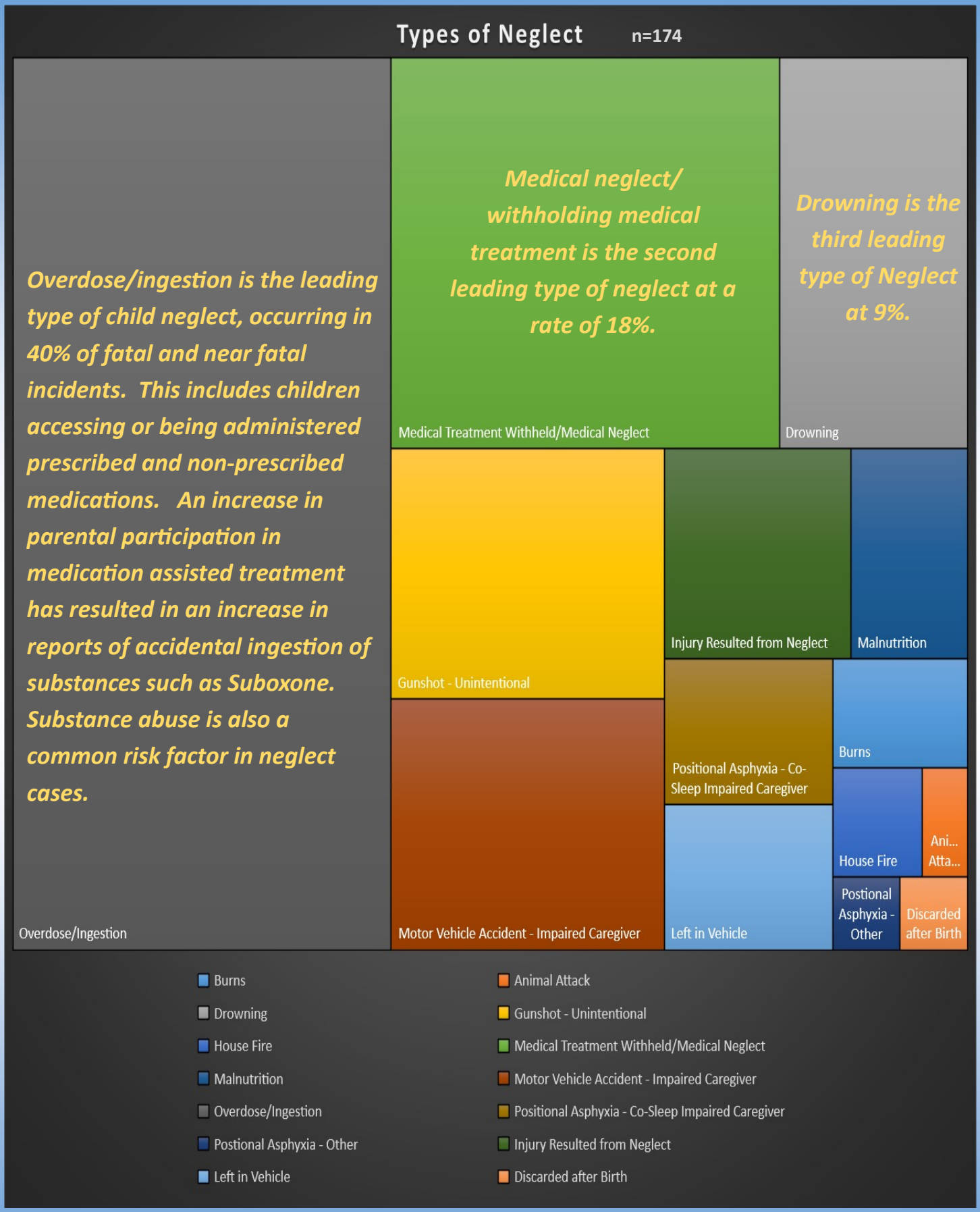
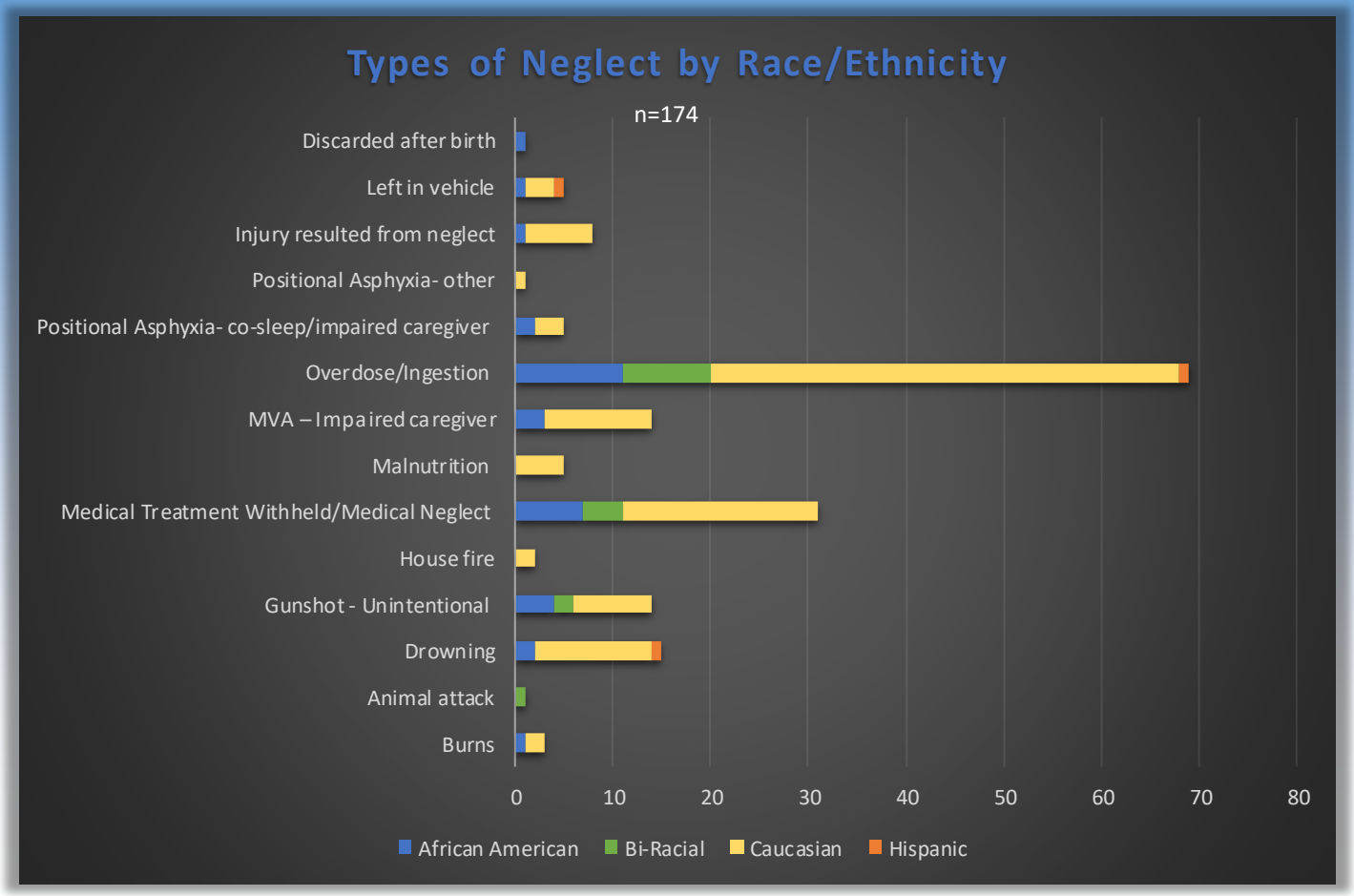


"There can be no keener revelation of a society's soul than the way in which it treats its children."

— Nelson Mandela, Former President of South Africa


Types of Neglect
n=174
Overdose/ingestion is the leading type of child neglect, occurring in 40% of fatal and near fatal incidents. This includes children accessing or being administered prescribed and non-prescribed medications. An increase in parental participation in medication assisted treatment has resulted in an increase in reports of accidental ingestion of substances such as Suboxone. Substance abuse is also a common risk factor in neglect cases.
Medical neglect/ withholding medical treatment is the second leading type of neglect at a rate of 18%.
Drowning is the third leading type of Neglect at 9%.
Overdose/Ingestion
Medical Treatment Withheld/Medical Neglect
Drowning
Gunshot - Unintentional
Injury Resulted from Neglect
Malnutrition
Motor Vehicle Accident - Impaired Caregiver
Positional Asphyxia - Co-Sleep Impaired Caregiver
Burns
Left in Vehicle
House Fire
Ani... Atta...
Postional Asphyxia - Other
Discarded after Birth
Burns
Drowning
House Fire
Malnutrition
Overdose/Ingestion
Postional Asphyxia - Other
Left in Vehicle
Animal Attack
Gunshot - Unintentional
Medical Treatment Withheld/Medical Neglect
Motor Vehicle Accident - Impaired Caregiver
Positional Asphyxia - Co-Sleep Impaired Caregiver
Injury Resulted from Neglect
Discarded after Birth



Child neglect is a form of child abuse and is a deficit in meeting a child's basic needs. This includes the failure to provide adequate health care, supervision, clothing, nutrition, housing as well as their physical, emotional, social, educational, and safety needs.

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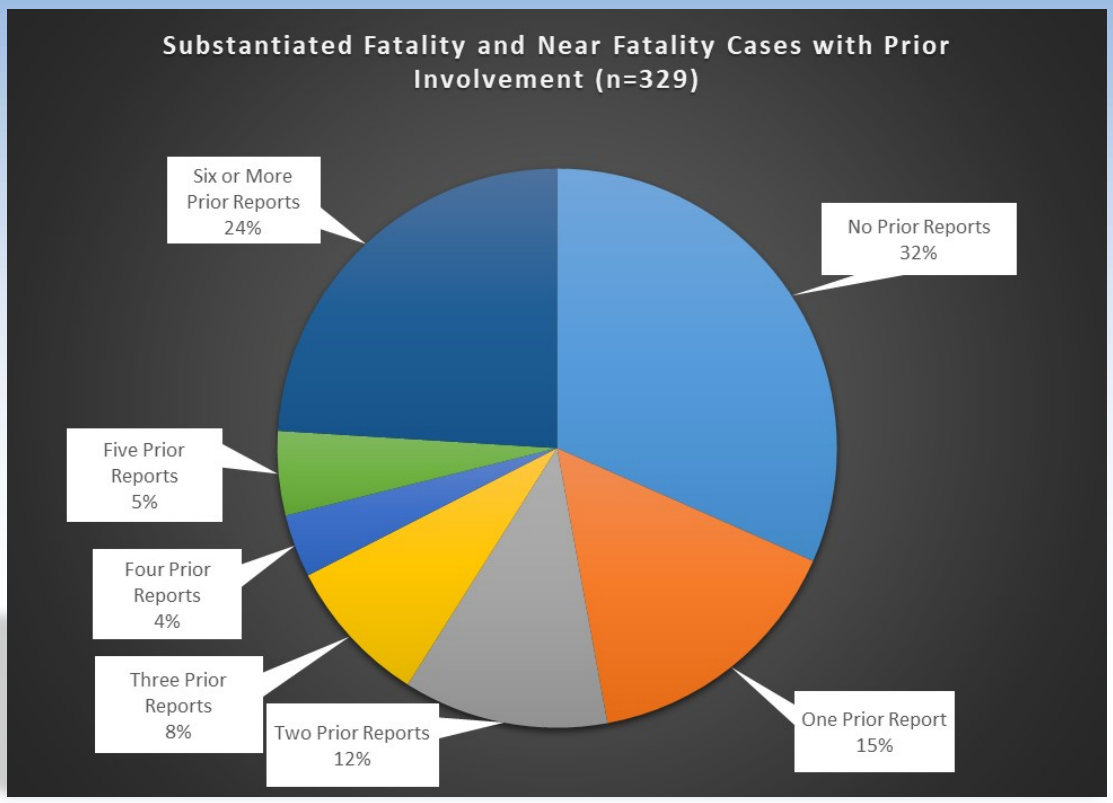
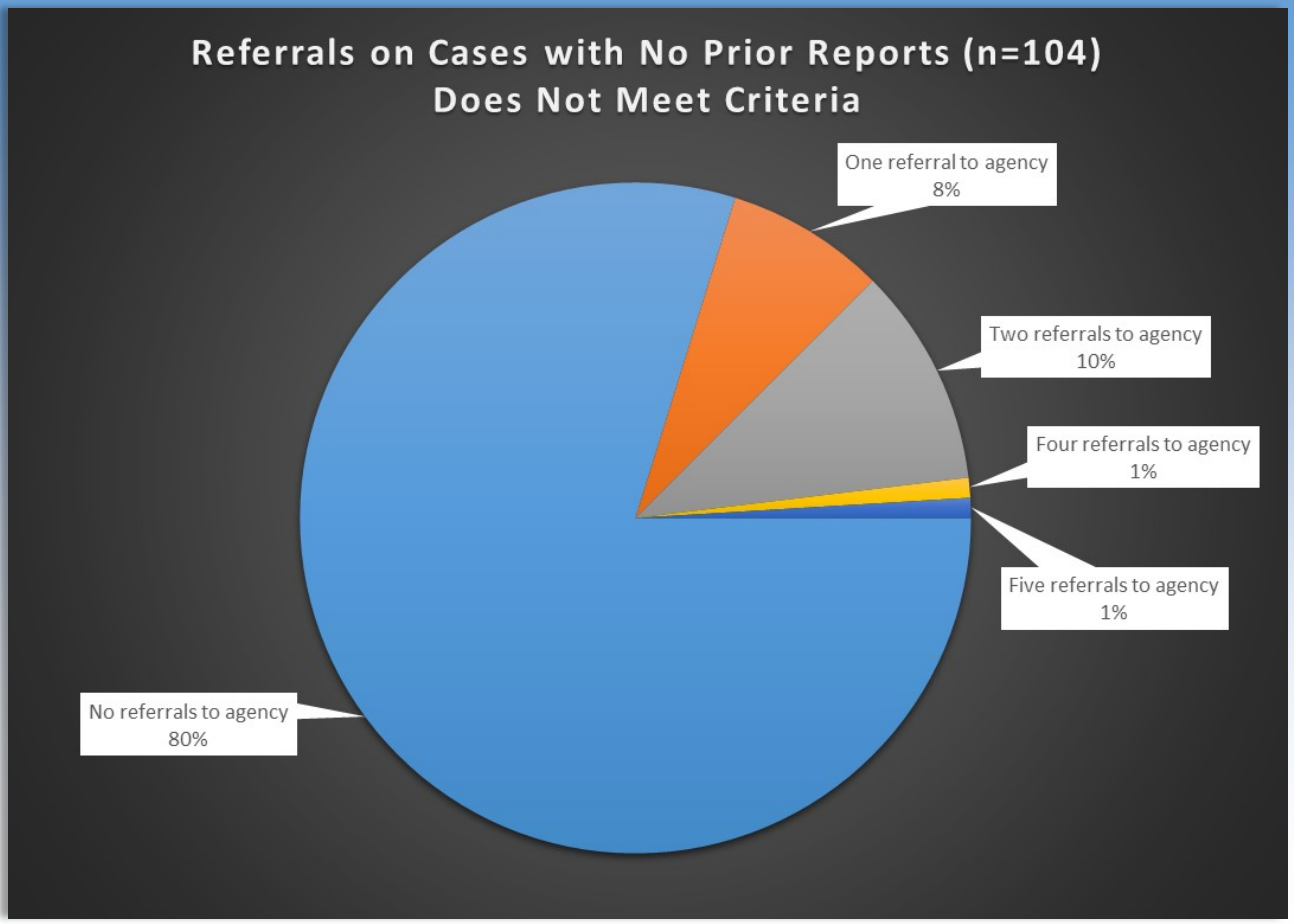
Section IV:
Prior Involvement with Families of F/NF Victims



Prior involvement is defined as any assessment or investigation with a child or family by Protection and Permanency. Thirty-two percent (32%) of the of the families where maltreatment was found to have contributed to their child's fatal or near fatal condition had no prior DCBS involvement. Thirty-five percent (35%) of those families had fewer than three prior interactions with the agency. Only 9% had up to five prior interactions with the agency. Twenty-four percent (24%) of the families in which maltreatment was found to have contributed to their child's fatal or near fatal condition had six or more interactions with the agency.



Of the 32% of families with no prior reports referenced on page 11, 80% had never been referred to the agency. Fewer than 20% of those families without prior reports only had one or two referrals to the agency which did not meet acceptance criteria. Only 2% of these families without prior reports had three or more referrals to the agency which did not meet acceptance criteria.

Cases with prior involvement through an investigation or assessment are subject to an internal review. The internal review process primarily focuses on agency involvement in the 24-months prior to the fatal or near fatal incident and is designed to review the effectiveness of the previous casework. Missed opportunities were identified and used to develop regional action plans aimed at improving practice. During SFY 2020, steps were taken to enhance the internal review process to explore the way the system influences perceived missed opportunities and to identify ways that the system can be improved, or enhanced, to create a work environment and practices that support safety for staff, children, and families. This new internal review process is described in the next section.

Section V:

Program Improvement Efforts

Internal Review

KRS 620.050 (12)(b) requires that the Cabinet for Health and Family Services (CHFS/cabinet) "conduct an internal review of any case where child abuse and neglect has resulted in a fatality or near fatality and the cabinet had prior involvement with the child or family." The statute also requires that the cabinet submit an annual report by September 1 to the Governor, the General Assembly, and the state child fatality review team that includes a summary of the internal reviews and an analysis of historical trends.

Introduction to the System Safety Review Process and Process Overview

In 2019, the department partnered with Collaborative Safety to develop a new internal review process known as the culture of safety system safety review (SSR). The SSR process uses safety science to guide the analysis of critical incidents and the response to areas identified for improvement. Industries such as aviation, healthcare, and nuclear power champion this approach. Child welfare agencies throughout the U.S. have adopted this approach for reviewing their critical incidents. DCBS has defined critical incidents as any child fatality or near fatality accepted for investigation or a death of a child on an active case.

The process focuses on understanding the complex nature of child welfare work and the factors that influence decision-making and practice in real time. It moves away from the simplistic approach, which has a tendency to assess blame and results in the application of "quick fixes" that fail to address the underlying issues. The process recognizes that frontline workers strive to make the best decisions in their cases based on information available to them at that time and that those decisions are affected by the system around them. This approach emphasizes shared accountability. Frontline workers participate in human factors debriefings to provide their insight into how adverse events occur and how they can be avoided. Staff at various levels within the agency and external stakeholders are accountable to contribute to the systemic analysis. Furthermore, agency leadership is accountable for making improvements to create a more resilient and reliable system which improves capacity to provide safe outcomes for children, families, and employees.

The intended outcome of the SSR is to gain information about the entire system surrounding an adverse event that will guide meaningful systemic change. In pursuit of this goal, it is necessary to create a safe environment for staff to communicate the influences in their decision making and other system barriers without fear of punitive actions. The culture of safety environment will lead to staff being able to provide enhanced and more effective services to families.

The process moves away from the simplistic approach, which has a tendency to assess blame and results in the application of "quick fixes" ....

Since the onset of the SSR, there has been one data action group meeting in which the data collected from 63 cases that met criteria for review was analyzed. Of those 63 cases reviewed, 23 cases were selected for full review to include human factors debriefings and system mappings. From those studies, the following systematic themes have emerged as having the most significant impact on systemic agency practice in real time.

Emerging Systemic Themes:

Procedural Drift:
An accepted gradual departure away from written procedure due to system constraints and influences, workforce/local team acceptance, and experienced success.

Production/Efficiency Pressure:
Demands to increase production and/or efficiency (workload/economic), which impacts safe work practices.

Cognition:
A faulty understanding of a situation due to cognitive fixation or cognitive biases (confirmation bias, focusing effect, tunneling).

Teamwork/Coordinating Activities:
Ineffective joint coordination of activities between two or more entities including internal staff and external partners. (Child Protective Services (CPS) and licensing, CPS and law enforcement, foster care and other external entities, etc.)

Demand-Resource Mismatch:
When resources within the agency are not compatible with the needs of staff (training for onboarding staff, staff shortages).

TOWARDS A CULTURE OF ACCOUNTABILITY

TOWARDS ADDRESSING UNDERLYING SYSTEMIC ISSUES

TOWARDS SEEING WORKERS AS A SOLUTION

Family First Prevention Services Act (FFPSA)

FFPSA allows states to utilize existing federal funding for the provision of prevention services designed to preserve the family unit through quality prevention services. Since implementation of FFPSA in October of 2019, Kentucky has built clinical capacity for providers and workers to ensure families are receiving quality, trauma-informed interventions. Kentucky has also been successful in expanding existing prevention services, such as Family Preservation Program (FPP) and Kentucky Strengthening Ties and Empowering Parents (KSTEP) services to serve more families. DCBS continues to create new partnerships and expand program areas to serve more families. FFPSA related services target families with children who are at risk of removal due to safety and risk factors present in the home or children reunified with families after removal. Prevention services include in-home skill-based parenting programs, substance abuse treatment and prevention, and mental health treatment to mitigate safety threats and risk factors in the home. DCBS has implemented an approved five-year prevention plan, outlining the evidence based practices (EBPs), trauma-informed care, evaluation procedures, and continuous quality improvement (CQI) process.

Implementing Safety Model

In November of 2018, DCBS leadership made the decision to purchase a safety model, which is a research and evidence-based decision that provides a comprehensive framework for assessing families that can be used in real time by workers and supervisors in the field to aid in case decision-making. DCBS leadership created a safety workgroup that researched national safety models and collaborated with various states prior to selecting the Structured Decision Making (SDM) model created by the National Council on Crime and Delinquency (NCCD). A contract was executed in March 2020 with NCCD and the initial groundwork phase began. A review of state regulations and policies, surveys of frontline staff and community partners, review of current system practices, and other relevant areas of the state child welfare system was conducted in preparation of the safety models implementation to intake and assessment of CPS cases. A second contract has been executed with NCCD for full implementation of the safety and risks assessments and specific assessment tools related to intake, risk, and safety assessments are currently being reviewed.

The intake screening assessment tool will be used to aid in determination of agency response to allegations of child maltreatment, the speed of that response, and ensure consistency in intake screening with relevant statutes. The safety assessment tool will be used to aid staff in identifying safety threats and appropriate interventions. The risk assessment tool will be used to help staff determine risk of future maltreatment using empirical research and factors statistically shown to predict future maltreatment.

"An ounce of prevention is worth a pound of cure."

— Benjamin Franklin

Safety, Prevention, and Aftercare Planning

DCBS has made standards of practice (SOP) and practice changes for the use of safety, prevention, and aftercare plans. These plans are completed with families during various stages of casework, from investigation, ongoing case work, and case closure. The practice changes highlight the importance for staff to recognize the difference between safety threats and risk factors and implementing the appropriate agency response to any intervention that results in limiting or restricting parental/custodial rights. Practice changes in this area include the use of a new form for safety planning, which can be utilized electronically by field staff and distributed to all parties involved. The safety plan is used to address any immediate safety threats to children and is subject to a 14 business day time limit. Safety planning stresses the voluntary nature of the plan, the importance of informed consent by all parties involved, the importance of practical and measurable tasks to address the safety threats, the importance of proper tracking of tasks to be identified, utilizing the least intrusive means possible to mitigate safety threats.

Prevention planning also underwent robust practice changes similar to safety planning. The practice changes recognizes that prevention planning is used to address risks that are not imminent, but present a likelihood of harm to a child absent preventative intervention and connection to appropriate services. The prevention plan is subject to a 30 business day time limit, stresses the voluntary nature of the plan, the importance of informed consent by all parties involved, practical and measurable for families, and identifies proper tracking of tasks. New SOP surrounding the use of safety and prevention plans require supervisory consultation prior to the implementation and termination of all safety plans and supervisory review of the implementation and termination of all prevention plan). Practice changes were also made to aftercare plans and their intended long term effectiveness. Aftercare planning is utilized when risk factors remain, but do not rise to the level of need for opening a case for ongoing services, and used as part of the closure process for investigations and ongoing cases. It is negotiated in agreement with the family and other parties involved and identifies the continuum of services needed, or desired, by the family to address remaining risks. Specifically, aftercare planning outlines the need for follow-up services and the party that will continue to provide those services.

Safety and Risk Assessment Consultation

DCBS developed changes to the SOP and practice of case consultations. Recognizing that supervision is integral to ensuring appropriate and timely services are assessed, offered, and provided to the vulnerable families and children served by DCBS, changes in SOP and practice highlight the importance of supervisory support to staff in critical thinking and decision making. Changes also highlight the importance of staff recognizing the difference between safety threats and risk factors and triggers a case consultation once safety threats are identified that may prohibit children from remaining in the home. In June 2020, the new Safety and Risk Consultation form (DPP 20) was introduced to assist workers, supervisors, and regional staff with evaluating safety threats and risk factors of children, and replaces the Utilization Review form and process. Consultation is used to gain the expertise knowledge of supervisors and regional staff to support mutual decision making to guide casework and services offered to families. New SOP and practice changes highlight two key decision making points during the evaluation of the child's safety that should be addressed in consultation: the first contact with the child and family and the conclusion of the investigation.

DID YOU KNOW?

Kentucky is a mandatory reporting state. If you suspect abuse or neglect of a child, you are required by law to make a report. You can call 1-877-KY-SAFE1 (1-877-597-2331) 24/7 or you can make a web-based report at https://prd.webapps.chfs.ky.gov/reportabuse/home.aspx.

The Child Help National Abuse Hotline

1 (800) 4-A-CHILD (422-4453)

Remember the TEN-4 bruising rule. Children under the age of four should not have bruising to their **T**orso, **E**ars, or **N**eck. Non-mobile infants should not have any bruises.

–Norton Children's Hospital, UL Pediatric Forensics