

# 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, 2021



KENTUCKY  
Cabinet for Health and  
Family Services

TEAM  
KENTUCKY

# Table of Contents



Section I: Comparative Referral Data	3
Section II: Child Demographics	5
Section III: Perpetrator and Maltreatment Demographics	7
Section IV: Prior Involvement with Families of Fatality/Near Fatality (F/NF) Victims	9
Section V: Program Improvement Efforts	10

In accordance with KRS 620.050(12)(c), the Cabinet for Health and Family Services (CHFS/cabinet), Department for Community Based Services (DCBS/department) is required to submit an 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.

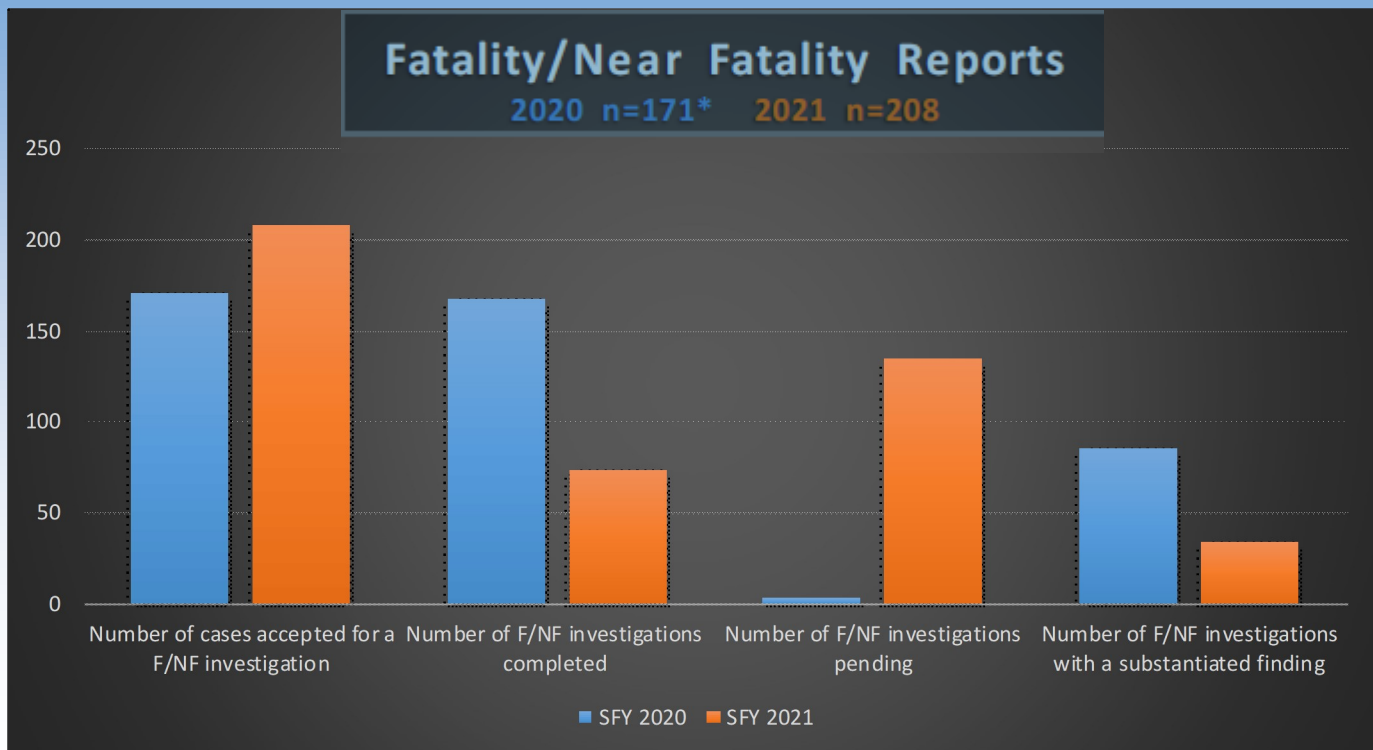
The report is organized into five sections. Historical data in this report spans five state fiscal years (SFYs) and includes only child abuse and neglect fatalities and near fatalities.

*"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



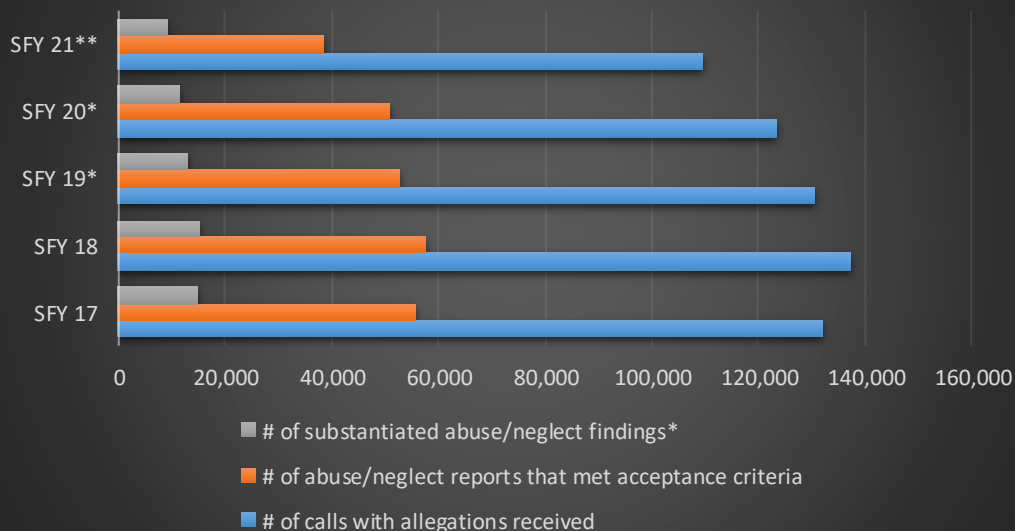
DCBS data reflects a twenty-two percent (22%) increase in fatality and near fatality (F/NF) reports in SFY 2021 compared to SFY 2020. The graph above illustrates data from all completed investigations at the time of this report. Additionally, there continues to be a large number of pending investigations 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 SFY due to SFY 21 ending June 30, 2021.

*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; thus, resulting in delays in finalizing the investigation. Despite an increase in reports for SFY 21, there has been a 208% increase in completed reports for the most recent SFY at the time of this report. Last year's report only contained data for twenty-four completed reports and this year's report contains seventy-three total completed reports.*

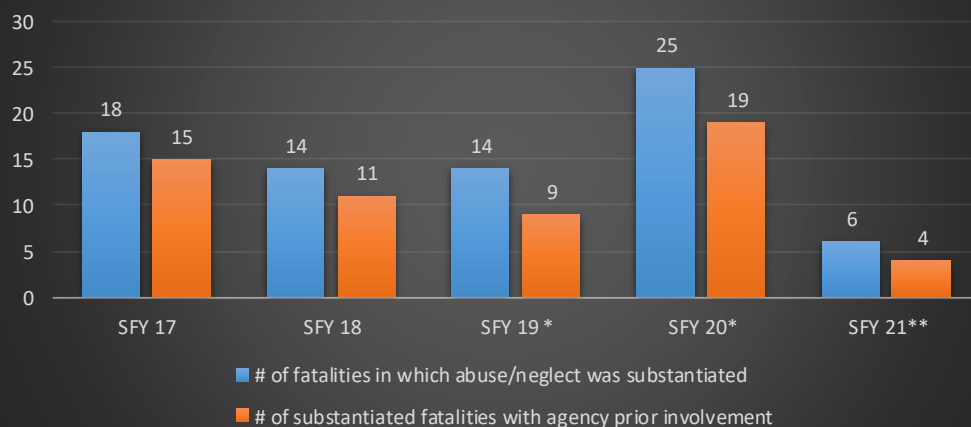
\* Indicates adjustment to the number of substantiations from prior year's report due to completed investigations

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 during the 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, 20, and significantly in 21.

## Statewide Child Maltreatment Reports

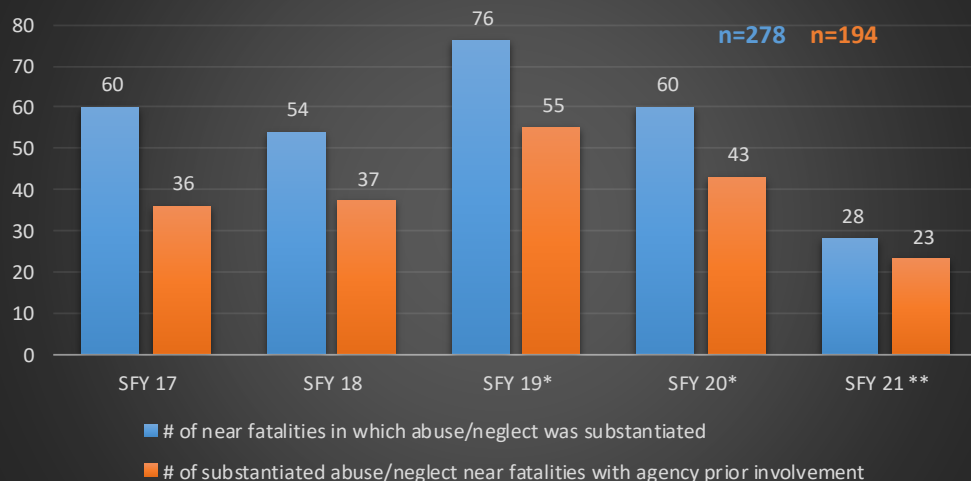


## Fatality Substantiation with Prior Involvement n=77 n=58



There was an increase in substantiated fatalities in SFY 20. Due to limits of the SFY 2021 data currently available, it is currently unknown if this is an aberration specific to SFY 2020 or part of a continuing trend.

## Near Fatality Substantiation with Prior Involvement n=278 n=194

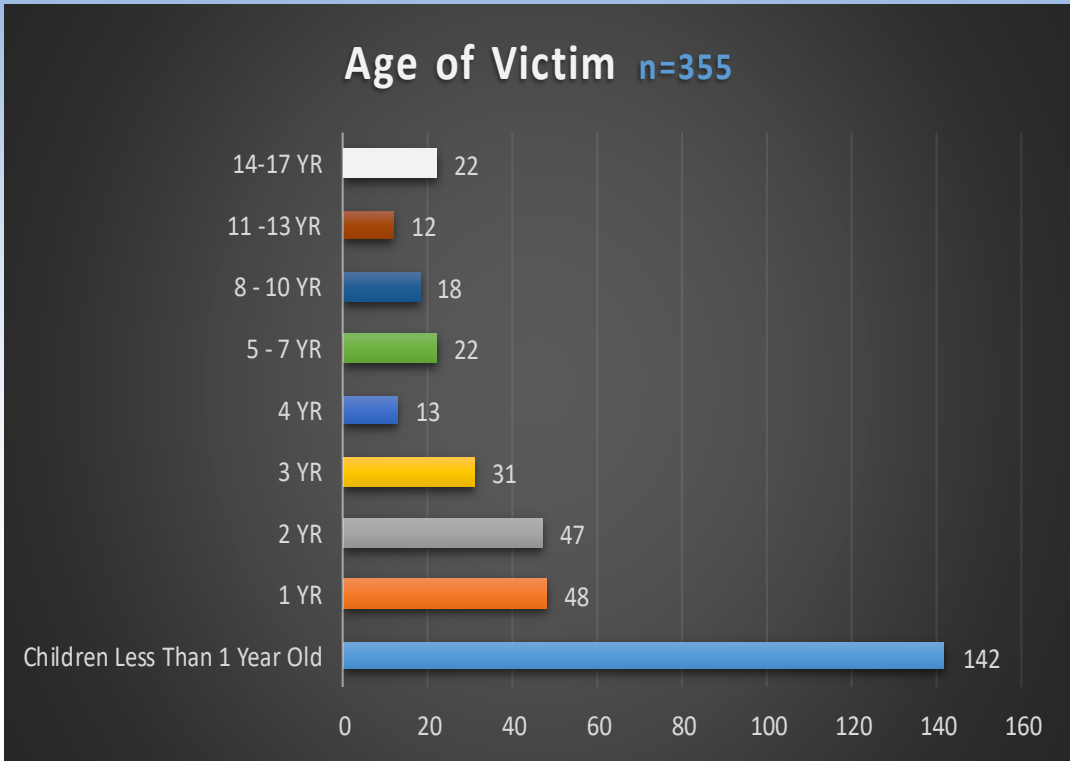


\* Indicates adjustment to the number of substantiations from prior year's report due to completed investigations

\*\*Indicates incomplete data for investigations

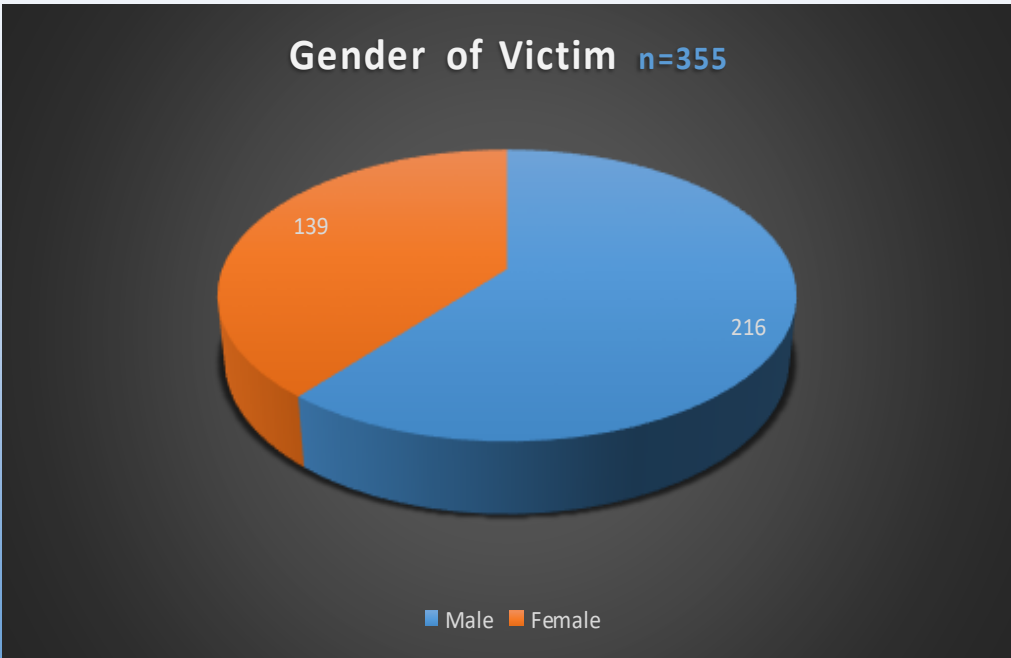
# Section II: Child Demographics

The data represented below is from SFY 2017 to SFY 2021

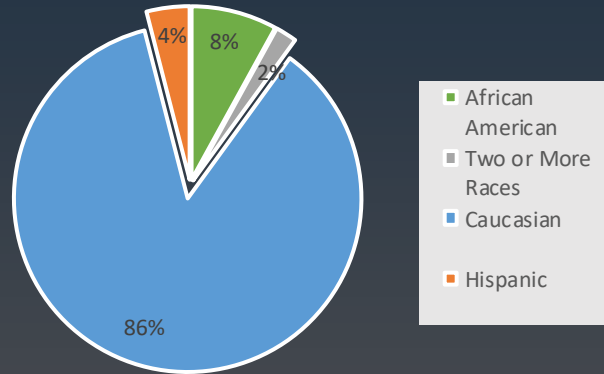


Children three and under comprise more than half of all F/NF victims, with children one and under representing the vast majority of victims.

The majority of the F/NF victims in the data set were male. This is consistent with data reported in previous years



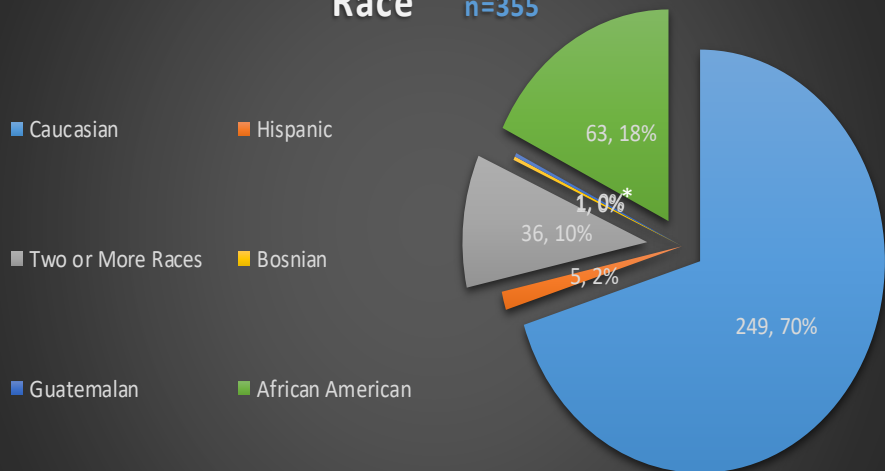
## KY Child Population by Percentage



The Census Bureau estimates that as of July 1, 2019, the African American population comprises eight and a half percent (8.5%) of the total Kentucky population. African American children constitute eighteen percent (18%) of victims in fatal and near fatal reports over the five-year period.

The cabinet is continuing to work in addressing racial disproportionality and disparity.

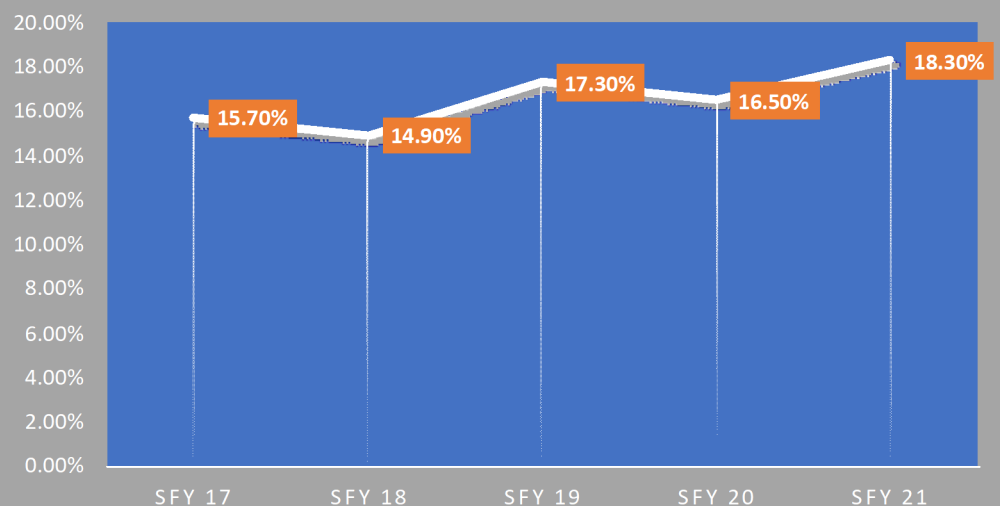
## KY Fatality and Near Fatality Victims by Race



\*Guatemalan and Bosnian races each represent one.

The African-American population consistently makes up fifteen percent (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.

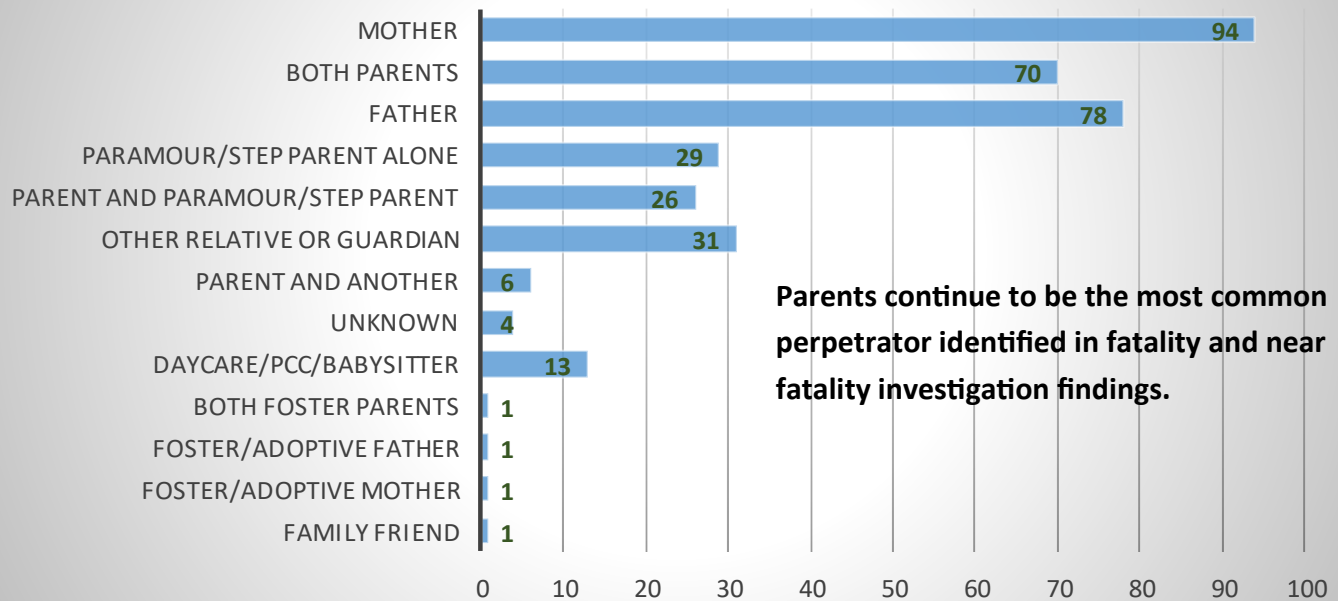
## % OF F/NF REFERRALS ACCEPTED ON AFRICAN AMERICAN CHILDREN



## Section III:

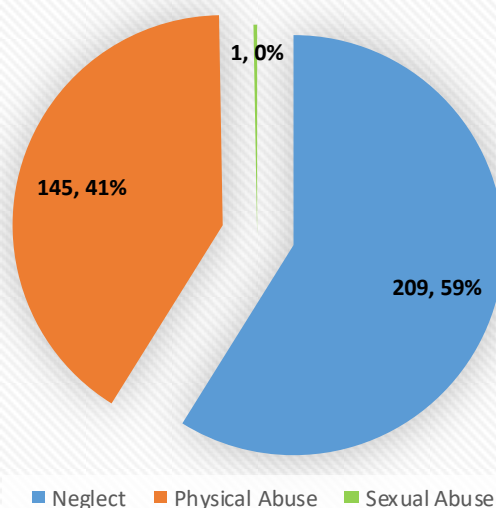
# Perpetrator and Maltreatment Demographics

**Perpetrator Relationship to Victim** n=355



**Types of Maltreatment**

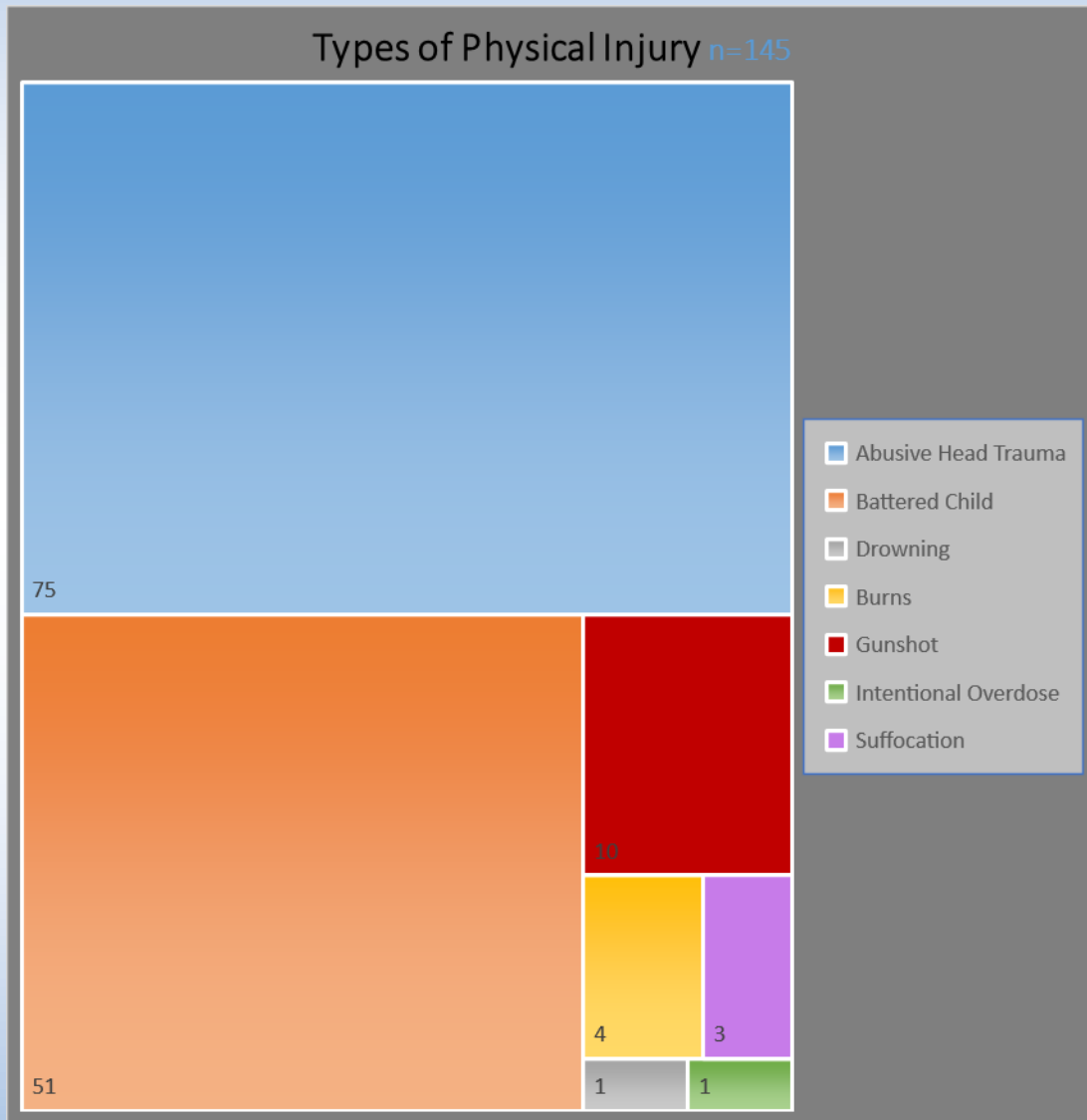
n=355



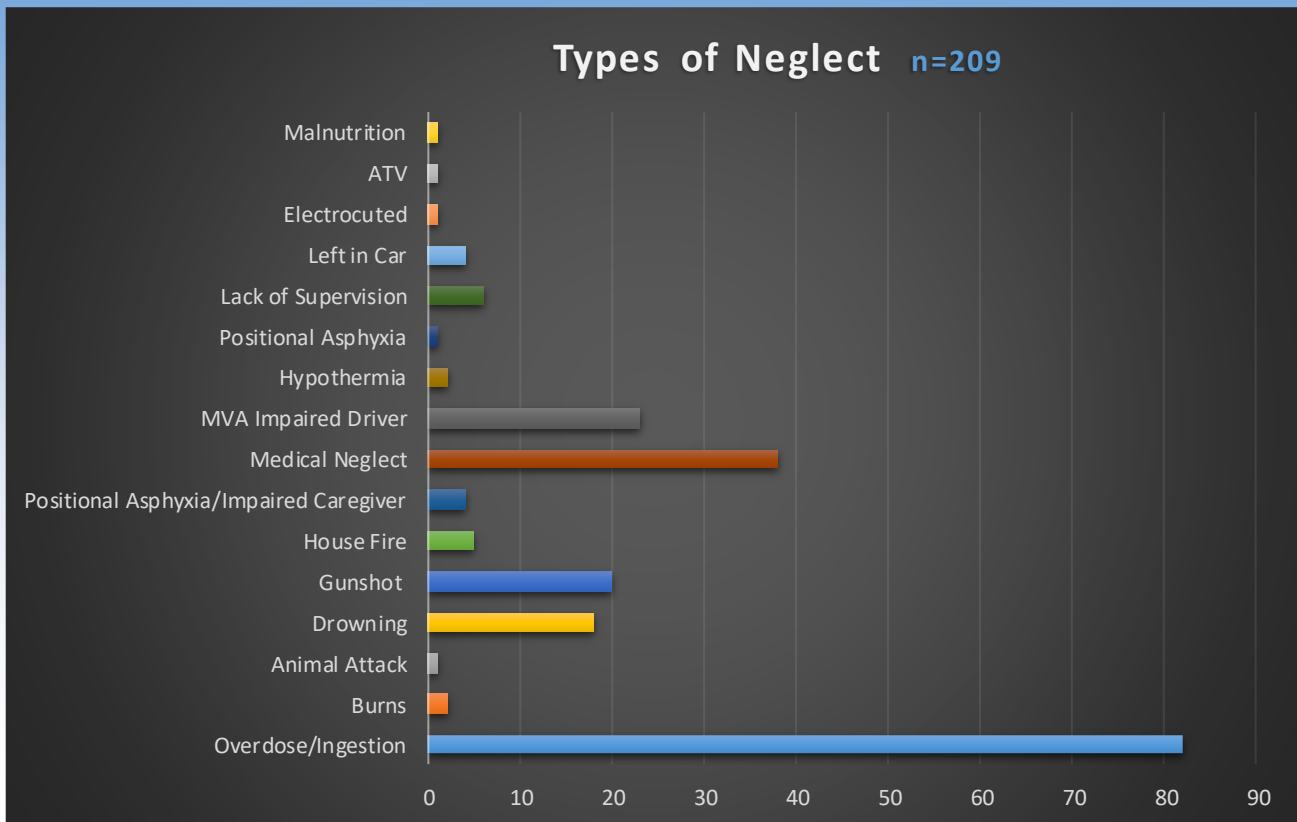
Neglect continues to be the leading type of maltreatment in fatality and near fatality investigation findings. There is one sexual abuse substantiation associated with a fatality designation.

Eighty-seven percent (87%) 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.



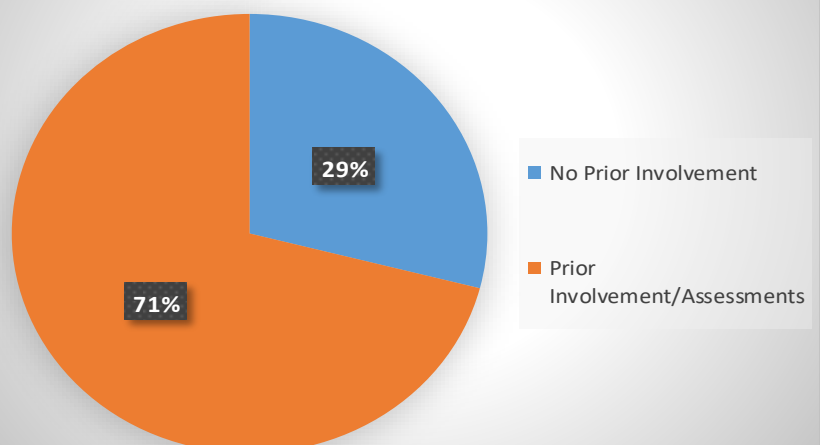




The leading cause of neglect has been accidental overdose/ingestion cases. These cases are typically the result of environmental neglect, when prescribed or illegal drugs are left accessible to children. To address safety threats associated with prescription medications, local DCBS service regions and other community partners are working to provide families with lockboxes to secure prescription medications safely within their home.

Of the 355 substantiated near fatalities and fatalities, 103 did not have prior involvement with the cabinet prior to the fatal or near fatal event. The remaining 252 had prior involvement with the cabinet. Prior involvement is defined as any assessment or investigation with a child or family. The data collected on prior involvement considers all household members at the time of the F/NF incident and represents the history for those individuals. The F/NF victim may not have been identified as a case individual in the reported history.

### Prior Involvement/Assessments Completed n=355



# Section V: Program Improvement Efforts

## Internal Review

KRS 620.050(12)(b) requires that the cabinet “conduct an internal review of any case where child abuse or neglect has resulted in a child 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.

## System Safety Review Process and 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.

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. 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.

Each case accepted as a near fatality or fatality investigation is assigned to a system safety analyst. The analyst then conducts a review of any case history, focusing in on the most recent twenty-four months. This information is then presented to the multi disciplinary team that is comprised of individuals from differing entities, including the Department for Public Health (DPH), Training Branch, Office of Legal Services (OLS), Division of Service Regions (DSR), and staff from the Division of Protection and Permanency (DPP). Cases are selected for further study based on specific features identified during the initial case review, which are

referred to as to as interesting features or learning points.

Human factor de-briefings are conducted with the staff involved in decision making around the time of the interesting feature identified for further study. A systems mapping is conducted following the human factors debriefing. The mapping process includes staff from all organizational levels and may include community partners such as court personnel and local service providers. The systems mapping works to draw out environmental and systemic influences that contributed to or shaped the decisions made in the features being studied. The system map is narrated and scored using a scoring tool provided by Collaborative Safety. The scoring tool allows the team to produce data about the systemic themes influencing practice. The data collected from all the case studies is presented to DCBS leadership, safety action group, and then used to help inform and influence systemic change to support safer work practices.

Change has been actively occurring due to mapping discussions and discoveries. While the System Safety Review process is designed to identify larger systemic features that require response from cabinet leadership, there are occasions when the process reveals features that can be addressed at the division level. Those features are reviewed at monthly quick wins meetings where plans are formulated to activate a response. Plan development requires input from staff throughout DPP. In some instances, plans can be implemented immediately. In others, the plan includes further exploration of the feature identified before defining the response. Each feature proposed as a quick win is tracked to monitor progress and resolution of the issue identified.

## Implementing a Safety Model

DCBS is in the process of implementing three Structured Decision Making (SDM) tools in collaboration with the contracted vendor, Evident Change. The tools will be used during the intake and assessment phase of a child protective services case. The intake assessment tool uses a consensus based model to operationalize policy, regulation, and statute to assist workers in making consistent and supported decisions. The safety and risk tools are actuarial tools that will assist workers in classifying child safety threats and risk factors based on their current situation in real time. DCBS is in the process of customizing and automating the tools with an implementation goal date of June 2022.

## Prevention Efforts

Prevention services pilot programs are in the process of being created to deliver MultiSystemic Therapy (MST) in three DCBS service regions, with one pilot beginning on July 1, 2021. The chosen provider is currently the only provider in Kentucky qualified to deliver this intervention, meeting the needs of youth with serious criminal offenses or substance use disorders to maintain them safely in their communities.

The largest prevention service, Family Preservation Program (FPP), serves families across all need and risk levels for children zero to seventeen years of age, expanded to serve an additional 25% of families in April of 2020, and will expand further to serve an additional twenty-five percent (25%) of families in October of 2021. Significant evidence-based practice (EBP) capacity growth has occurred within provider agencies, with the majority having capacity to deliver most Family First Prevention Services Act (FFPSA) EBPs, including Homebuilders, Parent-Child Interaction Therapy (PCIT), Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), Motivational Interviewing (MI), and Functioning Family Therapy (FFT). In calendar year (CY) 2020, 90% of children involved with FPP remained safely in their home at closure.

Kentucky Strengthening Ties and Empowering Parents (KSTEP) is currently serving eighteen counties in Kentucky. In the Northeastern Service Region, KSTEP has expanded to the full fifteen counties which are Carter, Greenup, Rowan, Mason, Bath, Montgomery, Fleming, Lewis, Morgan, Menifee, Bracken, Robertson, Boyd, Lawrence, and Elliott. KSTEP also received SAMHSA funding through the Kentucky Opioid Response Effort (KORE), allowing expansion into Franklin, Spencer, and Trimble counties in the Salt River Trail Service Region on May 1, 2021. Funding was also added for KSTEP to expand into the remaining counties in Salt River Trail Service Region and another three counties in the Cumberland Service Region, which are still to be determined. For sustainability, an independent systematic review was completed for KSTEP, determining it to be a supported intervention.

For primary and secondary prevention efforts, the Community Collaboration for Children (CCC) provides the following services for families across the state of Kentucky:

*In-home based services*

*Parent engagement meetings*

*Regional networks*

# 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) or make a web-based report at [https://  
prd.webapps.chfs.ky.gov/reportabuse/home.aspx](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

