

Commonwealth of Kentucky



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

**Prepared by:
Cabinet for Health and Family Services
Department for Community Based Services
Division of Protection and Permanency**

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Table of Contents

Introduction.....	3
Executive Summary.....	3
Historical Trends (data from SFY 2000-2008).....	4
Child Fatality and Near Fatality SFY 2008.....	14
Appendix A Regional Map.....	24
Appendix B Data Tables for SFY 2008.....	26



Child Abuse and Neglect Annual Report of Child Fatalities and Near Fatalities State Fiscal Year 2008 (July 1, 2007 to June 30, 2008)

Introduction

Every year, the Division of Protection and Permanency (DPP), under the Cabinet for Health and Family Services, investigates allegations of child abuse or neglect that result in a fatality or near fatality.¹ As mandated by KRS 620.050(12)(c), the cabinet submits an annual report to the Governor, the General Assembly and the state child fatality review team summarizing the cases where DPP had prior involvement with the child or family.² The purpose of the annual report is to provide trend analysis and to discuss actions the cabinet is taking as a result of reviewing child fatality and near fatality cases.

This report only includes cases where DPP has prior involvement with the child or family and is organized into four sections: executive summary; historical trends from state fiscal years 2000-2008; case data for state fiscal year 2008; and actions the cabinet is taking as a result of findings from internal reviews.

Section I- Executive Summary

In the nine year period between July 1, 1999 and June 30, 2008 (SFY 2000-2008), 253 children have died or been seriously injured as a result of caretaker abuse or neglect in cases where DPP had prior involvement with the child or family.

The number of child fatalities where DPP had prior involvement with the child or family increased each year between 2001 and 2004. However, the number of child abuse or neglect related fatalities began to decrease during state fiscal year 2005 and continued to decrease during 2006 and 2007. Data for state fiscal year 2008 is subject to revision due to investigations still pending at the time of this report.

¹ Near Fatality is defined by KRS 600.020(37) as an injury that, as certified by a physician, places the child in serious or critical condition.

² Prior involvement is defined by 922 KAR 1:420 as any assessment or investigation of which the Cabinet has record, with child or family in the area of protection and permanency.

Historical Trends- Overview SFY 2000-2008

In the nine year trend analysis that includes 253 abuse or neglect related child fatality and near fatality cases where the child or family also had prior involvement with the Division of Protection and Permanency:

- 71% of child victims were 3 years of age or younger
- 80% of children were Caucasian
- 78% of perpetrators were either one or both parents
- type of maltreatment- neglect 59% and physical abuse 41%
- risk factors present in fatality and near fatality cases
 - caretaker substance abuse was present in 71% of cases
 - caretaker criminal history was present in 61% of cases
 - domestic violence was present in 53% of cases

SFY 2008 Overview- Child Fatality and Near Fatality Case Data

During state fiscal year 2008, 43 children in Kentucky³ were victims of abuse or neglect related child fatalities or near fatalities where the child or family had prior involvement with DPP. Of the 43 total cases, 13 were child fatalities and 30 were near fatalities. In these cases:

- 58% of child victims were 3 years of age or younger
- 79% of child victims were Caucasian
- 79% of perpetrators were one or both parents
- type of maltreatment- neglect 54% and physical abuse 46%
- risk factors present in fatality and near fatality cases
 - caretaker substance abuse was present in 70% of cases
 - caretaker criminal history was present in 72% of cases
 - domestic violence was present in 67% of cases

The Division of Protection and Permanency continues to work to understand the differences between child protective service cases that result in fatal or serious child abuse and neglect and those that do not. DPP utilizes these data to identify the children and families who had had prior involvement with child and adult protective services and to assess the risk factors indicated in those cases.

Action Steps Taken by the Cabinet as Result of Internal Review of Fatalities and Near Fatalities

Training and Pilot Projects

- Medical Elements of Child Abuse and Neglect (MECAN) trainings continue to be developed in response to needs identified by the service regions. It has also been converted into modules and is on the KYTRAIN network for online training by both Department for Community Based Services (DCBS) staff and community partners.
- The Child Fatality Specialist and the Nurse Service Administrator attended training on Child Fatality Investigations sponsored by the U. S. Department of Justice and the Office of Juvenile Justice. Information obtained at this training is being used to develop training for field staff.
- Prevent Child Abuse Kentucky continues the Child Abuse Recognition Education (CARE) project which works with physicians and their staff at identifying child abuse and assisting in child abuse investigations. Prevent Child Abuse Kentucky (PCAKY) has plans to expand this project in the near future.
- Root Cause Analysis (RCA) was discontinued during this state fiscal year as a second formalized process for reviewing child fatalities and near fatalities. Components of the RCA process are now incorporated into the internal reviews of selected cases.

Development of Supportive Resources for CPS Investigations

- Medical Support staff provide consultation to Child Protective Services (CPS) investigators on analyzing injuries and medical reports. In partnership with the Commission for Children with Special Health Care Needs, nine regional nurses continue to provide CPS consultation in the field. Working in partnership with the Nurse Service Administrator, medical consultation is available for all fatalities and near fatalities.
- The Child Fatality Nurse Service Administrator continues the development of fact sheets and online resources to assist CPS investigators.

Enhanced Policy and Practices to Improve Child Protection

- Acceptance Criteria was refined for both Adult Protective Services (APS) and Child Protective Services (CPS) cases to better assess abuse and neglect allegations during the referral intake process. Training was provided to all regions on the updated acceptance criteria. All regions now have Centralized Intake to better service clients.
- Staff De-Briefing through the Crisis Response Board as well as the Kentucky Employee Assistance Program (KEAP) supports staff in their work and allows them to work through issues associated with secondary trauma. Service regions have developed local protocols for the provision of these services.

Data and Technology

- Outcome Based Data Tracking System. The Department has developed a data tracking system to track elements of child welfare. This information is sent to service regions and used in quality assurance and improvement in training and practice.
- Child Fatality Data Base. The Department continues to use a data base to track and trend cases of child fatality and near fatality. This information is used to guide improvements throughout Kentucky's child welfare system.

Section II- Historical Trends

The occurrence of every child fatality is so keenly felt and highly visible that reporting multiple cases can appear dauntingly large. Thus without diminishing the personal impact of a single

occurrence, it is instructive to understand the relative infrequency of these cases in relationship to all child protective service cases. In the nine year period between July 1, 1999 and June 30, 2008 (SFY 2000-2008), 253 children have died or been seriously injured as a result of caretaker abuse or neglect in cases where DPP had prior involvement with the child or family. Table 1 shows that in SFY 2001, DPP received 44,128 reports of child abuse and neglect. In SFY 2008, that number reached 71,573 reports; an increase of over 27,000 reports. The number of children involved in these cases has increased proportionally from 55,062 in SFY 01 to 86,843 in SFY 08⁴.

Table 1- SFY 2001-2008 Abuse and Neglect Data

	SFY 01	SFY 02	SFY 03	SFY 04	SFY 05	SFY 06	SFY 07	SFY 08
Number of abuse/neglect reports rec'd	44,128	45,357	46,494	50,318	65,408	64,988	65,820	71,573
Number of children involved	55,062	56,934	59,071	64,767	67,252	79,796	81,350	86,843
Number of reports abuse/neglect was found	11,959	10,828	11,151	12,131	12,201	12,358	11,971	11,728
Number of children involved in cases where abuse/neglect was found	16,633	15,795	16,586	18,275	18,827	19,003	18,469	18,094
Number of <i>fatalities</i> where abuse/neglect found	26	29	32	36	34	36	26	25*
Number of abuse/neglect fatalities with DPP history	10	13	17	25	21	21	13	15*
Number of <i>near fatalities</i> where abuse/neglect found	Data not collected	Data not collected	Data not collected	16	36	26	34	48*
Number of abuse/neglect near fatalities with DPP history	Data not collected	Data not collected	Data not collected	10	23	17	20	28*

³ 6 fatality cases and 2 near fatality cases with prior DPP involvement are still under review

* Numbers are not final as there are child fatality and near fatality cases still under review

⁴ Data source: TWS-Y084run for respective SFY time periods.

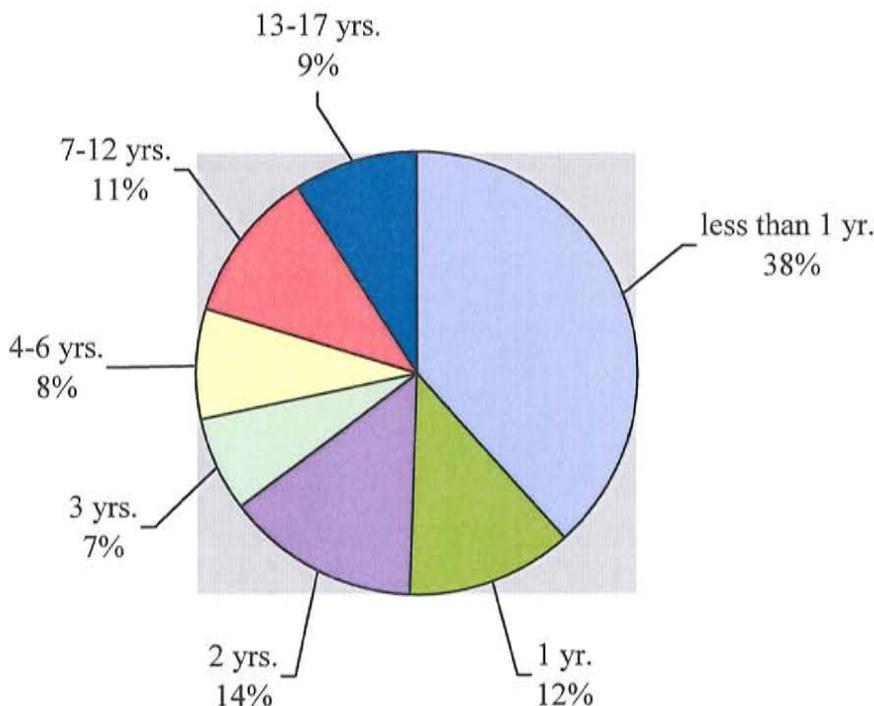
The Cabinet for Health and Family Services began submitting an annual report outlining individual state fiscal year trends in SFY 2004. However, the small number of annual occurrences results in significant fluctuation in trends from year to year and does not provide a representative picture of child abuse or neglect related fatality and near fatality cases. In order to establish a context against which the data can be evaluated and improvement measured, this report provides an analysis of Kentucky's data across nine state fiscal years and compares Kentucky's child fatality data to the most recent national data.

Once the context of data is established, consideration can be given to the trends in basic demographic information of the child victim, caretaker risk factors and family/household dynamics. Since July 1, 1999, 253 children who have prior involvement with DPP have either died or been seriously injured as a result of abuse or neglect. The analysis of these data is presented into three categories: victim characteristics, caretaker demographics and family/household dynamics.

Victim Characteristics- Age and Gender

In Kentucky, child victims 3 years of age or younger account for 180 of the 253 total fatality and near fatality cases (71%). The national average in 2006 for child fatalities among children 3 years of age or younger was 78%⁵ Children under the age of 1 year comprised 38% of KY deaths or serious injuries compared to 44.2% of child deaths nationally.

Table 2- Percentage of children by age (KY N=253)

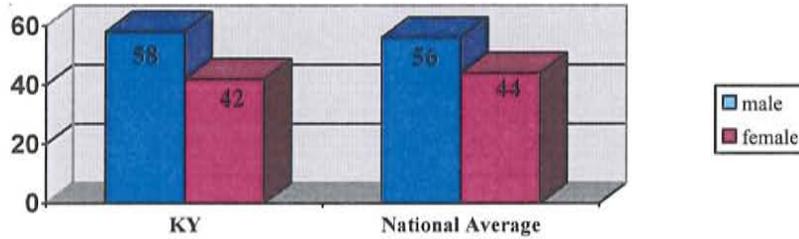


⁵All National Data referenced is taken from: ACF children's Bureau 2006 Child Maltreatment Report

Of the 253 children in this data set whose death or serious injury was the result of abuse or neglect,

147 victims were male (58%) and 106 were female (42%). In the 2006 national data, males accounted for 56% of victims and females 44%.

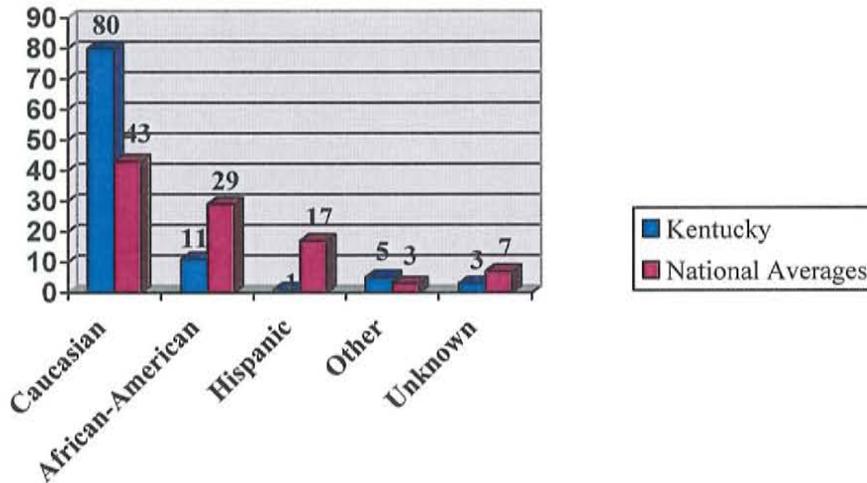
Table 3- Percentage of child victims by gender (KY N=253)



Victim Characteristics- Race and Ethnicity

Caucasian children account for 202 of the 253 child fatalities and near fatalities from SFY 01-08 (80%). African American children account for 28 of the child victims (11%), and bi-racial children account for 14 of the child victims (5%). Two children are of Hispanic ethnicity (1%) and the race or ethnicity of 7 children was unknown (3%). The chart below shows how Kentucky's rates compare with the national data.

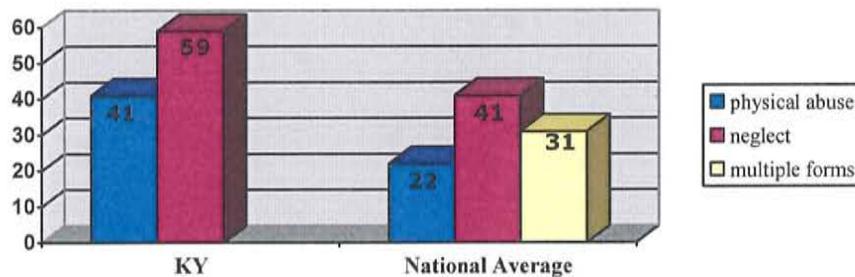
Table 4- Percentage of KY child victims by race/ethnicity (N=253)



Victim Characteristics- Type of Maltreatment

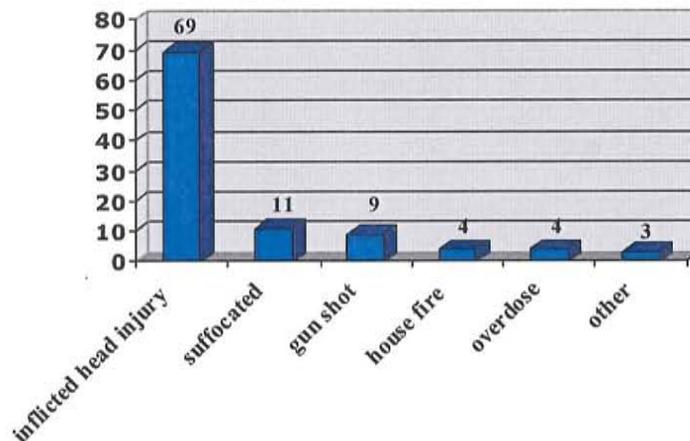
In this analysis, child maltreatment is broken into two categories; physical abuse and neglect. Of the 253 cases in Kentucky occurring between SFY 2000 and SFY 2008, 103 died or were seriously injured as a result of physical abuse (41%) and 150 died or were seriously injured as a result of neglect (59%). These data suggest that physical abuse is much more lethal than neglect considering that neglect reports accounted for 74% of all child abuse and neglect reports received in SFY 08, and physical abuse only accounted for 21% of all reports received. The national data for the most recent year published show 22% of fatalities are result from physical abuse, 41% of fatalities result from neglect and 31% were the result of combinations of maltreatment which is accounted for by varying ways of reporting among states. The remaining types of maltreatment are identified in the national data as 3% psychological abuse, 2% medical neglect, and 0.3% sexual abuse. For child fatality or near fatality reporting purposes, Kentucky only reports the maltreatment type that resulted in death or serious injury of the victim.

Table 5- Percentage of child victims by maltreatment type (KY N=253)



Of the 103 physical abuse fatalities and near fatalities in KY, the number one cause of death or serious injury was inflicted head injury, otherwise referred to as shaken baby syndrome, which accounted for 69% of injuries resulting from physical abuse. Manual strangulation or suffocation accounted for 11% of child deaths or serious injuries. Table 6 below shows the distribution of inflicted injury included in this category.

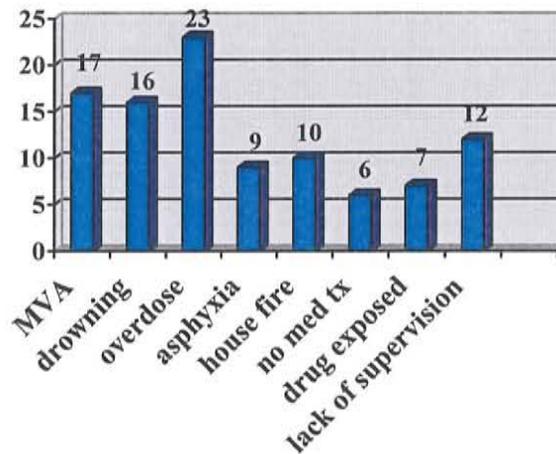
Table 6- Percentage of KY child victims- physical abuse (N=103)



Of the 150 neglect fatalities and near fatalities, the number one cause of death or serious injury is child overdose which accounted for 23% of the cases. Overdose cases include self administration,

accidental ingestion as a result of lack of supervision and overmedication by a caregiver. Motor vehicle accidents involving an impaired driver accounted for 17% of cases. Drowning, resulting from lack of adult supervision, accounted for 16% of neglect cases, positional asphyxia for 9% and house fires for 10% of neglect cases. Lack of supervision comprises a total of 12%.

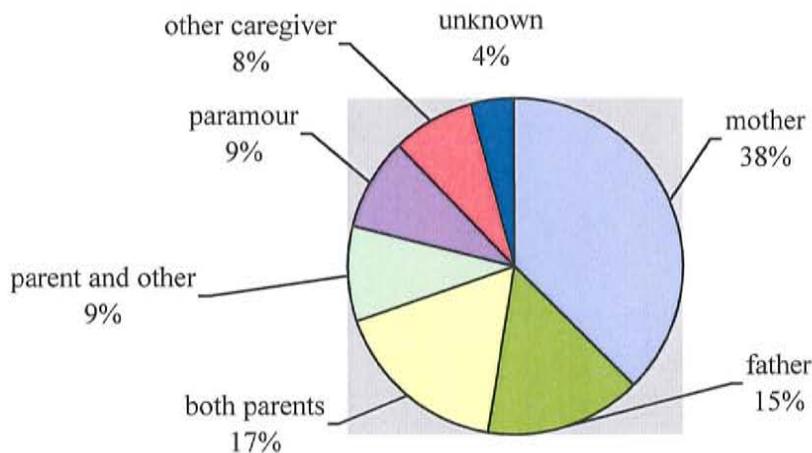
Table 7- Percentage of KY child victims- neglect (N=150)



Caregiver Information- Relationship to Victim

In the 253 cases included in this analysis, 78% of perpetrators of abuse or neglect related child fatalities and near fatalities are either one or both biological parents. The 2006 national average is 76.8% for this element.

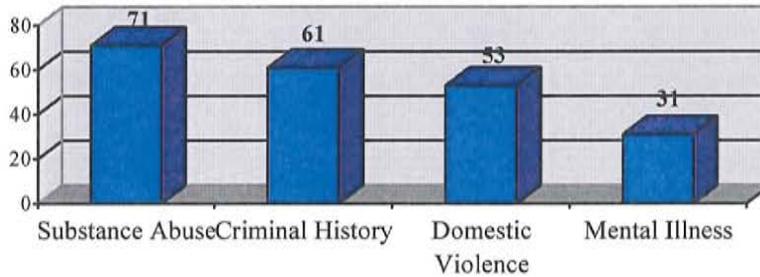
Table 8- Percentage of KY caregiver relationship to victim (N=253)



Caregiver Information- Risk Factors

Substance abuse, domestic violence, criminal history and mental illness are commonly known antecedents in child abuse and neglect cases and child fatality and near fatality cases are no exception. Of the 253 cases included in this report, 181 had substance abuse indicated by one or both caretakers (71%), in 154 cases one or both caregivers had a criminal history not including traffic violations (61%), 135 families experienced domestic violence (53%) and in 79 cases at least one caregiver struggled with mental illness (31%).

Table 9- Percentage of risk factors in KY fatality and near fatality cases (N=253)

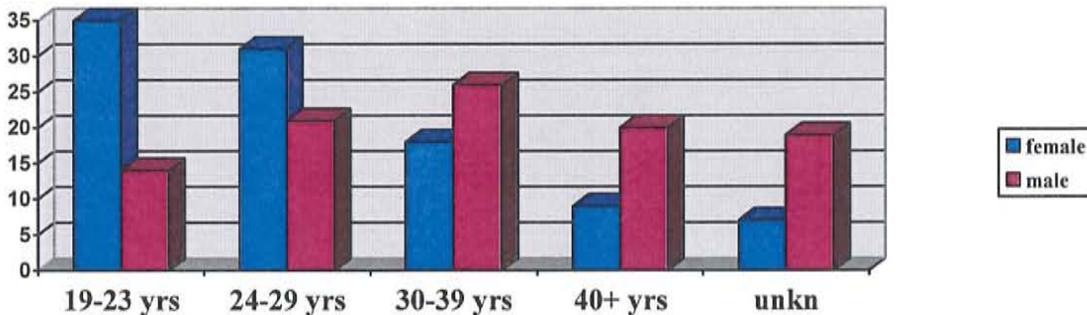


Often there are multiple risk factors in families that experience a child fatality or near fatality. Substance abuse and criminal history co-occurred most frequently and domestic violence was often an additional risk factor. Serial relationships, an element that was not collected for all state fiscal years and therefore not included in this analysis, also occurred proportionally more often in child fatality and near fatality cases than in all child protective services cases⁶.

Family/Household Dynamics- Age of Caregivers

The median age of female caregivers in abuse or neglect related fatality and near fatality cases was 25.5 years while the median age of male caregivers was slightly higher at 28 years of age. The 2006 national data show a similar trend with male caregivers median age of 34 years and the female median age of 31 years.

Table 10- Caregiver age in Percentage (N=253)

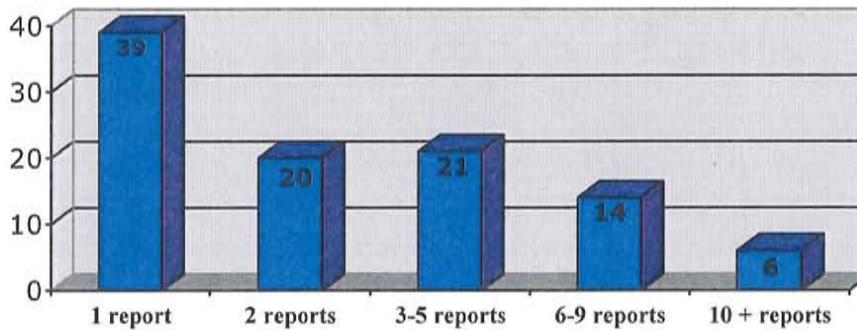


⁶ Building and Using Models of Lethality: R. Huebner, T. Webb 2006

Family/Household Dynamics- Number of previous CPS reports

All cases included in this analysis have at least one previous child protective services (CPS) report resulting in an assessment of the child or family. Table 11 below depicts the amount of CPS history associated with child fatality and near fatality cases.

Table 11- **Percentage** of cases by number of previous CPS reports (N=253)



Regional Differences- Fatality and Near Fatality Data SFY01-SFY08

Table 12- Number of Abuse/Neglect Fatality and Near Fatality cases by region (N=253)

Service Region	# of abuse/neglect fatalities with DPP history	# of abuse/neglect near fatalities with DPP history	Total fatality/near fatality with DPP history	Percentage of statewide total
Cumberland	10	17	27	11%
Eastern Mountain	23	21	44	17%
Jefferson	27	7	34	13%
Northeastern	11	4	15	6%
Northern Bluegrass	18	7	25	10%
Salt River Trail	17	11	28	11%
Southern Bluegrass	12	10	22	9%
The Lakes	16	6	22	9%
Two Rivers	20	16	36	14%
Statewide Totals	154	99	253	100%

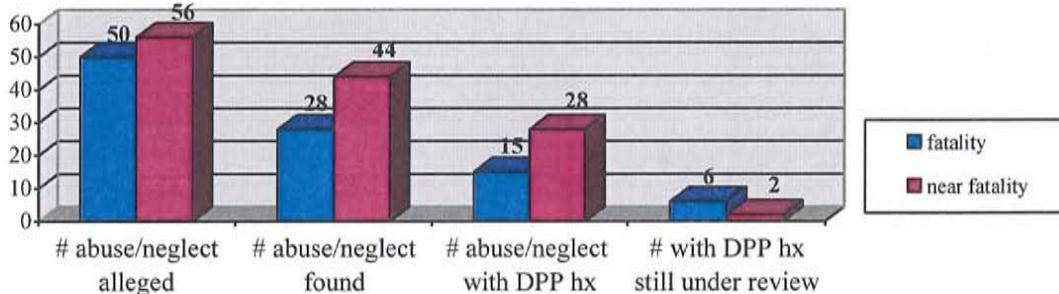
Of the 253 child fatality and near fatality cases in this analysis, Eastern Mountain Service Region had the highest number of fatality and near fatality cases that were the result of abuse or neglect with 44 cases. Two Rivers Service Region was the second highest at 36 cases. Northeastern Service Region had the lowest number of child fatality and near fatality cases at 15. See Appendix A for a regional map showing counties in each service region.

Section III- Child Fatality and Near Fatality Analysis SFY 2008

During SFY 2008, (July 1, 2007-June 30, 2008) DPP received a total of 71,573 child abuse and neglect reports involving 86,843 children. Child abuse or neglect was found in 11,728 of those cases (14%) and involved 18,049 children. Of the 18,049 children, 25 died as a result of abuse or neglect (.13%) and 48 were seriously injured as a result of abuse or neglect (.26%). Of the 25 child fatality cases, **15** (60%) had prior involvement with DPP; an equal number from last SFY. Of the 48 near fatality cases **28** (58%) had prior involvement with DPP; an increase of 8 near fatality cases from SFY 07.⁷ The data shows that there has been an increase in near fatalities this

SFY. The increase in numbers of near fatality cases is attributed in some degree to a concentrated effort with DCBS staff and community partners in identifying cases that meet the near fatality criteria.

Table 13- Number of abuse/neglect related fatalities and near fatalities SFY 2008

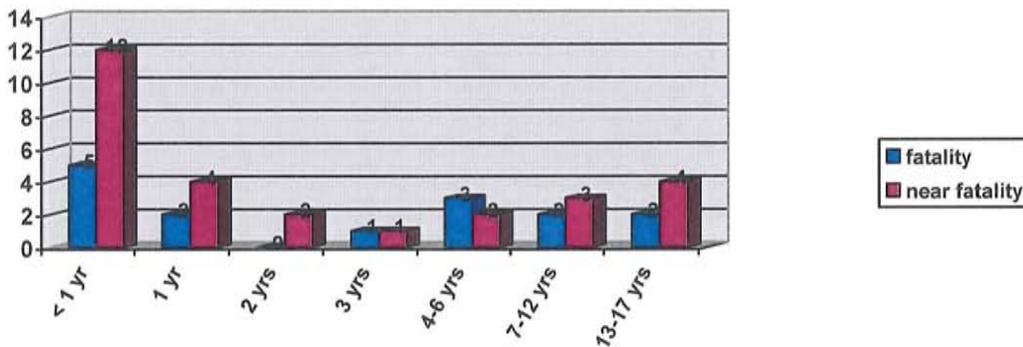


State Fiscal Year 2008 data is presented in four categories: the child victim, caretaker risk factors, family/household dynamics and regional differences. Due to the small number of cases presented, all data for this section will be reported in numbers and supplemented with percentages.

Victim Characteristics- Age and Gender

There were 15 child fatalities and 28 near fatalities that were the result of abuse or neglect where the family had prior involvement with DPP. Children 3 years of age and younger accounted for the majority of child victims at 27 victims (58%). Seventeen (40%) of the child victims in this reporting period were under the age of 1 year. The age range of children in this reporting period was 0-17 years. Table 14 shows the number of child fatality and near fatality victims by age group.

Table 14 – Age distribution by number of victims (N=43)



The distribution of the victim gender during this state fiscal year is similar to national averages in that boys are more likely to be a fatality or near fatality with 26 of the fatality and near fatality victims being male (60%) and 17 female (35%).

Victim Characteristics- Race, Ethnicity and Disability

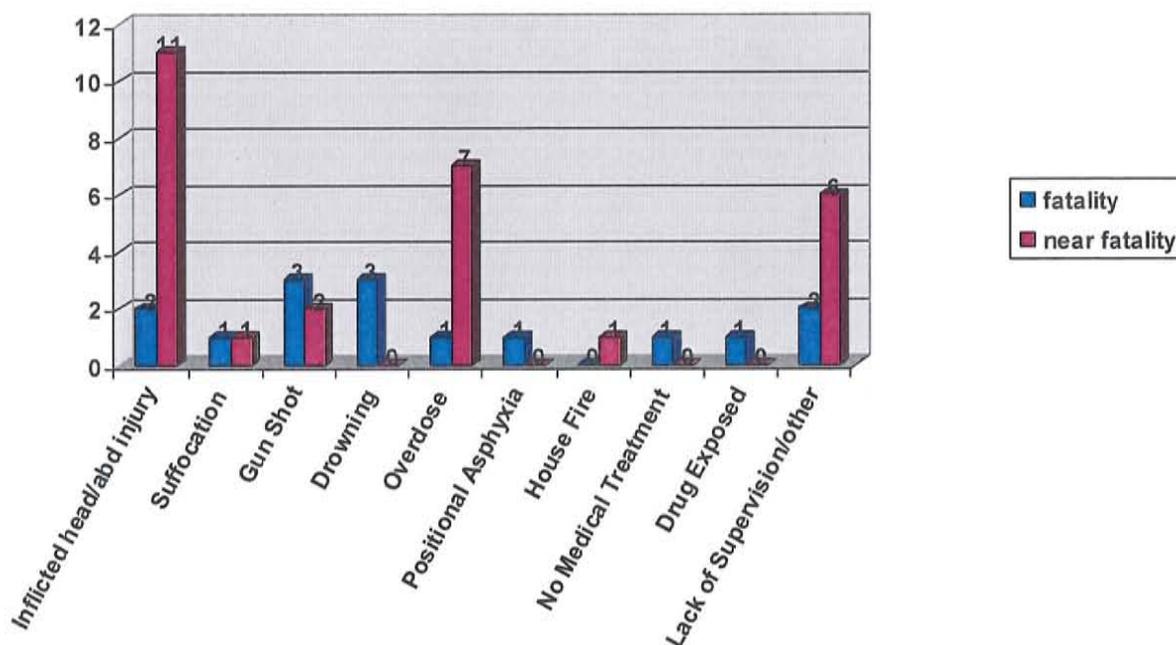
During SFY 2008, 34 of the 43 victims were Caucasian (79%), 5 victims were African American (12%) and 3 children were listed as having multiple races (7%) and 1 Hispanic child (2%).

Victim Characteristics- Type of Maltreatment

Physical abuse accounted for 20 of the 43 total child fatality and near fatality cases in SFY 08. Of the 20 cases, 6 were fatalities (30%) and 14 were near fatalities (70%). As seen in previous years, the cause of death or serious injury was most often inflicted head injury or abdominal trauma, accounting for 13 of the 20 cases (65%). Unlike previous years, 5 of the children were victims of gun shot injuries (25%); of those 5 gun shot injuries, 3 children died. Suffocation accounted for the 2 remaining cases.

Neglect accounted for 23 of the 43 total child fatality and near fatality cases in SFY 08. Of the 23 cases 9 were fatalities (39%) and 14 of were near fatalities (61%). Child overdose accounted for 8 of the 23 cases (35%). Lack of adult supervision also accounted for 8 of the 23 cases (35%) involving injuries or death associated with ATVs, homicide and a motorcycle accident. Drowning accounted for 3 of the 23 cases (13%). Complications from drug exposure accounted for 1 neglect case. Of the three remaining cases, one child died from positional asphyxia, another child died from lack of medical treatment and one child was seriously injured during a house fire. It is noted that the drowning cases and the house fire could also be placed under the category of lack of supervision, but in accordance with historical data, they will remain as separate categories.

Table 15- Number of child victims by cause of injury (N=43)

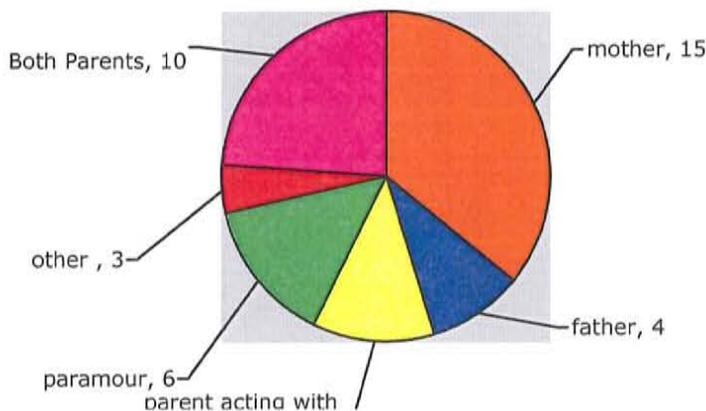


Caregiver Information- Relationship to Victim

As previously stated, data indicate that 78% of perpetrators of abuse or neglect related child fatalities and near fatalities are one or both biological parents. During the SFY 2008, in 13 of the 15 fatalities (87%) and 21 of the 28 near fatalities (75%) one or both biological parents were the perpetrator of abuse or neglect that resulted in death or serious injury to the child victim. Of the total 43 cases, parents acting alone, with each other or with another person were the perpetrators in

34 cases (79%). For the remaining cases the caregivers were parent paramours for 6 cases (14%) and 3 were listed as other (7%).

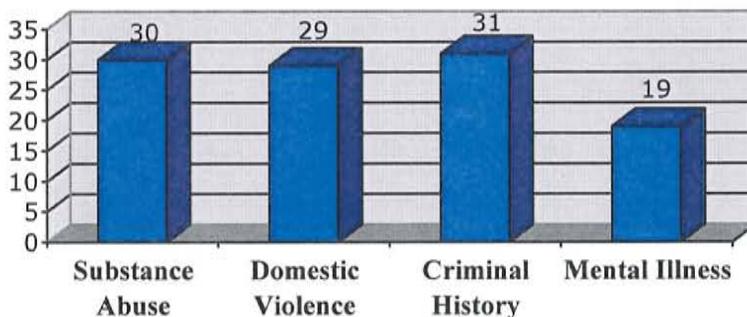
Table 16- Number of Caregiver relationship to victims (N=43)



Caregiver Information- Risk Factors

The most prevalent risk factor in the SFY 2008 fatality and near fatality cases was criminal history which was indicated in 31 of the 43 cases (72%). Substance abuse was a risk factor in 30 of the 43 cases (70%) and domestic violence was present in 29 of the 43 fatality and near fatality cases (67%) an increase of 13 cases (19%) from SFY 07. Mental illness was indicated in 19 of the 43 child fatality cases and near fatality cases (44%) an increase of 5 cases from SFY 07. Caregivers in one family are likely to have more than one risk factor.

Table 17- Number of risk factors in SFY 08 fatality and near fatality cases (N=43)

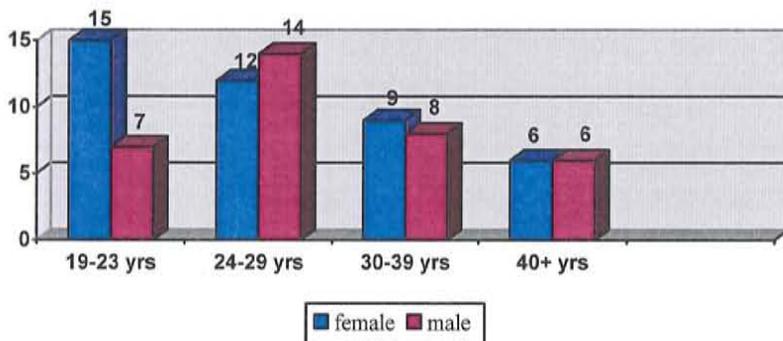


Family/Household Dynamics- Caretaker Age

The median age for female caregivers during this reporting period was 25.5 years of age which is 5.5 years less than the national median. The median age for male caregivers was 28 years of age, which is lower than the national median by 6 years. Table 18 on the following page shows the

distribution of female and male caregivers involved in cases of child fatality and near fatality in SFY 08.

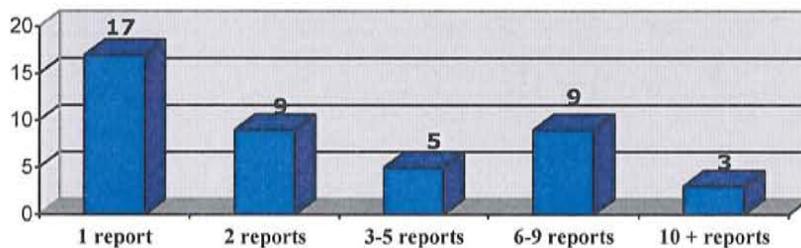
Table 18- Number of caregivers by age group and gender (N=77)



Family/Household Dynamics- Number of previous CPS reports

All cases included in the SFY data have at least one previous child protective services (CPS) report resulting in an assessment of the child or family. The preceding chart depicts the amount of CPS history associated with child fatality and near fatality cases.

Table 19- Number of cases by number of previous CPS reports (N=43)



Family/Household Dynamics- Number of siblings

The number of siblings in homes where a child fatality or near fatality occurred ranges from no siblings in 10 cases (23%) to 3 siblings in 4 cases (9%). In SFY 2008, 33 families (77%) had other children in the home at the time the fatality or serious injury occurred. Of the 33 families 21 had one sibling in the home (63%); 8 families had 2 other children in the home (24%) and 4 families had 3 other children in the home (12%).

Regional Differences

Child fatality and near fatality cases are the worst case scenario of child abuse or neglect. A look into regional differences is instructional. The chart below depicts the number of child fatality cases with history and the near fatality cases with DPP history in each of the nine service regions.

Table 20- Number of abuse/neglect fatality and near fatality cases for SFY 2008

Service Region	# of abuse/neglect fatalities with DPP history	# of abuse/neglect near fatalities with DPP history	Total fatality/ near fatality with DPP history
Cumberland	1	4	5
Eastern Mountain	3	9	12
Jefferson	5	1	6
Northeastern	0	3	3
Northern Bluegrass	1	0	1
Salt River Trail	2	1	3
Southern Bluegrass	0	1	1
The Lakes	2	2	4
Two Rivers	1	7	8
Statewide Totals	15	28	43

Section IV- Action Steps Taken by the Cabinet as a Result of Findings

The cabinet has taken numerous actions as a result of the internal reviews completed in the child fatality and near fatality cases. The action steps fall into the following 4 categories: training and pilot projects, resource development, policy and procedure refinements, and data and technology.

Training and Pilot Projects

- Medical Elements of Child Abuse and Neglect (MECAN) was developed by the Child Fatality Nurse Service Administrator in response to requests from field staff to provide training sessions on topics such as bruises, burns and bites, inflicted head injury and bone injuries. Both the location and length of the trainings were designed to provide the fewest disruptions to the workday of field staff and are topics specifically requested by field staff and supervisors. Training has been provided in all nine regions to approximately 1200 DCBS staff. Additionally the training has been provided face to face to local health department nurses and early childhood educators. The training has been converted to modules and placed on the KYTRAIN network for access to DCBS staff and community partners.
- Two additional MECAN courses are currently in development. In partnership with the Kentucky State Medical Examiner's Toxicology Laboratory "Newborn Drug Testing and the DCBS Implications" has been developed. This three hour training is currently being piloted in two regions. Evaluations are positive and scheduling is now occurring for presentations in the remaining seven service regions. The second course, "Photo documentation of Abusive Injuries and Neglect", is a collaborative effort with the Kentucky State Police and will be presented as a train the trainer course in September. At least two individuals in each service region will be trained.
- Prevent Child Abuse Kentucky initiated project CARE (Child Abuse Recognition Education) to work with physicians and their staff at identifying child abuse and assisting in child abuse investigations. At the end of the SFY 08, a total of 1,731 people across the Commonwealth have received the CARE training. A survey of physicians was also completed and the CARE team has developed a workgroup to address specific issues identified by physicians in the survey. By October 2008, a total of 64 trainings will have been completed across the state.
- Training was held with the regional fatality/near fatality liaisons from each region. This training focused on the new finding in TWIST, the data system used by DCBS; near fatalities; update on MECAN trainings; internal review process; and protocols. One focus of this meeting was to have participants make suggestions in ways of improving assessments and the recognition and identification of risk factors.
- Training is in development to help support field staff in recognizing, identifying and assessing risk factors with critical thinking. The training will also support the need for appropriate collateral contacts and documentation gathering during the assessment. Collaboration in the development and delivery of this training consists of individuals from different disciplines that include CPS, APS, Training Branch, mental health, and chemical dependency prevention. This training will become available during SFY 09 in all nine regions.

- Training for conducting fatality/near fatality investigations is currently in development. This training will be developed in collaboration with law enforcement, Coroner's Association and the Training Branch. This training will be designed to assist field staff with documentation, conducting joint investigations, assessing the family situation and roles of each discipline. Once the training has been developed, it will be presented in two locations. The training will then be available on-line so all field staff will have access.

Resource Development

- Through collaboration between the Commission for Children with Special Health Care Needs and the Department for Community Based Services, one nurse is available in each of the nine regions. The nurses provide medical consultations to regional staff on cases of child abuse and neglect.
- The Child Fatality Nurse Service Administrator continues to develop fact sheets to assist front line staff during child fatality and near fatality investigations. The fact sheets are available on the DCBS intra-net site and range from the x-rays to obtain during a skeletal survey, to quick facts about drowning, to photo-documentation of injuries. The child fatality nurse is also available to provide medical consultation on every child and near fatality case, including medical record and autopsy reviews.
- Collaboration between DCBS and the Department of Public Health continues to focus on assessing the local child fatality review team process and assisting counties in creating local teams in areas where a void has been identified. Both the Child Fatality Nurse Service Administrator and the Child Fatality Specialist are working on this effort. The Child Fatality Specialist and the Child Fatality Nurse Administrator have scheduled monthly meetings with the State Child Fatality Team Chairperson to discuss local teams and current fatality trends being seen in data from DCBS and Public Health.
- PCAKY received a grant that has been used to educate and train local community partners in the eastern part of the state regarding child fatalities. This training included DCBS staff, UK staff and representatives from the Coroner's Association. One of the purposes of this training was to promote the local child fatality teams. Two trainings have occurred in Lexington and Corbin. The Child Fatality Specialist and Child Fatality Nurse Service Administrator attended both of these trainings.

Policy and Procedure Refinements

- Debriefing for staff is provided by the Crisis Response Board and by KEAP. Each region has developed a local protocol, based upon staff needs, for providing debriefing services for staff that experience secondary trauma.
- The internal review process is currently being refined using some of the principals that came from the RCA (Root Cause Analysis) project. During SFY 08, at least one RCA was completed in all 9 regions, which has led the way to incorporate some of the fact finding techniques and problem solving skills into some of the more difficult internal reviews conducted.

- In SFY 2008, the State Child Fatality Team worked diligently on passage of the Senate Bill 121 Booster Seat Bill. The Child Fatality Specialist and the Child Fatality Nurse Service Administrator, as members of the State Team and the DCBS Child Fatality Program, supported the endeavor in multiple venues.

Data and Technology

- To assist in tracking fatalities and near fatalities and to help in being more consistent with National Child Abuse and Neglect Data System (NCANDS) a new finding has been added to TWIST, the data system used by DCBS. The system will now allow a worker or supervisor to choose the finding of ***Death/Near Death Substantiated*** when the caretaker's actions of physical abuse or neglect caused or contributed to the fatality or near fatality. With this finding, data can easily be pulled on the number of fatality/near fatality cases that have been substantiated. On-going training is conducted during Specialist meetings and internal reviews with field staff on the proper use of this finding.
- The Department continues to use a database to track and trend cases of child fatality and near fatality. While these cases all exist in the TWIST system, it is difficult to extract them for analysis purposes. The database was largely responsible for the historical analysis provided in this report.
- Understanding the difference between child abuse and neglect cases that result in child fatalities or near fatalities and those that do not was the center of a research project conducted by Dr. Ruth Huebner and other DCBS staff. The study was designed to look at lethality and chronicity as predictors of child safety issues, specifically child fatalities and near fatalities. This study was presented at the Kids Are Worth It! Conference held in Lexington in September 2007. The data for this study continues to be collected through the Child Fatality Program. Preparation has begun in putting this study in manuscript form to be submitted to the *Journal of Child Abuse and Neglect*. Collaborative research on these issues will continue to be a primary focus of the child fatality program in the Division of Protection and Permanency.

Annotated Bibliography

Huebner, R., Webb, T., Cox, G. (2006). *Building and Using Models of Lethality: Research, Data, and Practice*.

The Building and Using Models of Lethality study was presented at the 9th Annual Child Welfare and Data Technology Conference and the 16th Annual Child Abuse and Neglect Conference. The research includes a logistic regression analysis of child protective service cases most likely to experience a child fatality or near fatality. The study found that fatality and near fatality cases were more likely than other child protective service cases to have serial relationships in the home, a caregiver with mental health issues, and more adults in the home and previous physical abuse of the child victim.

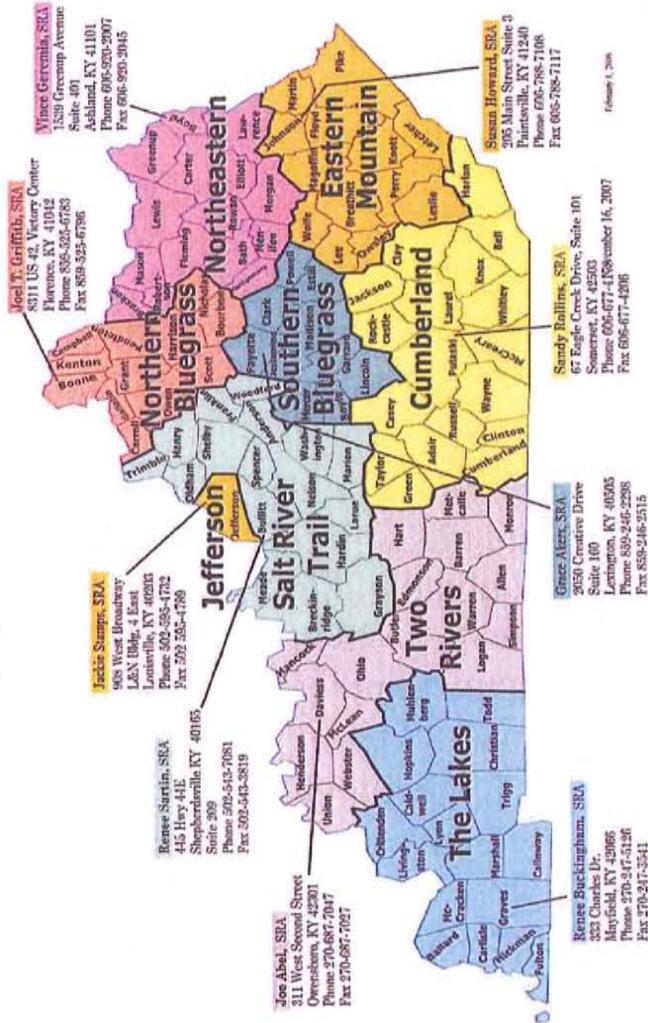
The U.S. Department of Health and Human Services, Administration on Children, Youth and Families, *Child Maltreatment 2006*.

The Administration on Children, Youth and Families compiles national and state statistics about child maltreatment that are derived from the data collected by child protective services agencies through the NCANDS. The data are analyzed, disseminated, and published in an annual report. Variables included in the report are: age and gender of fatality victims, race and ethnicity of fatality victims, perpetrator relationships to fatality victims, maltreatment types in fatality cases and prior CPS contact with fatality victims.

Appendix A

KY Map of Service Regions

DCBS Service Regions



February 1, 2008

Appendix B

Data Tables

Age- (N=253)

Age of child	SFY 2008		SFY 2000-2007 totals	Pending from previous SFYs	SFY 2000-2008 totals
	Fatality	Near Fatality			
Under 1 yr	5	12	75	5	97 (38%)
1 year	2	4	25	0	31 (12%)
2 years	0	2	33	0	35 (14%)
3 years	1	1	15	0	17 (7%)
4-6 years	3	2	15	0	20 (8%)
7-12 years	2	3	24	0	29 (11%)
13-17 years	2	4	17	1	24 (9%)
Total	15	28	204	6	253 (99%)

Gender (N=253)

Gender of child	SFY 2008		SFY 2000-2007 totals	Pending from previous SFYs	SFY 2000-2008 totals
	Fatality	Near Fatality			
Male	8	18	116	5	147 (58%)
Female	7	10	88	1	106 (42%)
Total	15	28	204	6	253 (100%)

Race and Ethnicity (N=253)

Race of child	SFY 2008		SFY 2000-2007 totals	Pending from previous SFYs	SFY 2000-2008 totals
	Fatality	Near Fatality			
African American	1	4	23	0	28 (11%)
Bi-racial	2	1	11	0	14 (5%)
Caucasian	11	23	162	6	202 (80%)
Hispanic	1	0	1	0	2 (1%)
Unknown	0	0	7	0	7 (3%)
Total	15	28	204	6	253 (100%)

Type of Maltreatment by category (N=253)

Type of Maltx	SFY 2008		SFY 2000-2007 totals	Pending from previous SFYs	SFY 2000-2008 totals
	Fatality	Near Fatality			
Physical abuse	6	14	80	3	103 (41%)
Neglect	9	14	124	3	150 (59%)
Total	15	28	204	6	253 (100%)

Physical Abuse (N=103)

Physical Abuse	SFY 2008		SFY 2000-2007 totals	Pending from previous SFYs	SFY 2000-2008 totals
	Fatality	Near Fatality			
Inflicted head and abdomen injury	2	11	55	3	71 (69%)
Suffocation	1	1	10	0	12 (11%)
Gun shot	3	2	4	0	9 (9%)
House fire	0	0	4	0	4 (4%)
Overdose	0	0	4	0	4 (4%)
Other	0	0	3	0	3 (3%)
Total	6	14	80	3	103 (100%)

Neglect (N=150)

Neglect	SFY 2008		SFY 2000-2007 totals	Pending from previous SFYs	SFY 2000-2008 totals
	Fatality	Near Fatality			
MVA impaired driver	0	0	26	0	26 (17%)
Drowning	3	0	20	1	24 (16%)
Overdose	1	7	24	2	34 (23%)
Positional asphyxia	1	0	12	0	13 (9%)
House fire	0	1	14	0	15 (10%)
No medical treatment	1	0	8	0	9 (6%)
Drug exposed	1	0	10	0	11 (7%)
Lack of supervision/other	2	6	10	0	18 (12%)
Total	9	14	124	3	150 (100%)

Caregiver Relationship to Child (N=253)

Relation	SFY 2008		SFY 2000-2007 totals	Pending from previous SFYs	SFY 2000-2008 totals
	Fatality	Near Fatality			
Mother	6	9	78	0	93 (37%)
Father	0	4	33	1	38 (15%)
Both parents	4	6	32	2	44 (17%)
Parent and other	3	2	16	2	23 (9%)
Paramour	1	5	16	1	23 (9%)
Other	1	2	18	0	21 (8%)
Unknown	0	0	11	0	11 (4%)
Total	15	28	204	6	253 (100%)

Caregiver Risk Factors (N=253)

Risk	SFY 2008	SFY 2000-2007 totals	Pending from previous SFYs	SFY 2000-2008 totals
Substance Abuse	30	149	2	181 (71%)
Domestic violence	29	104	2	135 (53%)
Mental Illness	19	60	0	79 (31%)
Criminal history	31	121	2	154 (61%)

Note: Numbers will not total 253 because the majority of cases have more than one risk factor identified.

Prior History with P&P (N=253)

Amount of history	SFY 2007	SFY 2000-2007 totals	Pending from previous SFYs	SFY 2000-2008 totals
1 prior report	17	81	1	99 (39%)
2 prior reports	9	41	0	50 (20%)
3-5 prior reports	5	46	3	54 (21%)
6-9 prior reports	9	24	2	35 (14%)
10 + reports	3	12	0	15 (6%)
Total	43	204	6	253 (100%)