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Janie Miller
Secretary

December 1, 2011

Honorable Steven L. Beshear
Governor
Commonwealth of Kentucky
The Capitol, Suite 100
700 Capitol Avenue
Frankfort, Kentucky 40601

Dear Governor Beshear:

Pursuant to KRS 620.050(12), enclosed is the Child Abuse and Neglect Annual Report of Fatalities and Near Fatalities from the Cabinet for Health and Family Services, Department for Community Based Services.

Should you have any questions, please contact me.

Sincerely,

Janie Miller
Secretary

JM:DPP:MC:sr

Enclosure

cc: Robert Sherman, Director
Legislative Research Commission

Child Abuse and Neglect
Annual Report of Fatalities and Near Fatalities

prepared by
Division of Protection and Permanency
Department for Community Based Services
Cabinet for Health and Family Services

December 1, 2011

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Introduction

Childhood is a time of growth, nurturing and support. Good memories and freedom from worries and responsibilities are the wishes for every child. Unfortunately, for many children, their childhood is difficult at best. Poverty, unsafe neighborhoods, lack of basic necessities, and lack of parental support/supervision make growing up a challenge rather than an opportunity. For some children, childhood is tragic. Those children who are abused or neglected suffer trauma that can have a lasting impact on their lives. The most tragic of circumstances is when abuse or neglect results in the death or serious injury of the child. In this country, more than 1,600 children lose their lives every year as the result of abuse or neglect.[1]

The Cabinet for Health and Family Services, Department for Community Based Services, began submitting an annual report detailing instances of child fatality and near fatalities attributable to abuse or neglect in state fiscal year 2004. At inception, the intent was to produce a report that offered instruction to the department and to communities about steps that could be taken to limit future occurrences of fatalities and near fatalities. However, the small number of annual occurrences results in significant trend fluctuation from year to year and, as such, did not provide a representative pattern of child abuse and neglect related fatality and near fatality cases.

In order to establish a context to evaluate the data and measure improvement, this report provides an analysis of Kentucky's fatality data across five state fiscal years, reports recent data, and compares Kentucky's data to national data. This report assesses the effectiveness of department level interventions, identifies quality assurance and program improvement measures taken by the department, and provides descriptive statistics about child fatalities that resulted from abuse or neglect.

Kentucky Revised Statute, KRS 620.050(12), which requires the submission of this report, also requires an internal review in cases where the family has "a prior assessment or investigation." Because the law does not specify the time frame of the prior involvement, a 28 year old father who spent time in foster care when he was 12 years of age is nominally equivalent to the father

[1] As reported in successive years between 2007 and 2009 in the most recent federal publication available: U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. (2010). Child Maltreatment 2009. Available from http://www.acf.hhs.gov/programs/cb/stats_research/index.htm#can. (pages 54-59)

who had an allegation of violence six months prior to his child's fatality. This lack of differentiation compromises a reviewer's ability to extract potentially relevant factors regarding effective interventions that the department could take in the future. This report includes all prior contact as required by statute, but focuses on prior investigations of the household or caretaker that occurred within twelve months of the fatality or near fatality. Within the report, the narrative discussion specifies whether the reader should apply the context of "any prior contact" or "contact within the preceding 12 months."[2]

Section I: Summary of Fatality Characteristics

In the past five years (SFY 2007-2011), there were 211 child fatality and near fatality cases in which the child or family had prior involvement with the department (i.e., at least one family member had some prior assessment or investigation). A summary of fatality and near fatality case features across the previous five years state fiscal years is included below.[3] These data are consistent with national trends in child fatality cases resulting from abuse or neglect:

- 77% of perpetrators were one or both parents.
- The average age for female caregivers was 28 years; for male caregivers, 31 years.
- Abusive head trauma accounted for 49% of the physical abuse fatalities/near fatalities.
- In neglect fatalities/near fatalities, the leading cause of death or serious injury is drug related, accounting for 28% of the cases. This includes children ingesting a caretaker's medication (via a lack of supervision) and over-medicating by a caretaker.

Across state and national reporting, the most widely verified element in child fatalities and near fatalities is the age of the victim: the data show that younger children are more vulnerable. Figure 1 indicates that children under the age of 4 were more often the victims of fatal or near fatal instances of child abuse and neglect. This age group represents the majority of childhood victims in fatalities or near fatalities (73%).

[2] In state fiscal year 2011, the department substantiated 9,595 of the 32,835 allegations it investigated in child protective services cases. In that year, 69 of those cases were child fatalities or near fatalities. Of those cases, 35 had prior history, but only 11 had a prior investigation or assessment within the 12 months preceding the fatality or near fatality.

[3] The appendix includes data tables containing descriptive data for distinct years, including 2011.

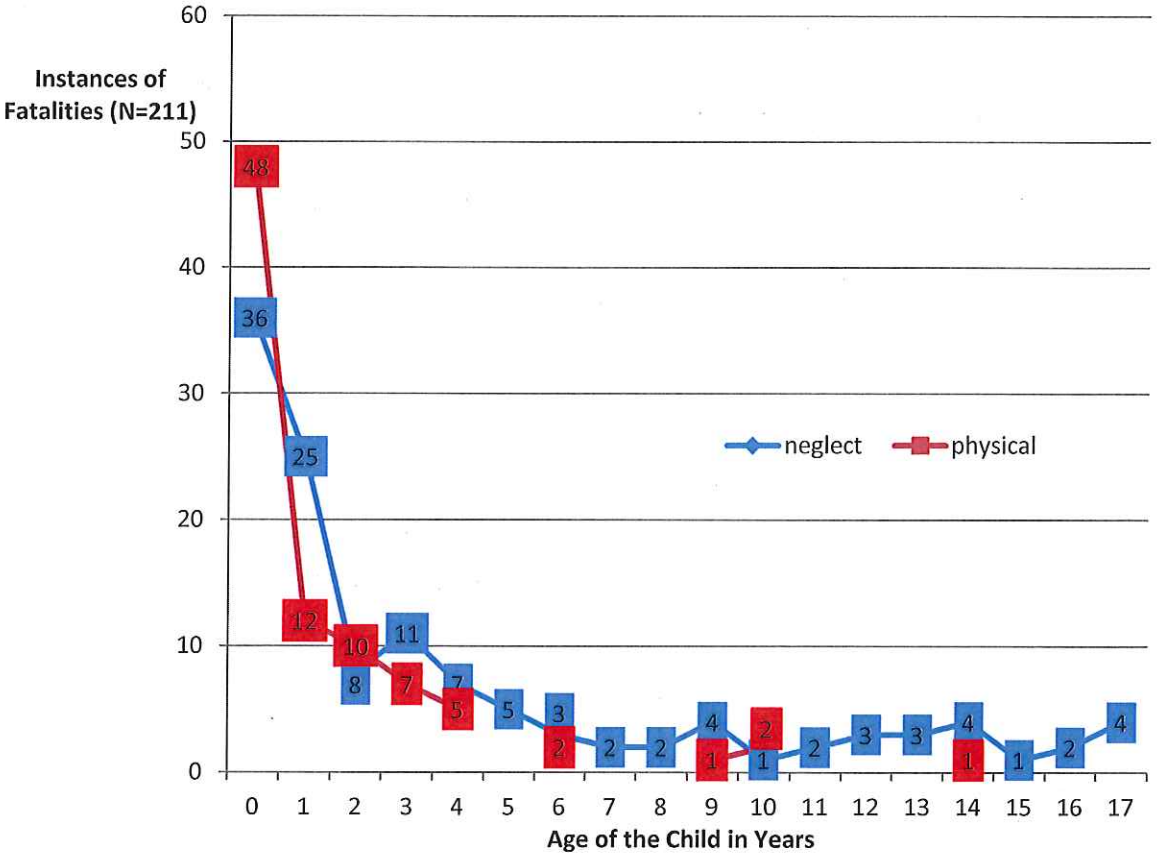


Figure 1: Fatalities and Near Fatalities (Cause and Number) By the Age Group for SFYs 2007 – 2011

When separated by type of maltreatment (physical abuse versus neglect), nearly all of the victims of fatal or near fatal physical abuse are under age 4. By contrast, the age of children in neglect related fatalities or near fatalities is more equally distributed across the age groups.

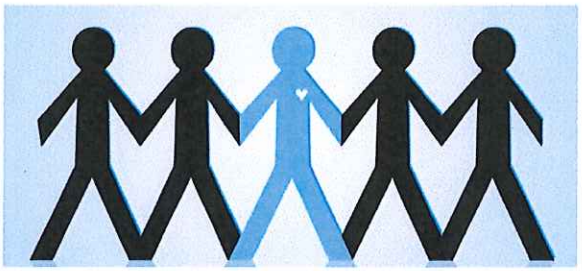
Section II: Predictive Ability

One value of an analysis of fatalities resulting from abuse or neglect is a greater ability to identify risks or case characteristics that predict which cases will be most likely to result in lethal child abuse or neglect. To be appropriately instructive, the phenomenon of hindsight bias must be controlled in the analysis. Hindsight bias is the tendency to rate a case more negatively or more positively when the analyst or reviewer is aware of the case's outcome.[4] In fatality or near

[4] Caplan, Posner, and Cheney. "Effect of Outcome on Physician Judgments of Appropriateness of Care." JAMA. 1991;265:1957-1960.

fatality cases, knowing that the case ended in fatality or near fatality may predispose an analyst more likely to rate the case as substandard. It is very easy to review case details that ended in a child fatality and attribute a cause and effect relationship to any particular detail of the case; however, in the full context of child welfare the department works with thousands of families who present with similar case features, and the vast majority of those cases do not end in fatality or near fatality. Perhaps the best example is the perception that a drug screen by itself is sufficient basis for case action, particularly when the case outcome was negative. Such a perception is an example of hindsight bias. In fact, there is insufficient evidence to indicate that a positive drug screen alone has any predictive value for maltreatment or repeat maltreatment. A positive drug screen confirms drug use approximate in time to the drug screen. It does not provide information about the extent of the caregiver's use or dependence on a drug, information about the caregiver's attachment to the child, nor does it carry information about the caregiver's tendency towards violence. The department's intent is to conceive practice changes based on analysis and by limiting the effects of hindsight bias.

In previous years, the annual child fatality report has drawn comparisons between near fatalities and fatalities. This strategy only allowed a reader to identify differences and similarities in cases in which both comparison groups experienced negative case outcomes. For evaluative purposes, the factors that differentiate the cases with positive outcomes from cases with negative outcomes have the potential to provide the most utility. In this section, the comparison is made between:



- fatality or near fatality cases with prior contact,
- cases with substantiated maltreatment (although not a fatality or near fatality), and
- all investigative cases.

When child protective services workers are handling cases, they conduct risk assessments that include components for assessing the allegation, the child's vulnerability, parenting ability, community support systems available to the family, protective capacity of the caretaker, and caretaker/child attachment. Workers weigh that information and make a recommendation about whether services are necessary to address risks identified during assessment and whether children can remain safely in their home. In assessing which factors are the most reliable for

predicting future maltreatment, Figure 2 compares: 1) the assessed presence of certain risk factors in fatality and near fatality cases with history over the last five years; 2) substantiated cases that did not end in fatality or near fatality in SFY 2011; and 3) all cases assessed or investigated in SFY 2011, including unsubstantiated cases.

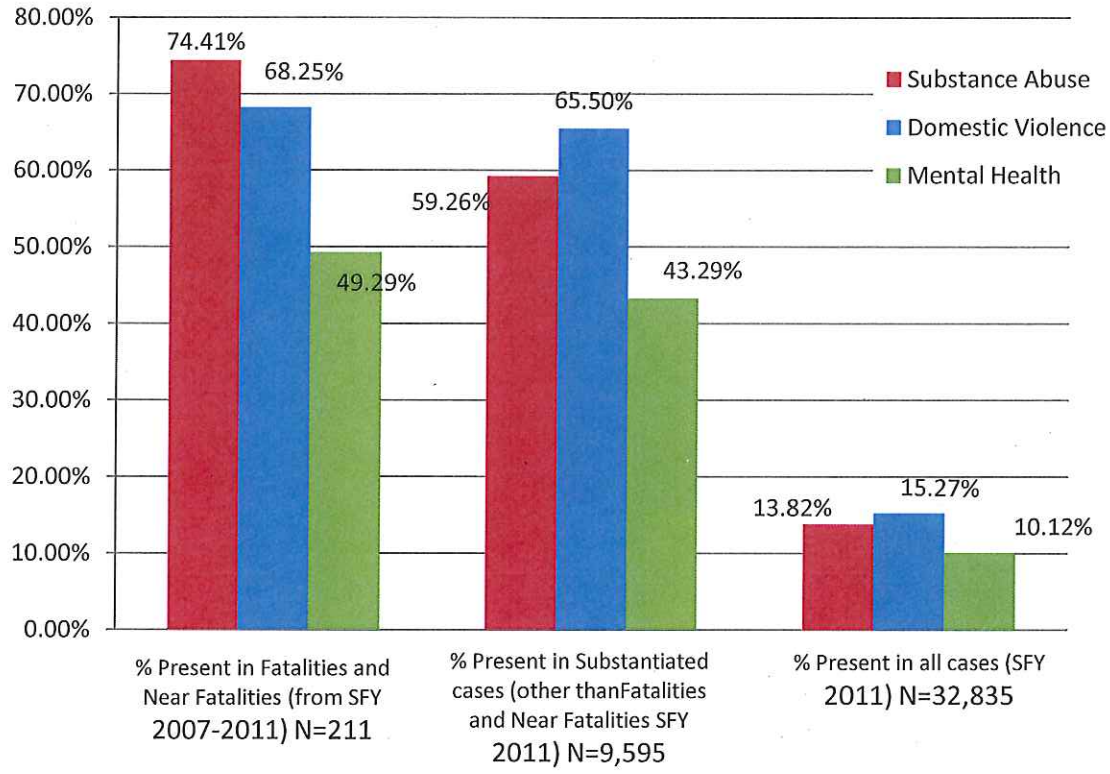


Figure 2: Risk Factors Noted as Present Among Three Comparison Groups

In Figure 2 the three groups are compared by the prevalence of substance abuse indicators; domestic violence indicators; and mental health indicators. Data indicate that cases with any substantiated child abuse or neglect, regardless of whether the case ended in a fatality or near fatality, are assessed as having a comparatively high presence of each of the risk factors when compared to all cases that were investigated.

Of these risk factors, substance abuse was assessed to be present at a slightly higher rate than other risk factors in fatality and near fatality cases. However, previous research had evidenced that substance abuse was only slightly more significant as a risk factor of any predictive value.[5]

[5] "Using Models of Lethality to Enhance Child Welfare Risk and Safety Assessment." Huebner, Webb, Brock, and Rock. American Humane Association. 2010: Volume 25, No. 3 (pages 76-89).

Prior to drawing conclusions about the influence of substance abuse in child welfare cases, including those with fatalities and near fatalities, the department must have the capacity to measure the severity of a risk factor, not just its presence. For example, the range of substance using behaviors includes anything from the presence of an alcohol-related DUI criminal charge to a full addiction to substances, such as methamphetamine or cocaine. Currently, the department database cannot extract that information in a nuanced way for analysis, even if the worker was appropriately sensitive to the severity of the substance issue in the investigative narrative and risk assessment.

In summary, all families that come to the attention of child protective services with a substantiated instance of abuse or neglect have a tendency to present with risk factors, and the mere presence of a risk factor will not necessarily allow a field worker to predict whether or not the case is likely to end in a fatality or near fatality. However, as the department continues to compile and refine data pertaining to child welfare cases, the value of these and other risk factors as predictors will become more discernible.

Section III: Effectiveness of Interventions

A prudent assessment of fatalities or near fatalities should also seek to evaluate the department's interactions with families prior to the occurrence of the fatality or near fatality. Two elements which contribute to that interaction and that are under the control of the agency are: the ability of the worker to obtain an objective and complete assessment of the family; and, the ability of the worker to match appropriate services to any needs identified during the assessment. However, if the department reviewed only those investigative assessments in which a fatality occurred, even with five years of data, it would only represent less than one-half of one percent of the department's interventions in the previous five years.[6]

For a more representative sample of agency practices, fatalities and near fatalities should be a subset of a larger group—cases in which the agency applied an intervention, but another incident of abuse or neglect occurred following that intervention, commonly referred to as "repeat maltreatment." Two mechanisms to evaluate agency interventions, used by Kentucky and approved by the federal government are: a) a measure of the state's overall rate of repeat

[6] Within the previous five years, the department investigated 161,593 allegations of abuse or neglect. Of those, 390 were fatalities or near fatalities as the result of abuse or neglect. Of those, 211 were children from families who had any prior child or adult protective services involvement.

maltreatment; and b) a case analysis process conducted through a standardized assessment tool.

Repeat Maltreatment Measures

The U.S. Department of Health and Human Services, Administration for Children and Families (ACF) defines how repeat maltreatment is to be measured and reported by states. "Repeat maltreatment" is measured as the percentage of children who experienced a second incident of substantiated abuse or neglect in the 12-month period following an intervention by the state child welfare agency. Kentucky's rate of repeat maltreatment (averaged across quarters from 7/2010 to 7/2011) is 5.1%, which remains consistently below the national standard of 6.1%. ACF also requires that states report the percentage of children who were free from repeat maltreatment following an intervention by the state child welfare agency, commonly referred to as its measure of "absence of recurrence."[7]

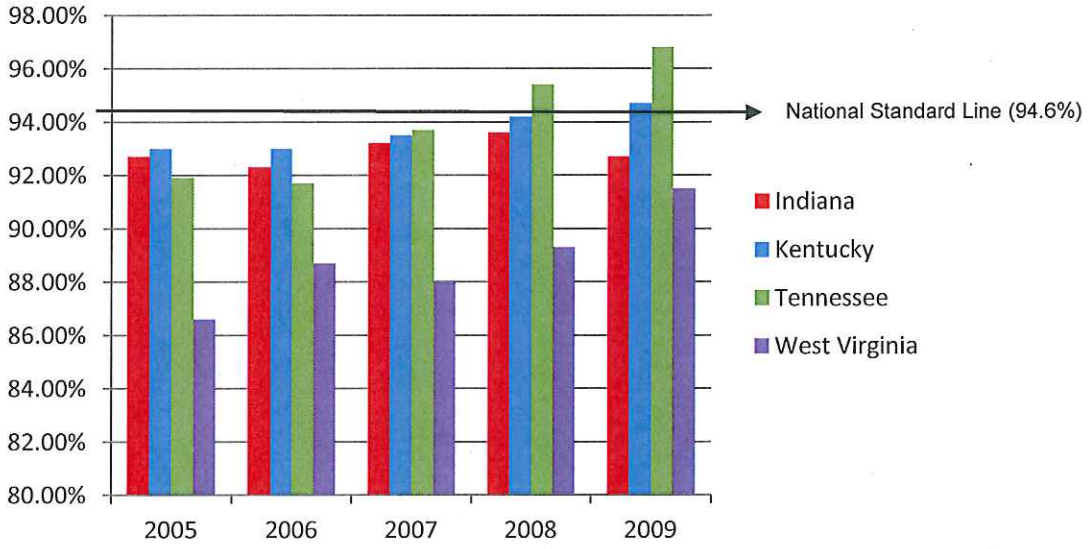


Figure 3 Absence of Recurrence, Federal Recurrence Measure

Figure 3 indicates Kentucky's most recently reported performance as measured by ACF in comparison with neighboring states. The single horizontal line at 94.6% represents the current accepted national standard for absence of recurrence, and states strive to meet that standard. "Absence of recurrence" is measured as the percentage of children who were free from a

[7] U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. (2010). Child Maltreatment 2009. Available from http://www.acf.hhs.gov/programs/cb/stats_research/index.htm#can. (pages 54-59)

second substantiated incident of child abuse or neglect within the 12 month period following an intervention by the state's child welfare agency.

Case Analysis

The department also evaluates case practices through monthly analysis of a number of randomly selected cases. Cases are scored using an instrument vetted through ACF to isolate and measure individual points of practice such as timely initiation of an investigation, the incorporation of collateral information that informs the assessment, and the inclusion of every household member in the assessment. The more complicated the case, the more points of practice to evaluate as part of the case analysis. Data from the collective analyses are evaluated for trends and practice issues. In contrast, "The Annual Child Fatality Report" in previous years has not included case analysis data. However, for the SFY 2011 report, the eleven cases identified as having a prior assessment within twelve months of the fatality were targeted for review.

A single analyst evaluated and scored the investigation that immediately preceded the fatality or near fatality in those 11 cases. That analysis lead to some noteworthy observations:

- Only 1 of the 11 had the same victim and perpetrator pairing from the previous report to the fatality/near fatality report, an important variable when considering previous family assessment or investigation.
- In 9 of the 11 cases, the prior assessment or investigation were reports of neglect, while the subsequent report, which resulted in the fatality or near fatality, involved physical abuse.
- All 11 cases with prior agency involvement involved children under ten years of age, and 6 of the children were under one year of age.
- Seven died or received life threatening injuries as a result of physical abuse.
- Four of the children were victims of neglect resulting from lack of appropriate adult supervision.

Data collected from the 11 reviews concentrated on descriptive information only. Due to the small sample size, no generalizations about trends in such cases can be drawn; however, the practice of conducting these analyses will continue and expand to include a group of repeat maltreatment cases that did not result in fatality or near fatality. Ultimately the accumulation of these reviews will build database capacity for analysis in each successive year.

Section IV: Quality Assurance and Program Improvement

The department engages in a variety of quality assurance activities aimed at driving program improvements through better data and competent analysis. Those activities include random case reviews, fatality reviews, and federally conducted reviews. These reviews have provide opportunity for community collaboration and capacity building in agency staff.

Collaboration with Public Health and Medical Consultations

- Meetings are occurring between the Department for Public Health and the Department for Community Based Services regarding data sharing between the programs. These meetings were convened to explore the use of data in developing prevention/education strategies with the ultimate goal of lowering incidences of substantiated child abuse, neglect, and dependency.

- The Commission for Children with Special Health Care Needs (CCSHCN) and the Department for Community Based Services continue the collaborative effort providing medical consultations to regional staff on cases of child abuse and neglect. The CCSHCN maintains nurse coverage in all nine service regions to provide consultation.

- The Child Fatality Nurse Service Administrator continues to develop and provide information to assist front line staff during child fatality and near fatality investigations. This information includes both fact sheets and resources available from creditable sources on medical issues pertinent to the types of cases. The child fatality nurse is also available to provide medical consultation on every child fatality and near fatality case, including medical record and autopsy reviews.

- A collaborative initiative between DCBS and the Department for Public Health is underway to examine sleep-related deaths of children in Kentucky. The initiative is exploring the information available to both Public Health and DCBS to assist in developing prevention strategies.

Staff Capacity Building (new activities)

- Staff from the Child Safety Branch and the nurse service administrator represent DCBS on the Department for Behavioral Health, Developmental and Intellectual Disabilities' new "Substance Exposed Infants" workgroup. The workgroup's collaborative goals

include reducing the incidence of substance exposure during pregnancy; protecting children from harm; and, improving the functioning of prenatally drug exposed children and their families.

- The staff of the Child Safety Branch and the Family Violence Prevention Branch have collaborated to develop a presentation to assist front line staff in the challenges they face each day when working with families who battle addiction. The training will provide staff an understanding of the physical/medical issues that characterize substance abusing adults and the implications for substance exposure to their children. Sessions have been scheduled for the fall and winter of 2011 in each service region.

- "Risk Factors and the Assessment of Child Protective Service Investigations" training was provided to child protective service workers and front-line supervisors. The training, focused on case review between the supervisor and worker, will guide participants into discussion of specific risk factors that were identified as critical in assessment during the CPS investigation, substance abuse, domestic violence, mental health issues, criminal behavior and current history of serial relationships.

Practice Change

A particular example of practice change relevant child fatalities and near fatalities is the department's current use of case consultations. The department determined that multiple case reviews/consults were occurring in cases, and at different case junctures; however, the reviews did not seem to be impacting case outcomes. In addition, there was a keen focus on understanding child fatalities and near fatalities that were the result of child abuse and neglect in order to evaluate whether those cases had any characteristics that would set them apart from the rest of the child welfare cases. The culmination of these assessments resulted in a case consultation model implemented in February 2011 that is designed to support clinical decision making in real time while investigations are occurring. The newly developed consultation process eliminated duplicative consults, standardized a process for all case types, established specific timeframes for consultations, and established templates to guide each consultation.

Initial staff feedback has been positive about the impact the process could have in identifying high risk situations with more efficacy, reducing barriers to timely permanency, and better overall service delivery to families. The consultation process was created both to improve

service on the target case, but to guide skill development for front-line staff. Practice guidance and follow-up technical assistance has been intentional in reinforcing that regional staff should use consultations as an opportunity to support critical thinking skills for frontline staff, help them problem-solve case scenarios, and remain objective in case decision-making. Frontline supervisors are expected to replicate these strategies during their formal monthly consultations and as part of regular supervisor/field staff interactions. The department is in the process of an evaluation of the consultation process, and that evaluation may take a full year or longer to obtain enough case reviews to evaluate any effect.

Section V: Conclusions and Recommendations

Despite the challenges associated with the work of child protective services, there are many things the department does well and does consistently. The department has always had a strategy of early contact for families, particularly when in receipt of allegations regarding young children. As part of agency protocol, allegations and case circumstances that affect children four years and younger are evaluated as more urgent both in initiation and investigative protocol, and as part of ongoing assessment protocol. Additionally, as part of both investigative and ongoing assessment, the department protocol is to assess both the child's vulnerability and the parent's capacity to protect. The department utilizes a comprehensive and standardized assessment tool, and a random standardized case analysis process for quality assurance purposes. The department also has a mechanism to drive practice improvements based on data collected during case reviews and has developed both training and practice guides when areas needing improvement are uncovered. The department's overall strategy towards improvement has included a consistent leadership team, measurable and data driven improvement efforts, and a framework of training and protocols that support quality casework.

There are real challenges facing the child welfare system in Kentucky. Some are internal, some external, and many are observable in other states as well. The department has chosen to produce a more evaluative annual fatality report, and take the opportunity to communicate its findings with the executive and legislative branches, as well as the public. In doing so, the department, has identified both systemic and casework practices for possible improvement.

Systemically:

- The department can promote the understanding that child welfare data, on either local or national levels, is not sufficiently developed to predict which cases have a greater propensity for a fatal or near fatal outcome compared to all the other cases with similar risk factors.
- The department can continue to develop its database, and thus increase its capacity to compare fatality and near-fatality cases against non-fatality cases.
- The department can advocate that the regulation requiring an annual child fatality report (922 KAR 1:420) refine its definition of "prior history."
- The department can continue to advocate that detailed communication of fatality/near fatality data should be conveyed in the context of the totality of child welfare data and quality of work.

In terms of casework practices:

- The department has standardized and expanded the use of consultations based on program evaluation.
- The department continues to refine worker skills around family and risk assessments.

In conclusion, in an effort to make a more meaningful and improvement-focused report, the Department for Community Based Services reconsidered the scope of the annual child fatality report. The department sought to expand beyond descriptive information about fatalities summarized across five years of information and an inventory of agency initiatives. For this year, the department has submitted what it hopes will become a template for future reports: an objective and evaluative report of fatalities and near fatalities, applied in the larger context of the agency's service provision and quality assurance mechanisms. Hopefully, this report can facilitate a greater level of understanding of the work conducted in Kentucky's child welfare system and facilitate a constructive conversation about systemic needs as they are identified.

Appendix

A. SFY 2011 Fatalities and Near Fatalities with Prior Agency Involvement

	Neglect Fatalities or Near Fatalities	Physical Abuse Fatalities or Near Fatalities	Average Age of the Child in Years	Percent of Female Victims	Percent of Male Victims	Average of female caretaker's age at time of death or injury	Average of male caretaker's age at time of death or injury
Cumberland	0	3	3	33.33%	66.67%	32	28
Eastern Mountain	4	2	3	16.67%	83.33%	28	31
Jefferson	3	5	1.25	62.50%	37.50%	28	30
Northeastern		1	<1	100.00%	0.00%	59	60
Northern Bluegrass	2	0	<1	100.00%	0.00%	27	33
Salt River Trail	1	2	<1	66.67%	33.33%	25	23
Southern Bluegrass	1	2	1.3	33.33%	66.67%	24	24
The Lakes	1	2	1.6	33.33%	66.67%	25	27
Two Rivers	4	2	4	16.67%	83.33%	25	29
Statewide Totals	16	19	2	42.86%	57.14%	28	30

B. SFY 2007-2011 Abuse and Neglect Data, Updated to Reflect the Resolution of Pending Reports from Prior Years and the Deletion of Previously Miscategorized Reports

	SFY 07	SFY 08	SFY 09	SFY 10	SFY 11
Number of abuse/neglect reports that meet criteria for investigation	31,584	30,964	33,001	33,209	32,835
Number of children involved in reports that met criteria	43,296	41,402	44,992	45,657	45,104
Number of abuse/neglect reports that were substantiated	9,960	9,845	9,112	9,470	9,595
Number of children involved in cases where abuse/neglect were substantiated	15,500	14,695	14,475	15,083	15,510
Number of *fatalities* where abuse/neglect was substantiated as the cause	33	30	27	33	18
Number of substantiated *fatalities* abuse/neglect fatalities with "prior history"	16	14	15	21	10
Number of *near fatalities* where abuse/neglect was substantiated as the cause	35	47	61	55	51
Number of substantiated abuse/neglect *near fatalities* with "prior history"	20	27	34	29	25

C. Data released in 2009 by Every Child Matters, updated with the most recent 2010 and 2011 KY child fatality numbers. 2001-2009 numbers reflect Federal FY data; 2010 and 2011 reflect State FY data. (Note: *These numbers are preliminary and may change pending legal or medical determinations. **The data for 2011 reflects substantiated child fatalities through the date of the report (September 2011).)

Time period	KY Substantiated Child Fatalities	KY national rank	National Totals for Child Fatalities
2001	26	3rd	1,321
2002	29	13th	1,390
2003	32	44th	1,177
2004	36	4th	1,387
2005	34	7th	1,371
2006	38	3rd	1,376
2007	34	1st	1,586
2008	31	19th	1,630
2009	29	Not yet released	Not yet released
2010	33*	Not yet released	Not yet released
2011**	18*	Not yet released	Not yet released

D. Regional Map