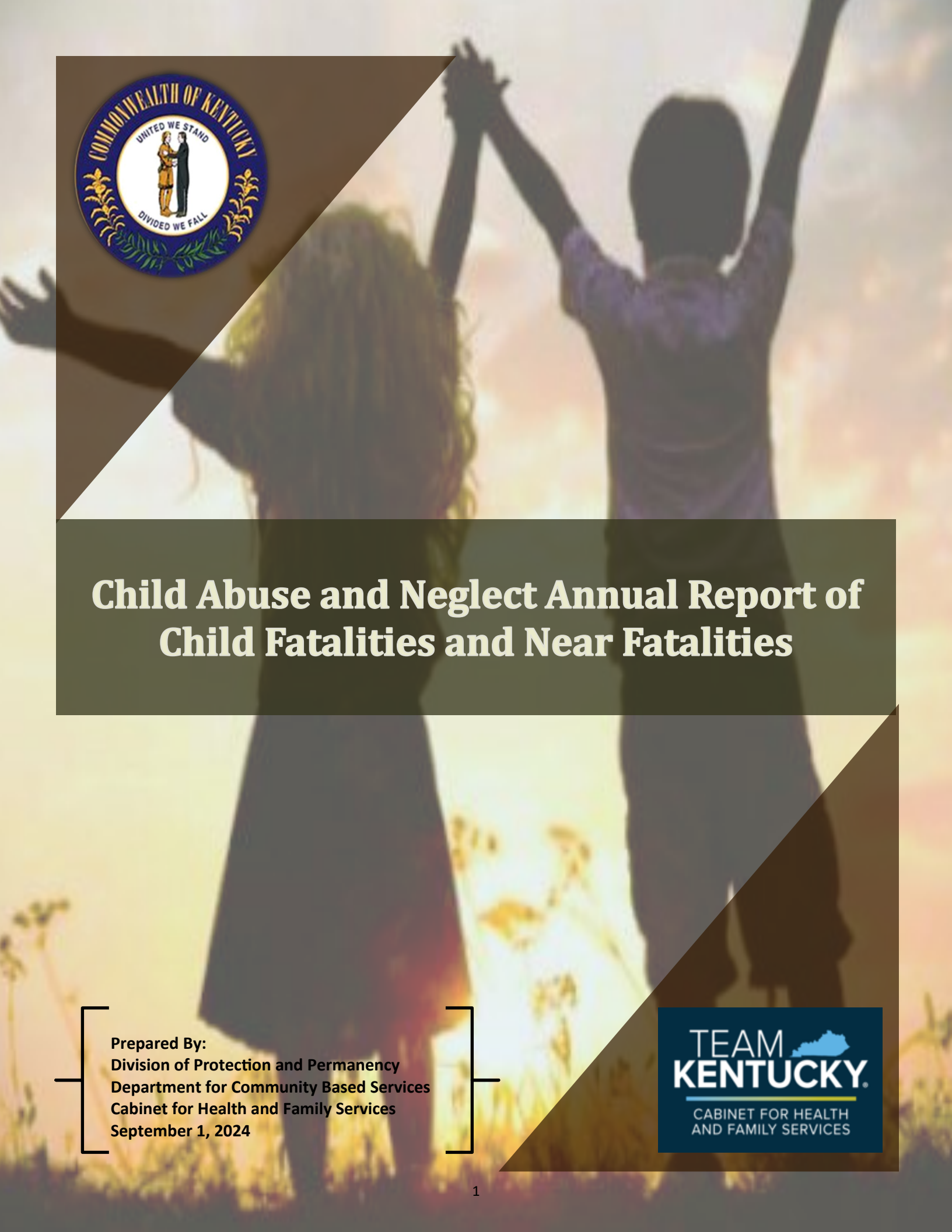

Child Abuse and Neglect Annual Report of Child Fatalities and Near Fatalities

Prepared By:
Division of Protection and Permanency
Department for Community Based Services
Cabinet for Health and Family Services
September 1, 2024

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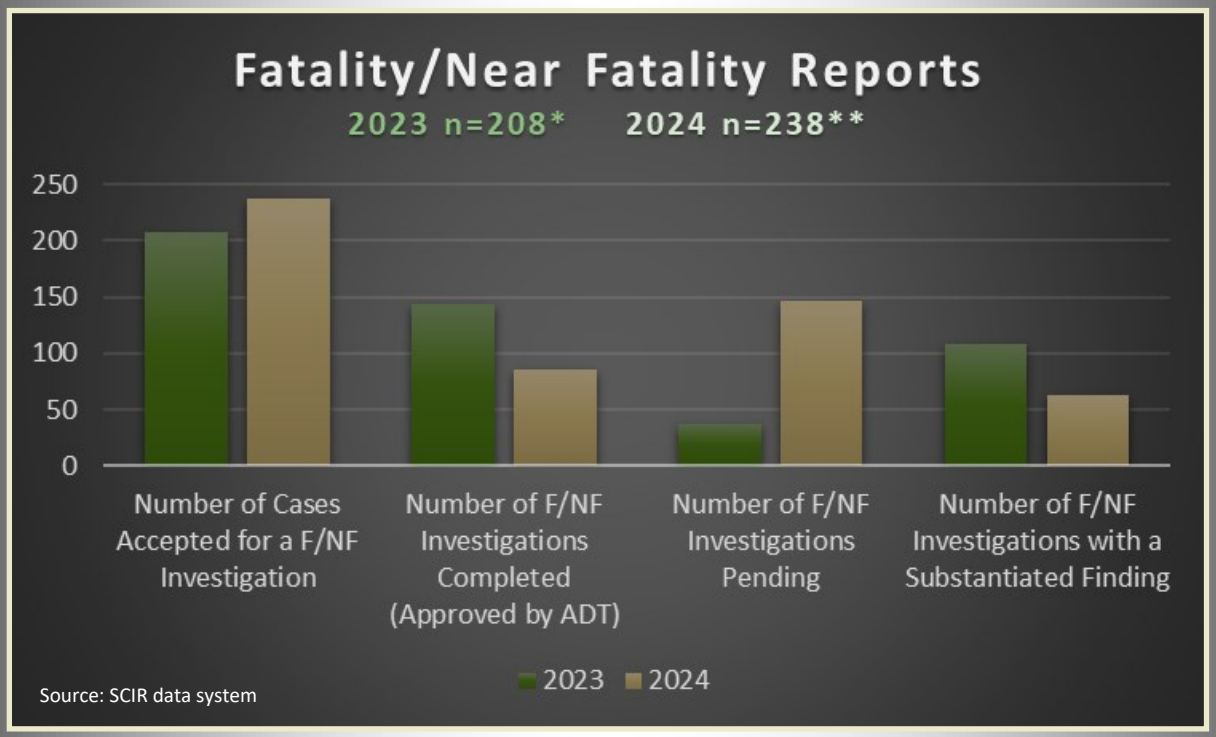
In accordance with KRS 620.050 (12)(c), the Cabinet for Health and Family Services (CHFS/Cabinet), Department for Community Based Services (DCBS/ Department) is required to submit an annual report of child abuse and neglect fatalities and near fatalities. A near fatality is defined by KRS 600.020 (40) 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, and 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.

"Child abuse casts a shadow the length of a lifetime.'
- Herbert Ward

Section I: Comparative Referral Data

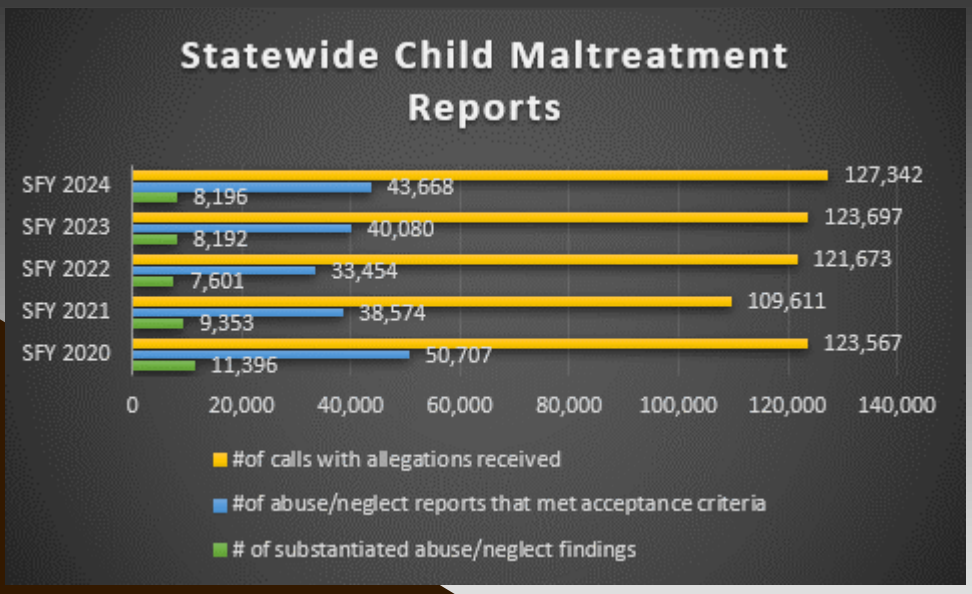
There is extensive work required in fatality and near fatality investigations of child maltreatment. Investigations are conducted jointly with law enforcement, require records collection, and include collaboration with other agencies, such as pediatric protection specialists and the medical examiner's office. This collaboration takes additional time, which contributes the delay in finalization of some investigations.



The graph above illustrates data from all investigations from SFY 2023 and 2024 completed and pending at the time of this report. The large number of pending investigations can be attributed to the complex nature of the work and ongoing staffing shortages for specialized teams that handle these types of investigations.

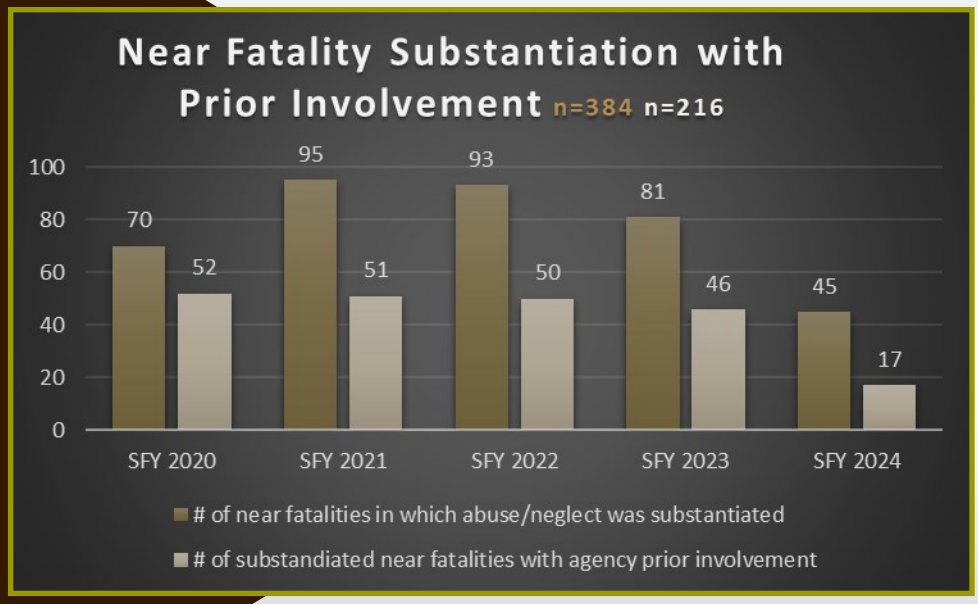
*Indicates adjustment to the number of substantiations from the prior year's report due to completed investigations.

** Indicates this number will change in the next year's annual report since the data is not complete due to pending investigations.



Source: TWS-M272F

This data shows that in SFY 2024, the Cabinet saw an increase in the number of referrals received alleging child abuse and neglect from the previous fiscal years. This is reflected in a **2.95%** increase from the previous SFY (2023) with a corresponding **8.95%** increase in referrals that met acceptance criteria. This has not resulted in an increase of cases with substantiated outcomes which has steadily decreased over the last five fiscal years. Factors contributing to these increases may merit further study.

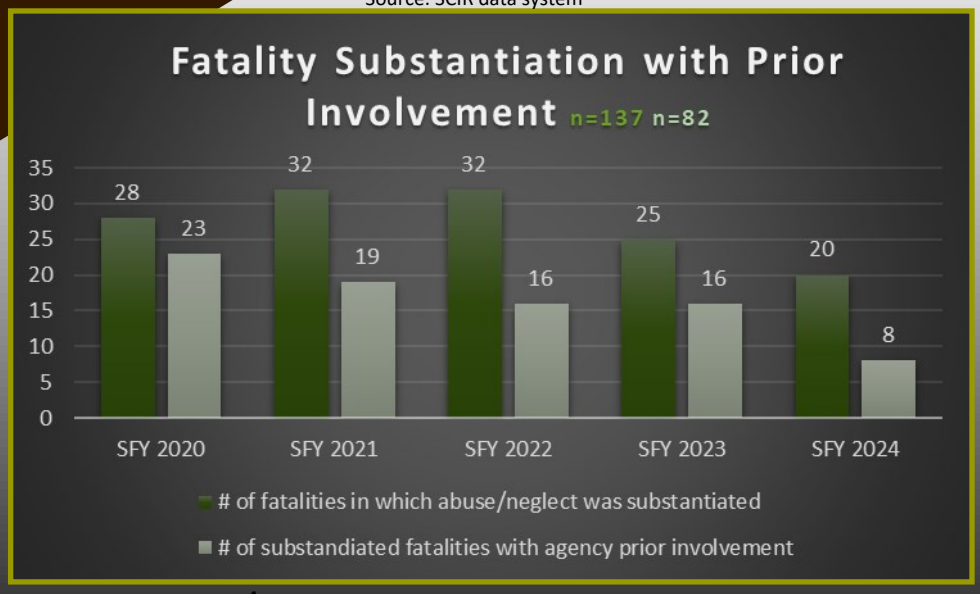


Source: SCIR data system

Data indicates an overall decrease in the number of child fatality substantiations with prior involvement since SFY 2020.

NOTE: Data from SFY 2023 reflects adjustments of substantiated findings due to completed investigations. Data from SFY 2024 indicates incomplete data due to pending investigations.

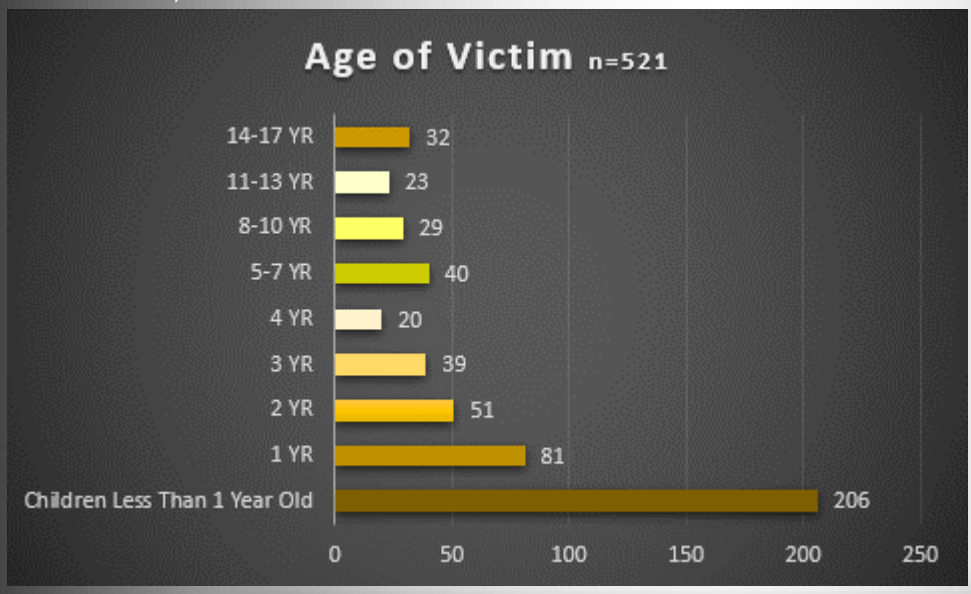
Further, discrepancies from prior annual report data in SFY 2020 represents a change in how the data is collected that created duplication in previous numbers reported. SFY 2021 also contained a typographical error in the number of prior involvement from 61, that was corrected this year to 51.



Section II: Child Demographics

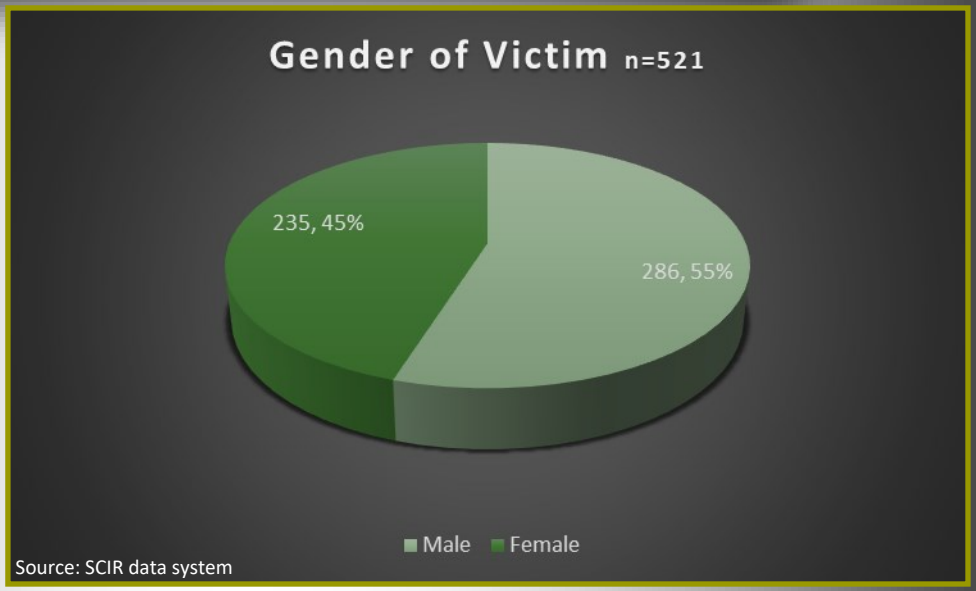
The data represented below is from SFY 2019 to SFY 2023

Source: SCIR data system



Children age four and under comprise approximately 76% of all fatal and near fatal victims, with children under the age of one representing the majority of victims.

The majority of fatality/ near fatality victims were male. This is consistent with data reported in previous years.

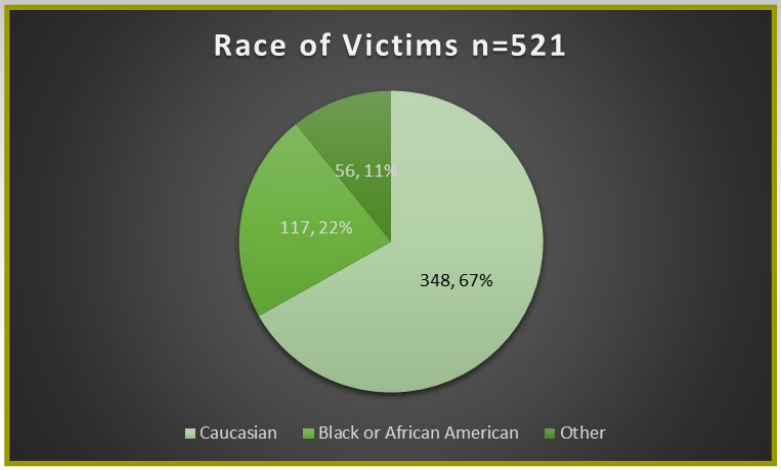


Source: SCIR data system

KY US Census Data 2020	
Caucasian/White Alone	87.1
Black or African American Alone	8.6
American Indian and Alaska Native	0.3
Asian Alone	1.7
Native Hawaiian and Other Pacific Islander	0.1
Two or More Races	2.2
Hispanic or Latino	4.2

Chart above is pulled from US Census Bureau at www.census.gov.

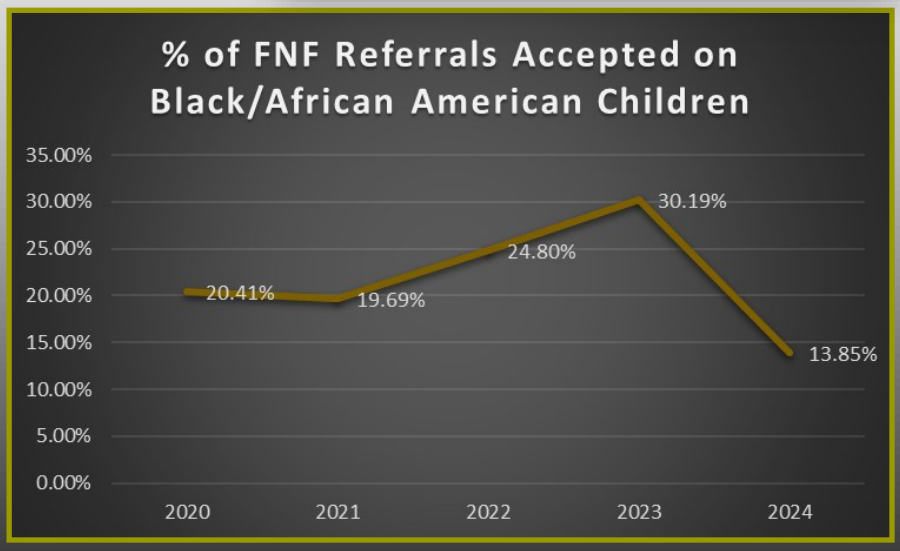
The Census Bureau estimates, as of July 1, 2021, the Black or African American population comprises 8.6% of the total Kentucky population. Black or African American children constitute 22% of victims in fatal and near fatal reports over the five year period. The Cabinet continues to work toward addressing racial disproportionality and disparity.



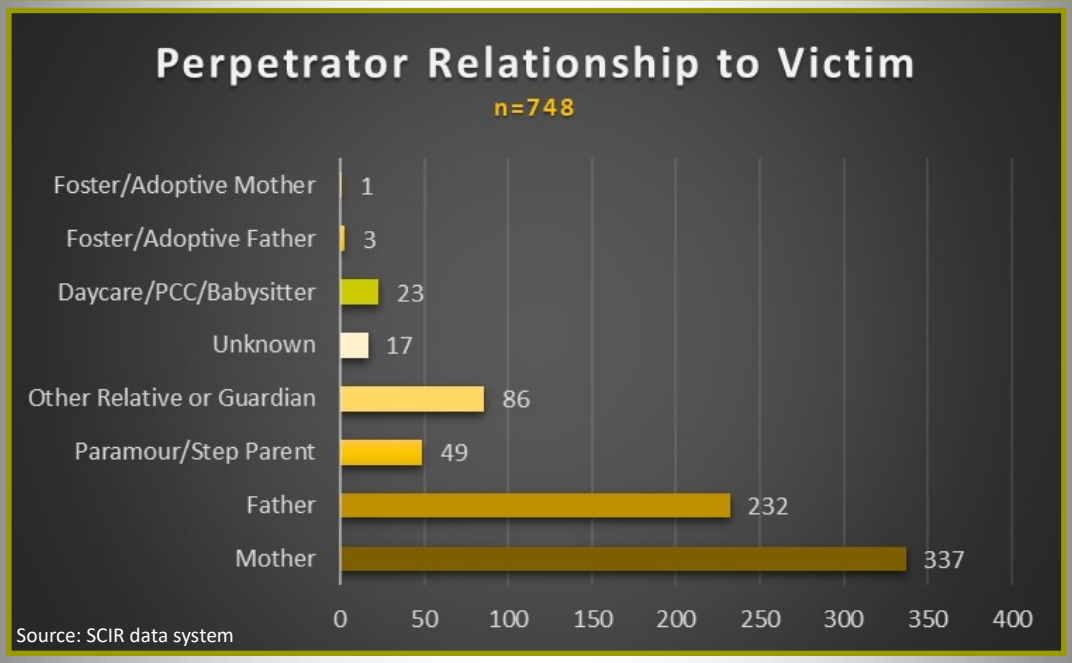
Source: SCIR data system

The African American population accounts for approximately 20% or greater of all fatal/near fatal reports received annually. The data also shows a steady increase of these reports since SFY 2020, after a slight drop in SFY 2021, from 19.7% to 30.2% in SFY 2023.

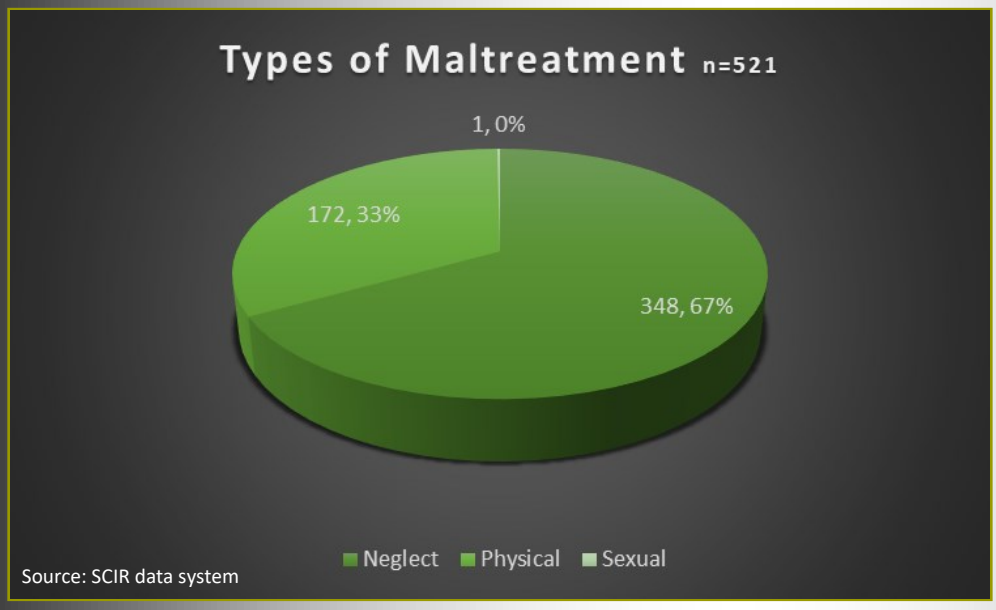
Note: There is corrected data in SFY 2020 from previous report due to a change in data collection from the previous year. Corrections in SFY 2021 through SFY 2023 reflect changes due to completed investigations. SFY 2023 and 2024 still have several pending referrals.



Section III:
Perpetrator and Maltreatment Demographics



Parents remain the most common perpetrator identified in fatality and near fatality investigation findings. Of the 521 victims, there were 748 perpetrators identified. Many fatality/near fatality cases have more than one identified perpetrator.

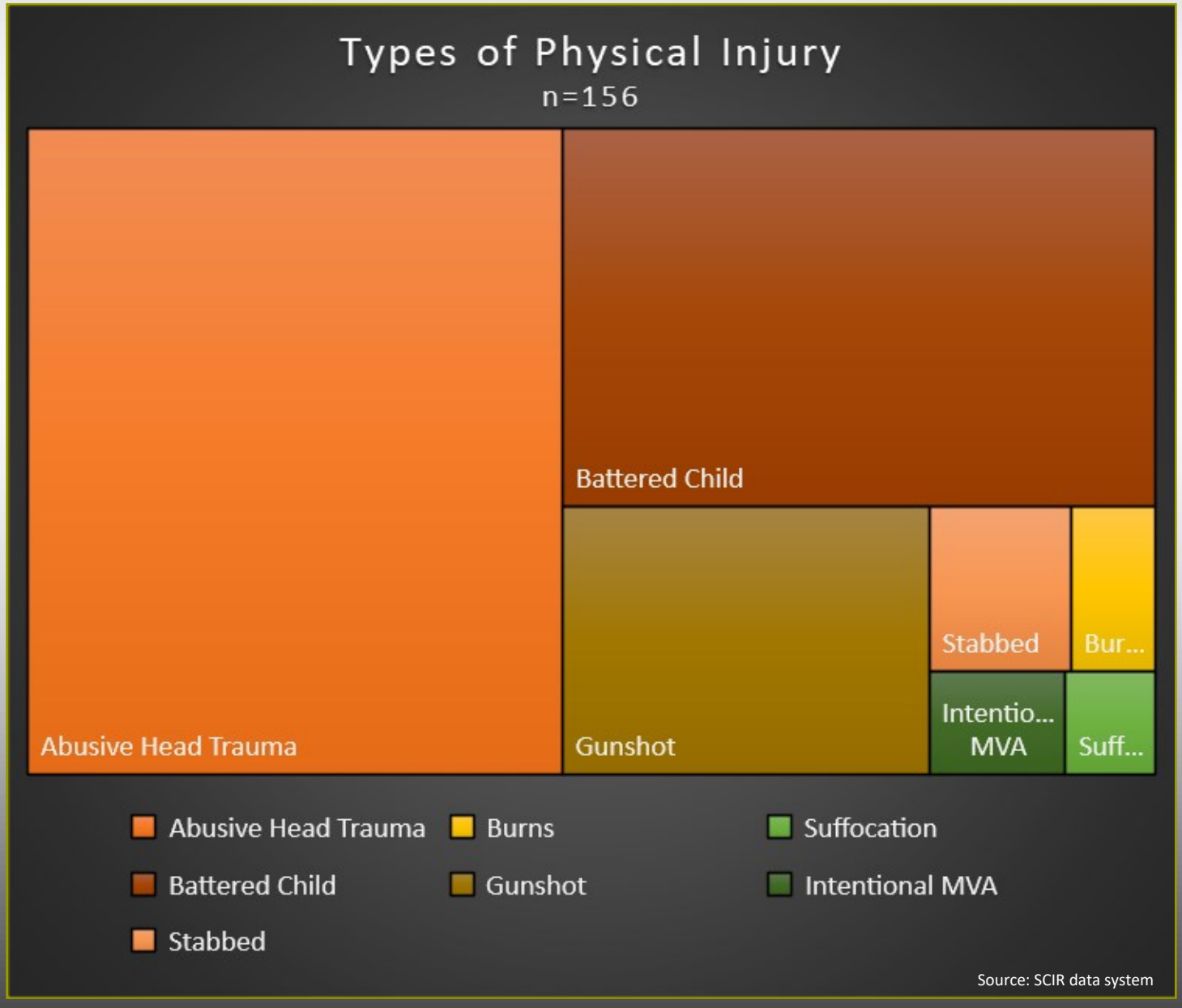


Neglect continues to be the leading type of maltreatment responsible for substantiated fatalities and near fatalities. There is one sexual abuse substantiation associated with a fatality designation.

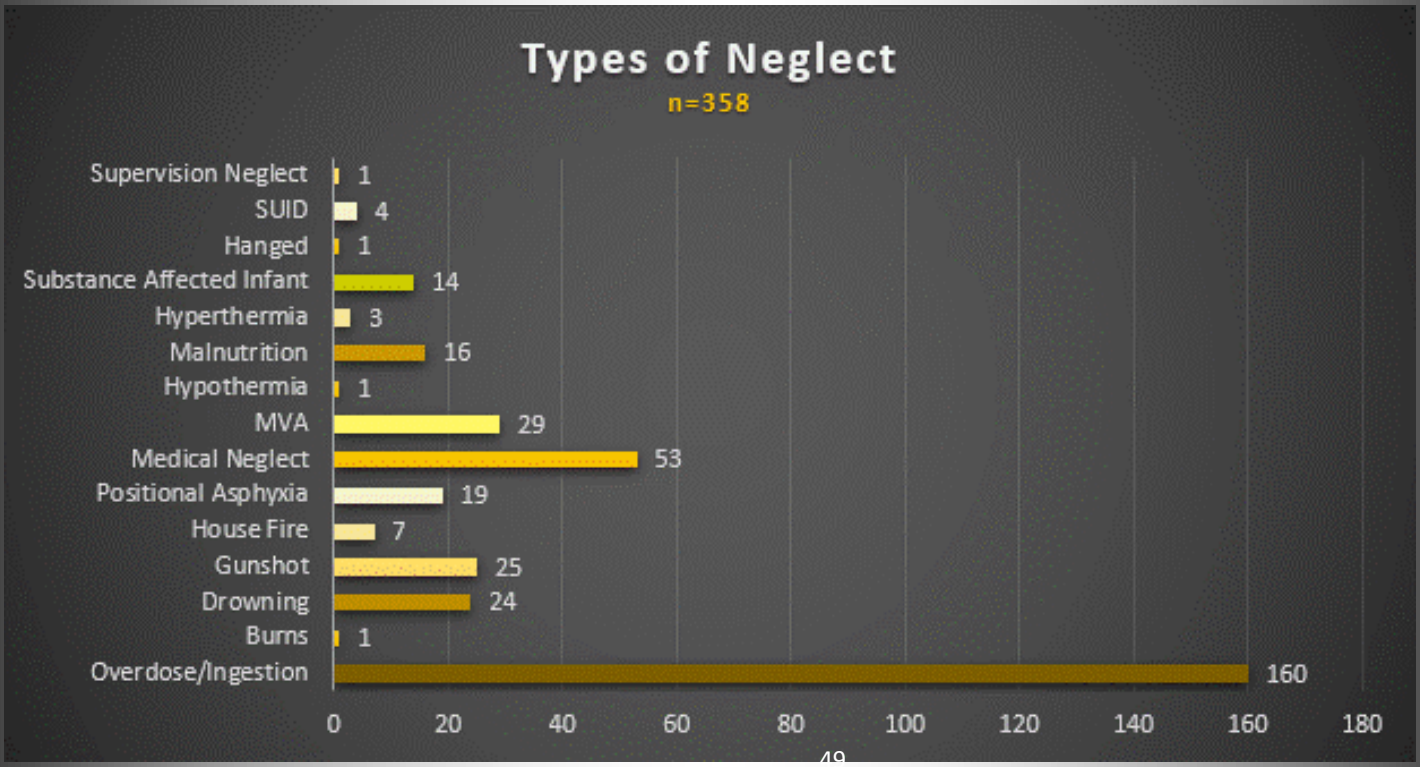
Abusive head trauma and battered child are the leading cause of fatalities and near fatalities from physical abuse.
The majority of these victims were three years of age and under.

Source: SCIR data system

Injury	Total
Abusive Head Trauma	74
Burns	3
Suffocation	2
Battered Child	48
Gunshot	21
Intentional MVA	3
Stabbed	5



Source: SCIR data system



*MVA-Motor Vehicle Accident

The leading cause of fatal/near fatal neglect is accidental overdose/ingestion cases. These incidents are typically the result of environmental neglect, when prescribed or illegal drugs are left accessible to children. There continues to be an increase in ingestions from the candy form of THC and/or Delta 8. THC and Delta 8 edibles/candies are packaged in a way that is appealing to children in that they appear in candy, cookie, and other edible forms.

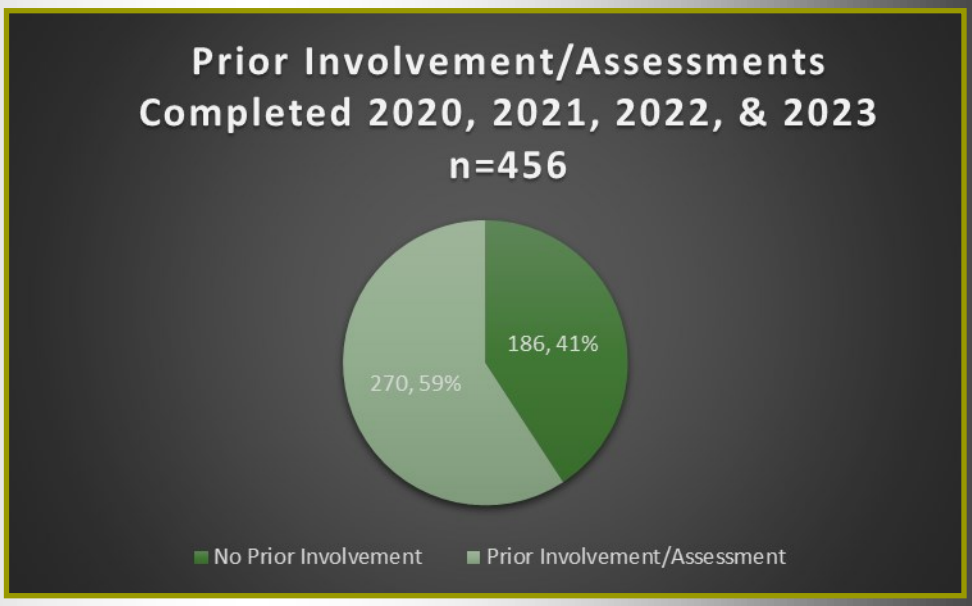
Note: The substance affected infant category was not previously included in this report and was included due to changes in definitions of acceptance criteria in SFY 2023 and 2024. The Cabinet continues to work though medical consultation to more narrowly define this category, which will be amended in coming policy updates.

Source: SCIR data system

Neglect Type	Total
Overdose/Ingestion	160
Burns	1
Drowning	24
Gunshot	25
House Fire	7
Positional Asphyxia	19
Medical Neglect	53
MVA	29
Hypothermia	1
Malnutrition	16
Hyperthermia	3
Substance Affected Infant	14
Hanged	1
SUID	4
Supervision Neglect	1

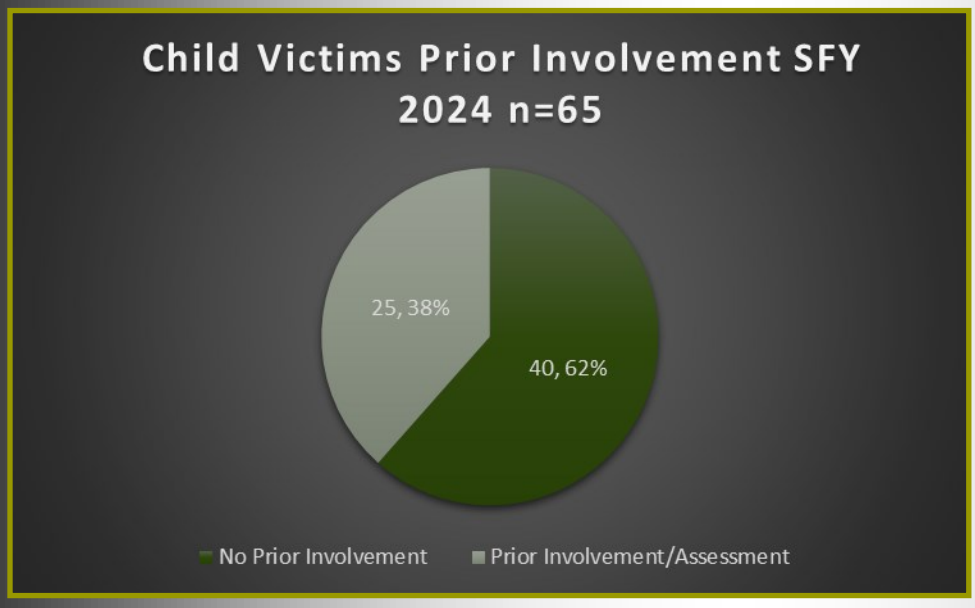
Section IV: Prior Department Involvement with Families of Fatality/Near Fatality (F/NF) Victims

The data collected on prior involvement for SFY 2020 considered 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 that reported history.



Source: SCIR data system

As noted in the previous report, DCBS has changed the focus of it's data collection of agency history. Data is now collected on history with the agency specific to the fatality/near fatality victim.



Source: SCIR data system

Prior history with DCBS is defined as any report made to DCBS. This includes substantiated and unsubstantiated reports, and reports that did not meet criteria for investigation or resource links.

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

Process Overview

In partnership with Collaborative Safety (CS), DCBS has developed and implemented the System Safety Review (SSR) process for the internal review of all fatality, near fatality, and active fatality cases (fatalities that occur on open DCBS cases without allegations of maltreatment). The goal of this implementation was the development of a culture of safety, which moves away from blaming individuals and embraces an environment where DCBS staff feel safe to openly speak about how the system impacts their work. The goal of psychological safety for DCBS staff is to better identify systemic barriers to casework. The SSR process was first implemented in October 2019, but due to challenges with COVID-19 and subsequent policy challenges, agency wide implementation of the culture of safety has been stifled. The SSR process has continued unabated despite these challenges, and with aid from CS this same review process was adopted by the Quality Assurance Branch in SFY 2024 in the KY Child and Family Services Review (CFSR) process. The System Safety Review Team (SSRT) continues to partner with CS in engaging DCBS staff and community partners with culture of safety training and workshops to better educate staff and community partners on the importance of the process and to garner a greater level of investment.

The SSR process focuses on understanding the complex nature of the child welfare system and the factors that influence decision-making and practice in real time. It moves away from a simplistic approach of root cause analysis, which tends to assess for blame and results in the application of "quick fixes" that do not address the underlying barriers and challenges faced by staff. The process recognizes that frontline workers strive to make the best decisions in their cases based on information available to them at the time and that those decisions are influenced by the system around them. The focal point of SSR is not to identify individual culpability. Instead, it seeks to create an environment where open and honest communication can lead to positive improvements within the system. It seeks to hold the system accountable instead of the individual. It requires that agency leadership share accountability when the casework barriers and challenges are revealed in process, and in turn, yields the opportunity to make systemic improvements to address barriers. The improvements in the system have a long-term goal of creating a more resilient and robust system which improves capacity to provide safe outcomes for children, families, and employees.

For a fuller description of the SSR process please, see the System Safety Review Process Manual.

Process Results

Previous annual fatality/near fatality reports have focused on agency changes that were not directly related to the review of fatality and near fatality cases and the results of those reviews. While it is important to track agency changes in practice (e.g., implementation of Structured Decision Making (SDM) as an aid to staff decision making, Community Response as a preventative "upstream" effort to prevent maltreatment, and Alternative Response to address lower risk allegations with a strengths-based perspective), these practice changes are not the result of the study of fatality and near fatality cases. Instead, they represent possibly new systemic challenges for staff that may be subject to the SSR process review. In pursuit of high-level system knowledge, the SSR process has revealed low-level factors that led to changes that would be tedious to report in this format. These lower-level changes have included improvement of policy language (language that was vague, confusing, or missing), changes in spurious local or regional level practices that were creating barriers to casework, or information sharing regarding resources or processes already in place that could aid casework. These lower-level changes do not involve leadership accountability or focus on high-level systemic themes that emerge in SSR process case studies. The following highlights high-level themes that emerged from the SSR process and have been presented to DCBS leadership in SFY 2024.

For SFY 2024, the SSRT team presented results of the SSR process to DCBS leadership on December 12, 2023, and May 5, 2024. The data represented the review of 223 cases, 55 of which were selected for full review. The parameters of leadership decisions on the emerging themes were to focus on "high-level" considerations (e.g., improvements in process, technological advancement, resource allocations, or support for legislative change), as opposed to "low-level" considerations (e.g., additional policy, oversight, training, documentation, or redundancies in practice).

The following recommendations made by the SSRT were received and selected by DCBS leadership based on SSR process data identifying them as barriers in casework. DCBS leadership made the decision to move forward to address these recommendations:

Standards of Practice (SOP) 2.24 Emotional Injury Process:

- Evaluate SOP 2.24 around use of Qualified Mental Health Professional (QMHP) for emotional injury assessments to identify barriers and conflicts between policy and regulation.
- Provide supports and resources to execute policy as defined, specifically designated providers and method of payment.

Case Consultation:

- Study of the guidance informing case consultation to evaluate the efficacy of the frequency, address redundancies, and how to use system resources to automate the process.

Evaluate the hiring process for frontline staff:

- Collaborate with Office of Human Resource Management (OHRM) to evaluate the hiring process and its influence on the delays seen at the field level.
- Collaborate with OHRM to improve the efficiency of hiring process.

Evaluation Process:

- Develop a workgroup to gather information from other states about their employee performance evaluation metrics.
- Define outcome-based measures and observable skills to incorporate into performance evaluation process.

Evaluate Practice Expectations:

- Across all program areas: Identify redundancies that can be revised or eliminated to support efficiency and thoroughness of safe work practices.

Intimate Partner Violence (IPV):

- Service Availability
    - Assess availability and expand services availability for Batters Intervention Program (BIP) statewide.
    - Engage community partners in plan for expansion.
- Training
    - Enhance requirements for DCBS staff to increase capacity for assessing and case planning when IPV is identified as a safety threat or risk factor.
    - Use EB – BIP to create curriculum.
- Court
    - Engage the Administrative Office of the Courts (AOC) to determine oversight of judges or support staff to provide court ordered services and desired outcomes.
    - Advocate for AOC oversight of court orders issued outside of recommendations made by DCBS.
    - Define for staff how to navigate shared accountability when IPV orders are issued for families that also have DCBS involvement.
    - Consider engaging the Division of Prevention and Community Wellbeing (victims to enhance protective capacities).

Medical Neglect/Medical Complexity:

- Training
    - Enhance required training curriculum for DCBS staff to increase capacity for assessing and case planning medical neglect cases or cases involving children with complex medical conditions (CMC).
        - Include disease specific.
        - Understand CMC (i.e., syndromes).
        - Support for facilitating collateral interviews with medical providers.
- Utilization of regional nurse consult/inspectors (NCI)
    - Evaluate the policy guiding NCI scope of work.
    - Enhance policy guidance to address where clarity is lacking.
    - Define roles and responsibilities of the NCI (Notes: SOP 30.27 Medical Support Section).

Future annual reports will provide updates to action steps taken by DCBS leadership on these selected recommendations, highlight any barriers or challenges to their implementation, and provide further recommendations drawn out of future emerging themes from the SSR process.

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.

The Kentucky Abuse and Neglect Hotline

1-877-597-2331 or 1-800-752-6200

Referrals may also be made by using the web based reporting system at https://prd.webapps.chfs.ky.gov/reportabuse/home.aspx

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.

Source-Norton Children's Hospital, UL Pediatric Forensics