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, 2018

Contents

Introduction

In accordance with KRS 620.050(12)(c), the Cabinet for Health and Family Services (cabinet), Department for Community Based Services (DCBS or department), submits this annual report of child abuse and neglect fatalities and near fatalities. A near fatality is defined by KRS 600.0200(40): "an injury that, as certified by a physician, places a child in serious or critical condition." This report provides insights into the demographics of the children who were the victims of abusive or neglectful deaths and near deaths, as well as the circumstances around these events. This report focuses on child victims whose family had a protection service history with DCBS. The report is organized into four sections: Characteristics of Child Fatality and Near Fatality Cases; Trends in Child Fatality and Near Fatality Cases; Child Fatalities and Near Fatalities in State Fiscal Year (SFY) 2018; and State Program Improvement Efforts. Historical data in this report spans five state fiscal years and includes only child abuse and neglect fatalities and near fatalities in which the department had a previous assessment or investigation with the family.

Historical trend data presented in Table 2 have been updated from the annual report submitted in SFY 2017. An asterisk indicates that the number has been updated from previous reports. The number of child fatality and near fatality victims are subject to change as cases pending at the time of the previous report writing are resolved. Alternately, cases that were initially reported as near fatalities, but ultimately ended in the child's death, have been updated to reflect the death. Additionally, numbers may fluctuate as a result of administrative hearings or court determinations requiring a change in finding. Fatality and near fatality cases for SFY 2018 are reported as they are reflected in the database at the time of the writing of the report.

Section I: Characteristics of Child Fatality and Near Fatality Cases

Case Demographics

From the completed cases of SFY 18, 20 child fatality and near fatality cases were identified as being the result of maltreatment. Of those 20 cases, 70% (14 cases) had prior involvement with DCBS. Of the 14 cases with prior involvement, 87% (13 cases) had a prior investigation or assessment within a 24-month period prior to the fatal or near fatal event. There were 12 near fatalities and two fatalities. Of these 14 cases, 10 investigations alleged neglect and four investigations alleged physical abuse.

Regional Differences

Table 1 shows the distribution of child fatality and near fatality cases in each of the nine (9) DCBS service regions during SFY 2018.

Table 1:

Service Region (N=14)	**# of abuse/neglect fatalities with prior involvement***	**# of abuse/neglect near fatalities with prior involvement***	**Total fatality/near fatality with prior involvement***
Cumberland	1	3	4
Eastern Mountain	1	0	1
Jefferson	0	0	0
Northeastern	0	0	0
Northern Bluegrass	0	2	2
Salt River Trail	0	2	2
Southern Bluegrass	0	4	4
The Lakes	0	0	0
Two Rivers	0	1	1
Statewide totals	**2**	**12**	**14**

*These are point-in-time data, current at the time that the report was written, and do not include unresolved cases or cases awaiting administrative hearings.
Source: Fatality/Near Fatality Excel Database

Section II: Trends and Demographics of Child Fatality and Near Fatality Cases over Time

In order to establish a context under which child death and serious injury occurs, general child maltreatment data are included in this report. Table 2 provides data from SFY 2018 on the overall number of calls with allegations received by DCBS, the total number of child abuse and neglect calls that met acceptance criteria, the number of substantiated abuse and neglect findings made by DCBS, and the number of fatality and near fatality victims. Though the number of fatality cases appears to be lower than previous years, there is no indication that the change is statistically significant.

Table 2:

	SFY 14	SFY 15	SFY 16	SFY 17	SFY 18
# of calls with allegations received	73,692^	106,197	105,527	110,585	137,001
# of abuse/neglect reports that met acceptance criteria	53,225	59,077	52,424	55,752	57,626
# of substantiated abuse/neglect findings	11,120	12,914	15,378	16,548	17,457
# of *fatalities* in which abuse/neglect was substantiated	17*	21	19	16*	2
# of substantiated *fatalities* with agency prior involvement	13*	16	12*	13*	2
# of *near fatalities* in which abuse/neglect was substantiated	53*	52*	62	56*	18
# of substantiated abuse/neglect near fatalities with agency prior involvement	32	28	34	33*	12

Note: An asterisk (*) indicates adjustment from prior years' reports.
^In 2014, DCBS made a system change that allowed for separation of allegation calls from all other agency calls.

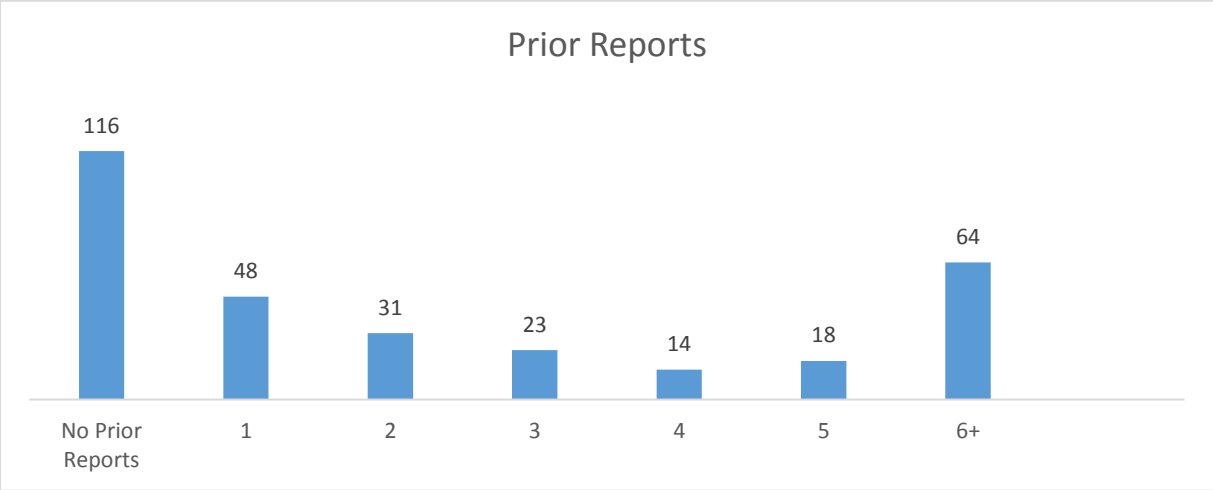
Source TWS-Y084, Run Date 7/17/2017

The small number of child maltreatment cases that result in serious injury or death each year creates pronounced trend fluctuations and does not provide a representative picture of these cases. For this report, DCBS includes data over a five (5) state fiscal year period (SFY 2014–SFY 2018) on all substantiated fatality and near fatality victims in which there had been prior protection and permanency involvement in order to strengthen the capacity to evaluate trends and describe characteristics for this report.

Prior Involvement

Prior involvement is defined as any assessment or investigation with a child or family in the area of protection and permanency. Figure 1 displays all 314 substantiated fatality and near fatality victims from SFYs 2014–2018. The data in Figure 1 are consistent with prior years' reports.

Figure 1:



In the past five SFYs, there have been 314 children who died or nearly died due to abuse or neglect (Figure 1.) Of those children, 198 had prior family or perpetrator involvement with DCBS. Of the 314 victims, 74 were fatalities and 240 were near fatalities. Section II of this report focuses on the 198 children that had prior involvement with DCBS and received a substantiated death/near death finding.

Child Victim Demographics

Nationally, children under the age of three die at a significantly higher rate compared to older children. According to the 2016 Administration for Children and Families (ACF) child maltreatment report[1], 70% of children who died from maltreatment were under the age of three. The ACF report does not include near fatal maltreatment, but one can see the percentage replicated in Kentucky with both fatal and near fatal maltreatment. In Kentucky, children age four and younger comprise 83% of the maltreatment deaths and near deaths. Table 3 reflects the age of victims related to maltreatment fatalities and near fatalities.

[1] U.S. Department of Health & Human Services; Administration for Children and Families; Administration on Children, Youth and Families; Children's Bureau; Child Maltreatment 2016.

Table 3:

Age of the Victim		
KY (n=198)		
Age	# of Children	Percentage
<1	82	41%
1	25	13%
2	26	13%
3	20	10%
4	12	6%
5-7	11	5%
8-10	8	4%
11-13	7	4%
14 +	7	4%

In Kentucky, male children are victims of a fatality or near fatality more than females. For SFY 2014–2018, 60% of the child fatality and near fatality victims were male, and 40% were female. Table 4 references the percentage of Kentucky's male and female victims compared to the national child fatality data.

Table 4:

Gender of the Victim		
	KY (n=198)	National Fatality Data (ACF 2016 NCANDS Report n=1,447)
Male	60%	58.6%
Female	40%	41.3% (.1% unknown)

In the United States, Caucasian children accounted for 45.1% of the child victims for fatal maltreatment from SFY 14. 28.5% of child victims were listed as African-American, 13.8% of child victims were listed as Hispanic, and 4.8% of child victims were identified as having two or more races. In Kentucky, African-American children are victims of fatal or nearly fatal maltreatment at a higher rate, 24.1 per 100,000 compared to Caucasian children at 4.65 per 100,000[2]. These data align with other data analysis conducted

[2] U.S. Department of Health & Human Services; Administration for Children and Families; Administration on Children, Youth and Families; Children's Bureau; Child Maltreatment 2016.

by DCBS, which indicates racial disproportionality between African-American children and Caucasian children. Table 5 displays the racial and ethnic backgrounds of child victims in Kentucky contrasted with national data.

Table 5:

Race/Ethnicity*	KY Child Population		KY (n=198) # of Children involved in a fatality/near fatality and also had prior involvement with DCBS		National Fatality Data (ACF 2015 NCANDS Report)**	
	#	%	#	%	#	%
African-American	91,960	9	25	13.2	401	28.5
American Indian or Native American	8,642	0.8	0	0.0	16	1.1
Asian	12,910	1.3	0	0.0	13	0.9
Hispanic*	49,949	4.9	2	1.0	194	13.8
Pacific Islander	643	0.1	0	0.0	3	0.2
Unknown	***	***	***	***	78	5.5
Caucasian	828,136	80.9	160	80.2	634	45.1
Two or More Races	35,230	3.4	11	5.60	67	4.8

*Hispanic ethnicity is separate from race, not mutually exclusive

** States with more than 25 percent of victim race or ethnicity as unknown or missing were excluded from this analysis

Perpetrator Demographics

In the 198 cases that are the subject of this report, there are 279 identified perpetrators:

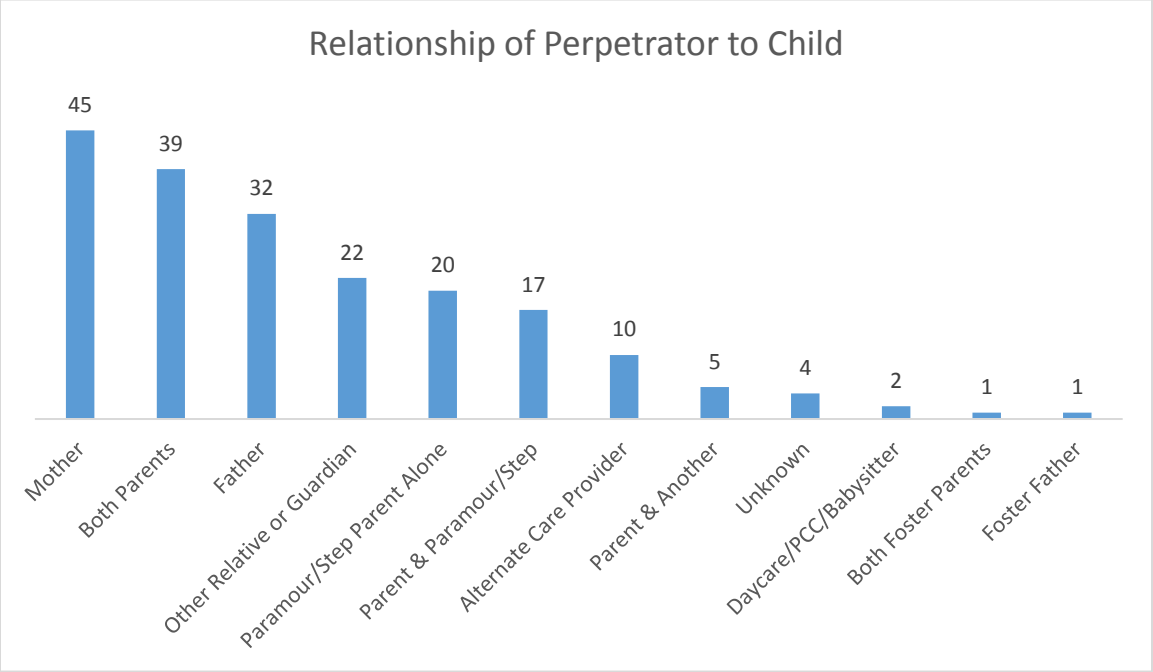
- There are 141 female perpetrators, 134 male perpetrators, and four unknown perpetrators.
- Thirty-six physical abuse cases had solely a male perpetrator, 11 physical abuse cases had solely a female perpetrator, and 34 physical abuse cases had a male and female listed as the perpetrators. This totals 81 physical abuse cases.

- Fifty-two neglect cases had a female perpetrator, 21 neglect cases had a male perpetrator, and 44 neglect cases had a male and female listed as the perpetrator. This totals 117 neglect cases.

For this and prior reports, female perpetrators were more frequently found in neglect fatalities and near fatalities, while males tend to be the more frequent perpetrators of physical abuse. This is a reoccurring theme from previous years as well.

Figure 2 displays the perpetrator relationship to the victim for the 198 children who are the subject of this section of report. In 41% (82) of the cases, there is more than one identifiable perpetrator responsible for the fatal or near fatal maltreatment, and in four of the cases the perpetrator was unable to be determined. Data consistently show that parents, acting alone or in collusion with each other, are more often the perpetrators of fatal or near fatal child maltreatment. Nationally, only 13.7% of child fatalities had perpetrators *without* a parental relationship[3]. In Kentucky, 19% of child fatalities had perpetrators without a parental relationship.

Figure 2:



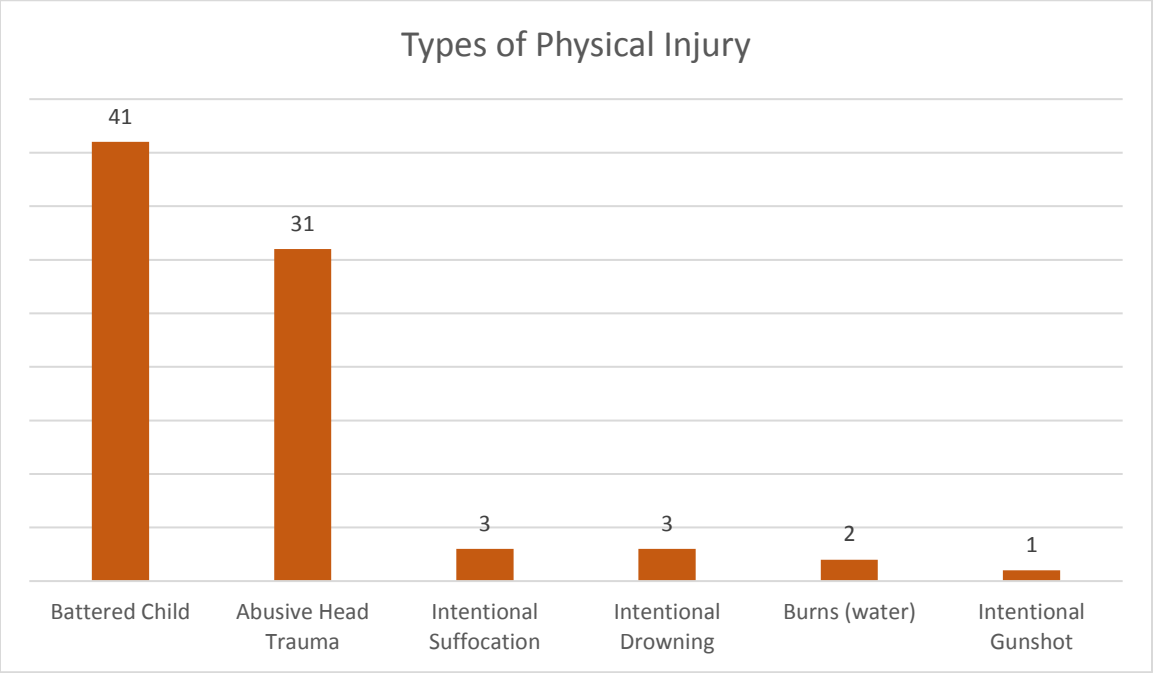
The average age for female perpetrators in Kentucky is 31.45 years old, and the average age for male perpetrators is 31.11 years old. Nationally, 83.2% of the perpetrators are between the ages of 18 and 44 years old.

[3] U.S. Department of Health & Human Services; Administration for Children and Families; Administration on Children, Youth and Families; Children's Bureau; Child Maltreatment 2014.

Maltreatment Type

In this analysis, child maltreatment is broken into two categories: physical abuse and neglect. Of the 198 cases, physical abuse was substantiated as the cause 78 times, and neglect was substantiated 120 times with a total of 198 findings. Figure 3 displays the cause of death or serious injury in the 81 physical abuse findings for SFY 2014–2018. The leading cause of child physical abuse fatal or near fatal maltreatment is battered child (i.e., the child suffers multiple injuries across several planes of the body) followed closely by abusive head trauma.

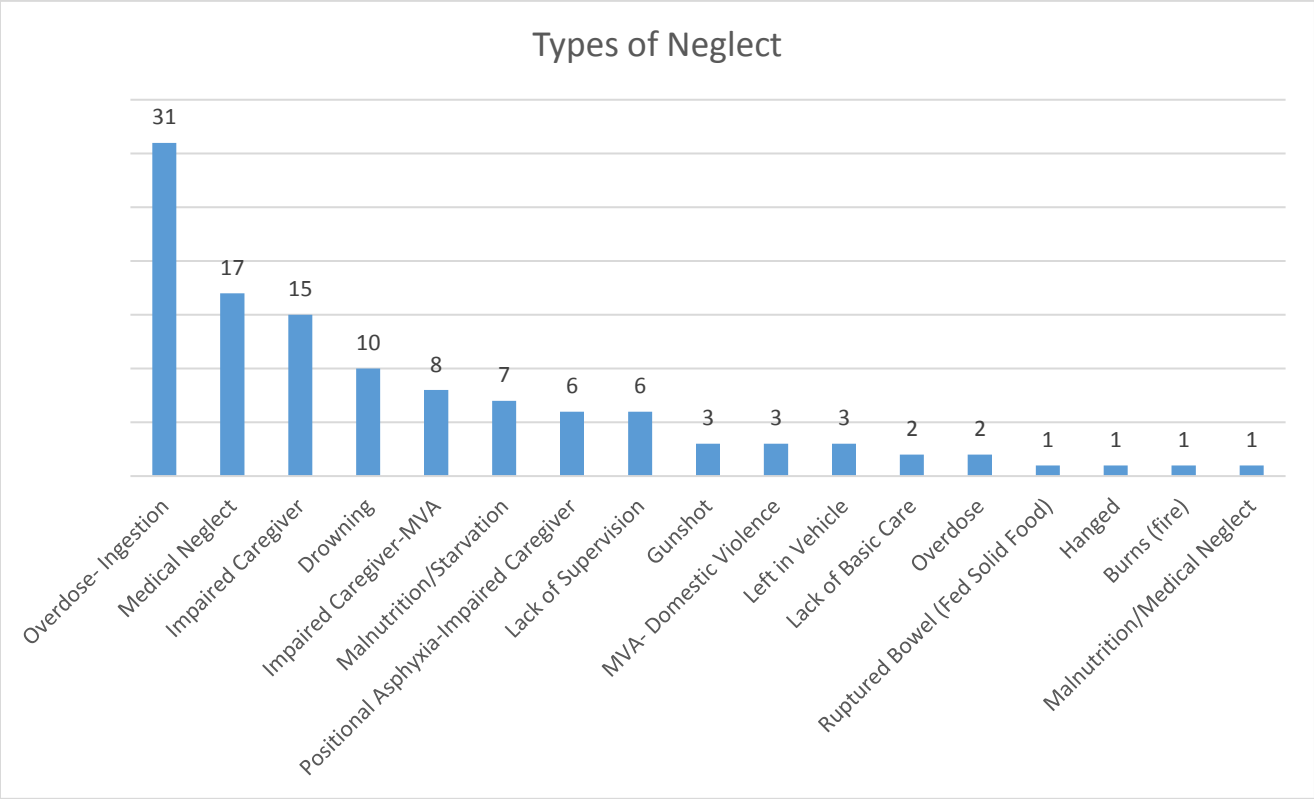
Figure 3:



For SFY 2014-2018, the remaining 120 findings were a result of neglectful behavior. For purposes of this report, neglect types have been delineated into several different categories: impaired caregiver, overdose by ingestion, medical neglect, lack of supervision, drowning, malnutrition, impaired caregiver-motor vehicle accident, gunshot, positional asphyxia, domestic violence-motor vehicle accident, suffocation, burns, and a ruptured bowel. Impaired caregivers include any incident of death or near death in which the caregiver's substance use contributed to the maltreatment.

Figure 4 delineates the causes of fatal and near fatal child maltreatment as a result of neglect. The most common category of neglect maltreatment that resulted in a fatality or a near fatality is from the victim overdosing on medication or other toxic substance. This is followed by situations where an impaired caregiver was providing care for the child at the time of the fatal or near fatal incident.

Figure 4:



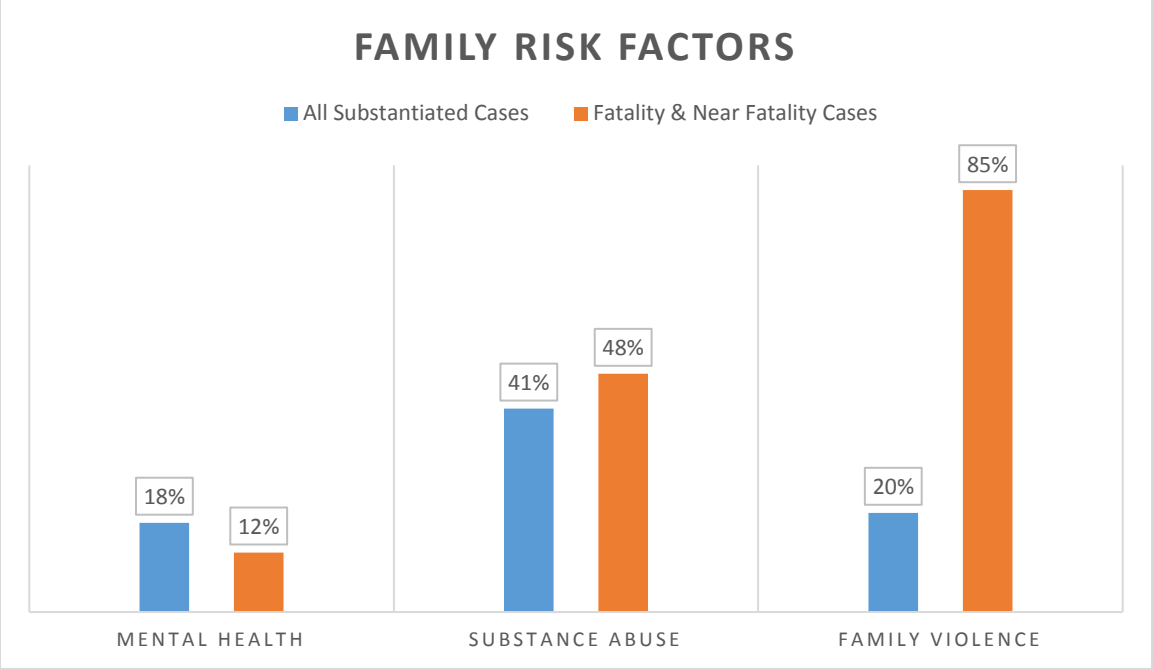
Family Risk Factors

Abuse of or dependency on substances, family violence, and mental illness or cognitive impairment are commonly known antecedents in child abuse and neglect cases. DCBS collects data on how these three risk factors play a role in maltreatment. Data for fatality and near fatality cases were collected for all substantiated cases completed in SFY 14 through SFY 18. In these 198 fatality and near fatality cases, substance abuse directly contributed to the maltreatment in 32% (64 cases). In SFY 18, substance abuse directly or indirectly contributed to the child maltreatment in 48% of all child protective services cases and only 41% of the fatal or near fatal cases.

Family violence was present in 85% of the fatal and near fatal maltreatment cases in SFY 14 through SFY 18, whereas it is noted as contributing to only 20% of all substantiations from SFY 18. Lastly, mental health or cognitive impairment directly or indirectly contributed to 12% of the fatalities and near fatalities and 18% of the substantiated cases in SFY 18.

Figure 5 displays the percentages of substance abuse, family violence, and mental health as contributors in all substantiated or family-in-need of services cases contrasted with fatal and near fatal maltreatment.

Figure 5



A comparison of figures 3, 4, and 5 identifies some suggested risk factors within fatality and near fatality cases. Identification of risk factors can be useful for state administrators to establish prevention priorities; however, it is not necessarily a predictive feature that allows child welfare workers to triage risk and adjust cases for prioritization of services or other interventions.

Child Risk Factors

The age of the victim has been the one point of risk assessment that has consistently been useful as a predictive feature for caseworkers in cases. As aforementioned, 83% of children who were the victims of fatal or near fatal maltreatment were age four and under. The age of children in neglect-related deaths or near deaths is more equally distributed among age groups, although the majority of victims tend to be age four or younger. Figures 6 and 7 show the distribution of victim age in fatal and near fatal cases (N=198.) Infants are consistently more represented in fatal and near fatal cases. Figure 7 contrasts the age of the victim to the referral type.

Figure 6:

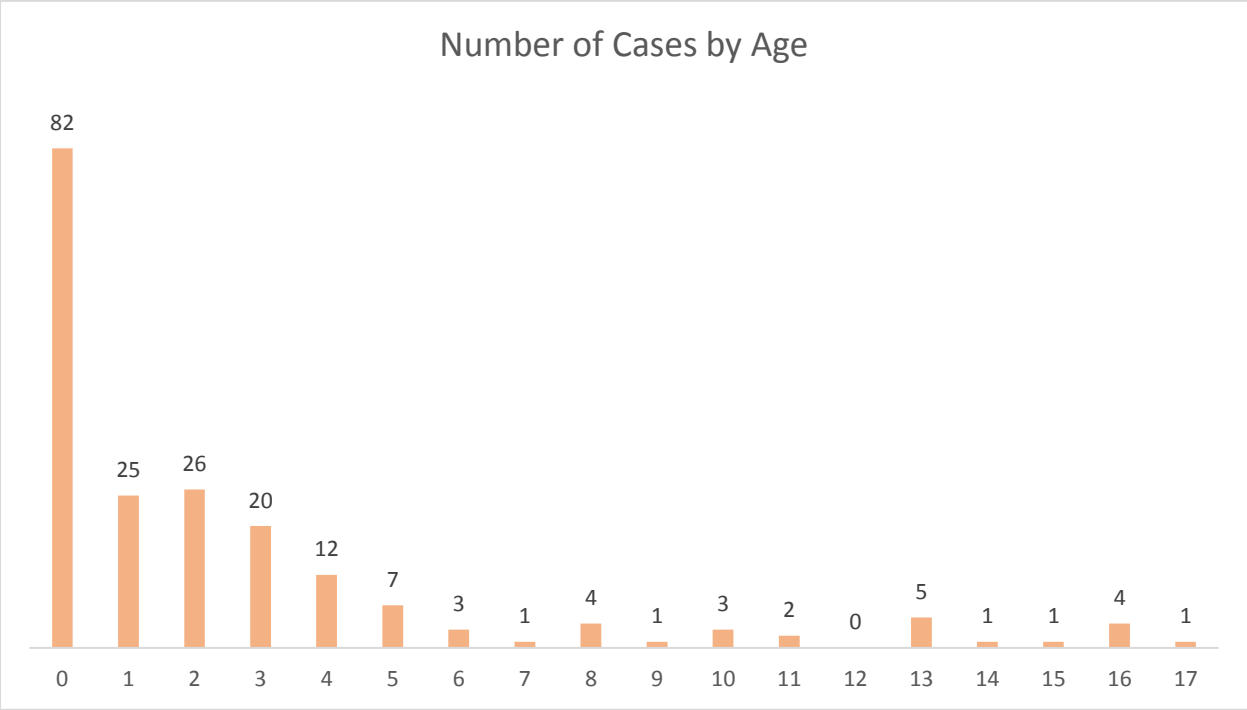
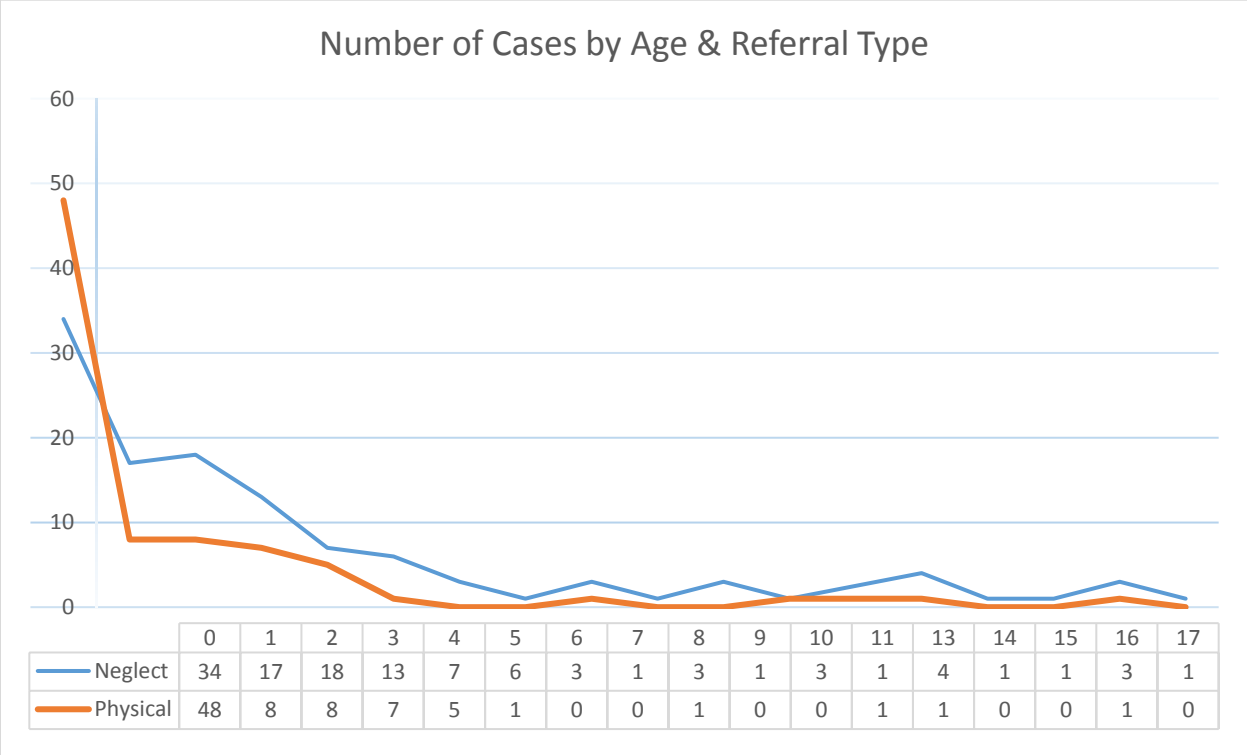


Figure 7:



	0	1	2	3	4	5	6	7	8	9	10	11	13	14	15	16	17
Neglect	34	17	18	13	7	6	3	1	3	1	3	1	4	1	1	3	1
Physical	48	8	8	7	5	1	0	0	1	0	0	1	1	0	0	1	0

Section III: Kentucky's Program Improvement Efforts

Internal Reviews

Internal reviews are conducted on child fatality and near fatality cases as mandated by KRS 620.050(12)(b). Prior involvement is defined by 922 KAR 1:330 as "any assessment or investigation, of which the cabinet has record, with a child or family in the area of protection and permanency prior to the child's fatality or near fatality investigation."

The internal review process was reviewed and enhancements were made at the end of SFY 15. To more closely align with the updated case review process, case review worksheets were developed that are applied to any assessment that was conducted in the 24 months preceding the fatal or near fatal incident. Action items are identified from the areas for improvement noted in the worksheets, and the regional staff strategizes ways to improve in those areas. Since SFY 16, the fatality liaisons and regional staff have been able to consistently track and identify areas of strength and concerns within the regions.

Regional staff monitors the identified areas through the continuous quality improvement (CQI) case reviews. In SFY 18, the regions noted the areas needing most improvement include comprehensive assessments and initiation timeframes. There were a few instances where the regions noted concerns regarding ongoing case tasks, including an absent parent or non-offending parent in the case plan process, but the majority of the tasks related to investigative assessments.

Program Improvement Efforts

The lack of a comprehensive risk assessment[4] has been an area of concern in all previous annual reports. Adding corrective action items post-fatality to bolster worker risk assessment has not worked in isolation. In SFY 19, the fatality program is working with regional leadership to ensure that frontline supervisors' approvals of assessments are adequately addressing the risk and safety factors within each family. As a part of regular fatality reviews, fatality program staff have previously taken corrective action plans to focus on skill building; however, program staff have started to include items around regional efforts to review supervisor approvals and to ensure supervisors are only approving thorough assessments.

Data collected show that all areas of the assessment need improvement. The workers discuss the three main family risk factors, but fail to thoroughly understand the existing indicators' impact on the safety and well-being of the children. Additionally, workers do not recognize the need to assess the caregiver's tendency to become overwhelmed with daily tasks, ability to prioritize the child's safety, and the effectiveness of parenting skills. In addition to incomplete assessments, central office staff are observing instances where the information gathered does not support the decision made or the conclusions reached. The results of the data analysis indicate that the department needs to continue its work to enhance their documentation to provide a more thorough risk assessment. Workers need to consistently capture the risks associated with the most vulnerable child within the home. Each region has developed

[4] *"Risk assessment"* means the capacity to identify protective factors, risk factors, and/or safety factors.

its own method to implement improvements including one-on-one meetings with the workers, holding regular staff meetings, and conducting region-wide trainings.

Through the Child Welfare Transformation efforts within the DCBS Commissioner's Office, several work groups have been developed to assist with practice improvement, including a safety workgroup. This group is working to develop a tool to assist staff with determining safety and risk factors in the home. The purpose of the tool is to ensure that proper services are provided to assist with the risk and safety factors within the home. This tool will also assist the workers when making a determination regarding removal or if the child will remain in the home with services.

Another work group formed, addresses staff retention and supervisory supports. High worker turnover resulting in the loss of experienced staff has negatively influenced the agency's quality of work. The purpose of this workgroup is to identify areas of staff satisfaction and the quality of their work experience, which will be used to make changes in order to retain staff.

Kentucky completed its third federal onsite child welfare services review in July 2016. The department has worked with the federal oversight agency, ACF-Children's Bureau, and has negotiated a program improvement plan (PIP). DCBS has also consulted with Capacity Building Center for States (through ACF's advisement) to build targeted interventions to support improvements in the child welfare safety program, including the development of a safety model, as well as in other areas of practice. The draft PIP has been submitted to the Children's Bureau for review and approval.

Trainings

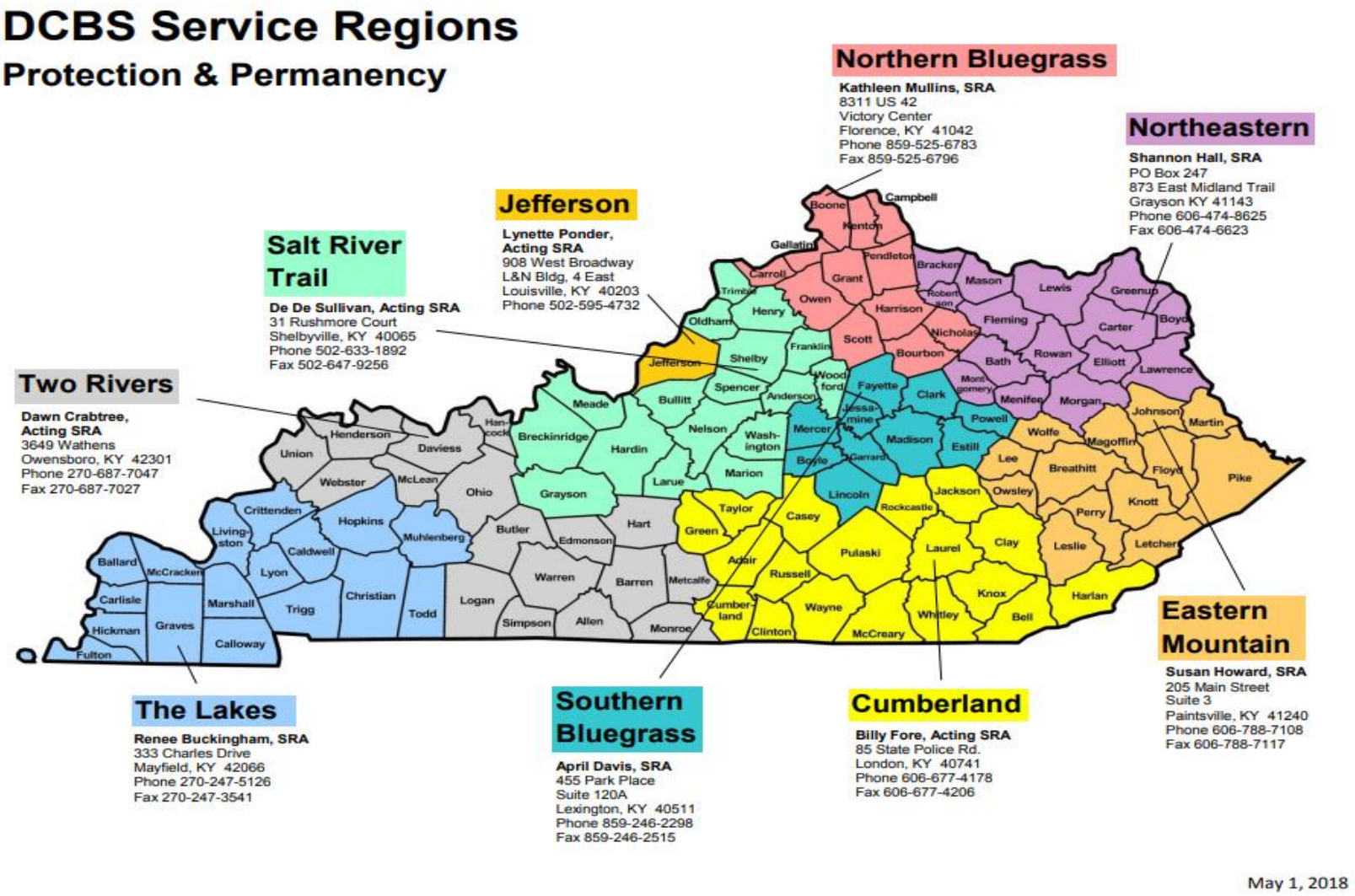
DCBS utilizes information gathered during internal reviews to shape training materials in order to enhance staff capacities. The Child Protection Branch participated in and/or provided several trainings to field staff this past state fiscal year:

- *"Specialized Referrals and Assessments in Daycares, School, and other OOHC Settings Training"* occurred in one region. This training is intended for investigative workers and supervisors who are identified as the workers in their region to initiate investigations involving day cares, schools, human trafficking, residential facilities, foster homes, and other PCC placements. The training discusses the roles of DCBS and other agencies in these investigations. The final component focuses on physical management and its relationship to the referrals received in many cases.
- *"Plan of Safe Care"* trainings were completed in all regions in conjunction with the 14 statewide community mental health centers. DCBS partnered with the Department for Behavioral Health, Developmental and Intellectual Disabilities (DBHDID) to meet the requirements of the Comprehensive Addiction Recovery Act (CARA) of 2016. Both agencies worked diligently with community partners. A grant was secured by DBHDID for Kentucky's community mental health centers to conduct trainings with appropriate community partners. The trainings were presented as a collaboration of efforts and highlighted the plan of safe care as being a community response. The trainings consisted of topics related to substance exposed infants and neonatal abstinence syndrome, adverse childhood experiences scores/trauma, substance abuse,

medication assisted treatment, systems of care, motivational interviewing, and DCBS mandatory reporting.

- *"Centralized Intake Technical Assistance"* is a specialized training created by the department's Child Protection Branch and was provided to centralized intake staff in all nine service regions. This training provides information about child protective services and adult protective services acceptance criteria. It incorporates new information about screening intakes related to children who are four years of age and younger presenting with a physical injury of unknown origin. This training was specifically created to ensure that high-risk cases are identified and screened appropriately by centralized intake staff.

Appendix A: Regional Map



Appendix B: Data Tables

AGE OF CHILD	**SFY 2014-2018 (n=198)**		
	Fatality	Near Fatality	Total
Under 1 year	21	61	82
1 year	5	20	25
2 years	10	16	26
3 years	7	13	20
4-6 years	4	18	22
7-12 years	4	7	11
13-17 years	6	6	12
Total	**57**	**141**	**198**

GENDER OF CHILD	**SFY 2018 (n=14)**		**SFY 2014-2018 (n=198)**
	Fatality	Near Fatality	
Male	1	7	119
Female	1	5	79
Total	**2**	**12**	**198**

RACE/ETHNICITY OF CHILD	SFY 2018 (n=14)		SFY 2014-2018 (n=198)
	Fatality	Near Fatality	
African American	0	1	25
Two or More Races	0	2	11
White	2	9	160
Hispanic	0	0	2
Total	**2**	**12**	**198**

TYPE OF MALTREATMENT	SFY 2018 (n=14)		SFY 2014-2018 (n=198)
	Fatality	Near Fatality	
Physical Abuse	1	3	81
Neglect	1	9	117
Total	**2**	**12**	**198**

PERPETRATOR RELATIONSHIP TO VICITM	**SFY 2018 (n=14)**		**SFY 2014-2018 (n=198)**
	Fatality	Near Fatality	
Mother	1	2	45
Father	0	0	32
Both Parents	0	3	39
Both Foster Parents	0	0	1
Parent Paramour/Step	0	3	20
Parent & Another	1	1	22
Alternate Care Provider	0	0	13
Other Relative	0	2	22
Unknown	0	1	4
Total	**2**	**12**	**198**