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

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Department for Community Based Services
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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 600.020(40) to mean, "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 families had protection service histories with DCBS. The report is organized into three sections: Characteristics of Child Fatality and Near Fatality Cases; Trends in Child Fatality and Near Fatality Cases; and State Program Improvement Efforts. Historical data in this report span five state fiscal years and include 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 2018. An asterisk indicates that the number has been updated from previous reports. The numbers of child fatality and near fatality victims are subject to change as cases pending at the time of 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 2019 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

In SFY 2019, there were 139 reports of suspected child maltreatment that resulted in a near fatal or fatal incident. This report will reflect the data found from the 15 completed cases of child fatality or near fatality that were identified as being the result of maltreatment. Of those 15 cases, 60% (nine cases) had prior involvement with DCBS. Of the nine cases with prior involvement, 33% (three cases) had a prior investigation or assessment within a 24-month period prior to the fatal or near fatal event. There were six near fatalities and three fatalities. Of these nine cases, six investigations alleged neglect and three investigations alleged physical abuse. There was a total of 37 reports of child fatality and 102 child near fatality reports of possible maltreatment. Therefore, 124 cases are still pending at the time of this report.

Regional Differences

Table 1 shows the distribution of the completed child fatality and near fatality cases across the nine DCBS service regions during SFY 2019. It should be noted that there are several pending SFY 2019 reports of child fatality and near fatality.

Table 1:

Service Region (N=9)	# of abuse/neglect fatalities with prior involvement*	# of abuse/neglect near fatalities with prior involvement*	Total fatality/near fatality with prior involvement*
Cumberland	2	2	4
Eastern Mountain	0	0	0
Jefferson	0	0	0
Northeastern	0	0	0
Northern Bluegrass	0	0	0
Salt River Trail	1	4	5
Southern Bluegrass	0	0	0
The Lakes	0	0	0
Two Rivers	0	0	0
Statewide totals	**3**	**6**	**9**
*These numbers are as of the writing of the report and do not include unresolved cases or cases awaiting administrative hearings.			

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

In order to establish the context under which child death and serious injury occurs, national and state child maltreatment data is included in this report. Table 2 provides data from SFY 2019 on the overall number of calls of alleged child abuse or neglect received by DCBS, the total number of child abuse or 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:

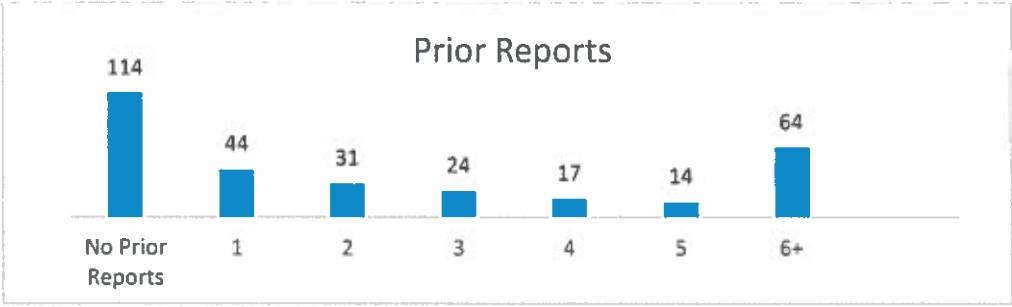
	SFY 15	SFY 16	SFY 17	SFY 18	SFY 19
# of calls with allegations received	106,197	105,527	110,585	137,001	130,455
# of abuse/neglect reports that met acceptance criteria	59,077	52,424	55,752	57,626	52,628
# of substantiated abuse/neglect findings	12,914	15,378	16,548	17,457	15,182
# of *fatalities* in which abuse/neglect was substantiated	21	19	16	14*	4
# of substantiated *fatalities* with agency prior involvement	16	12	13	13*	3
# of *near fatalities* in which abuse/neglect was substantiated	52	62	56	53*	11
# of substantiated abuse/neglect near fatalities with agency prior involvement	28	34	33	36*	6
Note: An asterisk (*) indicates adjustment from prior years' reports. Source TWT Y084, Run Date					

The small number of child maltreatment cases that resulted in serious injury or death each year in comparison to the number of CPS investigations does not provide an adequate representation of the fatality/near fatality cases. For this report, DCBS includes data over a five state fiscal year period (SFY 2015–SFY 2019) on all substantiated fatality and near fatality victims in which there was prior agency 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 by Protection and Permanency. As the figure below shows, several cases of fatality and near fatality have had prior involvement with the agency. This is a trend that the agency regularly tracks and reviews. Figure 1 displays the number of prior reports for all 308 substantiated fatality and near fatality victims from SFYs 2015–2019.

Figure 1:



In the past five state fiscal years, there have been 308 children who died or nearly died due to abuse or neglect (Figure 1). Of the 308 victims, 74 were fatalities, 234 were near fatalities, and 194 had a prior history with the agency. Section II of this report focuses on the 194 children who 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 2017 Administration for Children and Families (ACF) child maltreatment report[1], 71.8% 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 number replicated in Kentucky with both fatal and near fatal maltreatment. In Kentucky, children age four and younger comprise 85% of the maltreatment deaths and near deaths. Table 3 reflects the age of victims related to maltreatment fatalities and near fatalities.

Table 3: *SFY 2015-2019 Data*

Age of the Victim		
KY (n=194)		
Age	# of Children	Percentage
<1	77	40%
1	23	12%
2	31	16%
3	23	12%
4	10	5%
5-7	10	5%
8-10	8	4%
11-13	5	3%
14 +	7	3%

In Kentucky, male children are victims of a fatality or near fatality more than females. For SFY 2015–2019, 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=194)	National Fatality Data (ACF 2017 NCANDS Report)
Male	57%	57.9%
Female	43%	41.9% (.2% unknown)

[1] U.S. Department of Health & Human Services; Administration for Children and Families; Administration on Children, Youth and Families; Children's Bureau; Child Maltreatment 2017.

In FFY 17, national data indicated that 41.9% of the child victims for fatal maltreatment were Caucasian, 31.5% African-American, 15.1% Hispanic, and 4.2% 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]. This data aligns with other department data analysis, which indicates racial disproportionality between African-American children and Caucasian children. Table 5 displays the racial and ethnic backgrounds of child victims in Kentucky in comparison to national data.

Table 5:

Race/Ethnicity*	KY Child Population		KY (n=194) # of children involved in a fatality/near fatality and also had prior involvement with DCBS		National Fatality Data (ACF 2017 NCANDS Report)**	
	#	%	#	%	#	%
African-American	91,960	8.9	26	13.4	416	31.5
American Indian or Native American	8,642	0.8	0	0.0	15	1.1
Asian	12,910	1.3	0	0.0	14	1.1
Hispanic*	49,949	4.9	2	1.0	199	15.1
Pacific Islander	643	0.1	0	0.0	4	0.3
Unknown	***	***	***	***	63	4.8
Caucasian	828,136	80.6	155	79.9	554	41.9
Two or More Races	35,230	3.4	11	5.70	56	4.2

*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

Case data indicates that there were 258 perpetrators of the 194 child fatality/near fatalities. Of those 258 perpetrators:

- There are 131 female perpetrators, 122 male perpetrators, and five unknown.
- Thirty-eight physical abuse cases had solely a male perpetrator, ten physical abuse cases had solely a female perpetrator, and 28 physical abuse cases had a male and female listed as the perpetrators for a total of 76 physical abuse cases.

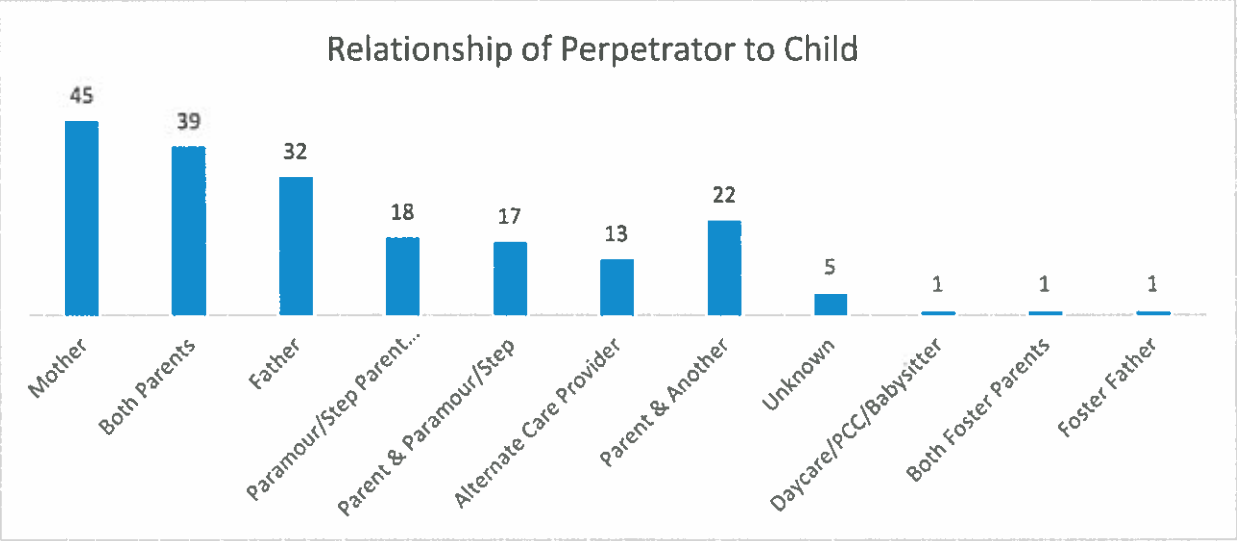
[2] U.S. Department of Health & Human Services; Administration for Children and Families; Administration on Children, Youth and Families; Children's Bureau; Child Maltreatment 2017.

- Forty-seven neglect cases had a female perpetrator, 25 neglect cases had a male perpetrator, and 41 neglect cases had a male and female listed as the perpetrator for a total of 113 neglect cases.
- Five cases were listed as unknown perpetrators.

Female perpetrators were more frequently found in neglect fatalities and near fatalities, while males tend to be the more frequent perpetrators of physical abuse fatalities and near fatalities. This is a reoccurring theme from previous years.

Figure 2 displays the perpetrator relationship to the victim for the 194 children who are the subject of this section of the report. In 40.7% (79) of the cases, there is more than one identifiable perpetrator responsible for the fatal or near fatal maltreatment. Data consistently shows that parents, acting alone or in collusion with each other, are more often the perpetrators of fatal or near fatal child maltreatment. Nationally, only 12.3% of child fatalities had perpetrators *without* a parental relationship[3]. In Kentucky, 12.13% 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.

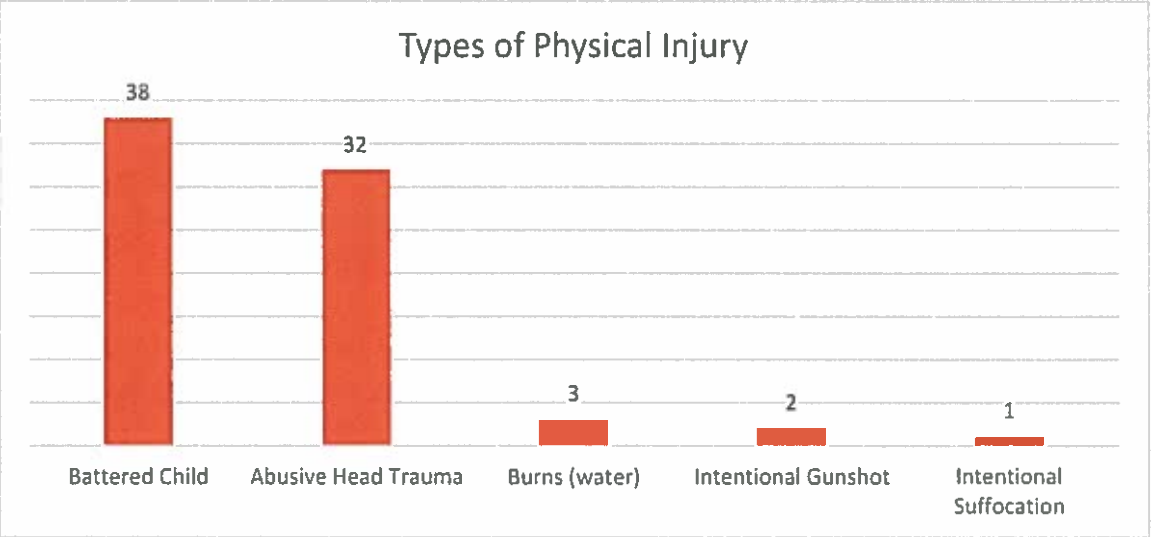
Maltreatment Type

In this analysis of SFY 2015-2019, child maltreatment is broken into two categories: physical abuse and neglect. Of the 194 cases, physical abuse was substantiated 76 times and neglect was substantiated 118

[3] U.S. Department of Health & Human Services; Administration for Children and Families; Administration on Children, Youth and Families; Children's Bureau; Child Maltreatment 2017.

times. Figure 3 displays the cause of death or serious injury in the 76 physical abuse findings for SFY 2015-2019. In SFY 2015-2019, 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.

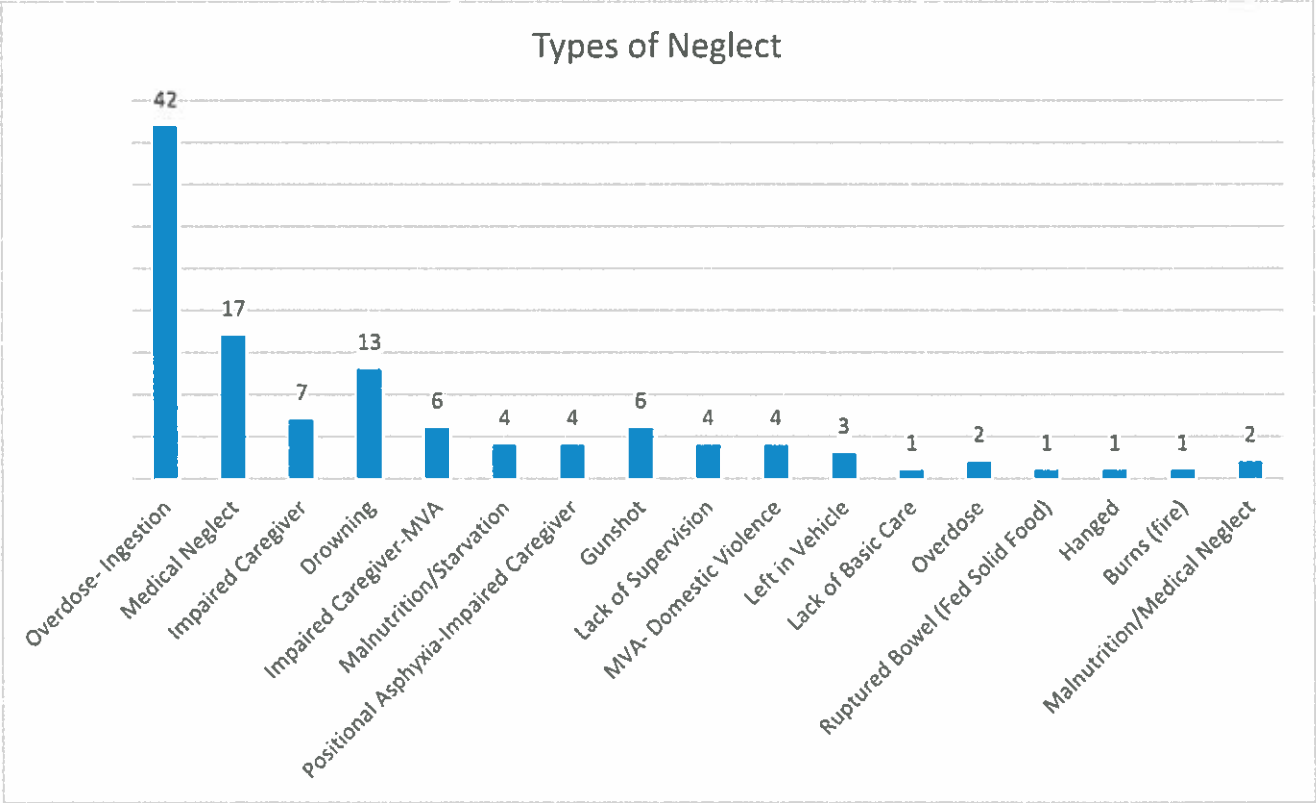
Figure 3:



The remaining 118 findings between SFY 2015-2019, were determined to be 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 for which the caregiver's substance use contributed to the maltreatment.

Figure 4 below illustrates 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 another 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:



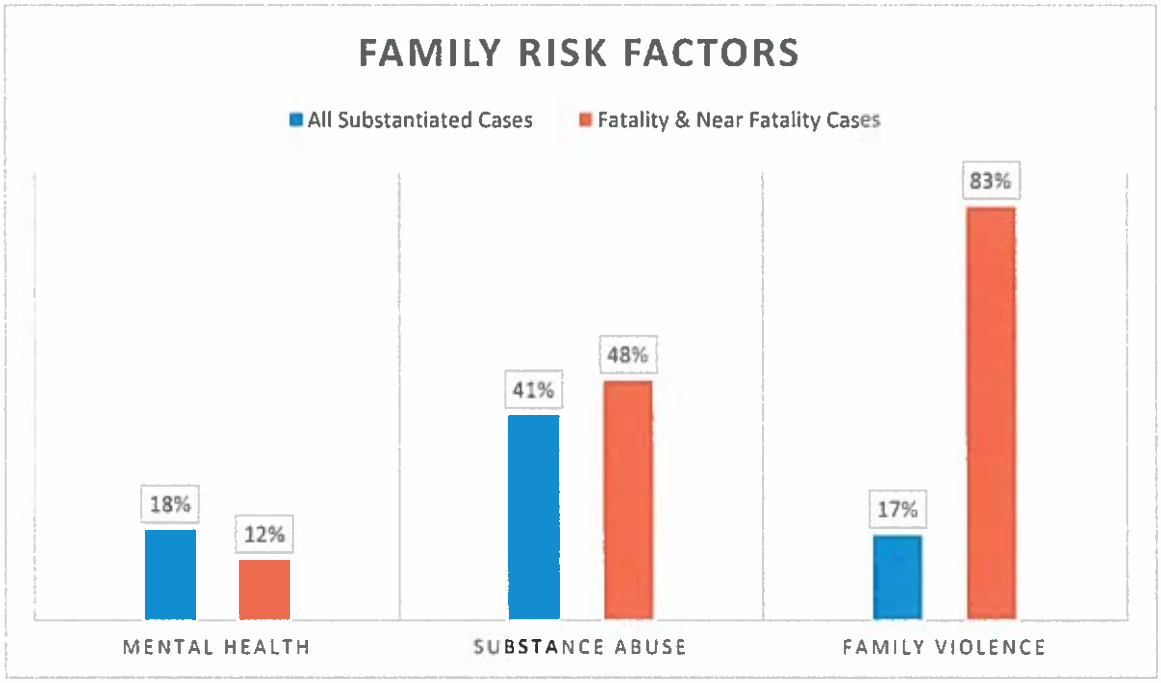
Family Risk Factors

Substance abuse/misuse, family violence, and mental illness or cognitive impairment are commonly known antecedents in child abuse and neglect cases. DCBS collects data on how these risk factors play a role in maltreatment. Data analysis of the 194 cases identified for this report indicates substance abuse/misuse directly contributed to the maltreatment in 33% (64 cases). In SFY 19, substance abuse directly or indirectly contributed to the child maltreatment in 48% of all child protective services cases and only 41% of the fatal/near fatal cases.

Family violence was present in 83% of the fatal and near fatal maltreatment cases in SFY 2015-2019, whereas it is noted as contributing to only 18% of all substantiations from SFY 19. Lastly, mental health or cognitive impairment directly or indirectly contributed to 12% of the fatality and near fatalities and 18% of the substantiated cases in SFY 19.

Figure 5 illustrates the role of family risk factors among all substantiations in comparison to the fatality/near fatality cases.

Figure 5:



An analysis between Figures 3, 4, and 5 may suggest that 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. As aforementioned, 85% of children who were the victims of fatal or near fatal maltreatment were under the age of four. 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 aged four or younger. Figure 6 shows infants are consistently more represented in fatal and near fatal cases, with 77 children being represented that are under 12 months of age, which is more than double when compared to any other age group.

Figure 6:

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.

Finally, regional staff monitor the identified areas through the continuous quality improvement case reviews. In SFY 19, the regions noted the areas needing most improvement include comprehensive assessments and timeliness of the response to assessment completion and finalization. Workers and supervisors unfailingly identify caseload size and worker retention issues as factors affecting their ability to perform assessments and case management duties effectively.

Program Improvement Efforts

Each region develops its own action plan to address the issues identified for improvement during the internal reviews. Those plans tend to focus on enhancing worker and supervisor capacity in the areas of comprehensive assessment and timely responses since caseloads and staff retention issues are often impacted by factors that are outside the regions' influence. Their approaches vary but often include trainings meant to enhance participants' skill sets for assessing specific aspects of the risk and protective factors assessment, development of support tools for use in the field, and coaching and mentoring for supervisors to build skills around their approach to case consultation. Meanwhile, the agency is pursuing alternative responses to the underlying issues of caseload size and staff retention. Those

efforts include the purchase of a safety model, implementation of Culture of Safety - System Safety Analysis, Child Welfare Transformation initiative, and implementation of the Family First Prevention Services Act (FFPSA).

Purchasing a safety model

A safety model is a research and evidence-based decision-support system that provides a comprehensive framework for assessing families. The goals of a safety model are to promote safety, expedite permanency, and support wellbeing by providing specific tools that guide the agency's decision-making processes. The model will provide tools for referral screening, acceptance, and setting response priority; distinguishing between safety and risk and planning effective responses; recognizing factors preventing the parent from creating safety, permanency or well-being; and prioritizing services delivery and measuring changes in those factors. DCBS is currently exploring the purchase of a safety model. DCBS hopes to begin work on the development of the model in winter 2019/2020 with a tiered roll out of the tools at six months intervals over the following 18 months. This purchase will include training to all field staff, training of trainers, and additional training for supervisors. Implementation of this model will include changes to The Worker's Information System (TWIST).

Culture of Safety – System Safety Analysis

DCBS has partnered with Collaborative Safety to develop a systematic critical incident review process using safety science to guide its analysis of critical incidents and its response to areas identified for improvement. Industries such as aviation, health care, and nuclear power champion this approach and it is used by child welfare agencies in other states including Arizona, Minnesota, and Tennessee. The process focuses on understanding the complex nature of child welfare work and the factors that influence decision-making and practice in real-time.

This process moves away from a simplistic approach to critical incident review, which has a tendency to assess for blame and results in the application of quick fixes that fail to address underlying issues. In the new approach, accountability is shared; frontline workers are engaged through human factors debriefings to provide their insight in how adverse events occur and how they can be avoided; and agency leadership is accountable for making improvements to create a more resilient and reliable system, which improves its capacity to provide safe outcomes for children, family, and employees.

Collaborative Safety is providing training to leadership and field staff about the philosophies of safety science and the general approach to systematic critical incident review as the agency moves toward implementation on October 1, 2019. Similar training is being provided to partner agencies and community partners. System Safety Analysts, who are responsible for conducting the human factors debriefing and facilitating the System Safety Analysis, received in-depth training in March and will receive ongoing technical assistance through the implementation.

Child Welfare Transformation

Child Welfare Transformation began in 2018. The primary goals of the transformation are to safely reduce the number of children entering out of home care, improve timeliness of appropriate permanency, and reduce staff caseloads. The steering committee formed nine work groups consisting of a multidisciplinary panel of stakeholders focusing on core strategies of Culture of Safety, aligned service array, shared focus on outcomes, and collaborative practice approach. The work groups are Workforce Supports, Prevention Supports, Foster Care and Adoption, Transition Ages Youth, Prevention Supports, Permanency, Fiscal Modernization, DCBS Service Region/Field Implementation, and Relative Supports. In its one-year progress report, the project identified the implementation of the Culture of Safety and deployment of mobility solution for front-line staff through the provision of new tablets as gains that affect the identified issues.

Family First Prevention Services Act (FFPSA)

The Family First Prevention Services Act of 2018 is designed to prioritize preservation of the family unit through quality prevention services. It allows states to utilize federal funding in a more flexible way for the development of or enhancements to preventative services. Kentucky will be among the first states to implement FFPSA beginning in October 2019. The state is engaging the entire community in planning and gathering ongoing feedback on improving Kentucky's preventative services and practice models to better support children and families. Improvements in preventive services go hand in hand with the reduction in maltreatment reoccurrence by reducing risk and enhancing parents' protective capacities and can be expected to be viewed as a support to frontline staff and to reduce caseload size.

Training

DCBS uses information gathered during the internal reviews to shape training materials in order to enhance staff capacities. DCBS provided the following trainings to field staff in this past fiscal year.

"Substance Misuse Disorder Training" was provided to frontline social workers and supervisors. This was provided at the request of regional management and provided guidance on how to assess for substance misuse, services and interventions, and safety and risk factors associated with parental substance misuse.

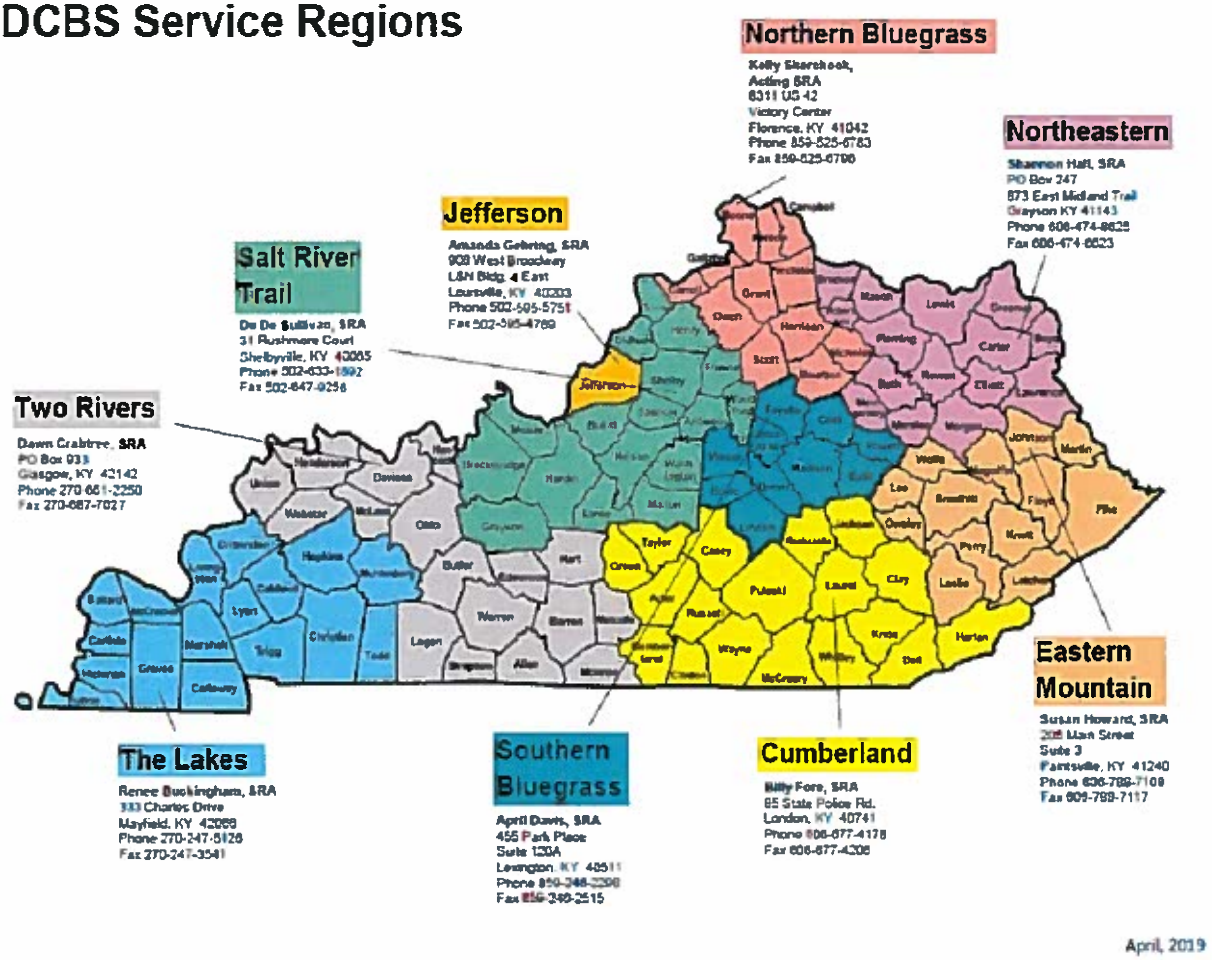
"Specialized Referrals and Assessments in Daycares, School, and other OOHC Settings Training" occurred in the Jefferson Service Region. This training is intended for investigative workers and supervisors who are identified as the workers who will initiate investigations involving day cares, schools, 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.

"Centralized Intake Refresher Training" specialized training created by the department's Child Safety Branch was provided to centralized intake staff in Salt River Trail and the Lakes Service Regions. This

training was offered at the request of individual regions to provide technical assistance on acceptance criteria and to clarify inconsistencies in interpretation of those criteria. It offered a review tool available to assist with determining acceptance including physical injury and assault to children four and younger, neonatal abstinence syndrome, and Adult Protective Services medication tools.

"Medical Neglect/Diabetes Training" specialized training was provided in July 2018 in the Jefferson Service Region to all field staff who may be responsible for initiating, assessing, or providing ongoing services to cases involving medical neglect specific to management of Type 1 diabetes. A nurse from the Medical Support Section and a diabetes nurse educator from Norton's Children's Hospital in Louisville co-led this training. DCBS anticipates offering a second session in the near future.

Appendix A: Regional Map



Appendix B: Data Tables

AGE OF CHILD	SFY 2015-2019 (n=194)		
	Fatality	Near Fatality	Total
Under 1 year	17	60	77
1 year	4	19	23
2 years	12	19	31
3 years	6	17	23
4 years	3	7	10
5-7 years	3	7	10
8-10 years	3	5	8
11-13 years	1	4	5
14 to 17 years	3	4	7
Total	**52**	**142**	**194**

GENDER OF CHILD	SFY 2019 (n=15)		SFY 2015-2019 (n=194)
	Fatality	Near Fatality	
Male	4	5	120
Female	1	5	74
Total	**5**	**10**	**194**

RACE/ETHNICITY OF CHILD	SFY 2019 (n=15)		SFY 2015-2019 (n=194)
	Fatality	Near Fatality	
African American	0	1	25
Two or More Races	0	1	8
White	5	8	159
Hispanic	0	0	2
Total	**5**	**10**	**194**

TYPE OF MALTREATMENT	SFY 2019 (n=15)		SFY 2015-2019 (n=194)
	Fatality	Near Fatality	
Physical Abuse	2	3	76
Neglect	1	9	118
Total	**3**	**12**	**194**

PERPETRATOR RELATIONSHIP TO VICTIM	SFY 2019 (n=15)		SFY 2015-2019 (n=194)
	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	1	3	20
Parent & Another	1	1	22
Alternate Care Provider	0	0	13
Other Relative	0	2	17
Unknown	0	1	5
Total	**3**	**12**	**194**