2021 Annual Report

Child Fatality and Near Fatality External Review Panel

Child Fatality and Near Fatality External Review Panel
125 Holmes Street
Frankfort, Kentucky 40601

EXECUTIVE SUMMARY

The Child Fatality and Near Fatality External Review Panel, "the Panel", was created in 2012, for the purpose of conducting comprehensive reviews of child fatalities and near fatalities suspected to be the result of abuse or neglect. Kentucky Revised Statutes 620.055(1) established the multidisciplinary panel of twenty professionals from the medical, social services, mental health, legal, and law enforcement fields, as well as other professionals who work on behalf of Kentucky's children.

The Panel reviews cases referred from the Cabinet for Health and Family Services, Department for Community Based Services, and the Department for Public Health. The Department for Community Based Services (DCBS) conducts their own investigation into the fatality or near fatality and determines whether to substantiate abuse or neglect. The Panel conducts an external review of these cases regardless of the DCBS finding. The Panel may also review cases referred from other sources, if the fatality or near fatality is suspected to be a result of abuse or neglect perpetrated by a parent, guardian, or other person exercising custodial control or supervision. The cases reviewed from the Department for Public Health, are referred from the local child fatality review teams and the state Sudden Unexpected Infant Death (SUID) team. These cases either were not reported to or were not accepted for investigation by the Department for Community Based Services.

As a part of this external review, relevant information may be requested from a variety of sources and may include autopsy reports, medical records, law enforcement records, and records held by any Family, Circuit, or District Court. The purpose of these retrospective reviews is to identify systemic deficiencies and to make recommendations for improvements to prevent child fatalities and near fatalities due to abuse and neglect.

As specified in KRS 620.055(2), the Panel is comprised of five ex officio nonvoting members and fifteen voting members. Of the fifteen voting members, eight members are currently pending reappointment from their appointing authority. However, these members continue to serve in their respective roles while awaiting their official reappointment. The Panel has not received any recommendations for members from the Board of Social Work or the Kentucky Association of Addiction Professionals.

This annual report is to be published and submitted to the Governor, the secretary of the Cabinet for Health and Family Services, the Chief Justice of the Supreme Court, the Attorney General, and the director of the Legislative Research Commission for distribution to the Child Welfare Oversight and Advisory Committee and the Judiciary Committee by December 1 of each year as specified in KRS 620.055(10). In order to publish a statistically accurate report, the Panel voted to extend the deadline by sixty days.

In 2021, the Panel began monthly meetings to meet the demand of their increased caseload. Cases reviewed were from state fiscal year 2020 (July 1, 2019 through June 30, 2020). The Panel reviewed a total of 200 cases comprised of 80 fatalities and 120 near fatalities. Of the eighty fatalities, six of those cases were reported to DCBS as near fatalities which ultimately resulted in a fatality. Twenty-seven of those cases were referred to the Panel from the Department for Public Health.

For a greater understanding of the Panel's work, all interested citizens are encouraged to read this report and to visit the Justice and Public Safety Cabinet's website (http://justice.ky.gov/Pages/CFNFERP.aspx) for prior years' reports and case summaries.

2020 IN REVIEW

The Panel has continued to focus on their statutory requirement of conducting thorough and thoughtful reviews of all referred cases. As a part of the review process, the Panel tracks various data points to assist in formulating annual recommendations. During 2021, the Legislative Oversight and Investigations Committee conducted their statutorily required annual review of the Panel's operations and made recommendations for improvement.

As a result of these recommendations, the Panel has reevaluated the data tool and partnered with Maternal and Child Health epidemiologists from the Department for Public Health to improve current methods. The Panel will continue to utilize the SharePoint website in conjunction with the web-based Research Electronic Data Capture (REDCap), a secure web application. The SharePoint website will continue to allow the Panel to store, share, and access case information. REDCap will store the revised data tool which will allow the Panel to collect, organize, and export the data for enhanced analysis. Through the development process within the REDCap instrument, a data dictionary will be available. In addition, the Panel has expanded its current data tool documentation by creating an Analyst Binder, which includes guidelines for each data element to ensure consistency.

The Panel has continued to use expert case analysts to streamline their case reviews. The Panel currently has one full-time social worker analyst and one contracted pediatric forensic medical analyst. During testimony to the Legislative Oversight and Investigations Committee, the Panel expressed their desire to hire additional staff to meet their increasing caseload and to assist them with implementing recommendations. The Panel is grateful for the recommendations and support they received from the legislators and are looking forward to continuing to work with them on these important issues.

As previously stated, the Panel is required to make annual recommendations for system and process improvements to help prevent child fatalities and near fatalities. However, the Panel lacks the authority and resources to implement those recommendations. To overcome this challenge, the Panel has formed subcommittees and partnered with various agencies to continue to move towards implementation and prevention.

→ Several panel members formed a subcommittee to address various law enforcement training concerns. Representatives from Prevent Child Abuse Kentucky and the Department of Criminal Justice Training have joined these efforts to implement a solution. The subcommittee plans to shift focus to coroner's training in FY 2022.

→ Last year, the Panel partnered with the Kentucky Safety and Alignment Network (KSPAN) to form the Child Home Safety Committee. The Committee now consist of 75 members from across the Commonwealth with the goal of reducing the number of unintentional overdose/ingestion and firearm injuries in children. Utilizing funding from the CDC, the Committee was able to purchase and distribute medication lock boxes and trigger locks. Prevention tools were distributed throughout the state and partners were required to provide face-to-face education regarding best practices for safe storage. Each family that received a medication storage container or a trigger lock also received educational material from Prevent Child Abuse Kentucky and KY Youth Advocates. The Committee recently partnered with the Office of Drug Control Policy and the Kentucky Agency for Substance Abuse Policy (KY-ASAP) to receive additional funding to further expand the program.

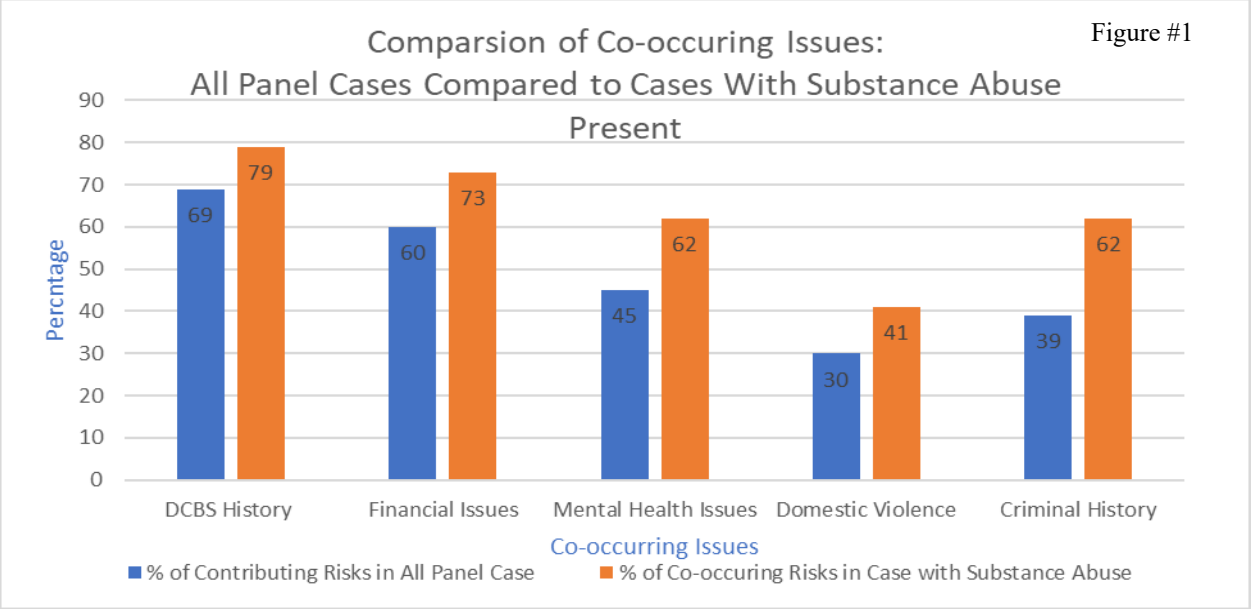
We would like to express our deepest gratitude to each of our valuable partners.

RECOMMENDATIONS REGARDING SUBSTANCE MISUSE

Addressing the Complexities of Substance Misuse Within Families

Among the cases reviewed by the Panel, substance misuse continues to be an area of great need. Nearly half (49%) of all cases reviewed found substance misuse in the home; a caregiver was identified as having a substance misuse issue at almost the same rate (46%). The destructive impact of substance misuse on child and family well-being is well documented. Families impacted by substance misuse are at greater risk of child abuse and neglect, while simultaneously struggling with other co-occurring risks. Risk factors such as, mental health concerns, poverty, domestic violence, and criminal history are common among Panel cases. These issues occur at greater rates within families identified as having substance misuse issues. Comparing the rate at which these risk factors occur in all Panel cases, to those in which substance misuse has been identified reinforces the complexity of need among families struggling with this issue. As seen in the following chart (Figure #1), these risk factors are found at significantly higher rates among families where substance misuse has been identified. The multi-issue families require a multi-agency comprehensive response.

Figure #1



Data Source: Child Fatality and Near Fatality External Review Panel Data

Families with child welfare involvement and substance misuse issues require holistic services, delivered in a multidisciplinary, strength-based, and collaborative environment. There are several promising practices and programs in Kentucky to meet this need. One example is Sobriety Treatment and Recovery Teams (START). This program began in Kentucky over ten years ago and has developed into an evidence-based and nationally recognized model. Kentucky has also implemented the Kentucky Strengthening Ties and Empowering Parents (KSTEP) program, an evidence informed program designed to provide collaborative services to high-risk families. Similarly, the Cabinet for Health and Family Services (CHFS) has contracted with Volunteers of America (VOA) to expand the Freedom House model to provide collaborative services to families struggling with substance use disorder. The Panel acknowledges and strongly supports efforts to expand these important programs. However laudable, the Panel is concerned these efforts do not meet the existing need across the Commonwealth.

Recommendation:

1. The General Assembly should review the Cabinet for Health and Family Services' plan for expansion of programs to families that have child welfare involvement and substance misuse issues, identify existing gaps, and allocate necessary funding.

Enhancing Court Capacity

The primary role of a juvenile or family court is to protect the child and help the caregiver provide a safe environment.[1] Of the total cases reviewed by the Panel, 62% had prior court involvement. (See Figure #2) The Panel has, in five prior Annual Reports, recommended expansion of Family Drug Court programming. Unfortunately, there is still only one county in Kentucky with a Family Drug Court model. This program, previously funded with private funds, recently received grant funding from the Office of Juvenile Justice and Delinquency Prevention. While this is an important step, it is woefully short of the resources needed throughout the Commonwealth. Family Drug Courts and other efforts to implement Model Court practices have fallen victim to budget cuts, resulting in the loss of important resources for families involved with the child welfare system due to substance use. Despite these limitations, some jurisdictions have been able to implement some elements of Model Court Practice. For example, Hardin County Family Court has collaborated with community partners to implement use of a Best Practice Assessment Tool. This tool is used by community mental health partners, present at court, to conduct assessments and immediately engage families in services. Kentucky's family court system should use a multidisciplinary, collaborative approach to best serve the family's complex needs.

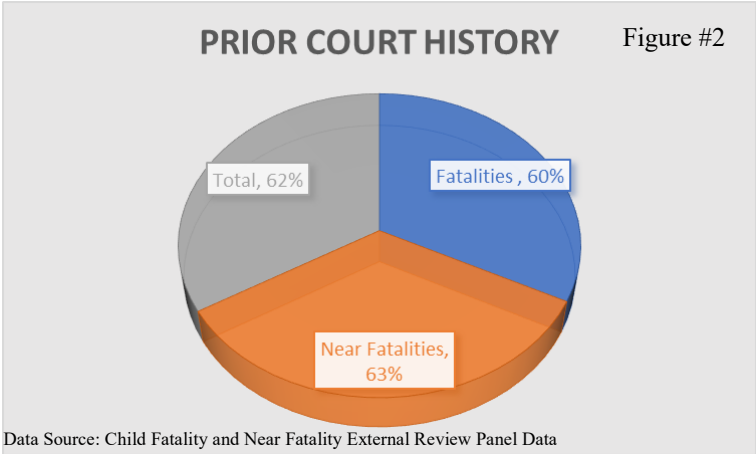


Figure #2

Data Source: Child Fatality and Near Fatality External Review Panel Data

Recommendation:

2. The Administrative Office of the Courts should develop a budgetary proposal to expand Family Drug Courts throughout Kentucky. The Kentucky Opioid Advisory Committee should examine this proposed budget and provide the additional required funding for implementation.

Plans of Safe Care (POSC) for Substance Exposed Infants

In SFY 2020, the Panel documented 33 cases in which children were exposed to substances prenatally, 10 of those had a reported diagnosis of NAS/NOWS. (More commonly known as Neonatal Abstinence Syndrome (NAS), and sometimes diagnosed as Neonatal Opioid Withdrawal Syndrome (NOWS). These infants were exposed to a variety of drugs, prescribed and illicit. Almost half (45%) had been exposed to more than one drug. Figure #3 identifies the frequency and type of substances identified.

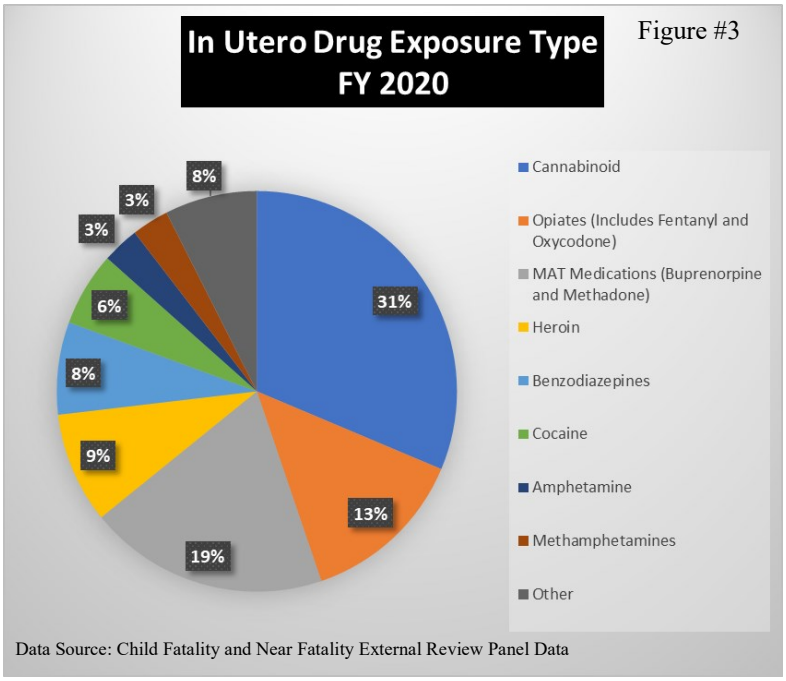


Figure #3

Data Source: Child Fatality and Near Fatality External Review Panel Data

RECOMMENDATIONS REGARDING SUBSTANCE MISUSE

The number of Panel cases involving children affected by prenatal substance use is a small subset of the overall problem in Kentucky. The *Public Health Neonatal Abstinence Syndrome Reporting Registry* cited 1,102 NAS cases in 2019. This number would include only those children with withdrawal symptoms and does not represent the full incidence of children exposed prenatally. [2]

The Plan of Safe Care (POSC), a federally mandated practice since 2003, is intended to address the needs of infants identified as being affected by or having withdrawal symptoms resulting from prenatal drug exposure or Fetal Alcohol Spectrum Disorder.[3] The intent of the federal mandate is clear: to ensure the health and safety of the affected infant. In addition to addressing the needs of the infant, the POSC is intended to address the treatment needs of the parent. Best practices suggest the plan be developed with input from the parents and caregivers, in collaboration with agencies serving the family. Needed services extend beyond the drug treatment needs of the parents, but should also address comprehensive needs such as parent education, vocational training, etc. While there are effective programs in some areas of the state, the implementation of POSC best practices observed in Panel cases has been sporadic.

The need for effective and consistent implementation of POSC's has been addressed in every Panel report, beginning in 2017, and remains an area of significant concern. In FY 2020, five of the 33 cases (15%) involving substance exposed infants were found to be lacking a POSC. Practice observed by the Panel involves substance exposed infants being assessed as part of a CPS investigation, often without other elements of the POSC. Comprehensive assessments, linkages between medical care providers, and the full array of support services are often absent. Meaningful engagement of community partners is lacking. Perhaps most importantly, although federal guidelines provides latitude in terms of which agency is responsible for implementation and monitoring of the POSC, this responsibility in Kentucky is seemingly left solely to CPS. However, CPS does not accept all referred cases. According to a 2020 report from Child Welfare Gateway, Kentucky has regulations governing the investigation of substance exposed infants, but no specific "statute or regulation" regarding services for the infant and parents or other caregivers, and perhaps most importantly the monitoring of the POSC.[4] While infants exposed to substances must be assessed by DCBS for safety risks, the services and monitoring aspect of the POSC should engage the community, with active support and ownership from the behavioral and public health system.

Recommendations:

1. The Health and Welfare Committee should investigate current POSC practices in Kentucky; identify model programs, as well as areas of improvement, and identify statutory and budgetary resources to enhance statewide practice.

2. The Department for Behavioral Health, Developmental and Intellectual Disabilities, in conjunction with the Department for Public Health, should accept responsibility for implementing POSC and develop strategies to assure statewide implementation of collaborative Plans of Safe Care that are consistent with the federal mandate.

RECOMMENDATIONS REGARDING SUBSTANCE MISUSE

MEDICATION-ASSISTED TREATMENT PROGRAMS

Medication-Assisted Treatment (MAT) is an evidence-based practice and an important treatment option for individuals diagnosed with substance use disorder. Only 15% of cases reviewed by the Panel were identified as either currently or previously involved in MAT. In most cases reviewed, families benefited from MAT as a tool to achieve and maintain sobriety. Although MAT is an effective treatment modality, opportunities for improvement were noted, primarily related to the needs of clients with young children. Ideally all MAT providers would include prevention strategies to address issues such as co-sleeping while taking these medication and unintentional ingestions. (e.g., medication lockboxes) Further best practice opportunities would include identification of MAT clients with CPS involvement and intentional efforts to collaborate with CPS in service provision. While the provision of MAT services is confidential, obtaining a release of information would allow communication with other partners serving the family and allow MAT providers to be informed advocates for their clients.

Recommendations:

1. The Cabinet for Health and Family Services should convene a study group to develop a regulatory and contractual framework to support best practices for MAT providers serving clients with young children. The study group should include representatives from MAT providers in Kentucky, experts in serving child welfare involved families, as well as Department of Medicaid and regulatory entities.

2. The Kentucky Opioid Abatement Advisory Council should consider funding medication lockboxes with educational material to MAT providers for their clients with young children in the home.

F-044-20

This case involved the death of one-month old infant determined to be a result of overlay by the mother who had overdosed on heroin. Father called 911 after finding mother and child unresponsive after returning to the room from getting breakfast. (Police suspected the father had left the home to obtain more heroin.) Father admitted to heroin use at approximately 1:00AM, and reported they woke to feed the baby during the night. He said mother had also used heroin with him, reportedly while the child and sibling were in the bedroom (a razor blade and heroin residue were found on the nightstand). The incident occurred at the home of a paternal aunt, where the family had been staying. Records indicate no criminal charges were filed against the father.

The infant's postmortem blood toxicology was positive for Fentanyl. The infant was exposed to amphetamines, buprenorphine (Subutex), and smoking in-utero. The baby was not diagnosed with neonatal abstinence syndrome and was released to the parents at five days old. A CPS report was investigated and unsubstantiated when the child was born substance exposed. Another CPS referral regarding the child was made four days before the death. That referral was not accepted for investigation.

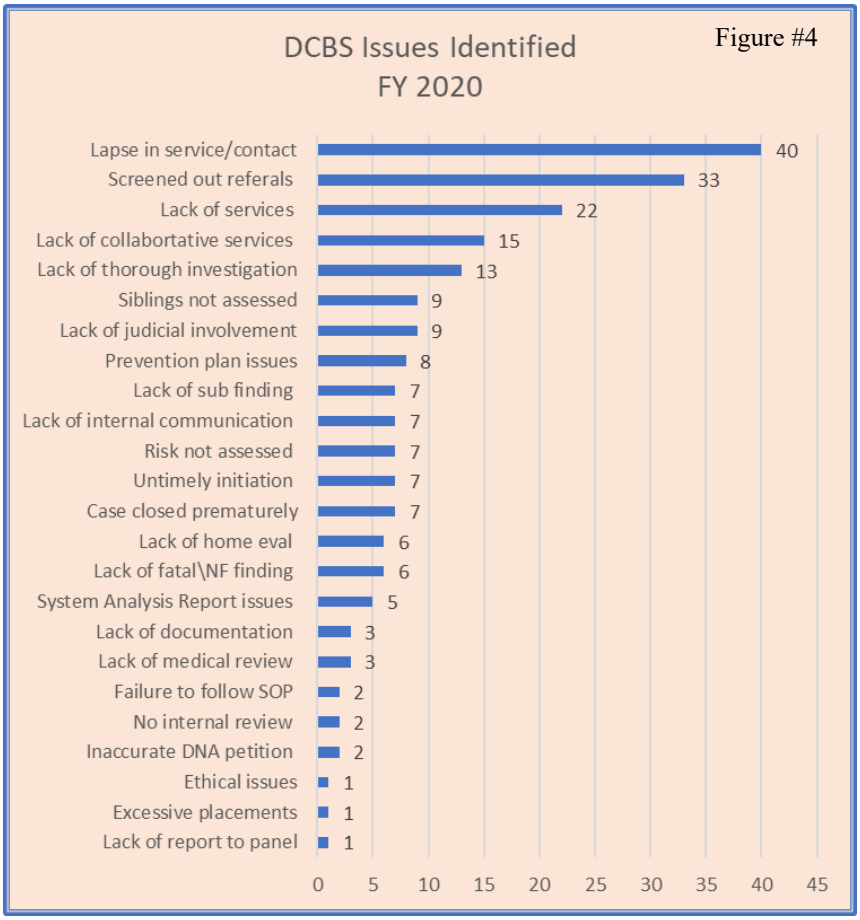
Mother and father met in rehab and had been together about a year. Father reported a ten-year history of heroin addiction. Mother had a significant history of substance abuse including opiates, methamphetamine, and alcohol. The family lacked stable employment and were chronically homeless. This case reflects the lack of a statewide, consistent collaborative approach to substance affected families and plans of safe care.

RECOMMENDATIONS REGARDING DCBS

DCBS History and Issues

Prior history with the Department for Community Based Services (DCBS) was documented in 69% of all cases. Prior history is defined CPS referrals (accepted for investigation or screened out), APS investigations, or ongoing CPS casework within five years of the fatal or near fatal incident. DCBS issues were identified in 48% of all Panel cases. Identified issues include concerns identified in service provision before or after the fatal or near fatal incident.

Figure #4



Data Source: Child Fatality and Near Fatality External Review Panel Data

The Panel compiles DCBS issues into categories. Figure #4 depicts the type of issue and incidence rate of each issue. A single case may have more than one identified issue. While the total number of cases with DCBS issues identified is 97, the total number of issues identified is 216. The issues identified within Panel cases may serve as a proxy for the capacity of DCBS to provide quality services. The drivers behind each of these concerning issues is complex. Contributing or causal factors likely include training, worker experience, supervisory oversight, etc. While these contributing factors are important, the primary influence is staff vacancies, turnover, high caseloads and burn out. This is not a new issue. Previous Panel reports have made specific recommendations to address the staffing needs within DCBS. While efforts were made in previous years, they failed to meet the demand. Additionally, it appears staffing issues have been exacerbated by the COVID pandemic. Addressing the staffing issues within DCBS is a prerequisite to any effort to improve service provision within DCBS. Until the need to stabilize staff is addressed, it seems futile to expect improvement in DCBS's capacity to provide quality services. Briefly stated, this not primarily a worker performance issue; it is a workforce issue.

The Panel has limited access to DCBS caseload data, but the evidence the staffing crisis within DCBS is abundantly clear. DCBS has implemented a new internal review process known as Culture of Safety System Safety Review (SSR). This involves reviewing case history and multidisciplinary reviews of selected cases to identify factors influencing staff decision making. The Panel has access to reports from these reviews and has noted frequent identification of staff vacancies and high caseloads as drivers behind decision making.

RECOMMENDATIONS REGARDING DCBS

It can reasonably be assumed that issues such as lapse in contact, lack of services, and closing cases prematurely are often a direct result of DCBS staff's effort to manage high caseloads with an unstable workforce. In addition to SSR reports, Panel case reviews frequently note multiple worker changes and assessments being completed by new workers reading the notes of staff who have previously left the agency.

Recommendations:

1. Budget proposals from the General Assembly and the Administration to address this issue are cause for optimism. These proposals are in the best interest of Kentucky's children and families, and the Panel recommends enactment of these proposals be prioritized in the 2022 Session.

2. DCBS should provide the Panel with caseload data, when requested, on a regional, county, unit/ team and individual level.

DCBS Intake Process

While many of the issues seen in Panel cases are closely related to staffing issues, the issue of screened out CPS referrals warrants study through a different lens. Screening out CPS referrals has been a longstanding area of concern, and a topic of national examination of child fatalities. The chairman of the National Commission to Eliminate Child Abuse and Neglect Fatalities stated, "A call to a child protection hotline, regardless of the disposition, is the best predictor of a later child abuse or neglect fatality. This points to the importance of the initial decision to 'screen-out' certain calls. Screening out referrals leaves children unseen who may be at a high risk for later fatality."[5]

Efforts to address this issue are underway. DCBS has reported plans to pilot a Differential Response program in a few counties across the state. This model is designed to engage community partners in serving low risk families. This is an important step in assuring those families who do not meet CPS acceptance criteria receive services, thereby allowing DCBS to focus on higher risk cases. The Panel supports this important step, but given the impact of this issue, further action is needed. There are Panel cases in which reports have met criteria for investigation but were nevertheless screened out. In prior annual reports the Panel has made policy recommendations to address this issue. Those recommendations are restated in this year's report.

Recommendations:

1. DCBS should revise current screening policies to: 1) ensure the adequacy of existing acceptance criteria; 2) implement a supervisory/management review process for referrals involving children under four, medically complex children, or families with multiple prior referrals; and 3) implement a process for professional reporting sources to seek supervisory review of decisions to screen out referrals they have made.

2. The Health and Welfare Committee should examine national best practices surrounding Alternative Response models, as well as monitor the outcomes of the pilot efforts in Kentucky. This should result in recommendations leading to rapid statewide expansion of the model.

In-Home Service Providers

In FY 2020 the Panel began collecting data regarding In-home Service Provider Issues. This data element is intended to capture missed opportunities involving providers working within the home. Examples would include HANDS, First Steps, Private Child Care (PCC) providers, and Family Preservation Program (FPP). As this is a new data element, and not all cases involve in-home services, the number of documented incidents is small. Ten cases involved In-home Service Provider Issues. Six of the ten cases involved FPP providers, with the remainder being First Steps and PCCs. Within the small data set, one trend involving FPP emerged.

Specifically, in all six FPP cases, the Panel noted lack of documentation of collaborative service provisions. FPP is a service contracted through DCBS and is typically an intensive short-term service meant to prevent removal of children from the home. Because it is short-term, it is important to assure the family has identified and engaged community partners to continue supporting the family following conclusion of the FPP service. Ideally, this would include engagement of non-traditional sources of social/emotional support such as friends, extended family, faith groups, 12-Step Groups, etc.

Recommendation:

1. DCBS should contractually require collaborative service provisions by FPP providers. Contract language should include the following components:

   * A service planning meeting at the beginning of the FPP case, engaging the family's existing support system and involved agencies.
   * Regular contact with agencies serving the family (medical care, mental health, substance abuse, etc.) through the duration of the program.
   * At case closure, a second service planning meeting should focus on the development of a detailed aftercare plan. This meeting should involve the family's support system, as well as any providers recommended to provide follow-up services with the family.

RECOMMENDATIONS REGARDING POVERTY

ADDRESSING THE COMPLEXITIES OF POVERTY

Cases are examined for indicators of "Financial Issues," which is defined by the Panel as a caregiver who is "financially unable to sustain standard care of the household without additional outside resources (e.g., SNAP, WIC, KCHIP)." The Panel does not have direct access to data systems which track family income. Alternatively, the Panel makes the determination of "financial issue" using statements within the record as proxies for actual income. Statements or indicators in the record include documentation of receipt of income based financial assistance (SNAP, TANF, KCHIP/Medicaid, housing assistance, etc.), fixed sources of income such as SSI disability, and caregiver statements indicating financial stress, unemployment/job losses, prior evictions, etc.

"Financial issues" was the second most frequently identified case characteristic, found in 60% of all cases. While issues such as substance abuse, criminal history, and mental illness are often identified as critical risk factors associated with maltreatment, financial issues were found at a significantly higher rate than any of these.

The pervasiveness of poverty in Kentucky is well documented. According to the 2021 Kids County Data Book, 20.9% of all Kentucky children lived in home below 100% of the federal poverty line, while 45% of children lived in low-income families (below 200% of the federal poverty line.)[6] While this is a slight improvement over the previous five years, it remains an untenable situation.

Examining co-occurring risk factors within Panel cases in which financial issues were identified points to the difficulty of living in, and escaping, poverty. Co-occurring risk factors examined included housing, childcare, availability of family support, overwhelmed caregiver, and treatment for mental health or substance abuse issues. As noted in Figure #5, each of these family risks occur at higher rates in families with financial issues when compared to all Panel Cases.

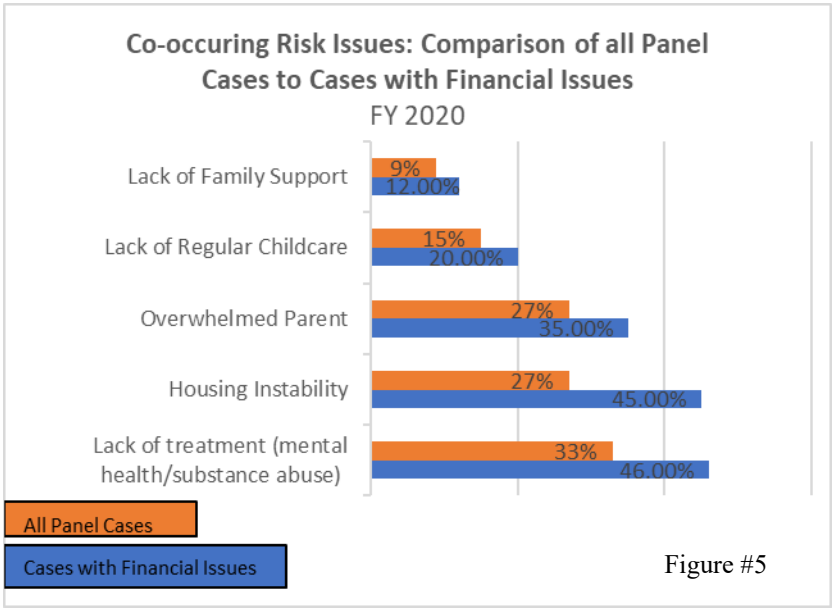


Figure #5

Data Source: Child Fatality and Near Fatality External Review Panel Data

Despite the level and entrenchment of poverty in Kentucky, there is reason for optimism. Much recent research has documented a positive correlation between increased family income and reduction of child maltreatment rates.

Based in part on research findings (page 12), DCBS programming has increased flexible funds available to in-home service providers working with high-risk families. This is an important and promising step. However further efforts are warranted, and Kentucky needs to take innovative and decisive action to reduce child maltreatment rates by increasing material resources to low-income families in the Commonwealth.

Recommendation:

1. The Health and Welfare Committee should study and utilize available research to identify evidence-based practices to increase family income and material resources as a strategy to reduce child maltreatment. The committee should also examine current funding levels available to DCBS to provide flexible funds for CPS families in crisis and take action to make needed increases.

Research Examples

⇒ Even modest increases in family income positively impact child abuse and neglect rates. (Pelton, L. H. (2015). The continuing role of material factors in child maltreatment and placement. *Child Abuse & Neglect, 41,* 30–39. https://doi.org/10.1016/j.chiabu.2014.08.001)

⇒ Earned income tax credits have been associated with reductions in foster care entry. (Rostad, W.L., Ports, K.A., Tang, S., & Klevens, J. (2020). Reducing the number of children entering foster care: Effects of state earned income tax credits. Child Maltreatment. www.doi.org/10.1177/1077559519900922)

⇒ Families receiving child support were less likely to be subjects of a CPS report than mothers who did not receive child support. (Cancian, M., Yang, M., & Slack, K. (2013). The Effect of Additional Child Support Income on the Risk of Child Maltreatment. Social Service Review, 87 (3), 417-437.)

⇒ Small increases in minimum wage ($1) were associated with declines in child maltreatment rates, particularly neglect. (Raissian, K., Bullinger, L., (2017). Money matters: Does the minimum wage affect child maltreatment rates? Children and Youth Services Review, Volume 72, January 2017, Pages 60-70)

F-006-20-C

This case involves the hyperthermia death of a two-year child. The father and index child laid down to take a nap at 8:00 a.m. When the father awoke the child was missing and he contacted the authorities. The child was discovered in a decommissioned police car located on the property. The rear doors of the vehicle could not be opened from the backseat. The child had just recently learned to open doors and apparently left the house and entered the vehicle while the father slept. The father worked late the previous evening and then woke up early to take the mother to work. It was reported the father had only had an hour or two of sleep.

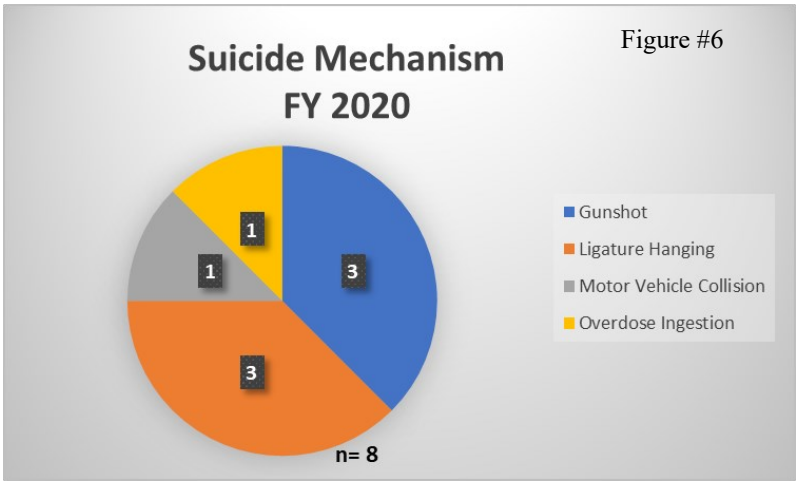
The household consisted of mother, father, index child and paternal grandfather. The paternal grandfather would typically provide childcare while the father slept. However, on this day the paternal grandfather had been admitted to the hospital. Mother and father worked minimum wage jobs and received SNAP and Medicaid. They had a history of domestic violence, financial issues and housing instability. They did not have the financial resources for childcare outside the home.

YOUTH SUICIDE

According to the Department for Behavioral Health, Developmental and Intellectual Disabilities, suicide is the second leading cause of death for youth and young adults in Kentucky.[7] In SFY 20, the Panel reviewed seven cases of children who died by suicide and one case involving a near fatal attempt. Based on a report by the Kentucky Department for Public Health, the eight cases reviewed by the Panel represent only about a third of the total children in Kentucky who died by suicide in 2020.[8] Only those cases with a concern for maltreatment were referred to the Panel.

The suicide mechanism within Panel cases are primarily gunshot and ligature hanging. (See Figure #6) Similar to findings reported by the Kentucky Department for Public Health, ingestions are a rare fatal suicide mechanism in children.

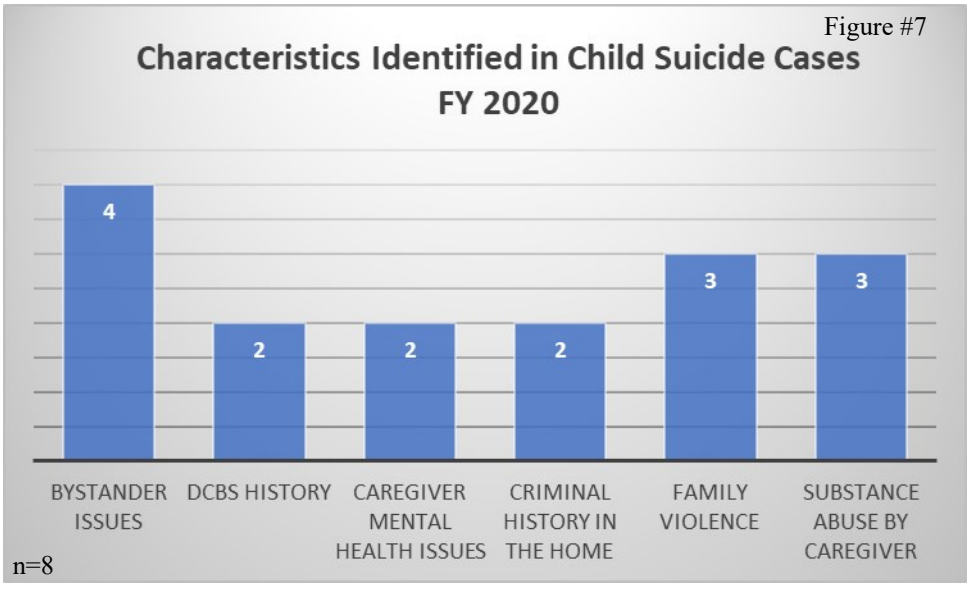
Figure #6



Data Source: Child Fatality and Near Fatality External Review Panel Data

Examining the family characteristics within these cases provides valuable insight. (See Figure #7) Adverse Childhood Experiences (ACEs) are common characteristic among Panel cases involving youth suicide. While the Panel review process does not include the complete ACEs questionnaire, although many of the characteristics measured by the Panel parallel with the ACEs criteria. Factors such as: history of family violence, substance abuse, criminal history, mental illness, and DCBS history can be considered indicators of ACEs. Two or more of these ACEs related characteristics were found in 50% of the suicide cases. Another prominent characteristic, found in half of these cases, was "bystander issues." This characteristic suggests someone in the child's support system (parent, friend, relative, etc.) was aware the child was at risk based on prior indicators of suicidal ideation. Often, and tragically, these individuals did not take any action to intervene on the child's behalf.

Figure #7



Data Source: Child Fatality and Near Fatality External Review Panel Data

RECOMMENDATIONS REGARDING MENTAL HEALTH

Although the Panel gathers significant information regarding the circumstances surrounding the suicidal incident, there is minimal information available regarding the social, emotional, and psychological issues facing the child prior to the suicide. It is exactly this type of information that is desperately needed to better understand the circumstances leading to the death and identify possible prevention measures. A Psychological Autopsy is a tool that involves a detailed review of the circumstances of the death, including review of medical records and structured interviews with family members, relatives or friends, and health care professionals. The Psychological Autopsy is conducted by a trained investigator who is certified by the American Association of Suicidology. The Panel is aware of only two individuals in Kentucky currently trained on how to conduct an Psychological Autopsy.

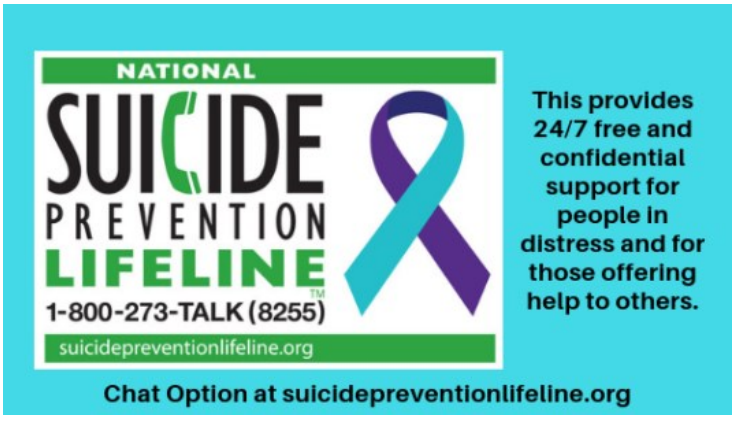
Recommendation:

1. The Department for Behavioral Health, Developmental and Intellectual Disabilities should take immediate steps to begin expanding the statewide utilization of the of the Psychological Autopsy in youth suicides. This should include, but not be limited to, identifying fiscal and personnel resources needed, exploring grant opportunities, and developing a specific timeline to achieve statewide implementation by FY 2024.

F-060-20-PH

This case involved the death of a 16-year-old transgender youth as a result of suicide by walking into oncoming traffic. The index child was residing in foster care and left the home after an argument with the foster parent. About an hour later, police received a call about an individual walking in the middle lane of the interstate. The child was eventually struck by multiple vehicles and pronounced dead. The child had a history of mental illness, behavioral issues, suicidal ideation, and a history of "playing chicken with cars".

The child was diagnosed with bipolar disorder and oppositional defiant disorder. He had a history of ongoing childhood trauma including physical abuse, sexual assault, exposure to substance misuse, removal from home, multiple residential placements, and the death by suicide of a sibling. The child had a toxic relationship with his biological parents, who refused reunification and visits. The first documented CPS report was received in 2012 and ten referrals were investigated within five years. Except for a dependency finding, none of these reports were substantiated and eighteen reports were screened out during this timeframe. Involved clinicians reported many of the child's allegations regarding the family were likely valid but it was hard to decipher the truth due to his mental illness and history of trauma. There was limited information available regarding his recent mental health treatment (or lack thereof). A Psychological Autopsy may have helped identify missed opportunities for intervention and informed future prevention efforts.

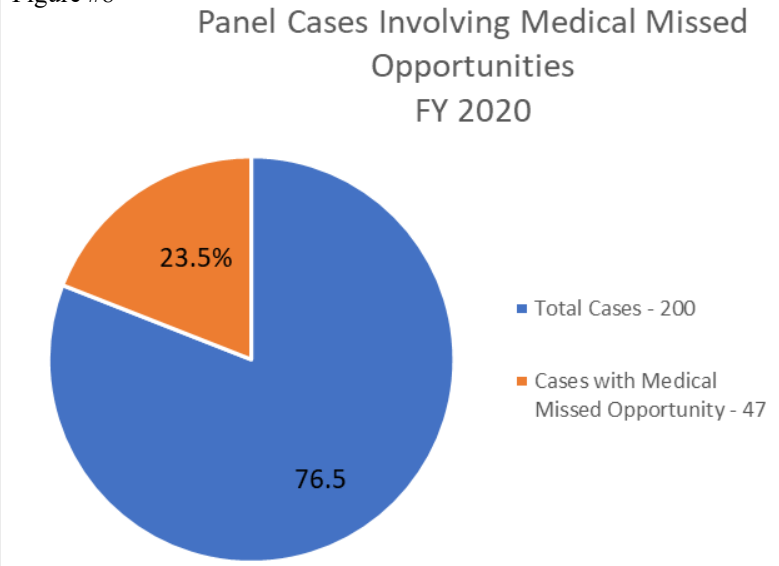


RECOMMENDATIONS REGARDING MEDICAL PROVIDERS

As part of the case review process, and assessing for systemic issues, the Panel identifies possible missed opportunities by health care providers. A medical issue is defined as "any missed opportunities by the medical professionals, for example: failure to educate caregivers, failure to notify DCBS or law enforcement, lack of adequate follow-up plan or referrals, etc." For the purpose of identifying medical missed opportunities, mental health providers are considered a health care professional. Determination of missed opportunities is based upon review of the medical records and other agency documentation. When conducting case reviews, the Panel has access to medical records that are a part of the DCBS record. If medical documentation is not included, Panel staff will request additional records. These records may include pediatric, primary care providers, birth, mental health, and emergency department documentation.

As illustrated in Figure #8, the Panel has documented medical missed opportunities in almost a quarter of all cases reviewed. The Panel, in the current data tool, utilizes narrative description to capture the nature of the missed opportunities. (Beginning with FY 2021 cases, a standardized drop-down list will be utilized.) These narrative descriptors are compiled in categories. Sixty-six types of missed opportunities were identified; a single case may have more than one type of missed opportunity.

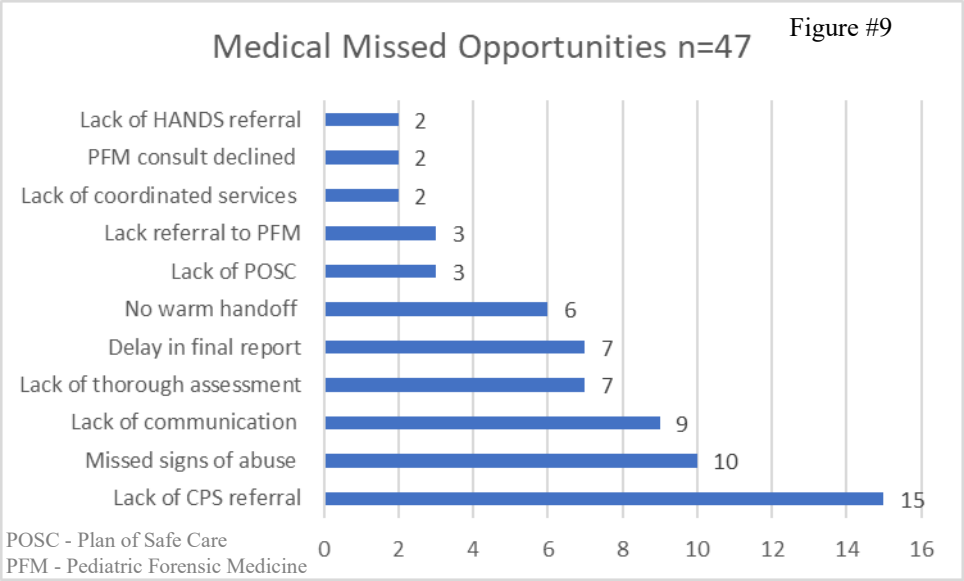
Figure #8



Data Source: Child Fatality and Near Fatality External Review Panel Data

As shown in Figure #9, the single most cited issue (15) is "Lack of a CPS referral". This finding reflects the Panel's determination that a health care provider had reason to suspect possible maltreatment but failed to notify authorities. This does not typically involve children with obvious indicators. More often the issue involves failure to report questionable injuries, subtle patterns of concerning behaviors, missed appointments, indicators of medical neglect, etc. Similarly, "missed signs of abuse" were noted in ten cases and involved a failure to detect or document signs of abuse, and in some cases accurately interpret tests or x-rays. "Lack of thorough assessment," cited in seven cases, is also a qualitative issue regarding the medical assessment of a high-risk child. During Panel discussions, it has been noted that the pediatric forensic medical staff are available to consult with health care providers statewide when confronted with questionable circumstances or suspicious injury.

Figure #9



Data Source: Child Fatality and Near Fatality External Review Panel Data

RECOMMENDATIONS REGARDING MEDICAL PROVIDERS

Many of the medical missed opportunities can best be captured under the umbrella of the need to improve communication between medical providers and other involved agencies. A practical example of an issue that falls under the umbrella of communication is the "warm hand off." This typically involves the birth hospital communicating directly with the pediatrician or primary care provider to assure awareness of the risk factors and implement an adequate aftercare plan– including steps to be taken if the aftercare plan in not followed. (Plans of Safe Care are further addressed on page 6) Gaps in communication occur when health care providers fail to refer high-risk families to support services such as HANDS (Health Access Nurturing Development Services) or fail to make referrals for forensic evaluations and other referrals to address issues such as substance misuse or mental health issues among caregivers.

The issue of "delay in final report" warrants specific explanation and discussion. This issue refers to a delay in receipt of the Pediatric Forensic Medicine (PFM) report and/or the autopsy report. These reports are needed by DCBS to assist in finalizing the CPS investigation and by law enforcement to determine criminality. These reports are also utilized by the courts in making a civil and or criminal finding in the case. The delay in receipt of these reports is typically attributed to work volume and staffing issues within Kentucky's two pediatric forensic medical centers and the Office of Medical Examiner.

Forensic reports conducted by PFM staff are time intensive, involving hands on evaluation of the child and siblings, interviews with parents/caretakers, review of current and prior medical records, development of recommendations for addressing ongoing risk, and/or testifying at criminal and family court proceedings. The existing capacity of Kentucky's two pediatric forensic medical centers are insufficient to meet the existing need. With additional resources, PFM staff could provide additional consultation to other health care providers, minimize delays in completing the forensic report, and provide training to community partners.

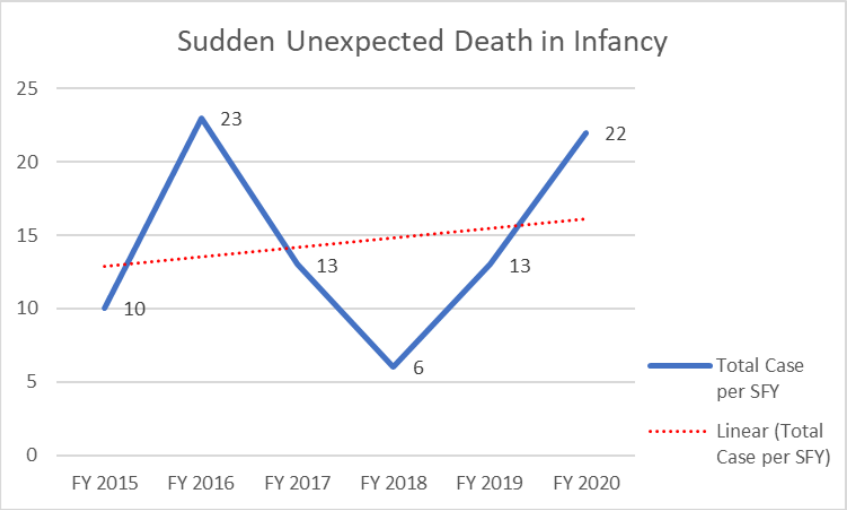
Recommendations:

1. Kentucky's pediatric forensic medical centers support the Cabinet for Health and Family Services in its quest to provide Child Protective Services to high-risk families, assist local law enforcement in investigating serious cases of child abuse and neglect, and provide testimony necessary to the County and Commonwealth attorneys charged to prosecute these cases. As such, the Cabinet for Health and Family Services, the Justice and Public Safety Cabinet, and the Office of the Kentucky Attorney General should convene a task force to explore the current capacity of pediatric forensic medical providers in Kentucky, identify current gaps, and develop a plan to expand existing resources.

2. The Kentucky Hospital Association and the Kentucky Chapter of the Academy of Pediatrics should develop a model protocol and accompanying training resources for addressing challenges to recognizing, reporting, and responding to situations in which health care professionals are confronted with families at high risk of abuse or neglect.

RECOMMENDATIONS REGARDING SUDI

For the purposes of categorization, the Panel describes a SUDI/near-SUDI case as the sudden and unexpected death/near death of a child less than one year old in which the cause of death was not obvious before investigation. In SFY 2020, the Panel documented 22 of these cases, with only one case as a near fatality. As noted in Figure #10, the number of SUDI cases reviewed by the Panel varied greatly between FY 2015 and FY 2020, but in general cases are trending upward. The Panel only receives a subset of the total state SUDI cases, with many not reported to or accepted for investigation by DCBS.



Data Source: Child Fatality and Near Fatality External Review Panel Data

Family risk factors are a critical element to consider when formulating prevention efforts. An examination of characteristics within Panel SUDI cases reveals a scenario common to families facing multiple complex risks and barriers (e.g. substance abuse, poverty, etc.). Figure #11 illustrates the risk factors identified in Panel SUDI cases, as well as the percentage these risks factors occur in all cases. Interestingly, risks associated with poverty, substance abuse in the home, and domestic violence are identified at greater rates in SUDI cases. Other factors, while not above the percentage seen in all Panel cases, occurred at significant rates.

Family Risk Factors Identified in Panel SUDI Cases (Total SUDI Panel cases = 22)	Incidence In SUDI Cases	Percentage In SUDI Cases	Percentage in All Panel Cases
Financial Issues	15	68%	60%
Substance Abuse	15	68%	49%
Mental Health Issues	9	40%	45%
Domestic Violence	8	36%	30%
Criminal History	7	31%	39%
Lack of Treatment (Substance or mental Health)	7	31%	33%
Overwhelmed Parent	5	22%	27%
Housing Instability	5	22%	27%
Lack of Childcare	3	13%	15%

Data Source: Child Fatality and Near Fatality External Review Panel Data Figure #11

RECOMMENDATIONS REGARDING SUDI

Additional panel findings regarding the SUDI cases revealed that in 21 of the 22 SUDI cases, the Panel made a determination of neglect related to unsafe sleep. Again, except for a single case, the Panel found the SUDI cases to be "apparently accidental" and "potentially preventable." While substance misuse was identified as a risk factor in well over half of the SUDI cases, the Panel found there was some indication the caregiver was impaired at the time of the event in four cases (18.1%). Children of color were significantly overrepresented in SUDI cases; nine of the Panel SUDI cases (40%) involved a child of color. Research related to all SUDI deaths indicates children of color are a greater risk.[9] Similarly, this overrepresentation is also noted in Kentucky, as infant mortality among black children is double that of their white counterparts.[9] While it is difficult to parse out all the driving factors behind this finding, the higher incidence of poverty and structural racism among people of color are likely one of several confounding issues.

Kentucky is fortunate to have excellent resources to address education of parents and caregivers. These resources, developed by the Department for Public Health are easily accessible at: http://www.safesleepky.com.

The Kentucky Department for Public Health recently published an annual report addressing child deaths in Kentucky.[10] This report recommends:

1. Continuing the Safe Sleep campaign, specifically encouraging hospitals to participate in the Crib for Kids© Program
2. Encouraging community child/family serving organizations to distribute free evidence-based prevention information
3. Health care providers serving NAS and other substance exposed infants should develop programs to educate parents to practice safe sleep and safe soothing techniques
4. Childcare agencies, domestic violence shelters, and emergency shelters should implement safe sleep policies.

The Panel wholeheartedly supports these recommendations. On page 7 of this report, the Panel also encourages MAT providers to specifically address safe sleep education when serving parents or caretakers of infants. In addition to the suggestions listed above, the Panel makes the following recommendation:

Recommendation:

1. The Cabinet for Health and Family Services should develop a plan to fund and implement a Safe Sleep Campaign specifically targeted to reach high risk populations.

F-003-20-C

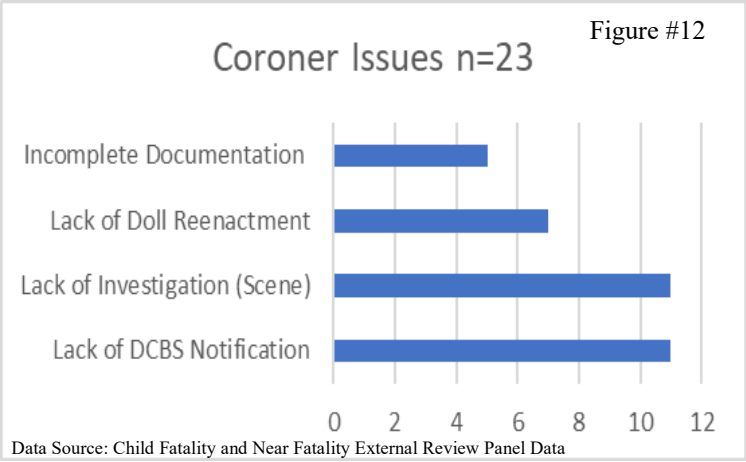
This case involves the SUDI death of a two-month-old infant who was co-sleeping with an intoxicated parent. The family was vacationing with extended family at a cabin and had spent the afternoon boating. Mother reported drinking 6-7 alcoholic beverages and the father reported to drinking 10-12 beers. Father reported about 30 minutes after the mother went to bed, he noticed she had fallen asleep while breast feeding the baby, and the baby was unresponsive. Father contacted 911 and they were transported to a local hospital. The hospital called law enforcement after mother was reportedly intoxicated and screaming "I've killed my baby".

Significant alcohol use while caring for children appeared to be a common and accepted practice in the family. Hospital staff noted in the birth record finding beer bottles in the delivery room trash can. Mother denied drinking but indicated family members had brought them.

RECOMMENDATIONS REGARDING CORONERS

Coroner issues were found in 29% percent of all fatality cases reviewed by the Panel. Even more interesting, coroner issues were found in 50% of the reviewed SUDI cases. As shown in Figure #12, the lack of statutory-required notification to DCBS and lack of scene investigation were the most commonly identified issues.

Figure #12



Data Source: Child Fatality and Near Fatality External Review Panel Data

In accordance with KRS 72.410, when a coroner receives notification of a child's death, they are to contact their local DCBS office *as soon as practicable*. It is often noted during panel reviews that DCBS is not notified of the child's death until the local child fatality meeting or they read about the incident in the local paper. Coroners should be contacting their local DCBS office for two reasons; 1.) to conduct joint investigations where applicable and, 2.) to obtain information about the family to assist in determining an accurate cause of death. A coroner may come onto a scene of what appears to be SUDI death only to find out later the parents had an open CPS case due to substance abuse issues. Without that crucial piece of information, the investigation may be misled.

Coroner's investigations should be conducted jointly with law enforcement and DCBS. While the Panel has documented best practices in some counties, it appears some coroners do not understand the importance of each agency's role. The coroner's role is to determine the cause and manner of death, law enforcement is to investigate any potential criminal elements, and DCBS is to ensure the protection of surviving or future siblings in the home and to provide community services to the family. It is crucial for each agency to understand their individual roles and collaborate throughout the investigation. Coroners play a crucial role during the scene investigation and often relay information to the Medical Examiner to assist them in determining a cause and manner of death. A thorough scene investigation, including a doll reenactment and completing the SUDI reporting form is key to collecting critical data used to prevent sudden unexplained death in infancy.

Local child fatality review teams play an important role in developing and implementing local prevention strategies. With support from the Department for Public Health, the number of active local teams has increased over the last several years. While some decline was noted in the early phases of the pandemic, the number of local team meetings appears to be returning to pre-pandemic levels. Despite these advances in practice, a reoccurring issue often discussed during panel meetings is when the child resides in one county, but the death occurs in another county. As a result of these jurisdictional issues, neither team is reviewing the fatality on a local level. Ideally, the child's death should be reviewed in both counties.

Recommendations:

1. The General Assembly should remove the language *"as soon as practicable"* in KRS 72.410(3)(a) and replace it with immediately.

2. The General Assembly should remove the discretionary language in KRS 211.686 and mandate coroners to establish a local child and maternal fatality review team.

3. The Justice Public and Safety Cabinet should review the coroner's training to ensure all coroners and deputies receive information on best practice and statutory intent of coroner notification and local child fatality meetings.

4. The Kentucky Coroner's Association should enact the best practice of reviewing the child's death in both the county of residence and county of death.

RECOMMENDATIONS REGARDING LAW ENFORCEMENT

Law enforcement issues were identified in 18% of all cases reviewed by the Panel. As shown in Figure #13, law enforcement agencies often failed to investigate the fatal or near fatal event, particularly ingestion cases. In 27% of all ingestion cases, the panel identified a law enforcement issue for either failing to investigate or failing to drug test the caregiver at the time of the event. Panel members have discussed a reluctance by law enforcement agencies to pursue criminal charges, even when a child has ingested an illicit substance.

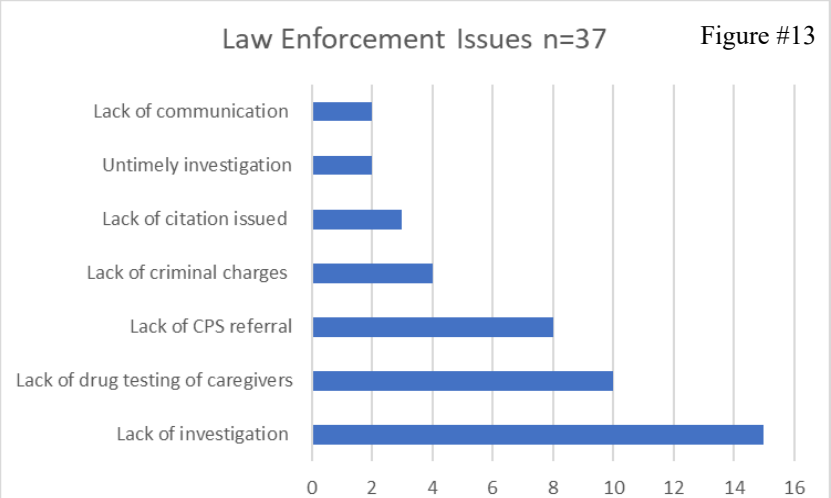


Figure #13

Data Source: Child Fatality and Near Fatality External Review Panel Data

The second most frequent missed opportunity among law enforcement is "Lack of drug testing." This issue is typically noted when there is suspicion a parent or caregiver may have been under the influence, but no blood, urine, or breath sample was requested or obtained. The Panel continues to advocate for mandatory drug testing of a caregiver at the time of a fatal/near fatal event when there are any indicators of substance abuse.

Several Panel members have participated in a subcommittee to better understand the training requirements of law enforcement officers across the state. This effort is in the early stages of implementation. Considering Kentucky has more than one law enforcement training agency, it has been difficult to develop a uniform recommendation. It does appear law enforcement may receive the proper training during their basic academy but best practice standards are not implemented in the field. Members are exploring options to resolve this issue.

Recommendation:

1. The General Assembly should mandate all supervisors in the field of law enforcement shall receive specialized training regarding Child Death Scene investigations every two years. The training should focus on obtaining drug testing of caregivers at the time of the event, collaborative investigations, pursuing criminal charges, and addressing secondary trauma to law enforcement officers.

F-048-20-C

This case involved the fentanyl overdose death of an 11-month-old child. The coroner, law enforcement and DCBS were all on the scene the day of the death. The coroner suspected the death was related to bedding material in the play pen (suffocation). Ingestion was not apparently considered. It was initially reported that law enforcement, or the coroner did not suspect any foul play. Weeks later the coroner was notified by the medical examiner the child's postmortem toxicology was positive for lethal levels of fentanyl and acetyl fentanyl. At this point an investigation was accepted.

After DCBS and local law enforcement gathered information regarding drug use, violence, and mental health concerns, the county attorney requested an ECO be filed for the remaining siblings. The worked informed the county attorney an ECO could not be filed as relatives were available but agreed to file a non-removal petition. Soon thereafter, the law enforcement officer filed an ECO petition, and all children were placed in DCBS custody.

The coroner's assumption that this child died from SIDS clearly misled the investigators. Law enforcement on the scene at the time of the event documented finding marijuana and pill bottles, yet no drug test was obtained on the caregivers.

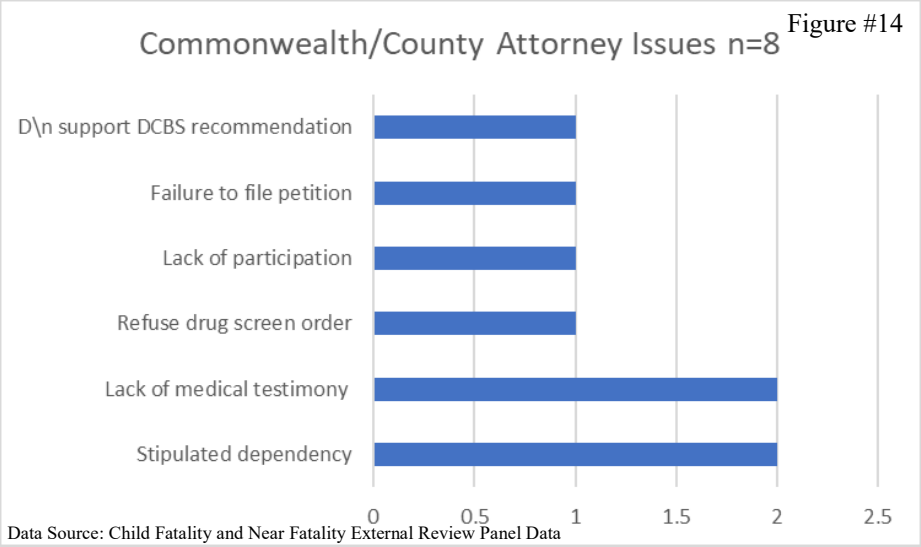
RECOMMENDATIONS REGARDING COMMONWEALTH/COUNTY ATTORNEYS

The Panel recently starting tracking Commonwealth/County attorney issues to further understand the barriers to appropriately prosecuting cases. (Figure #14) The decision to criminally prosecute a case is influenced by the Commonwealth and/or County Attorney, who has the final authority to proceed with a criminal case. Similarly, the County Attorney has sole discretion in prosecution of Dependency, Neglect, and Abuse (DNA) civil cases.

During review of the law enforcement records, it was discovered the failure to pursue criminal charges at times was made by the Commonwealth Attorney and not any fault of the officer. Likewise, in some cases, the County Attorney was unwilling to pursue DNA actions or recommendations made by DCBS. This leaves DCBS no recourse for review of this decision. Kentucky is one of the few states in which CPS staff do not have their own legal representation. How the cases are prosecuted is ultimately decided upon by the County Attorney — sometimes without any consultation with DCBS. Best practice would involve case discussion and collaboration between DCBS staff and the County Attorney throughout the life of a case. Some counties conduct collaborative training with prosecutors and their local DCBS representatives to facilitate this collaboration.

The Panel will continue to track this issue and work closely with the Kentucky Office of the Attorney General to implement recommendations.

Figure #14



Data Source: Child Fatality and Near Fatality External Review Panel Data

Recommendations:

1. The Prosecutor's Advisory Council should explore a protocol that would require County Attorneys to conference with their local DCBS staff prior to the hearing.

2. The Prosecutor's Advisory Council should provide additional training to prosecutors regarding obtaining criminal charges on caregivers when the child has ingested an illicit substance.

REFERENCES

[1] Child Welfare Information Gateway. (2016). Understanding child welfare and the courts. Washington, DC: U.S. Department of Health and Human Services, Children's Bureau

[2] Kentucky Cabinet for Health and Family Services (CHFS). (2020). Neonatal Abstinence Syndrome in Kentucky: Annual Report on 2019 Public Health Neonatal Abstinence Syndrome (NAS) Reporting Registry.

[3] Child Welfare Information Gateway. (2020). Plans of safe care for infants with prenatal substance exposure and their families. Washington, DC: U.S. Department of Health and Human Services, Administration for Children and Families, Children's Bureau.

[4] Child Welfare Information Gateway. (2020). *Plans of safe care for infants with prenatal substance exposure and their families.* Washington, DC: U.S. Department of Health and Human Services, Administration for Children and Families, Children's Bureau

[5] Commission to Eliminate Child Abuse and Neglect Fatalities. (2016). *Within our reach: A national strategy to eliminate child abuse and neglect fatalities.* Washington, DC: Government Printing Office

[6] 2021 Kentucky KIDS COUNT County Data Book, Kentucky Youth Advocates, Louisville, KY.

[7] https://dbhdid.ky.gov/dbh/sped.aspx

[8] Kentucky Cabinet for Health and Family Services, Department for Public Health. Child Fatality Report, 2020.

[9] https://www.mayoclinic.org/diseases-conditions/sudden-infant-death-syndrome/symptoms-causes/syc-20352800

[10] Kentucky Cabinet for Health and Family Services, Department for Public Health. Child Fatality Report, 2020.

COUNTY OF INCIDENT

SharePoint allows the Panel to track demographic information for each case reviewed. The data shows fatal and near fatal events due to child abuse and neglect occur throughout every region of the Commonwealth. The chart below indicates the number of cases per county of incident. State Fiscal Year 2014 through 2019 have been combined, please refer to previous Annual Reports for a complete breakdown.

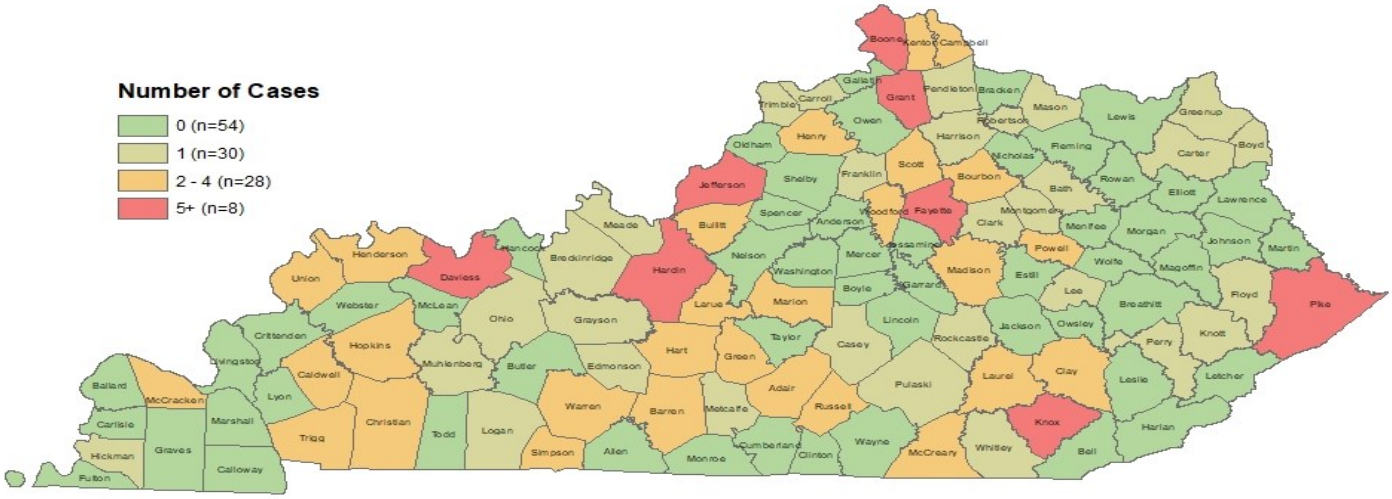
County of Incident Among All Cases Reviewed in SFY 14-19 and SFY20

County	Combined SFY 14-19	SFY 2020
Adair	5	2
Allen	4	0
Anderson	3	0
Ballard	3	0
Barren	7	2
Bath	1	1
Bell	14	0
Boone	15	7
Bourbon	1	2
Boyd	14	1
Boyle	6	0
Bracken	1	0
Breathitt	1	0
Breckinridge	8	1
Bullitt	8	2
Butler	2	0
Caldwell	1	2
Calloway	5	0
Campbell	12	3
Carlisle	1	0
Carroll	5	1
Carter	2	1
Casey	5	1
Christian	15	3
Clark	4	1
Clay	11	3
Clinton	3	0
Crittenden	2	0
Cumberland	1	0
Daviess	26	8
Edmonson	0	1
Estill	3	0
Fayette	27	13
Fleming	4	0
Floyd	4	1
Franklin	17	1
Gallatin	1	0
Garrard	1	0
Grant	3	5
Graves	4	0
Grayson	8	1
Green	2	3
Greenup	4	1
Hancock	2	0
Hardin	33	5
Harlan	6	0
Harrison	2	1
Hart	1	2
Henderson	15	3
Henry	3	2
Hickman	0	1
Hopkins	7	3
Jackson	1	0
Jefferson	161	47
Jessamine	6	0
Johnson	1	0
Kenton	30	4
Knott	2	1
Knox	10	6
Larue	9	3
Laurel	27	3
Lawrence	3	0
Lee	0	1
Letcher	2	0
Lewis	2	0
Lincoln	6	0
Logan	7	1
Madison	10	2
Marion	6	3
Marshall	9	0
Martin	3	0
Mason	3	1
McCracken	7	4
McCreary	5	3
Meade	8	1
Menifee	1	0
Mercer	2	0
Metcalfe	0	1
Monroe	3	0
Montgomery	3	1
Morgan	3	0
Muhlenberg	4	1
Nelson	11	0
Nicholas	1	0
Ohio	3	1
Oldham	5	0
Owen	6	0
Owsley	3	0
Pendleton	6	1
Perry	0	1
Pike	7	5
Powell	3	2
Pulaski	14	1
Robertson	0	1
Rockcastle	2	1
Rowan	3	0
Russell	2	2
Scott	12	2
Shelby	5	0
Simpson	2	3
Spencer	1	0
Taylor	4	0
Todd	3	0
Trigg	1	2
Trimble	5	1
Union	4	2
Warren	22	4
Washington	3	0
Wayne	1	0
Webster	6	0
Whitley	5	1
Wolfe	1	0
Woodford	3	3
Total Cases	**811**	**200**

Data Source: Child Fatality and Near Fatality External Review Panel

COUNTY OF INCIDENT

Cases Reviewed by County of Incident 2020



January 18, 2022
Data Source: Child Fatality Near Fatality External Review Panel
Shape files from Kentucky Geography Network.
Prepared by Emily Ferrell, MPH, CPH
200 cases total for this year.
Note: Not adjusted for county population.

Cases Reviewed by County of Incident 2014-2019

January 18, 2022
Data Source: Child Fatality Near Fatality External Review Panel
Shape files from Kentucky Geography Network.
Prepared by Emily Ferrell, MPH, CPH
811 cases total for these years.
Note: Not adjusted for county population.

DEMOGRAPHICS

Gender of All Index Children Reviewed SFY 2016—2020

	2016		2017		2018		2019		2020	
Gender	**# Cases**	**Percent**	**# Cases**	**Percent**	**# Cases**	**Percent**	**# Cases**	**Percent**	**# Cases**	**Percent**
Male	86	57%	75	56%	87	64%	113	62%	110	55%
Female	64	43%	59	44%	49	36%	69	38%	90	45%
Total	**150**		**134**		**136**		**182**		**200**	

Data Source: Child Fatality and Near Fatality External Review Panel Data

Race of All Index Children Reviewed SFY 2016—2020

	2016		**2017**		2018		2019		2020	
Race	# Cases	Percent	# Cases	Percent	# Cases	Percent	# Cases	Percent	# Cases	Percent
Black	24	16%	22	17%	19	14%	34	19%	35	18%
White	109	73%	94	70%	95	70%	124	68%	144	72%
Asian	1	1%	0	0%	1	< 1%	0	0	1	<1%
Biracial	11	7%	7	5%	20	15%	20	11%	16	10%
Other	5	3%	11	8%	1	< 1%	4	2%	4	<1%
Total	150		134		136		182		200	

Data Source: Child Fatality and Near Fatality External Review Panel Data

Ethnicity of All Index Children Reviewed SFY 2016—2020

	2016		**2017**		2018		2019		2020	
Ethnicity	# Cases	Percent	# Cases	Percent	# Cases	Percent	# Cases	Percent	# Cases	Percent
Hispanic	3	2%	12	9%	4	3%	12	7%	10	5%
Non-Hispanic	147	98%	122	91%	131	96%	159	87%	190	95%
Unknown					1	1%	11	6%		
Total	150	100%	134	100%	136	100%	182	100%	200	100%

Data Source: Child Fatality and Near Fatality External Review Panel Data

DEMOGRAPHICS

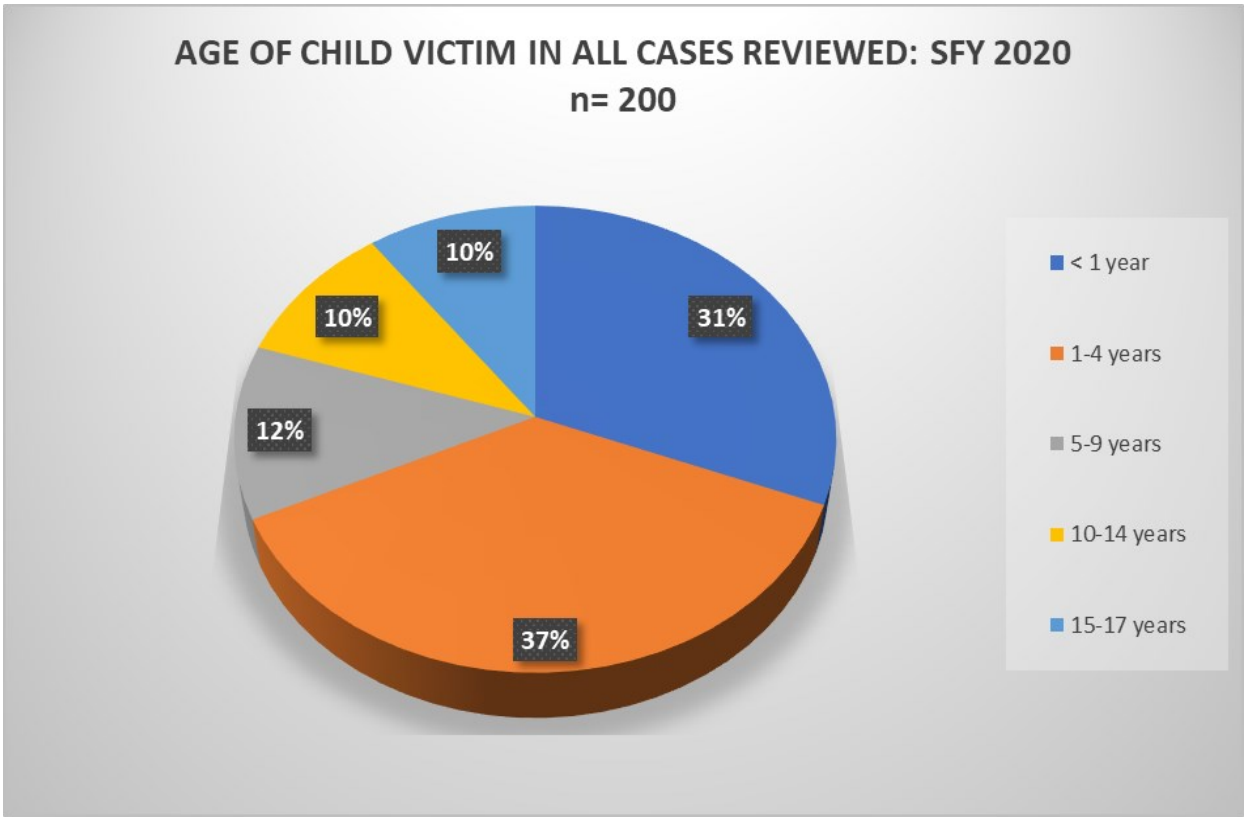
The Panel has continuously found that children four years of age or younger are at higher risk for a fatal/ near fatal event due to child maltreatment. Since 2014, 76% of all cases reviewed by the Panel were children four years or younger. Prevention efforts should continue to target these higher risk age groups.

Age of Child Victim in All Cases Reviewed

State Fiscal Years 2016—2020

Age	2016		2017		2018		2019		2020	
	# Cases	Percent	# Cases	Percent	# Cases	Percent	# Case	Percent	# Case	Percent
< 1 year	77	53%	60	45%	37	27%	69	38%	63	31%
1-4 years	49	32%	48	36%	65	48%	55	30%	75	37%
5-9 years	14	9%	7	5%	15	11%	16	9%	24	12%
10-14 years	5	3%	11	8%	10	7%	18	10%	20	10%
15-17 years	5	3%	8	6%	9	7%	24	13%	18	10%
Total	150		134		136		182		200	

Data Source: Child Fatality and Near Fatality External Review Panel Data



Data Source: Child Fatality and Near Fatality External Review Panel Data

FINDINGS AND DETERMINATIONS

The Panel designates the categorization or type of case, identifies the family characteristics associated with the fatality or near fatality, and makes a final determination of whether abuse or neglect exists and its type(s). The following pages provide findings specific to state fiscal year 2020 (SFY20) case reviews. Each case may encompass multiple categories and findings.

Final Categorization All Cases SFY20
n= 200

Category	Fatalities	Near Fatalities	Total
Neglect	60	91	151
Overdose/ingestion	4	44	48
Abusive Head Trauma	5	21	26
Physical Abuse	5	21	26
SUDI	21	1	22
Blunt Force Trauma-not inflicted MVC	7	12	19
Drowning\near drowning	10	6	16
Blunt Force Trauma-not inflicted	1	8	9
Natural Causes\medical diagnosis	8	1	9
Gunshot accidental	7	1	8
Failure to Thrive	1	5	6
Suicide Child	7	1	8
Other	5	0	5
Ligature hanging	4	0	4
Smoke inhalation/fire	3	1	4
Traumatic asphyxia	4	0	4
Gunshot (homicide)	3	1	4
Burn	1	2	3
Gunshot (suicide)	3	0	3
Sexual abuse/human trafficking	0	1	1
Apparent murder/suicide	1	0	1
Undetermined	1	0	1

Data Source: Child Fatality and Near Fatality External Review Panel

*Cases may be captured in more than one category. "Other" includes hyperthermia (2), dog attack (2), and asphyxia due to food choking (1).

KEY FINDINGS SFY20

- → The most commonly found family characteristics in a fatality/near fatality in order of precedence for FY20 cases reviewed:
  - –DCBS History (69%)
  - –Financial Issues (60%)
  - –Substance abuse (in home) (49%)
  - –DCBS Issues (48%)
  - –Supervisional neglect (48%)
  - –Substance abuse (caregiver) (46%)
- → Supervisory neglect was the most common Panel determination
- → Of the SUDI cases, 50% had coroner issues identified
- → 69% of all cases reviewed involved a child four (4) year of age or younger
- → 55% of all cases with a Panel Determination of Neglect due to unsafe access to deadly means were overdose/ingestion cases
- → 62% of Abusive Head Trauma cases involved substance abuse by a caregiver
- → 53% of all Blunt Force Trauma – not inflicted, MVC cases involved an impaired caregiver
- → 45% of all Suicide cases involved unsafe access to deadly/potentially deadly means
- → 62% of all Physical abuse cases involved caregivers with a criminal history

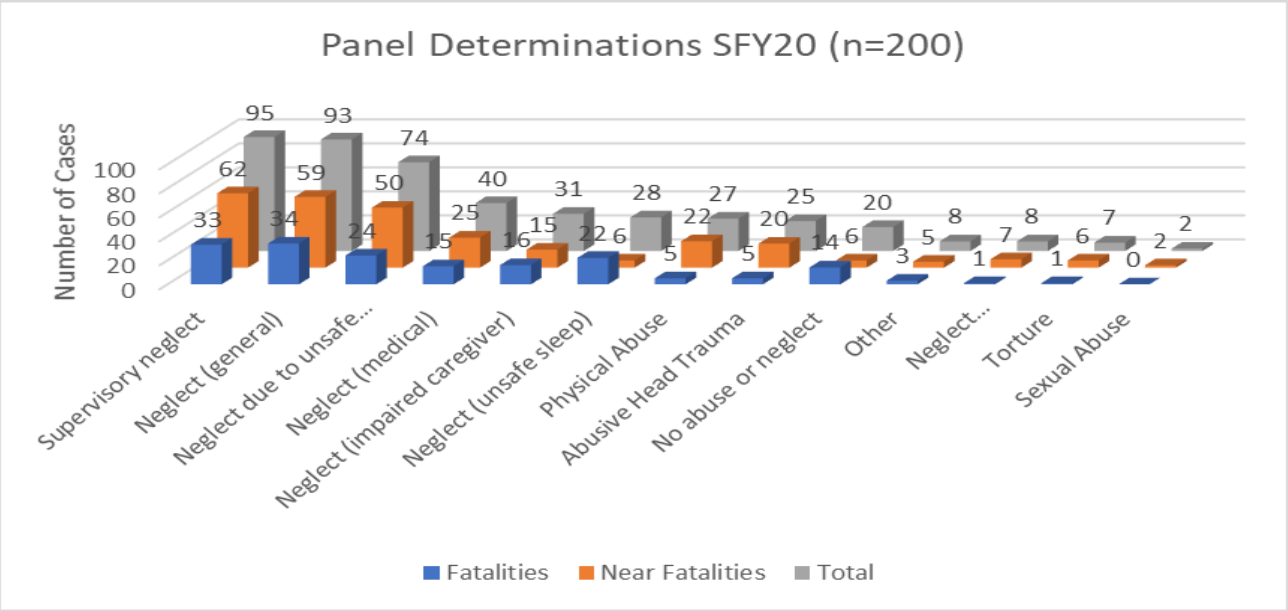
Panel Determinations All Cases SFY20

Panel Determinations	Fatalities	Near Fatalities	Total
Supervisory neglect	33	62	95
Neglect (general)	34	59	93
Neglect due to unsafe access to deadly/potentially deadly means	24	50	74
Neglect (medical)	15	25	40
Neglect (impaired caregiver)	16	15	31
Neglect (unsafe sleep)	22	6	28
Physical Abuse	5	22	27
Abusive Head Trauma	5	20	25
No abuse or neglect	14	6	20
Other	3	5	8
Neglect (inadequate/absent child restraint in a motor vehicle	1	7	8
Torture	1	6	7
Sexual Abuse	0	2	2

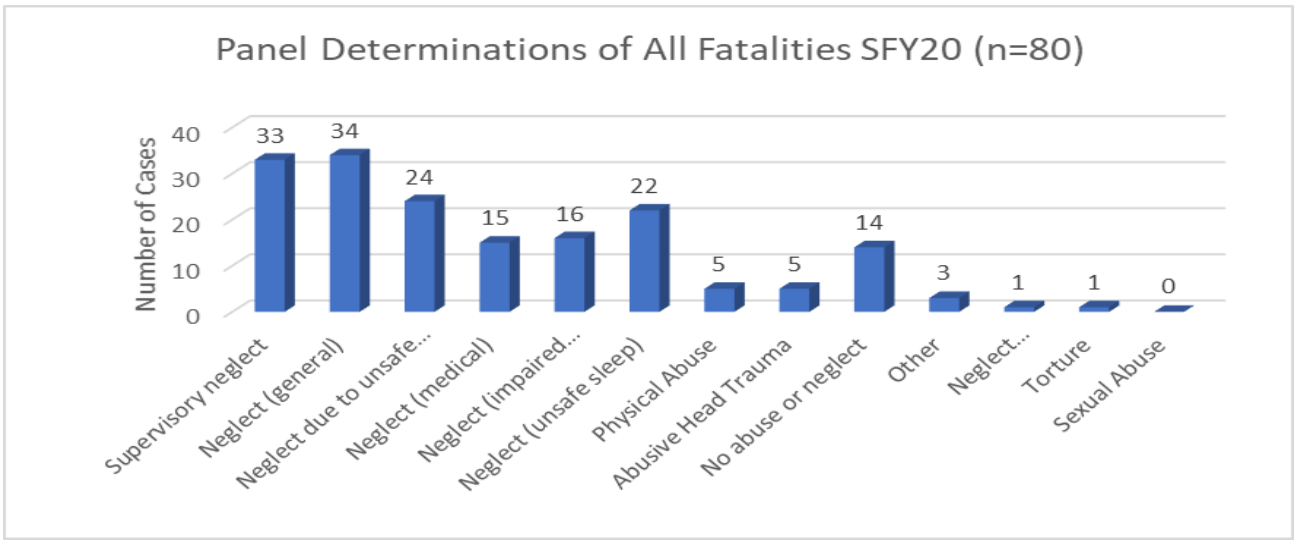
Data Source: Child Fatality and Near Fatality External Review Panel Data

*Cases may be represented in multiple categories. Other includes Undetermined (2), Emotional abuse/injury (1), Dependency-poverty (2), Inadequate information (1), intentional poisoning (1), and medical diagnosis (1).

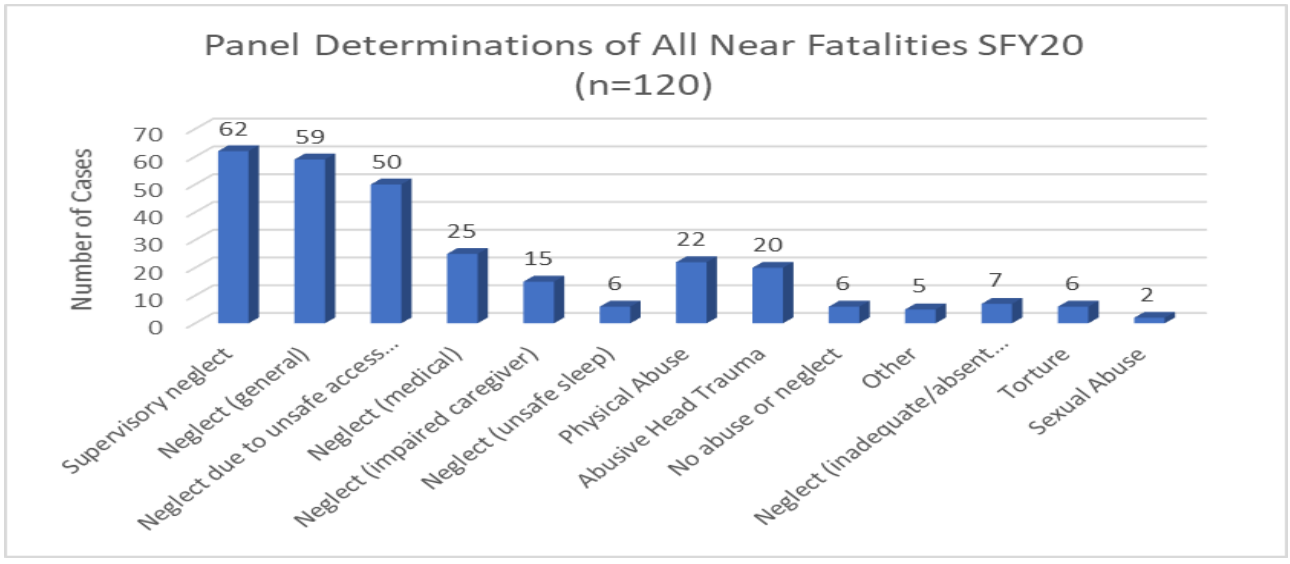
Findings Specific to Fiscal Year 2020



Data Source: Child Fatality and Near Fatality External Review Panel Data



Data Source: Child Fatality and Near Fatality External Review Panel Data



Data Source: Child Fatality and Near Fatality External Review Panel Data

Family Characteristics	Fatality	Near Fatality	Total
DCBS History	64	74	138
Financial Issues	50	70	120
Substance abuse (in home)	42	57	99
Supervisional neglect	34	63	97
DCBS Issues	37	60	97
Substance abuse (caregiver)	39	54	93
Mental Health issues (caregiver)	33	57	90
Other	36	52	88
Environmental neglect	33	47	80
Criminal history (in the home)	30	48	78
Criminal History (caregiver)	28	49	77
Unsafe access to deadly means	25	51	76
Lack of treatment (mental health or substance)	29	38	67
Domestic Violence	30	30	60
Housing Instability	25	29	54
Overwhelmed caregiver	21	33	54
Bystander issues/opportunities	22	29	51
Medical issues/management	23	24	47
Medical neglect	17	29	46
Statutory Issues	31	13	44
Medically Fragile child	19	18	37
Law Enforcement Issues	19	18	37
Impaired caregiver (any indication)	17	19	36
MAT involvement	6	25	31
Lack of regular child care	8	22	30
Mental Health issues (child)	15	12	27
Substitute caregiver at the time of event	8	17	25
Coroner Issues	23	0	23
Family Violence	10	11	21
Neglectful Entrustment	4	15	19
Lack of Family Support System	9	10	19
Cognitive disability (caregiver)	7	10	17
Unsafe sleep (bed sharing)	14	3	17
Cognitive disability (child)	7	10	17
Education/childcare issues	13	3	16
Lack of sleep plan	4	9	13
Failure to Thrive	3	9	12
Unsafe sleep (other)	8	3	11
Serial Relationships	5	5	10
Out of State CPS history	5	5	10
Substance abuse (child)	7	3	10
In-home Service Provider Issues	2	8	10
Inadequate restraint	1	8	9
Evidence of poor bonding	3	5	8
Commonwealth/County Attorney issues	2	6	8
Judicial process	3	4	7
Perinatal depression (caregiver)	3	4	7
Language/Cultural Issues	1	6	7
Unsafe sleep (co-sleeping/non-bed surface)	4	2	6
Military system issues	1	0	1

Data Source: Child Fatality and Near Fatality External Review Panel Data

Findings Specific to Fiscal Year 2020

The chart below shows the number of cases for which the finding included circumstances that made the incident potentially preventable. Of the 80 cases involving a child fatality, the Panel determined that 93% of those fatalities were potentially preventable. Among the near fatality cases, 89% were determined to be potentially preventable. Overall the Panel found that 91% of these incidents may have been prevented.

Potentially Preventable Fatalities and Near Fatalities SFY20
n = 200

	# of Cases	Total	Percent
Fatalities	75	80	**93%**
Near Fatalities	107	120	**89%**
Total	182	200	**91%**

Data Source: Child Fatality and Near Fatality External Review Panel Data

Most Common Category Among Cases with a Panel Determination of Supervisory Neglect (n=95)

Category	# of Cases	% Cases
Neglect	88	93%
Overdose/ingestion	43	45%
Drowning/near-drowning	14	15%
Blunt force trauma - not inflicted MVC	9	9%
Physical abuse	6	6%
Gunshot	4	4%
Blunt force trauma - not inflicted (farming machinery, ATV, fall)	4	4%
Abusive Head Trauma	3	3%
Ligature hanging	3	3%
Smoke inhalation/fire	3	3%
SUDI/near-SUDI/Brief Resolved Unexplained Event	3	3%
Other	3	3%

Data Source: Child Fatality and Near Fatality External Review Panel Data

*Cases may be represented in multiple categories. Other includes hyperthermia (2) and animal attack.

Most Common Family Characteristics Identified in Fatality/Near Fatality Among Cases with a Panel Categorization of Neglect (n=151)

Family Characteristics	# of Cases	% of Cases
DCBS History	111	74%
Financial Issues	97	64%
Supervisional neglect	90	60%
Substance abuse (in home)	87	58%
DCBS Issues	82	54%
Substance abuse (caregiver)	81	54%
Other	71	47%
Environmental neglect	70	46%
Mental Health issues (caregiver)	69	45%
Unsafe access to deadly means	65	43%
Criminal history (in the home)	64	42%
Criminal History (caregiver)	63	42%
Lack of treatment (mental health or substance)	54	36%
Domestic Violence	44	29%
Bystander issues/opportunities	44	29%
Housing Instability	43	28%
Overwhelmed caregiver	43	28%
Medical neglect	41	27%

Data Source: Child Fatality and Near Fatality External Review Panel Data

Most Common Family Characteristics Identified in Fatality/Near Fatality Among Cases with a Panel Categorization of Physical Abuse (n=26)

Family Characteristics	# of Cases	% of Cases
Financial Issues	20	77%
DCBS History	18	69%
Criminal history (in the home)	16	62%
Criminal History (caregiver)	16	62%
Overwhelmed caregiver	16	62%
Substance abuse (in home)	15	58%
DCBS Issues	15	58%
Substance abuse (caregiver)	15	58%
Mental Health issues (caregiver)	15	58%
Domestic Violence	14	54%
Medical neglect	14	54%
Other	13	50%
Bystander issues/opportunities	13	50%
Lack of treatment (mental health or substance)	12	46%
Neglectful Entrustment	11	42%
Substitute caregiver at the time of event	11	42%
Lack of regular child care	10	38%
Medical issues/management	9	35%
Housing Instability	7	27%
Lack of Family Support System	7	27%

Data Source: Child Fatality and Near Fatality External Review Panel Data

PANEL MEMBERS

Hon. Melissa Moore Murphy, Chair
Judge, Fayette District Court

Sen. Ralph Alvarado, Kentucky Senate,
Senate Health and Welfare Committee Chair

Rep. Kimberly Moser, Kentucky House of Representative
Health and Welfare Committee Chair

Dr. Melissa Currie
Child Abuse Pediatrician
Norton Children's Pediatric Protection Specialists
Professor and Kosair Charities Endowed Chair for
Pediatric Forensic Medicine
University of Louisville School of Medicine

Isela Arras, Chief Operating Officer
Kentucky Coalition Against Domestic Violence

Lori Aldridge, Program Director
Tri –County CASA

Dr. Jaime Pittenger
Prevent Child Abuse Kentucky

Honorable Libby Messer
Fayette Family Court Judge

Dr. Christina Howard, Child Abuse Pediatrician
University of Kentucky Department of Pediatrics

VACANT
Association of Addiction Professionals

VACANT
Board of Social Work

Marta Miranda-Straub, Commissioner
Department of Community Based Services

Detective Jason Merlo
Kentucky State Police

Hon. Dawn Blair
Hardin County Attorney

Betty Pennington
Family Resource and Youth Services Centers

Dr. Henrietta Bada,
Department for Public Health

Dr. William Ralston
Kentucky State Medical Examiner

Janice Bright, RN
Department for Public Health

Steve Shannon
Kentucky Association of Regional Programs, Inc.

Dr. Elizabeth Salt
Citizen Foster Care Review Board

Dr. David Lohr
Child & Adolescent Psychiatry

MEMBERS WHO LEFT THE PANEL IN 2021

Angela Yannelli, Executive Director
Kentucky Coalition Against Domestic Violence

Linnea Caldon
Citizen Foster Care Review Board

PANEL STAFF

Elisha Mahoney, Executive Staff Advisor
Justice & Public Safety Cabinet

Cynthia Curtsinger
Pediatric Forensic Case Analyst

Joel Griffith, Case Analyst
Justice & Public Safety Cabinet

CASE REVIEWS FOR FISCAL YEAR 2020

Case Number	Categorization	Family Characteristics	Family Characteristics Comments	Panel Determination	Other Qualifiers
F-001-20-NC	Gunshot (suicide)	Other; Statutory Issues; Unsafe access to deadly means; Mental health issues (child); Substance abuse (child)	Incident occurred during **Covid-19** restrictions. Child ended previous school year in NTI. He was involved with school-related athletic activities (work-outs, etc.) during the summer in anticipation of playing basketball in the fall. Incident occurred when school not in session (June 30).	Neglect due to unsafe access to deadly/ potentially deadly means	Potentially preventable
F-002-20-C	Neglect; SUDI/ near-SUDI/ apparent life-threatening event	Criminal history (caregiver); Criminal history (in the home); DCBS history; Environmental neglect; Evidence of poor bonding; Financial issues; Lack of family support system ; Lack of treatment (mental health or substance abuse); Substance abuse (in home); Substance abuse by caregiver (current); Supervisional neglect; Unsafe sleep (other)		Neglect (general - can include leaving child with unsafe caregiver); Supervisory neglect; Neglect (unsafe sleep)	Potentially preventable; Apparently accidental
F-003-20-C	SUDI/near-SUDI/apparent life-threatening event; Neglect	Commonwealth/County Attorneys; Coroner issues; DCBS history; Impaired caregiver; Lack of treatment (mental health or substance abuse); Law enforcement issues; Medical issues/ management; Mental health issues (caregiver); Statutory Issues; Substance abuse (in home); Substance abuse by caregiver (current); Supervisional neglect; Unsafe sleep (bed sharing); Environmental neglect; Judicial process issues; Bystander issues/ opportunities		Neglect (impaired caregiver); Neglect (unsafe sleep); Supervisory neglect; Neglect (general - can include leaving child with unsafe caregiver)	Apparently accidental; Potentially preventable

CASE REVIEWS FOR FISCAL YEAR 2020

Case Number	Categorization	Family Characteristics	Family Characteristics Comments	Panel Determination	Other Qualifiers
F-004-20-C	Blunt force trauma - not inflicted MVC; Neglect	Bystander issues/ opportunities; Cognitive disability (caregiver); Criminal history (caregiver); Criminal history (in the home); DCBS history; DCBS issues; Domestic Violence; Environmental neglect; Financial issues; Housing instability; In-Home Service Provider Issues; Lack of regular child care; Lack of treatment (mental health or substance abuse); Mental health issues (caregiver); Out of State CPS History; Overwhelmed Caregiver; Substance abuse (in home); Substance abuse by caregiver (current); Supervisional neglect	Complex family that requires extensive collaborative supports.	Neglect (general - can include leaving child with unsafe caregiver); Supervisory neglect	Apparently accidental; Potentially preventable
F-005-20-NC	Drowning/near-drowning; Neglect	Bystander issues/ opportunities; DCBS issues; Criminal history (caregiver); Criminal history (in the home); Environmental neglect; Financial issues; Housing instability; Lack of regular child care; Lack of treatment (mental health or substance abuse); Mental health issues (caregiver); Substance abuse (in home); Substance abuse by caregiver (current); Supervisional neglect; Unsafe access to deadly means; Statutory Issues; Law enforcement issues		Neglect due to unsafe access to deadly/potentially deadly means; Supervisory neglect; Neglect (general - can include leaving child with unsafe caregiver)	Apparently accidental; Potentially preventable

CASE REVIEWS FOR FISCAL YEAR 2020

Case Number	Categorization	Family Characteristics	Family Characteristics Comments	Panel Determination	Other Qualifiers
F-006-20-C	Other; Neglect	DCBS history; Domestic Violence; Environmental neglect; Family violence; Financial issues; Housing instability; Lack of regular child care; Lack of Sleep Plan; Lack of treatment (mental health or substance abuse); Mental health issues (caregiver); Substance abuse (in home); Supervisional neglect; Unsafe access to deadly means; Unsafe sleep (bed sharing)		Neglect (general - can include leaving child with unsafe caregiver); Supervisory neglect; Neglect due to unsafe access to deadly/potentially deadly means	Apparently accidental; Potentially preventable
F-007-20-C	Abusive head trauma; Physical abuse; Neglect	Bystander issues/ opportunities; Commonwealth/County Attorneys; Criminal history (caregiver); Criminal history (in the home); DCBS history; Domestic Violence; Evidence of poor bonding; Financial issues; Housing instability; Judicial process issues; Lack of family support system; MAT involvement; Neglectful entrustment; Overwhelmed Caregiver; Statutory Issues; Substance abuse (in home); Substance abuse by caregiver (current)		Abusive head trauma; Neglect (general - can include leaving child with unsafe caregiver); Physical abuse; Torture	Potentially preventable
F-008-20-C	Drowning/near-drowning; Neglect	Criminal history (caregiver); Criminal history (in the home); DCBS history; Supervisional neglect; Unsafe access to deadly means; MAT involvement		Supervisory neglect; Neglect due to unsafe access to deadly/potentially deadly means	Apparently accidental; Potentially preventable

Case Number	Categorization	Family Characteristics	Family Characteristics Comments	Panel Determination	Other Qualifiers
F-009-20-C	Neglect	Bystander issues/ opportunities; Coroner issues; Criminal history (caregiver); Criminal history (in the home); DCBS history; DCBS issues; Domestic Violence; Education/ child care issues; Family violence; Financial issues; Housing instability; Impaired caregiver; Lack of treatment (mental health or substance abuse); Law enforcement issues; Medical neglect; Mental health issues (caregiver); Mental health issues (child); Out of State CPS History; Substance abuse (child); Substance abuse by caregiver (current); Substance abuse (in home)		Neglect (medical); Neglect (impaired caregiver)	Potentially preventable
F-010-20-NC	Neglect; Other	Domestic Violence; Lack of family support system ; Language/ cultural issues; Substance abuse (in home); Substance abuse by caregiver (current); Supervisional neglect; Statutory Issues		Supervisory neglect; Neglect (general - can include leaving child with unsafe caregiver)	Apparently accidental; Potentially preventable
F-011-20-C	Neglect; Drowning/near-drowning	Bystander issues/ opportunities; Education/ child care issues; Environmental neglect; Overwhelmed Caregiver; Supervisional neglect; Unsafe access to deadly means		Neglect (general - can include leaving child with unsafe caregiver); Neglect due to unsafe access to deadly/potentially deadly means; Supervisory neglect	Apparently accidental; Potentially preventable

CASE REVIEWS FOR FISCAL YEAR 2020

Case Number	Categorization	Family Characteristics	Family Characteristics Comments	Panel Determination	Other Qualifiers
F-012-20-C	Abusive head trauma; Neglect; Physical abuse	Cognitive disability (caregiver); DCBS history; Domestic Violence; Family violence; Financial issues; Lack of regular child care; Lack of Sleep Plan; Lack of treatment (mental health or substance abuse); Medical neglect; Medically fragile child; Mental health issues (caregiver); Neglectful entrustment; Overwhelmed Caregiver; Serial relationships; Substance abuse (in home); Substance abuse by caregiver (current); Substitute caregiver at time of event ; Supervisional neglect; Other; Out of State CPS History	Delayed autopsy results.	Abusive head trauma; Neglect (general - can include leaving child with unsafe caregiver); Neglect (medical); Physical abuse; Supervisory neglect	Potentially preventable
F-013-20-C	Neglect; Other	Bystander issues/ opportunities; DCBS history; DCBS issues; Domestic Violence; Environmental neglect; Financial issues; Housing instability; Overwhelmed Caregiver; Supervisional neglect; Unsafe access to deadly means; Substance abuse (in home); Substance abuse by caregiver (current)		Neglect (general - can include leaving child with unsafe caregiver); Neglect due to unsafe access to deadly/ potentially deadly means; Supervisory neglect	Apparently accidental; Potentially preventable

CASE REVIEWS FOR FISCAL YEAR 2020

Case Number	Categorization	Family Characteristics	Family Characteristics Comments	Panel Determination	Other Qualifiers
F-014-20-C	Neglect; SUDI/ near-SUDI/ apparent life-threatening event	Criminal history (caregiver); Criminal history (in the home); DCBS history; Domestic Violence; Environmental neglect; Family violence; Financial issues; Housing instability; Lack of regular child care; Medical issues/ management; Medical neglect; Substance abuse (in home); Substance abuse by caregiver (current); Substitute caregiver at time of event ; Supervisional neglect; Unsafe sleep (bed sharing); Mental health issues (caregiver)		Neglect (general - can include leaving child with unsafe caregiver); Neglect (unsafe sleep); Neglect (medical); Supervisory neglect	Apparently accidental; Potentially preventable
F-015-20-C	Gunshot (suicide); Neglect	DCBS history; DCBS issues; Environmental neglect; Evidence of poor bonding; Family violence; Medical neglect; Medically fragile child; Mental health issues (child); Statutory Issues; Substance abuse (in home); Substance abuse by caregiver (current); Unsafe access to deadly means; Bystander issues/ opportunities; Medical issues/management; Other	Emotional abuse/injury to the children due to threats of returning children to "state," refusing to console at mother's death, etc.	Neglect (general - can include leaving child with unsafe caregiver); Neglect due to unsafe access to deadly/potentially deadly means; Neglect (medical); Other	Potentially preventable
F-016-20-C	Natural causes/ medical diagnosis	DCBS history; Domestic Violence; Family violence; Financial issues; Lack of treatment (mental health or substance abuse); Mental health issues (caregiver); Perinatal depression (caregiver); Substance abuse (in home); Substance abuse by caregiver (current)		No abuse or neglect	

CASE REVIEWS FOR FISCAL YEAR 2020

Case Number	Categorization	Family Characteristics	Family Characteristics Comments	Panel Determination	Other Qualifiers
F-016-21-C	Neglect; SUDI/near-SUDI/apparent life-threatening event	DCBS issues; DCBS history; Coroner issues; Criminal history (caregiver); Criminal history (in the home); Law enforcement issues; Environmental neglect; Financial issues; Housing instability; Lack of treatment (mental health or substance abuse); Other; Serial relationships; Statutory Issues; Substance abuse (in home); Substance abuse by caregiver (current); Unsafe sleep (bed sharing)	Incident occurred during COVID restrictions resulting in use of occasional virtual contacts.	Neglect (unsafe sleep); Neglect (general - can include leaving child with unsafe caregiver)	Apparently accidental; Potentially preventable
F-017-20-C	Neglect; SUDI/near-SUDI/apparent life-threatening event	Statutory Issues; Substance abuse (in home); Substance abuse by caregiver (current); Unsafe sleep (bed sharing)		Neglect (unsafe sleep)	Apparently accidental; Potentially preventable
F-018-20-C	Neglect; Drowning/near-drowning	DCBS history; Statutory Issues; Criminal history (caregiver); Criminal history (in the home); Financial issues; Housing instability; Impaired caregiver; Lack of treatment (mental health or substance abuse); Mental health issues (caregiver); Substance abuse (in home); Substance abuse by caregiver (current); Supervisional neglect; Serial relationships		Neglect (impaired caregiver); Supervisory neglect	Potentially preventable

CASE REVIEWS FOR FISCAL YEAR 2020

Case Number	Categorization	Family Characteristics	Family Characteristics Comments	Panel Determination	Other Qualifiers
F-019-20-C	Neglect; SUDI/ near-SUDI/ apparent life-threatening event; Abusive head trauma; Physical abuse	Domestic Violence; Environmental neglect; Financial issues; Impaired caregiver; Lack of treatment (mental health or substance abuse); Substance abuse (in home); Substance abuse by caregiver (current); Neglectful entrustment; Unsafe sleep (other); Criminal history (caregiver); Criminal history (in the home); Lack of regular child care; Medical neglect; Mental health issues (caregiver); Overwhelmed Caregiver; Other	Transportation and COVID restrictions.	Neglect (general - can include leaving child with unsafe caregiver); Neglect (impaired caregiver); Neglect (unsafe sleep); Abusive head trauma	Apparently accidental; Potentially preventable
F-020-20-C	Blunt force trauma - not inflicted MVC; Neglect	Criminal history (caregiver); Criminal history (in the home); DCBS history; Domestic Violence; Impaired caregiver; Law enforcement issues; Other; Substance abuse (in home); Substance abuse by caregiver (current); Coroner issues	Incident occurred when COVID restrictions were in place. DCBS contacts with the family were virtual.	Neglect (impaired caregiver); Neglect (general - can include leaving child with unsafe caregiver)	Apparently accidental; Potentially preventable
F-021-20-C	Neglect; SUDI/ near-SUDI/ apparent life-threatening event	DCBS history; Financial issues; Unsafe sleep (other); Other	Follow up services occurred during COVID restrictions.	Neglect (unsafe sleep)	Apparently accidental; Potentially preventable
F-022-20-C	Natural causes/ medical diagnosis	DCBS history; DCBS issues; Domestic Violence; Lack of treatment (mental health or substance abuse); Medical issues/ management; Mental health issues (caregiver); Other; Financial issues	The incident occurred pre – COVID, but ser-vices provided after incident {parenting, home visits, etc.	No abuse or neglect	

CASE REVIEWS FOR FISCAL YEAR 2019

Case Number	Categorization	Family Characteristics	Family Characteristics Comments	Panel Determination	Other Qualifiers
F-023-20-C	Natural causes/ medical diagnosis; SUDI/near-SUDI/apparent life-threatening event	DCBS history; Domestic Violence; Environmental neglect; Financial issues; Housing instability; Lack of treatment (mental health or substance abuse); Medical issues/ management; Mental health issues (caregiver); Overwhelmed Caregiver; Substance abuse (in home); Substance abuse by caregiver (current); Unsafe sleep (bed sharing)		No abuse or neglect	
F-024-20-C	Gunshot (accidental); Neglect	Environmental neglect; Supervisional neglect; Unsafe access to deadly means; Law enforcement issues		Neglect (general - can include leaving child with unsafe caregiver); Neglect due to unsafe access to deadly/potentially deadly means; Supervisory neglect	Apparently accidental; Potentially preventable
F-025-20-C	Ligature hanging	Other; Criminal history (caregiver); Criminal history (in the home); DCBS history; DCBS issues; Domestic Violence; Environmental neglect; Financial issues; Housing instability; Medical issues/ management; Medical neglect; Supervisional neglect; Unsafe access to deadly means	Occurred during COVID19 restrictions affecting some follow-up.	Neglect due to unsafe access to deadly/potentially deadly means; Supervisory neglect	Apparently accidental; Potentially preventable
F-026-20-C	Abusive head trauma; Physical abuse	Criminal history (caregiver); Criminal history (in the home); Financial issues; Lack of family support system ; Lack of Sleep Plan; Lack of treatment (mental health or substance abuse); Mental health issues (caregiver); Substitute caregiver at time of event ; Coroner issues; Other	Training issue for coroners: practice guidelines for cases with multi-county jurisdiction.	Abusive head trauma; Physical abuse	Potentially preventable

CASE REVIEWS FOR FISCAL YEAR 2020

Case Number	Categorization	Family Characteristics	Family Characteristics Comments	Panel Determination	Other Qualifiers
F-027-20-C	Ligature hanging; Neglect; Suicide (child)	Bystander issues/ opportunities; Coroner issues; Criminal history (caregiver); Criminal history (in the home); Family violence; Financial issues; Impaired caregiver; Lack of treatment (mental health or substance abuse); Law enforcement issues; Medical neglect; Mental health issues (caregiver); Mental health issues (child); Out of State CPS History; Statutory Issues; Substance abuse (in home); Substance abuse by caregiver (current); Supervisional neglect; Education/child care issues		Neglect (impaired caregiver); Supervisory neglect; Neglect (medical)	Potentially preventable
F-028-20-NC	Neglect	DCBS issues; Domestic Violence; Financial issues; Lack of treatment (mental health or substance abuse); Medical neglect; Mental health issues (caregiver); Substance abuse (in home); Substance abuse by caregiver (current); Other; Lack of family support system	Lack of transportation	Neglect (medical)	Potentially preventable
F-029-20-C	Neglect; SUDI/ near-SUDI/ apparent life-threatening event	Cognitive disability (caregiver); Criminal history (caregiver); Criminal history (in the home); DCBS history; Environmental neglect; Financial issues; Lack of Sleep Plan; Mental health issues (caregiver); Substance abuse (in home); Substance abuse by caregiver (current); Unsafe sleep (bed sharing); Unsafe sleep (cosleeping on a non-bed surface); Coroner issues; Statutory Issues		Neglect (general - can include leaving child with unsafe caregiver); Neglect (unsafe sleep)	Apparently accidental; Potentially preventable

Case Number	Categorization	Family Characteristics	Family Characteristics Comments	Panel Determination	Other Qualifiers
F-030-20-C	Traumatic asphyxia; Neglect	DCBS history; DCBS issues; Bystander issues/ opportunities; Criminal history (caregiver); Criminal history (in the home); Domestic Violence; Financial issues; Housing instability; Impaired caregiver; Inadequate restraint; Lack of treatment (mental health or substance abuse); Substance abuse (in home); Substance abuse by caregiver (current); Coroner issues; Law enforcement issues; Medical issues/ management		Neglect (impaired caregiver); Neglect (inadequate/absent child restraint in motor vehicle)	Apparently accidental; Potentially preventable
F-031-20-C	SUDI/near-SUDI/apparent life-threatening event; Neglect	DCBS history; DCBS issues; Environmental neglect; Impaired caregiver; MAT involvement; Mental health issues (caregiver); Other; Overwhelmed Caregiver; Statutory Issues; Substance abuse (in home); Substance abuse by caregiver (current); Unsafe sleep (other); Coroner issues; Bystander issues/ opportunities	(Incident occurred a month prior to implementation of COVID restrictions, resulting in follow up services being implement virtually.	Neglect (general - can include leaving child with unsafe caregiver); Neglect (impaired caregiver); Neglect (unsafe sleep)	Manner undetermined/foul play not ruled out
F-032-20-C	Other			No abuse or neglect	Apparently accidental
F-033-20-C	Gunshot (accidental); Neglect	DCBS history; Environmental neglect; Statutory Issues; Supervisional neglect; Unsafe access to deadly means		Neglect (general - can include leaving child with unsafe caregiver); Supervisory neglect; Neglect due to unsafe access to deadly/potentially deadly means	Apparently accidental; Potentially preventable

CASE REVIEWS FOR FISCAL YEAR 2020

Case Number	Categorization	Family Characteristics	Family Characteristics Comments	Panel Determination	Other Qualifiers
F-034-20-C	SUDI/near-SUDI/apparent life-threatening event; Neglect	DCBS issues; DCBS history; Criminal history (caregiver); Criminal history (in the home); Cognitive disability (caregiver); Financial issues; Lack of family support system ; Lack of regular child care; Lack of treatment (mental health or substance abuse); Law enforcement issues; MAT involvement; Medical issues/management; Medically fragile child; Mental health issues (caregiver); Other; Statutory Issues; Substance abuse (in home); Substance abuse by caregiver (current); Supervisional neglect; Unsafe sleep (bed sharing)	Transportation	Neglect (unsafe sleep)	Apparently accidental; Potentially preventable
F-035-20-C	Neglect; Smoke inhalation/fire	DCBS issues; Bystander issues/opportunities; DCBS history; Environmental neglect; Financial issues; Housing instability; Lack of treatment (mental health or substance abuse); Substance abuse (in home); Substance abuse by caregiver (current); Supervisional neglect; Overwhelmed Caregiver; Impaired caregiver; Statutory Issues		Neglect (general - can include leaving child with unsafe caregiver); Supervisory neglect; Neglect (impaired caregiver)	Apparently accidental; Potentially preventable
F-036-20-C	Neglect; Smoke inhala-tion/fire	Bystander issues/ opportunities; DCBS history; DCBS issues; Environmental neglect; Financial issues; Housing instability; Lack of treatment (mental health or substance abuse); Overwhelmed Caregiver; Substance abuse by caregiver (current); Supervisional neglect; Impaired caregiver; Statutory Issues; Substance abuse (in		Neglect (general - can include leaving child with unsafe caregiver); Supervisory neglect; Neglect (impaired caregiver)	Apparently accidental; Potentially preventable

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Case Number	Categorization	Family Characteristics	Family Characteristics Comments	Panel Determination	Other Qualifiers
F-037-20-NC	Neglect	Cognitive disability (child); Medical issues/ management; Medical neglect; Medically fragile child; Other	Incident occurred during COVID.	Neglect (medical)	Apparently accidental; Potentially preventable
F-038-20-C	Gunshot (accidental); Neglect	DCBS issues; DCBS history; Environmental neglect; Financial issues		Neglect (general - can include leaving child with unsafe caregiver)	Apparently accidental; Potentially preventable
F-039-20-C	Apparent murder/suicide; Gunshot (homicide)	Criminal history (caregiver); Criminal history (in the home); DCBS history; DCBS issues; Domestic Violence; Financial issues; Impaired caregiver; Lack of treatment (mental health or substance abuse); Medical issues/ management; Medically fragile child; Mental health issues (caregiver); Statutory Issues; Substance abuse (in home); Substance abuse by caregiver (current); Other; Overwhelmed Caregiver; Housing instability	Lack of transportation, lack of Family Drug Court, START or Plans of Safe Care. Lack of DV services in the area.	Physical abuse; Neglect (impaired caregiver)	Potentially preventable
F-040-20-C	Blunt force trauma - not inflicted (farm machinery, ATV, fall); Neglect	DCBS issues; DCBS history; Domestic Violence; Law enforcement issues; Medically fragile child; Statutory Issues; Substitute caregiver at time of event ; Supervisional neglect; Unsafe access to deadly means; Other; Medical issues/management	COVID 19 Restrictions - The hearings were held virtually, a few bumps here and there, but seemed to work okay. It seemed like the parents may have not been on directly, but were connected with their attorneys.	Supervisory neglect; Neglect due to unsafe access to deadly/potentially deadly means	Apparently accidental; Potentially preventable

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Case Number	Categorization	Family Characteristics	Family Characteristics Comments	Panel Determination	Other Qualifiers
F-041-20-C	Neglect; Drowning/near -drowning	DCBS issues; DCBS history; Domestic Violence; Environmental neglect; Financial issues; Lack of family support system ; Lack of treatment (mental health or substance abuse); Mental health issues (caregiver); Other; Overwhelmed Caregiver; Perinatal depression (caregiver); Supervisional neglect; Unsafe access to deadly means	1) Mother self reported a phone addiction-- others documented her inattention to children due to phone. 2) Incident occurred during COVID restrictions- MGPs were not visiting limiting support and awareness of situation, DCBS contact was primarily by text - not specified in record, but may be due to COVID.	Neglect (general - can include leaving child with unsafe caregiver); Supervisory neglect; Neglect due to unsafe access to deadly/potentially deadly means	Apparently accidental; Potentially preventable
F-042-20-C	Gunshot (accidental); Neglect	Cognitive disability (child); Criminal history (caregiver); Criminal history (in the home); DCBS history; Domestic Violence; Financial issues; Housing instability; Mental health issues (child); Substitute caregiver at time of event ; Unsafe access to deadly means		Neglect due to unsafe access to deadly/potentially deadly means	Apparently accidental; Potentially preventable
F-043-20-C	Blunt force trauma - not inflicted MVC	Military systems issues; Substitute caregiver at time of event		No abuse or neglect	Apparently accidental; Potentially preventable
F-044-20-C	Neglect; Traumatic asphyxia	Criminal history (caregiver); Criminal history (in the home); DCBS history; DCBS issues; Financial issues; Housing instability; Impaired caregiver; Law enforcement issues; MAT involvement; Mental health issues (caregiver); Substance abuse (in home); Substance abuse by caregiver (current); Supervisional neglect; Unsafe sleep (bed sharing); Other; Environmental neglect; Medical issues/ management; Neglectful entrustment; Statutory Issues	Incident occurred during COVID restrictions- prior report initiated via phone while family in hospital.	Neglect (impaired caregiver); Neglect (unsafe sleep); Supervisory neglect; Neglect (general - can include leaving child with unsafe caregiver)	Potentially preventable; Apparently accidental

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Case Number	Categorization	Family Characteristics	Family Characteristics Comments	Panel Determination	Other Qualifiers
F-045-20-C	Neglect; Overdose/ ingestion	Coroner issues; DCBS history; DCBS issues; Environmental neglect; Impaired caregiver; Law enforcement issues; Medically fragile child; Other; Statutory Issues; Unsafe access to deadly means; Supervisional neglect	Incident occurred during COVID limiting telephone access for remote central intake staff	Supervisory neglect; Neglect due to unsafe access to deadly/potentially deadly means; Neglect (general - can include leaving child with unsafe caregiver); Neglect (impaired caregiver)	Manner undetermined/foul play not ruled out
F-046-20-C	Neglect; Blunt force trauma - not inflicted MVC	DCBS history; Substance abuse (in home); Substance abuse by caregiver (current); Supervisional neglect; Other	COVID protocol in place at time of incident - limited use of phone contact with parents by DCBS, and no local team meeting documented (not sure if it is COVID or jurisdictional issue).	Supervisory neglect	Apparently accidental; Potentially preventable
F-047-20-NC	Drowning/near-drowning; Neglect	Financial issues; Substance abuse (in home); Substance abuse by caregiver (current); Supervisional neglect; Unsafe access to deadly means		Supervisory neglect; Neglect due to unsafe access to deadly/potentially deadly means	Apparently accidental; Potentially preventable
F-048-20-C	Neglect; Overdose/ ingestion	Bystander issues/ opportunities; Coroner issues; Criminal history (caregiver); Criminal history (in the home); DCBS history; DCBS issues; Domestic Violence; Environmental neglect; Financial issues; Housing instability; Impaired caregiver; Lack of regular child care; Law enforcement issues; Medical issues/ management; Medical neglect; Mental health issues (caregiver); Perinatal depression (caregiver); Statutory Issues; Substance abuse (in home); Substance abuse by caregiver (current); Supervisional neglect; Unsafe access to deadly means; Unsafe sleep (other); Other; MAT involvement	COVID protocol in place - FPP, court (post incident), DCBS visit telephonic, difficulty in getting siblings involved in virtual school when in kinship. Lack of process/ mechanism to share information among partners and coordinate services. Lack of transportation	Neglect (general - can include leaving child with unsafe caregiver); Neglect (impaired caregiver); Neglect (medical); Neglect (unsafe sleep); Neglect due to unsafe access to deadly/potentially deadly means; Supervisory neglect	Manner undetermined/foul play not ruled out

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Case Number	Categorization	Family Characteristics	Family Characteristics Comments	Panel Determination	Other Qualifiers
F-049-20-C	Neglect; Drowning/ near-drowning	DCBS history; DCBS issues; Cognitive disability (child); Environmental neglect; Financial issues; Housing instability; Law enforcement issues; Medical neglect; Medically fragile child; Mental health issues (caregiver); Overwhelmed Caregiver; Substance abuse (in home); Substance abuse by caregiver (current); Supervisional neglect; Unsafe access to deadly means; Other; Mental health issues (child); Serial relationships; Statutory Issues	Lack of Transportation.	Neglect (medical); Supervisory neglect; Neglect due to unsafe access to deadly/ potentially deadly means; Neglect (general - can include leaving child with unsafe caregiver)	Apparently accidental; Potentially preventable
F-050-20-C	Neglect; Drowning/ near-drowning	DCBS history; DCBS issues; Environmental neglect; Financial issues; Medically fragile child; Statutory Issues; Supervisional neglect; Unsafe access to deadly means; Other	The incident occurred while COVID restrictions were in place, resulting in some virtual contacts, loss of employment and childcare.	Neglect (general - can include leaving child with unsafe caregiver); Neglect due to unsafe access to deadly/potentially deadly means; Supervisory neglect	Apparently accidental; Potentially preventable
F-051-20-C	Neglect	DCBS issues; DCBS history; Medical issues/ management; Medical neglect; Other; Education/child care issues	The incident occurred during COVID restrictions; investigators were told to postpone contact until the autopsy was received to avoid possible COVID exposure.	Neglect (medical)	Potentially preventable

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Case Number	Categorization	Family Characteristics	Family Characteristics Comments	Panel Determination	Other Qualifiers
F-052-20-C	Natural causes/ medical diagnosis; Neglect	Cognitive disability (caregiver); Cognitive disability (child); Criminal history (in the home); DCBS history; DCBS issues; Financial issues; Housing instability; Judicial process issues; Lack of treatment (mental health or substance abuse); Medical issues/ management; Medical neglect; Medically fragile child; Mental health issues (caregiver); Overwhelmed Caregiver; Substance abuse (in home)		Neglect (medical)	Potentially preventable
F-053-20-PH	Failure to thrive/ malnutrition; Neglect; SUDI/ near-SUDI/ apparent life-threatening event	Bystander issues/ opportunities; DCBS history; DCBS issues; Domestic Violence; Failure to thrive; Financial issues; Medical issues/management; Medical neglect; Medically fragile child; Unsafe sleep (bed shar-ing)		Neglect (medical); Neglect (unsafe sleep)	Apparently accidental; Potentially preventable
F-054-20-PH	Gunshot (accidental)	Bystander issues/ opportunities; Substance abuse (child); Substitute caregiver at time of event ; Unsafe access to deadly means		No abuse or neglect	Apparently accidental; Potentially preventable
F-055-20-PH	Suicide (child); Ligature hanging	Bystander issues/ opportunities; DCBS history; Mental health issues (child)		No abuse or neglect	Potentially preventable
F-056-20-PH	Gunshot (accidental)	Unsafe access to deadly means; DCBS history		Neglect due to unsafe access to deadly/potentially deadly means	Apparently accidental; Potentially preventable
F-057-20-PH	Neglect; Blunt force trauma - not inflicted MVC	DCBS history; Supervisional neglect; Financial issues; Mental health issues (caregiver); Lack of treatment (mental health or substance abuse)		Supervisory neglect	Apparently accidental; Potentially preventable

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Case Number	Categorization	Family Characteristics	Family Characteristics Comments	Panel Determination	Other Qualifiers
F-059-20-PH	Gunshot (homicide)	Coroner issues; Education/child care issues; Mental health issues (caregiver); Mental health issues (child); Unsafe access to deadly means		Neglect due to unsafe access to deadly/potentially deadly means	Apparently accidental; Potentially preventable
F-060-20-PH	Blunt force trauma - not inflicted MVC; Suicide (child)	DCBS history; Family violence; Medically fragile child; Mental health issues (child); Statutory Issues		No abuse or neglect	Potentially preventable
F-061-20-PH	Natural causes/ medical diagnosis	Cognitive disability (child); DCBS history; Medically fragile child		No abuse or neglect	
F-062-20-PH	Neglect; SUDI/ near-SUDI/ apparent life-threatening event	DCBS issues; DCBS history; Bystander issues/ opportunities; Cognitive disability (caregiver); Environmental neglect; Failure to thrive; Financial issues; Housing instability; Lack of treatment (mental health or substance abuse); Medical issues/ management; Medical neglect; Mental health issues (caregiver); Overwhelmed Caregiver; Substance abuse (in home); Substance abuse by caregiver (current); Unsafe sleep (other)		Neglect (general - can include leaving child with unsafe caregiver); Neglect (unsafe sleep); Neglect (medical)	Apparently accidental; Potentially preventable
F-063-20-PH	Neglect; Natural causes/ medical diagnosis	Bystander issues/ opportunities; Cognitive disability (child); Criminal history (caregiver); Criminal history (in the home); DCBS history; Medical neglect; Medically fragile child; DCBS issues		Neglect (medical)	Potentially preventable

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Case Number	Categorization	Family Characteristics	Family Characteristics Comments	Panel Determination	Other Qualifiers
F-064-20-PH	Smoke inhalation/fire; Burn	Criminal history (caregiver); Criminal history (in the home); DCBS history; DCBS issues; Domestic Violence; Environmental neglect; Family violence; Financial issues; Housing instability; Mental health issues (child); Other; Overwhelmed Caregiver; Statutory Issues; Education/child care issues; In-Home Service Provider Issues	No transportation	No abuse or neglect	Apparently accidental; Potentially preventable
F-065-20-PH	SUDI/near-SUDI/apparent life-threatening event; Neglect	DCBS history; Domestic Violence; Coroner issues; Substance abuse by caregiver (current); Substance abuse (in home); Unsafe sleep (cosleeping on a non-bed surface); Mental health issues (caregiver)		Neglect (unsafe sleep)	Apparently accidental; Potentially preventable
F-066-20-PH	Neglect; Overdose/ ingestion	Coroner issues; Medical neglect; Other; Substance abuse (child); Law enforcement issues	Incident occurred early after COVID restrictions were implemented resulting in school counseling provided via NTI and training issue regarding coroner and LE communication with DCBS.	Other	Manner undetermined/foul play not ruled out
F-067-20-PH	SUDI/near-SUDI/apparent life-threatening event; Traumatic asphyxia	Bystander issues/ opportunities; DCBS history; DCBS issues; Domestic Violence; Financial issues; Housing instability; Lack of family support system ; Medical issues/ management; Statutory Issues; Unsafe sleep (cosleeping on a non-bed surface)		Neglect (unsafe sleep)	Apparently accidental; Potentially preventable
F-068-20-PH	SUDI/near-SUDI/apparent life-threatening event	Coroner issues; DCBS history; Family violence; Financial issues; Law en-forcement issues; Medical issues/management; Other; Overwhelmed Caregiver; Serial relationships; Unsafe sleep (cosleeping on a non-bed surface)	Occurred during COVID restrictions.	Neglect (unsafe sleep)	Apparently accidental; Potentially preventable

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Case Number	Categorization	Family Characteristics	Family Characteristics Comments	Panel Determination	Other Qualifiers
F-069-20-PH	Drowning/near-drowning; Natural causes/ medical diagnosis	DCBS history; DCBS issues; Lack of treatment (mental health or substance abuse); Medically fragile child; Mental health issues (caregiver); Other; Out of State CPS History; Overwhelmed Caregiver; Education/child care issues	The incident occurred the month COVID restrictions were implemented, which may have contributed to lack of a local team meeting.	No abuse or neglect	Apparently accidental; Potentially preventable
F-070-20-PH	Other	Cognitive disability (child); Criminal history (caregiver); Criminal history (in the home); Education/child care issues; Financial issues; Housing instability; Mental health issues (child)		No abuse or neglect	Apparently accidental; Potentially preventable
F-071-20-PH	Neglect; SUDI/ near-SUDI/ apparent life-threatening event; Traumatic asphyxia	Coroner issues; Unsafe sleep (bed sharing)		Neglect (unsafe sleep)	Apparently accidental; Potentially preventable
F-072-20-PH	Natural causes/ medical diagnosis	Bystander issues/ opportunities; DCBS history; DCBS issues; Education/child care issues; Environmental neglect; Lack of family support system ; Lack of treatment (mental health or substance abuse); Medical issues/ management; Medically fragile child; Mental health issues (caregiver); Overwhelmed Caregiver; Supervisional neglect		Neglect (general - can include leaving child with unsafe caregiver); Neglect (medical); Supervisory neglect	Manner undetermined/foul play not ruled out
F-073-20-PH	Neglect; SUDI/ near-SUDI/ apparent life-threatening event	Coroner issues; Criminal history (caregiver); Criminal history (in the home); DCBS history; DCBS issues; Domestic Violence; Financial issues; Medically fragile child; Other; Statutory Issues; Substance abuse (in home); Substance abuse by caregiver (current); Unsafe sleep (bed sharing)	Training Issue - Coroner did not understand purpose of DCBS contact is to find out history.	Neglect (unsafe sleep)	Apparently accidental; Potentially preventable

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Case Number	Categorization	Family Characteristics	Family Characteristics Comments	Panel Determination	Other Qualifiers
F-074-20-PH	Undetermined (cause of death or near-death event)	Criminal history (caregiver); DCBS history; Domestic Violence; Failure to thrive; Financial issues; Medical issues/ management; Medically fragile child; Overwhelmed Caregiver; Unsafe sleep (other)		No abuse or neglect	Apparently accidental; Potentially preventable
F-075-20-PH	Ligature hanging; Suicide (child)	Coroner issues; Education/child care issues; Lack of treatment (mental health or substance abuse); Mental health issues (child); Substance abuse (child); Statutory Issues		No abuse or neglect	Potentially preventable
F-076-20-PH	Neglect; Overdose/ ingestion	Bystander issues/ opportunities; DCBS history; Environmental neglect; Financial issues; Lack of treatment (mental health or substance abuse); Law enforcement issues; Mental health issues (caregiver); Substance abuse (child); Substance abuse (in home); Supervisional neglect; Mental health issues (child)		Neglect (general - can include leaving child with unsafe caregiver); Supervisory neglect	Apparently accidental; Potentially preventable
F-077-20-PH	SUDI/near-SUDI/apparent life-threatening event	Coroner issues; DCBS history; DCBS issues; Financial issues; Medical issues/management; Unsafe sleep (bed shar-ing)		Neglect (unsafe sleep)	Apparently accidental; Potentially preventable
F-078-20-PH	Suicide (child); Gunshot (suicide)	Coroner issues; Criminal history (in the home); DCBS issues; Education/ child care issues; Mental health issues (child); Statutory Issues; Sub-stance abuse (child); Unsafe access to deadly means		Neglect due to unsafe access to deadly/potentially deadly means	Potentially preventable
F-079-20-PH	Neglect; SUDI/ near-SUDI/ apparent life-threatening event	Substance abuse (in home); Substance abuse by caregiver (current); Unsafe sleep (bed sharing); Coroner issues; DCBS history; Impaired caregiver		Neglect (unsafe sleep); Neglect (impaired caregiver)	Apparently accidental; Potentially preventable

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Case Number	Categorization	Family Characteristics	Family Characteristics Comments	Panel Determination	Other Qualifiers
F-080-20-PH	Neglect; SUDI/ near-SUDI/ apparent life-threatening event	Coroner issues; DCBS history; Domestic Violence; Environmental neglect; Law enforcement issues; Medically fragile child; Other; Substance abuse by caregiver (current); Substance abuse (in home); Unsafe sleep (other); Statutory Issues	Incident occurred during COVID restrictions resulting in delays in attending physical therapy, index child's contact with father, and isolation/frustration reported by paramour.	Neglect (general - can include leaving child with unsafe caregiver); Neglect (unsafe sleep)	Apparently accidental; Potentially preventable
NF-001-20-C	Neglect; Smoke inhalation/fire	DCBS history; DCBS issues; Financial issues; Lack of regular child care; Lack of Sleep Plan; Language/cultural issues; Supervisional neglect; Overwhelmed Caregiver; Other	Social Justice - lack of protocol	Supervisory neglect	Potentially preventable; Apparently accidental
NF-002-20-C	Abusive head trauma; Neglect	Cognitive disability (caregiver); Criminal history (caregiver); Criminal history (in the home); Financial issues; Lack of regular child care; Lack of treatment (mental health or substance abuse); Substance abuse (in home); Substance abuse by caregiver (current); Substitute caregiver at time of event; Supervisional neglect; Unsafe sleep (bed sharing)		Abusive head trauma; Supervisory neglect; Neglect (unsafe sleep)	Manner undetermined/foul play not ruled out; Potentially preventable
NF-003-20-C	Ligature hanging; Neglect	DCBS history; Environmental neglect; Impaired caregiver; Law enforcement issues; Mental health issues (caregiver); Substance abuse (in home); Statutory Issues; Supervisional neglect; Unsafe access to deadly means; Substance abuse by caregiver (current)		Neglect (general - can include leaving child with unsafe caregiver); Neglect due to unsafe access to deadly/potentially deadly means; Supervisory neglect	Apparently accidental; Potentially preventable

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Case Number	Categorization	Family Characteristics	Family Characteristics Comments	Panel Determination	Other Qualifiers
NF-004-20-C	Neglect; Failure to thrive/ malnutrition	Medical issues/ management; DCBS history; DCBS issues; Cognitive disability (child); Criminal history (caregiver); Criminal history (in the home); Failure to thrive; Financial issues; Housing instability; Lack of regular child care; Lack of treatment (mental health or substance abuse); Medical neglect; Medically fragile child; Mental health issues (caregiver); Other; Substance abuse (in home); Substance abuse by caregiver (current)	Lack of transportation (handicapped van broken), transported in car.	Neglect (general - can include leaving child with unsafe caregiver); Neglect (medical)	Potentially preventable
NF-005-20-C	Neglect; Physical abuse	DCBS issues; DCBS history; Financial issues; Language/cultural issues; Medical issues/ management; Medical neglect; Supervisional neglect; Commonwealth/ County Attorneys; Failure to thrive; Judicial process issues; Statutory Issues		Supervisory neglect; Neglect (general - can include leaving child with unsafe caregiver); Neglect (medical); Physical abuse	Potentially preventable
NF-006-20-C	Neglect; Drowning/near-drowning	Unsafe access to deadly means; Supervisional neglect		Supervisory neglect; Neglect due to unsafe access to deadly/ potentially deadly means	Apparently accidental; Potentially preventable
NF-007-20-C	Abusive head trauma; Neglect; Physical abuse	Criminal history (caregiver); Criminal history (in the home); DCBS history; DCBS issues; Financial issues; Lack of family support system ; Lack of regular child care; Medical issues/management; Medical neglect; Overwhelmed Caregiver; Serial relationships		Abusive head trauma; Neglect (medical); Physical abuse	Potentially preventable
NF-008-20-C	Blunt force trauma - not inflicted (farm machinery, ATV, fall)	DCBS issues; Financial issues; Language/cultural issues; Medical issues/ management		Other	Manner undetermined/foul play not ruled out

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Case Number	Categorization	Family Characteristics	Family Characteristics Comments	Panel Determination	Other Qualifiers
NF-009-20-C	Neglect; Blunt force trauma - not inflicted MVC	DCBS history; DCBS issues; Bystander issues/ opportunities; Criminal history (caregiver); Criminal history (in the home); Domestic Violence; Family violence; Financial issues; Housing instability; Impaired caregiver; MAT involvement; Substance abuse (in home); Substance abuse by caregiver (current); Supervisional neglect		Neglect (impaired caregiver); Supervisory neglect	Apparently accidental; Potentially preventable
NF-010-20-C	Neglect; Over-dose/ingestion	DCBS history; DCBS issues; Criminal history (caregiver); Criminal history (in the home); Environmental neglect; Financial issues; Supervisional neglect; Unsafe access to deadly means		Supervisory neglect; Neglect due to unsafe access to deadly/potentially deadly means; Neglect (general - can include leaving child with unsafe caregiver)	Apparently accidental; Potentially preventable
NF-011-20-C	Abusive head trauma; Neglect; Physical abuse	DCBS issues; DCBS history; Bystander issues/ opportunities; Criminal history (caregiver); Criminal history (in the home); Evidence of poor bonding; Financial issues; Housing instability; Lack of treatment (mental health or substance abuse); Medical neglect; Mental health issues (caregiver); Neglectful entrustment; Substance abuse (in home); Substance abuse by caregiver (current); Substitute caregiver at time of event ; Domestic Violence; Overwhelmed Caregiver		Abusive head trauma; Neglect (general - can include leaving child with unsafe caregiver); Neglect (medical); Physical abuse	Potentially preventable
NF-012-20-NC	Overdose/ ingestion	Criminal history (in the home); Supervisional neglect; Unsafe access to deadly means		Neglect due to unsafe access to deadly/potentially deadly means; Supervisory neglect	Apparently accidental; Potentially preventable
NF-013-20-C	Drowning/near-drowning; Neglect	DCBS history; Financial issues; Supervisional neglect; Unsafe access to deadly means		Supervisory neglect; Neglect due to unsafe access to deadly/potentially deadly means	Apparently accidental; Potentially preventable

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Case Number	Categorization	Family Characteristics	Family Characteristics Comments	Panel Determination	Other Qualifiers
NF-014-20-C	Neglect; Drowning/near -drowning	DCBS history; Financial issues; Supervisional neglect; Unsafe access to deadly means		Neglect due to unsafe access to deadly/potentially deadly means; Supervisory neglect	Apparently accidental; Potentially preventable
NF-015-20-C	Neglect; Overdose/ ingestion	Law enforcement issues; Environmental neglect; Substance abuse (in home); Substance abuse by caregiver (current); Other; Supervisional neglect; Unsafe access to deadly means; Statutory Issues	Incident response occurred during COVID restrictions, after incident, some contacts were virtual.	Supervisory neglect; Neglect (general - can include leaving child with unsafe caregiver); Neglect due to unsafe access to deadly/potentially deadly means	Apparently accidental; Potentially preventable
NF-016-20-C	Neglect; Overdose/ ingestion	DCBS issues; Environmental neglect; MAT involvement; Mental health issues (caregiver); Supervisional neglect; Unsafe access to deadly means; Financial issues		Neglect (general - can include leaving child with unsafe caregiver); Neglect due to unsafe access to deadly/potentially deadly means; Supervisory neglect	Apparently accidental; Potentially preventable
NF-017-20-C	Neglect; Overdose/ ingestion	DCBS history; Environmental neglect; Financial issues; MAT involvement; Supervisional neglect; Unsafe access to deadly means		Neglect (general - can include leaving child with unsafe caregiver); Supervisory neglect; Neglect due to unsafe access to deadly/potentially deadly means	Apparently accidental; Potentially preventable
NF-018-20-NC	Neglect; Burn	Unsafe access to deadly means; Supervisional neglect		Neglect due to unsafe access to deadly/potentially deadly means; Supervisory neglect	Apparently accidental; Potentially preventable
NF-019-20-C	Abusive head trauma; Physical abuse	Criminal history (caregiver); Criminal history (in the home); DCBS history; Domestic Violence; Financial issues; Medical issues/ management; Mental health issues (caregiver); Other; Substitute caregiver at time of event	COVID restrictions in place.	Physical abuse; Abusive head trauma	Potentially preventable

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Case Number	Categorization	Family Characteristics	Family Characteristics Comments	Panel Determination	Other Qualifiers
NF-020-20-C	Physical abuse; Neglect	Bystander issues/ opportunities; Cognitive disability (caregiver); Criminal history (caregiver); Criminal history (in the home); DCBS issues; DCBS history; Domestic Violence; Financial issues; Lack of regular child care; Law enforcement issues; Other; Overwhelmed Caregiver; Substitute caregiver at time of event ; Neglectful entrustment	Incident occurred prior to COVID restrictions, but restrictions contributed to court delays, virtual hearings, lack of day care for kinship provider, virtual contacts, etc.	Physical abuse; Neglect (general - can include leaving child with unsafe caregiver)	Potentially preventable
NF-021-20-C	Neglect; Blunt force trauma - not inflicted (farm machinery, ATV, fall)	Criminal history (caregiver); Criminal history (in the home); Impaired caregiver; Inadequate restraint; Mental health issues (caregiver); Substance abuse (in home); Substance abuse by caregiver (current); Supervisional neglect		Supervisory neglect; Neglect (impaired caregiver)	Apparently accidental; Potentially preventable
NF-022-20-C	Overdose/ ingestion; Neglect; Suicide (child)	Bystander issues/ opportunities; DCBS history; DCBS issues; Environmental neglect; Mental health issues (caregiver); Mental health issues (child); Substance abuse (in home); Substance abuse by caregiver (current); Supervisional neglect; Unsafe access to deadly means; Overwhelmed Caregiver		Neglect due to unsafe access to deadly/potentially deadly means; Neglect (general - can include leaving child with unsafe caregiver); Supervisory neglect	Potentially preventable

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Case Number	Categorization	Family Characteristics	Family Characteristics Comments	Panel Determination	Other Qualifiers
NF-023-20-C	Neglect	DCBS history; DCBS issues; Education/child care issues; Financial issues; Lack of treatment (mental health or substance abuse); Medical issues/ management; Medical neglect; Medically fragile child; Mental health issues (child); Overwhelmed Caregiver; Supervisional neglect; In-Home Service Provider Issues		Neglect (medical); Supervisory neglect	Potentially preventable
NF-024-20-C	Abusive head trauma; Neglect; Physical abuse	DCBS history; DCBS issues; Bystander issues/ opportunities; Cognitive disability (child); In-Home Service Provider Issues; Lack of regular child care; Medical neglect; Medically fragile child; Out of State CPS History; Overwhelmed Caregiver; Mental health issues (child); Lack of family support system		Abusive head trauma; Neglect (medical); Physical abuse	Potentially preventable
NF-025-20-NC	Abusive head trauma; Neglect; Physical abuse	Bystander issues/ opportunities; Cognitive disability (caregiver); Domestic Violence; Evidence of poor bonding; Failure to thrive; Medical issues/ management; Medical neglect; Mental health issues (caregiver); Neglectful entrustment; Overwhelmed Caregiver		Abusive head trauma; Neglect (general - can include leaving child with unsafe caregiver); Neglect (medical); Physical abuse	Potentially preventable
NF-026-20-C	Drowning/near-drowning; Neglect	Supervisional neglect; Unsafe access to deadly means		Supervisory neglect; Neglect due to unsafe access to deadly/potentially deadly means	Apparently accidental; Potentially preventable

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Case Number	Categorization	Family Characteristics	Family Characteristics Comments	Panel Determination	Other Qualifiers
NF-027-20-C	Neglect; Physical abuse; Abusive head trauma	Bystander issues/ opportunities; Criminal history (caregiver); Criminal history (in the home); DCBS history; DCBS issues; Financial issues; Lack of regular child care; Lack of treatment (mental health or substance abuse); Law enforcement issues; MAT involvement; Medical neglect; Mental health issues (caregiver); Substance abuse (in home); Substance abuse by caregiver (current); Substitute caregiver at time of event		Abusive head trauma; Neglect (medical); Physical abuse	Potentially preventable
NF-028-20-C	Blunt force trauma - not inflicted MVC; Neglect	Criminal history (caregiver); Criminal history (in the home); DCBS history; Domestic Violence; Financial issues; Housing instability; Impaired caregiver; Lack of treatment (mental health or substance abuse); MAT involvement; Mental health issues (caregiver); Serial relationships; Substance abuse (in home); Substance abuse by caregiver (current); Supervisional neglect		Supervisory neglect; Neglect (impaired caregiver); Neglect (general - can include leaving child with unsafe caregiver)	Apparently accidental; Potentially preventable
NF-029-20-C	Gunshot (accidental); Neglect	Criminal history (caregiver); DCBS history; DCBS issues; Criminal history (in the home); Environmental neglect; Lack of regular child care; Lack of Sleep Plan; Unsafe access to deadly means; Substance abuse (in home); Substance abuse by caregiver (current); Statutory Issues		Neglect due to unsafe access to deadly/potentially deadly means; Neglect (general - can include leaving child with unsafe caregiver)	Apparently accidental; Potentially preventable

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Case Number	Categorization	Family Characteristics	Family Characteristics Comments	Panel Determination	Other Qualifiers
NF-030-20-C	Neglect; Physical abuse; Overdose/ ingestion	DCBS history; DCBS issues; Environmental neglect; Financial issues; Lack of family support system ; Lack of treatment (mental health or substance abuse); Mental health issues (child); Overwhelmed Caregiver; Substance abuse (child); Supervisional neglect; Unsafe access to deadly means; Neglectful entrustment; Bystander issues/opportunities		Neglect (general - can include leaving child with unsafe caregiver); Neglect (medical); Neglect due to unsafe access to deadly/potentially deadly means; Physical abuse; Supervisory neglect; Torture	Potentially preventable
NF-031-20-C	Abusive head trauma; Neglect; Physical abuse	Criminal history (caregiver); Criminal history (in the home); DCBS history; DCBS issues; Financial issues; Lack of regular child care; Medical issues/ management; Medical neglect; Overwhelmed Caregiver; Substance abuse (in home); Substance abuse by caregiver (current); Unsafe sleep (cosleeping on a non-bed surface)		Abusive head trauma; Neglect (medical); Neglect (unsafe sleep); Physical abuse	Potentially preventable
NF-032-20-C	Blunt force trauma - not inflicted (farm machinery, ATV, fall)	Medically fragile child		No abuse or neglect	Apparently accidental
NF-033-20-C	Neglect; Overdose/ ingestion	Criminal history (caregiver); Criminal history (in the home); DCBS history; DCBS issues; Environmental neglect; Financial issues; Lack of treatment (mental health or substance abuse); Mental health issues (caregiver); Substance abuse (in home); Substitute caregiver at time of event ; Supervisional neglect; Unsafe access to deadly means; Unsafe sleep (other); Overwhelmed Caregiver		Neglect (general - can include leaving child with unsafe caregiver); Neglect (unsafe sleep); Neglect due to unsafe access to deadly/potentially deadly means; Supervisory neglect	Apparently accidental; Potentially preventable

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Case Number	Categorization	Family Characteristics	Family Characteristics Comments	Panel Determination	Other Qualifiers
NF-034-20-C	Neglect	DCBS history; DCBS issues; Judicial process issues; Medical issues/ management; Medical neglect; Medically fragile child		Neglect (medical)	Potentially preventable
NF-035-20-C	Overdose/ ingestion; Neglect	Criminal history (caregiver); Criminal history (in the home); DCBS history; DCBS issues; Environmental neglect; Impaired caregiver; Lack of treatment (mental health or substance abuse); Law enforcement issues; Substance abuse (in home); Substance abuse by caregiver (current); Supervisional neglect; Unsafe access to deadly means; Substance abuse (child)		Neglect (general - can include leaving child with unsafe caregiver); Supervisory neglect; Neglect due to unsafe access to deadly/potentially deadly means	Potentially preventable
NF-036-20-C	Overdose/ ingestion	Bystander issues/ opportunities; Criminal history (caregiver); Criminal history (in the home); DCBS history; DCBS issues; Financial issues; Family violence; Housing instability; Impaired caregiver; Lack of treatment (mental health or substance abuse); Mental health issues (caregiver); Medical issues/ management; Mental health issues (child); Substance abuse (in home); Substance abuse by caregiver (current)		Neglect (impaired caregiver); Other; Physical abuse	Potentially preventable
NF-037-20-C	Overdose/ ingestion	Cognitive disability (caregiver); Cognitive disability (child); DCBS history; DCBS issues; Environmental neglect; Financial issues; Law enforcement issues; Medical neglect; Medically fragile child; Mental health issues (caregiver); Supervisional neglect; Unsafe access to deadly means		Neglect (medical); Neglect due to unsafe access to deadly/potentially deadly means; Supervisory neglect	Apparently accidental; Potentially preventable

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Case Number	Categorization	Family Characteristics	Family Characteristics Comments	Panel Determination	Other Qualifiers
NF-038-20-C	Blunt force trauma - not inflicted (farm machinery, ATV, fall)	DCBS history; Medically fragile child; Mental health issues (caregiver); Unsafe sleep (bed sharing)		No abuse or neglect	Apparently accidental; Potentially preventable
NF-039-20-NC	Blunt force trauma - not inflicted MVC; Neglect	Inadequate restraint; Mental health issues (caregiver); Supervisional neglect		Supervisory neglect; Neglect (inadequate/ absent child restraint in motor vehicle)	Apparently accidental; Potentially preventable
NF-040-20-C	Abusive head trauma; Neglect; Physical abuse	DCBS issues; Bystander issues/opportunities; Criminal history (caregiver); Criminal history (in the home); Domestic Violence; Financial issues; Housing instability; Medical neglect; Neglectful entrustment; Overwhelmed Caregiver; Substance abuse (in home); Substance abuse by caregiver (current)		Abusive head trauma; Neglect (general - can include leaving child with unsafe caregiver); Neglect (medical); Physical abuse; Torture	Potentially preventable
NF-041-20-C	Neglect; Over-dose/ingestion	DCBS history; DCBS issues; Environmental neglect; Language/cultural issues; MAT Involvement; Out of State CPS History; Supervisional neglect; Unsafe access to deadly means		Neglect due to unsafe access to deadly/ potentially deadly means; Neglect (general - can include leaving child with unsafe caregiver); Supervisory neglect	Apparently accidental; Potentially preventable
NF-042-20-C	Abusive head trauma	Lack of Sleep Plan; Lack of regular child care; Overwhelmed Caregiver; Law enforcement issues		Abusive head trauma	Potentially preventable
NF-043-20-C	Abusive head trauma; Neglect; Physical abuse; Failure to thrive/ malnutrition	Bystander issues/ opportunities; Domestic Violence; Evidence of poor bonding; Failure to thrive; In-Home Service Provider Issues; Language/cultural issues; Medical neglect; Medically fragile child; Mental health issues (caregiver); Overwhelmed Caregiver; Perinatal depression (caregiver); Supervisional neglect; Commonwealth/County Attorneys; Lack of family support system ; Law enforcement issues		Abusive head trauma; Neglect (general - can include leaving child with unsafe caregiver); Supervisory neglect; Physical abuse; Torture; Neglect (medical)	Potentially preventable

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Case Number	Categorization	Family Characteristics	Family Characteristics Comments	Panel Determination	Other Qualifiers
NF-044-20-C	Neglect	Commonwealth/County Attorneys; Criminal history (caregiver); Criminal history (in the home); DCBS history; DCBS issues; Domestic Violence; Environmental neglect; Family violence; Medical issues/ management; Medical neglect; Medically fragile child; Other; Overwhelmed Caregiver	Lack of transportation - COVID 19 restrictions	Neglect (general - can include leaving child with unsafe caregiver); Neglect (medical)	Potentially preventable
NF-045-20-C	Overdose/ ingestion; Neglect	Criminal history (caregiver); Criminal history (in the home); DCBS history; DCBS issues; Environmental neglect; Financial issues; MAT involvement; Mental health issues (caregiver); Substance abuse (in home); Supervisional neglect; Unsafe access to deadly means; Substance abuse by caregiver (current); Substitute caregiver at time of event		Neglect (general - can include leaving child with unsafe caregiver); Neglect due to unsafe access to deadly/potentially deadly means; Supervisory neglect	Apparently accidental; Potentially preventable
NF-046-20-NC	Abusive head trauma; Physical abuse	Bystander issues/ opportunities; Environmental neglect; Financial issues; Lack of regular child care; Lack of treatment (mental health or substance abuse); Mental health issues (caregiver); Other; Substance abuse (in home); Substance abuse by caregiver (current); Substitute caregiver at time of event	COVID restrictions in place.	Abusive head trauma; Neglect (general - can Include leaving child with unsafe caregiver); Physical abuse	Potentially preventable

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Case Number	Categorization	Family Characteristics	Family Characteristics Comments	Panel Determination	Other Qualifiers
NF-047-20-C	Neglect; Overdose/ ingestion	Criminal history (caregiver); Criminal history (in the home); DCBS history; Domestic Violence; Environmental neglect; Financial issues; Lack of treatment (mental health or substance abuse); Lack of family support system ; Substance abuse (in home); Substance abuse by caregiver (current); Supervisional neglect; Unsafe access to deadly means; Neglectful entrustment		Neglect (general - can include leaving child with unsafe caregiver); Neglect due to unsafe access to deadly/potentially deadly means; Supervisory neglect	Apparently accidental; Potentially preventable
NF-048-20-C	Neglect	DCBS history; DCBS issues; Failure to thrive; Financial issues; Lack of treatment (mental health or substance abuse); Medical neglect; Medically fragile child; Medical issues/ management; Statutory Issues; Substance abuse (in home); Substance abuse by caregiver (current); Other; MAT involvement	Hearings were held via COVID Restrictions. Seemed to work adequately.	Neglect (general - can include leaving child with unsafe caregiver); Neglect (medical)	Potentially preventable
NF-049-20-C	Overdose/ ingestion; Neglect	Environmental neglect; Mental health issues (caregiver); Supervisional neglect; Unsafe access to deadly means		Neglect (general - can include leaving child with unsafe caregiver); Neglect due to unsafe access to deadly/potentially deadly means; Supervisory neglect	Apparently accidental; Potentially preventable
NF-050-20-C	Neglect; Overdose/ ingestion	Environmental neglect; Supervisional neglect; Unsafe access to deadly means		Neglect (general - can include leaving child with unsafe caregiver); Neglect due to unsafe access to deadly/potentially deadly means; Supervisory neglect	Apparently accidental; Potentially preventable

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Case Number	Categorization	Family Characteristics	Family Characteristics Comments	Panel Determination	Other Qualifiers
NF-051-20-C	Abusive head trauma; Physical abuse	Criminal history (caregiver); DCBS history; DCBS issues; Environmental neglect; Financial issues; Impaired caregiver; Judicial process issues; Medical neglect; Out of State CPS History; Substance abuse by caregiver (current); Medical issues/ management; Commonwealth/County Attorneys; Criminal history (in the home); Substance abuse (in home)		Abusive head trauma; Physical abuse; Torture	Potentially preventable
NF-052-20-C	Drowning/near-drowning	DCBS history; Financial issues; Housing instability; Medical neglect; Overwhelmed Caregiver; Domestic Violence		No abuse or neglect	Apparently accidental; Potentially preventable
NF-053-20-C	Overdose/ ingestion; Neglect	Criminal history (caregiver); Criminal history (in the home); DCBS history; DCBS issues; Environmental neglect; Financial issues; Law enforcement issues; Mental health issues (caregiver); Substance abuse (in home); Substance abuse by caregiver (current); Supervisional neglect; Unsafe access to deadly means		Supervisory neglect; Neglect due to unsafe access to deadly/potentially deadly means; Neglect (general - can include leaving child with unsafe caregiver)	Apparently accidental; Potentially preventable
NF-054-20-C	Neglect; Overdose/ ingestion	DCBS issues; DCBS history; Criminal history (in the home); Criminal history (caregiver); Domestic Violence; Environmental neglect; Financial issues; MAT involvement; Medical issues/management; Substance abuse (in home); Substance abuse by caregiver (current); Supervisional neglect; Unsafe access to deadly means		Neglect (general - can include leaving child with unsafe caregiver); Neglect due to unsafe access to deadly/potentially deadly means; Supervisory neglect	Apparently accidental; Potentially preventable

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Case Number	Categorization	Family Characteristics	Family Characteristics Comments	Panel Determination	Other Qualifiers
NF-055-20-C	Neglect; Overdose/ ingestion	DCBS history; DCBS issues; Bystander issues/ opportunities; Criminal history (caregiver); Criminal history (in the home); Domestic Violence; Environmental neglect; Financial issues; Housing instability; Lack of family support system ; Lack of regular child care; Lack of Sleep Plan; Lack of treatment (mental health or substance abuse); Neglectful entrustment; Substance abuse (in home); Substance abuse by caregiver (current); Supervisional neglect; Unsafe access to deadly means; Medical neglect		Neglect (general - can include leaving child with unsafe caregiver); Neglect due to unsafe access to deadly/potentially deadly means; Neglect (medical); Supervisory neglect	Apparently accidental; Potentially preventable
NF-056-20-C	Neglect; Over-dose/ingestion	DCBS issues; DCBS history; Cognitive disability (child); Lack of regular child care; Medical neglect; Medically fragile child; Other; Overwhelmed Caregiver; Statutory Issues; Commonwealth/ County Attorneys; Judicial process issues; Financial issues; In-Home Service Provider Issues	Transportation, latter part of case work provided during COVID 19 restrictions. Nutritional neglect	Neglect (medical); Neglect (general - can include leaving child with unsafe caregiver)	Potentially preventable
NF-057-20-C	Neglect	DCBS history; DCBS issues; Medical neglect; Medically fragile child; Other; Overwhelmed Caregiver	Lack of transportation	Neglect (medical)	Potentially preventable

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Case Number	Categorization	Family Characteristics	Family Characteristics Comments	Panel Determination	Other Qualifiers
NF-058-20-C	Neglect; Blunt force trauma - not inflicted MVC	Bystander issues/ opportunities; Criminal history (caregiver); Criminal history (in the home); DCBS history; DCBS issues; Domestic Violence; Financial issues; MAT involvement; Mental health issues (caregiver); Substance abuse (in home); Substance abuse by caregiver (current); Law enforcement issues; Impaired caregiver; Lack of family support system ; Neglectful entrustment		Neglect (general - can include leaving child with unsafe caregiver); Neglect (impaired caregiver)	Apparently accidental; Potentially preventable
NF-059-20-C	Abusive head trauma	Domestic Violence; Financial issues; Housing instability; Lack of regular child care; MAT involvement; Mental health issues (caregiver); Substance abuse (in home); Substance abuse by caregiver (current)		Abusive head trauma	Potentially preventable
NF-060-20-C	Overdose/ ingestion	Cognitive disability (child); Environmental neglect; MAT involvement; Other; Supervisional neglect; Unsafe access to deadly means	COVID 19 delayed access to mother's records.	Neglect due to unsafe access to deadly/potentially deadly means; Supervisory neglect	Apparently accidental; Potentially preventable
NF-061-20-C	Neglect; Overdose/ ingestion	DCBS history; DCBS issues; Medical issues/ management; Law enforcement issues; Criminal history (caregiver); Criminal history (in the home); Environmental neglect; Financial issues; MAT involvement; Mental health issues (caregiver); Statutory Issues; Substance abuse (in home); Substance abuse by caregiver (current); Unsafe access to deadly means; Supervisional neglect		Neglect due to unsafe access to deadly/potentially deadly means; Neglect (general - can include leaving child with unsafe caregiver); Supervisory neglect	Apparently accidental; Potentially preventable

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Case Number	Categorization	Family Characteristics	Family Characteristics Comments	Panel Determination	Other Qualifiers
NF-062-20-C	Overdose/ ingestion; Neglect	Criminal history (caregiver); Criminal history (in the home); DCBS history; DCBS issues; Environmental neglect; Impaired care-giver; Mental health issues (caregiver); Other; Overwhelmed Caregiver; Substance abuse (in home); Substance abuse by caregiver (current); Supervisional neglect; Unsafe access to deadly means	Post incident services were impacted by COVID restrictions – virtual contact and delayed court hearings.	Neglect (general - can include leaving child with unsafe caregiver); Neglect (impaired caregiver); Neglect due to unsafe access to deadly/potentially deadly means; Supervisory neglect	Apparently accidental; Potentially preventable
NF-063-20-NC	Overdose/ ingestion; Neglect	Criminal history (caregiver); MAT involvement; Supervisional neglect; Unsafe access to deadly means; Other; Environmental neglect	COVID 19 restrictions - interviews and access to treatment was virtual.	Neglect due to unsafe access to deadly/potentially deadly means; Supervisory neglect; Neglect (general - can include leaving child with unsafe caregiver)	Apparently accidental; Potentially preventable
NF-064-20-NC	Abusive head trauma	Language/cultural issues		No abuse or neglect	Manner undetermined/foul play not ruled out
NF-065-20-C	Neglect; Fail-ure to thrive/ malnutrition	DCBS history; DCBS issues; Bystander issues/ opportunities; Cognitive disability (child); Cognitive disability (caregiver); Failure to thrive; Financial issues; Lack of regular child care; Medical neglect; Mental health issues (caregiver); Medically fragile child; Overwhelmed Caregiver; Other; In-Home Service Provider Issues	Incident occurred during COVID 19 restrictions - ongoing visits with DCBS and other provider after the incident were virtual. Post incident FPP services were also virtual.	Neglect (general - can include leaving child with unsafe caregiver); Neglect (medical)	Potentially preventable

Case Number	Categorization	Family Characteristics	Family Characteristics Comments	Panel Determination	Other Qualifiers
NF-066-20-C	Neglect; Overdose/ ingestion	Bystander issues/ opportunities; Criminal history (caregiver); Criminal history (in the home); DCBS history; Environmental neglect; Impaired caregiver; Lack of treatment (mental health or substance abuse); Law enforcement issues; Neglectful entrustment; Statutory Issues; Substance abuse (in home); Substance abuse by caregiver (current); Substitute caregiver at time of event ; Supervisional neglect; Unsafe access to deadly means		Neglect (impaired caregiver); Neglect (general - can include leaving child with unsafe caregiver); Neglect due to unsafe access to deadly/ potentially deadly means; Supervisory neglect	Apparently accidental; Potentially preventable
NF-067-20-C	Neglect; Overdose/ ingestion	DCBS history; Environmental neglect; Financial issues; MAT involvement; Supervisional neglect; Unsafe access to deadly means		Neglect (general - can include leaving child with unsafe caregiver); Neglect (unsafe sleep); Supervisory neglect	Apparently accidental; Potentially preventable
NF-068-20-C	Abusive head trauma; Neglect; Physical abuse	DCBS history; DCBS issues; Bystander issues/ opportunities; In-Home Service Provider Issues; Criminal history (caregiver); Criminal history (in the home); Domestic Violence; Financial issues; Housing instability; Lack of family support system ; Lack of regular child care; Lack of Sleep Plan; Lack of treatment (mental health or substance abuse); Mental health issues (caregiver); Neglectful entrustment; Overwhelmed Caregiver; Substance abuse (in home); Substance abuse by caregiver (current); Unsafe sleep (cosleeping on a non-bed surface); Unsafe sleep (bed sharing); Unsafe sleep (other); Failure to thrive		Abusive head trauma; Neglect (general - can include leaving child with unsafe caregiver); Physical abuse; Neglect (unsafe sleep); Torture	Potentially preventable

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Case Number	Categorization	Family Characteristics	Family Characteristics Comments	Panel Determination	Other Qualifiers
NF-069-20-NC	Abusive head trauma; Physical abuse; Neglect	Bystander issues/ opportunities; DCBS issues; Family violence; Financial issues; Housing instability; Lack of regular child care; Lack of Sleep Plan; Lack of treatment (mental health or substance abuse); Mental health issues (caregiver); Neglectful entrustment; Other; Overwhelmed Caregiver	Although the incident occurred prior to COVID, some court hearings were post-poned and contacts made virtually due to COVID restrictions. Also lack of transportation.	Abusive head trauma; Neglect (general - can include leaving child with unsafe caregiver); Physical abuse	Potentially preventable
NF-070-20-C	Neglect; Overdose/ ingestion	DCBS history; DCBS issues; Environmental neglect; Family violence; Financial issues; Housing instability; Lack of treatment (mental health or substance abuse); Law enforcement issues; Mental health issues (caregiver); Statutory Issues; Substance abuse (in home); Substance abuse by caregiver (current); Supervisional neglect; Unsafe access to deadly means		Neglect (general - can include leaving child with unsafe caregiver); Supervisory neglect; Neglect due to unsafe access to deadly/potentially deadly means	Apparently accidental; Potentially preventable
NF-071-20-C	Blunt force trauma - not inflicted (farm machinery, ATV, fall); Neglect	Financial issues; Mental health issues (caregiver); Supervisional neglect; Unsafe access to deadly means		Neglect due to unsafe access to deadly/potentially deadly means; Supervisory neglect	Apparently accidental; Potentially preventable
NF-072-20-C	Neglect; Overdose/ ingestion	DCBS history; DCBS issues; Environmental neglect; MAT involvement; Medically fragile child; Mental health issues (caregiver); Supervisional neglect; Unsafe access to deadly means		Neglect (general - can include leaving child with unsafe caregiver); Supervisory neglect; Neglect due to unsafe access to deadly/potentially deadly means	Apparently accidental; Potentially preventable
NF-073-20-C	Blunt force trauma - not inflicted MVC; Neglect	Bystander issues/ opportunities; Criminal history (caregiver); Criminal history (in the home); DCBS history; Financial issues; Housing instability; Impaired caregiver; Mental health issues (caregiver); Other; Substance abuse (in home); Substance abuse by caregiver (current)	COVID restrictions were implemented within two months of the incident, resulting in significant delays in DNA hearings, inability to refer to childcare, virtual home visits, etc.	Neglect (impaired caregiver)	Apparently accidental; Potentially preventable

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Case Number	Categorization	Family Characteristics	Family Characteristics Comments	Panel Determination	Other Qualifiers
NF-074-20-C	Blunt force trauma - not inflicted MVC; Neglect	Bystander issues/ opportunities; Criminal history (caregiver); Criminal history (in the home); DCBS history; Financial issues; Housing instability; Impaired caregiver; Mental health issues (caregiver); Other; Substance abuse (in home); Substance abuse by caregiver (current)	COVID restrictions were implemented within two months of the incident, resulting in significant delays in DNA hearings, inability to refer to childcare, virtual home visits, etc.	Neglect (impaired caregiver)	Apparently accidental; Potentially preventable
NF-075-20-C	Blunt force trauma - not inflicted MVC; Neglect	Bystander issues/ opportunities; Criminal history (in the home); DCBS history; Financial issues; Housing instability; Impaired caregiver; Mental health issues (caregiver); Other; Substance abuse by caregiver (current); Substance abuse (in home); Criminal history (caregiver)	COVID restrictions were implemented within two months of the incident, resulting in significant delays in DNA hearings, inability to refer to childcare, virtual home visits, etc.	Neglect (impaired caregiver)	Apparently accidental; Potentially preventable
NF-076-20-NC	Abusive head trauma	Mental health issues (caregiver)		Abusive head trauma	Potentially preventable
NF-077-20-C	Neglect	Cognitive disability (child); DCBS history; Domestic Violence; Financial issues; Housing instability; Lack of family support system ; Lack of treatment (mental health or substance abuse); Medical neglect; Medically fragile child; Mental health issues (caregiver); Mental health issues (child); Overwhelmed Caregiver		Neglect (medical)	Apparently accidental; Potentially preventable
NF-078-20-C	Neglect	Bystander issues/ opportunities; DCBS history; DCBS issues; Education/child care issues; Financial issues; Medical issues/ management; Medically fragile child; Mental health issues (caregiver); Mental health issues (child); Other; Overwhelmed Caregiver; Cognitive disability (caregiver); Medical neglect	COVID restrictions went in place after the event resulting in virtual contacts and court hearings.	Other	Apparently accidental; Potentially preventable

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Case Number	Categorization	Family Characteristics	Family Characteristics Comments	Panel Determination	Other Qualifiers
NF-079-20-C	Overdose/ ingestion; Sexual abuse/ human trafficking	Bystander issues/ opportunities; Criminal history (caregiver); Criminal history (in the home); DCBS history; DCBS issues; Domestic Violence; Family violence; Lack of treatment (mental health or substance abuse); Mental health issues (caregiver); Mental health issues (child)		Sexual abuse; Other; Neglect (general - can include leaving child with unsafe caregiver)	Potentially preventable
NF-080-20-C	Neglect; Drowning/near-drowning	Cognitive disability (caregiver); DCBS history; Mental health issues (caregiver); Lack of treatment (mental health or substance abuse); Substitute caregiver at time of event ; Supervisional neglect; Unsafe access to deadly means; Lack of regular child care		Neglect due to unsafe access to deadly/potentially deadly means; Supervisory neglect; Neglect (general - can include leaving child with unsafe caregiver)	Apparently accidental; Potentially preventable
NF-081-20-C	Overdose/ ingestion; Neglect	Environmental neglect; Financial issues; MAT involvement; Mental health issues (caregiver); Other; Supervisional neglect; Unsafe access to deadly means	Lack of transportation and investigation completed after COVID restrictions in place – resulting in virtual contacts.	Neglect (general - can include leaving child with unsafe caregiver); Neglect due to unsafe access to deadly/ potentially deadly means; Supervisory neglect	Apparently accidental; Potentially preventable
NF-082-20-NC	Neglect	DCBS issues; Cognitive disability (child); Domestic Violence; Financial issues; Housing instability; Lack of regular child care; Medical issues/ management; Medical neglect; Medically fragile child; Other; Out of State CPS History; Overwhelmed Caregiver	The incident occurred prior to COVID restrictions, but medical appointments and visits were made/ attempted under protocol.	Neglect (medical)	Potentially preventable

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Case Number	Categorization	Family Characteristics	Family Characteristics Comments	Panel Determination	Other Qualifiers
NF-083-20-C	Abusive head trauma; Physical abuse	Criminal history (caregiver); Criminal history (in the home); DCBS history; Domestic Violence; Financial issues; Housing instability; Lack of Sleep Plan; Lack of treatment (mental health or substance abuse); Mental health issues (caregiver); Other; Overwhelmed Caregiver; Substance abuse (in home); Substance abuse by caregiver (current); Substitute caregiver at time of event	The incident occurred just prior to COVID Restrictions. Some contacts were made virtually, delays in pursuing criminal charges.	Abusive head trauma; Physical abuse	Potentially preventable
NF-084-20-NC	Neglect; Overdose/ ingestion	Environmental neglect; Financial issues; Lack of treatment (mental health or substance abuse); Mental health issues (caregiver); Other; Substance abuse (in home); Substance abuse by caregiver (current); Supervisional neglect; Unsafe access to deadly means	The incident occurred prior to COVID restrictions, but follow up services were impacted – resulting in virtual contact and delays with FPP services, court hearings, school, etc.	Neglect (general - can include leaving child with unsafe caregiver); Neglect due to unsafe access to deadly/potentially deadly means; Supervisory neglect	Apparently accidental; Potentially preventable
NF-085-20-NC	Overdose/ ingestion	Criminal history (caregiver); Environmental neglect; Mental health issues (caregiver); Supervisional neglect; Unsafe access to deadly means		Neglect due to unsafe access to deadly/potentially deadly means; Supervisory neglect	Apparently accidental; Potentially preventable
NF-086-20-C	Neglect; Overdose/ ingestion	DCBS history; DCBS issues; Domestic Violence; Environmental neglect; Financial issues; Housing instability; Lack of family support system ; Lack of treatment (mental health or substance abuse); MAT involvement; Bystander issues/ opportunities; Mental health issues (caregiver); Other; Substance abuse by caregiver (current); Substance abuse (in home); Supervisional neglect; Unsafe access to deadly means	Event occurred during COVID restrictions, resulting in virtual/ delayed meetings/ services, delays in court hearings, complicating already contentious visitation arrangements in the relative placement, father working extra hours, etc.	Neglect (general - can include leaving child with unsafe caregiver); Neglect due to unsafe access to deadly/potentially deadly means; Supervisory neglect	Apparently accidental; Potentially preventable

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Case Number	Categorization	Family Characteristics	Family Characteristics Comments	Panel Determination	Other Qualifiers
NF-087-20-C	Neglect; Physical abuse; Gunshot (homicide)	Other; Bystander issues/ opportunities; Criminal history (caregiver); Criminal history (in the home); DCBS history; DCBS issues; Environmental neglect; Impaired caregiver; Mental health issues (caregiver); Mental health issues (child); Lack of treatment (mental health or substance abuse); Medical neglect; Substance abuse (in home); Substance abuse by caregiver (current); Substitute caregiver at time of event ; Neglectful entrustment; Supervisional neglect	Incident occurred during COVID restrictions resulting in virtual mental health services for the index child, school attendance, court hearings, visitation, home visits, etc.	Neglect (general - can include leaving child with unsafe caregiver); Neglect (impaired caregiver); Physical abuse; Supervisory neglect	Potentially preventable
NF-088-20-NC	Neglect; Failure to thrive/ malnutrition	Cognitive disability (child); Failure to thrive; Financial issues; Medically fragile child; Overwhelmed Caregiver		No abuse or neglect	
NF-089-20-NC	Gunshot (accidental); Neglect	DCBS history; Environmental neglect; Financial issues; Supervisional neglect; Unsafe access to deadly means		Neglect (general - can include leaving child with unsafe caregiver); Supervisory neglect; Neglect due to unsafe access to deadly/potentially deadly means	Apparently accidental; Potentially preventable
NF-090-20-C	Overdose/ ingestion; Neglect	Criminal history (caregiver); Criminal history (in the home); DCBS history; Environmental neglect; Impaired caregiver; In-Home Service Provider Issues; Lack of treatment (mental health or substance abuse); Law enforcement issues; MAT involvement; Mental health issues (child); Other; Substance abuse (child); Substance abuse (in home); Substance abuse by caregiver (current); Substitute caregiver at time of event ; Supervisional neglect; Statutory Issues; Unsafe access to deadly means	The incident occurred while COVID restrictions were in place – the decision was made not to interview the individuals in the home where the incident occurred due to COVID risk.	Neglect (impaired caregiver); Supervisory neglect; Neglect due to unsafe access to deadly/potentially deadly means	Potentially preventable

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Case Number	Categorization	Family Characteristics	Family Characteristics Comments	Panel Determination	Other Qualifiers
NF-091-20-C	Abusive head trauma	DCBS history; Law enforcement issues; Mental health issues (caregiver); Substance abuse (in home); Substance abuse by caregiver (current); Financial issues; Other	Incident occurred during COVID restrictions – DCBS made visit within protocol, some services were limited to virtual contact, school for older children was virtual.	Abusive head trauma	Potentially preventable
NF-092-20-C	Overdose/ ingestion; Neglect	Environmental neglect; Financial issues; Lack of treatment (mental health or substance abuse); Overwhelmed Caregiver; Substance abuse (in home); Substance abuse by caregiver (current); Supervisional neglect; Unsafe access to deadly means; Other	COVID restrictions were in place when incident occurred, some contacts were made virtually.	Neglect (general - can include leaving child with unsafe caregiver); Neglect due to unsafe access to deadly/potentially deadly means; Supervisory neglect	Apparently accidental; Potentially preventable
NF-093-20-C	Neglect; Gunshot (homicide)	DCBS history; DCBS issues; Cognitive disability (caregiver); Coroner issues; Criminal history (in the home); Education/child care issues; Financial issues; Housing instability; Other; Overwhelmed Caregiver	Incident occurred during COVID restrictions resulting in some use of virtual contacts.	Other	Manner undetermined/foul play not ruled out
NF-094-20-NC	Neglect; Overdose/ ingestion	Environmental neglect; Mental health issues (caregiver); Substance abuse (in home); Supervisional neglect; Unsafe access to deadly means; Other	COVID restrictions directly affected family and the DCBS investigation. Mom's work hours had been cut at work and daycare services closed.	Neglect due to unsafe access to deadly/potentially deadly means; Supervisory neglect	Apparently accidental; Potentially preventable
NF-095-20-C	Overdose/ ingestion; Physical abuse	Cognitive disability (caregiver); Criminal history (caregiver); Criminal history (in the home); DCBS history; Domestic Violence; Environmental neglect; Family violence; Impaired caregiver; Substance abuse (in home); Substance abuse by caregiver (current); Substitute caregiver at time of event ; Supervisional neglect; Unsafe access to deadly means		Neglect (general - can include leaving child with unsafe caregiver); Neglect due to unsafe access to deadly/potentially deadly means; Physical abuse; Supervisory neglect	Potentially preventable

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Case Number	Categorization	Family Characteristics	Family Characteristics Comments	Panel Determination	Other Qualifiers
NF-096-20-NC	Neglect; Overdose/ ingestion	Lack of treatment (mental health or substance abuse); Mental health issues (caregiver); Other; Unsafe access to deadly means; Substance abuse (in home); Substance abuse by caregiver (current); Environmental neglect; MAT involvement; Supervisional neglect	The incident occurred during COVID restrictions resulting in virtual contacts and services.	Neglect due to unsafe access to deadly/ potentially deadly means; Neglect (general - can include leaving child with unsafe caregiver); Supervisory neglect	Apparently accidental; Potentially preventable
NF-097-20-NC	Blunt force trauma - not inflicted (farm machinery, ATV, fall)	Other	Incident occurred during COVID restrictions, resulting in some video visits by DCBS.	No abuse or neglect	Apparently accidental
NF-098-20-C	Neglect; Blunt force trauma - not inflicted (farm machinery, ATV, fall)	DCBS history; DCBS issues; In-Home Service Provider Issues; Lack of regular child care; MAT involvement; Mental health issues (child); Supervisional neglect; Unsafe access to deadly means; Substitute caregiver at time of event ; Other	Incident occurred during COVID restrictions, some contacts virtual.	Neglect due to unsafe access to deadly/potentially deadly means; Supervisory neglect	Apparently accidental; Potentially preventable
NF-099-20-C	Blunt force trauma - not inflicted MVC; Neglect	Criminal history (caregiver); Criminal history (in the home); DCBS history; DCBS issues; Domestic Violence; Financial issues; Impaired caregiver; Mental health issues (child); Other; Substance abuse (in home); Substance abuse by caregiver (current); Education/child care issues	Incident occurred during COVID restrictions – the index child was attending school virtually.	Neglect (impaired caregiver)	Apparently accidental; Potentially preventable
NF-100-20-C	Neglect; Overdose/ ingestion	Criminal history (caregiver); Criminal history (in the home); DCBS history; DCBS issues; Environmental neglect; Financial issues; Mental health issues (caregiver); Other; Overwhelmed Caregiver; Substance abuse (in home); Substance abuse by caregiver (current); Substitute caregiver at time of event ; Supervisional neglect; Unsafe access to deadly means; Law enforcement issues	Incident occurred during COVID 19 restrictions - some virtual contacts made.	Supervisory neglect; Neglect due to unsafe access to deadly/ potentially deadly means; Neglect (general - can include leaving child with unsafe caregiver)	Potentially preventable; Manner undetermined/foul play not ruled out

CASE REVIEWS FOR FISCAL YEAR 2020

Case Number	Categorization	Family Characteristics	Family Characteristics Comments	Panel Determination	Other Qualifiers
NF-101-20-NC	Neglect; Overdose/ ingestion	DCBS issues; Environmental neglect; Financial issues; Medical issues/ management; Other; Substance abuse (in home); Substance abuse by caregiver (current)	Incident occurred during COVID restrictions – CPS report was initiated via FaceTime and all subsequent contacts were virtual, mother was unemployed due to day care closures, etc.	Neglect (general - can include leaving child with unsafe caregiver)	Apparently accidental; Potentially preventable
NF-102-20-C	Neglect; Failure to thrive/ malnutrition	Criminal history (caregiver); DCBS history; DCBS issues; Criminal history (in the home); Failure to thrive; Financial issues; Housing instability; Lack of treatment (mental health or substance abuse); Medical issues/ management; Medical neglect; Mental health issues (caregiver); Other; Overwhelmed Caregiver; Perinatal depression (caregiver); Substance abuse (in home); Substance abuse by caregiver (current); Evidence of poor bonding	Other- (overwhelmed parent, and, the incident occurred during COVID restrictions: DCBS conducted screens and completed face to face contacts as well as virtual contacts, the TRH was virtual and next hearing in person.)	Neglect (general - can include leaving child with unsafe caregiver); Neglect (medical)	Potentially preventable
NF-103-20-C					
NF-104-20-C	Blunt force trauma - not inflicted MVC; Neglect	DCBS history; DCBS issues; Domestic Violence; Financial issues; Housing instability; Inadequate restraint; Mental health issues (caregiver); Supervisional neglect; Unsafe access to deadly means; Other	Incident occurred during COVID restrictions - virtual visits were conducted.	Neglect (inadequate/ absent child restraint in motor vehicle); Neglect due to unsafe access to deadly/potentially deadly means; Supervisory neglect	Apparently accidental; Potentially preventable

Case Number	Categorization	Family Characteristics	Family Characteristics Comments	Panel Determination	Other Qualifiers
NF-105-20-C	Overdose/ ingestion; Neglect	Criminal history (caregiver); Criminal history (in the home); DCBS history; DCBS issues; Bystander issues/ opportunities; Domestic Violence; Environmental neglect; Financial issues; Housing instability; Lack of treatment (mental health or substance abuse); Medical issues/ management; Medical neglect; Statutory Issues; Substance abuse (in home); Substance abuse by caregiver (current); Other; Supervisional neglect; Unsafe access to deadly means	Incident occurred during COVID restrictions resulting in use of virtual communication with family and partners.	Neglect (general - can include leaving child with unsafe caregiver); Neglect (medical); Neglect due to unsafe access to deadly/potentially deadly means; Supervisory neglect	Apparently accidental; Potentially preventable
NF-106-20-C	Blunt force trauma - not inflicted (farm machinery, ATV, fall); Neglect	Criminal history (caregiver); Criminal history (in the home); DCBS history; Family violence; Impaired caregiver; Lack of treatment (mental health or substance abuse); Mental health issues (caregiver); Other; Substance abuse (in home); Substance abuse by caregiver (current); Inadequate restraint	Incident occurred during COVID restrictions – virtual visits.	Neglect (impaired caregiver); Neglect (inadequate/absent child restraint in motor vehicle)	Apparently accidental; Potentially preventable
NF-107-20-C	Blunt force trauma - not inflicted MVC; Neglect	Inadequate restraint; Law enforcement issues; MAT involvement; Other	The incident occurred while COVID restrictions were in place, limiting availability of UDS at the MAT office and face to face sessions.	Neglect (inadequate/absent child restraint in motor vehicle)	Apparently accidental; Potentially preventable
NF-108-20-C	Blunt force trauma - not inflicted MVC; Neglect	Inadequate restraint; Law enforcement issues; MAT involvement; Other	The incident occurred while COVID restrictions were in place, limiting availability of UDS at the MAT office and face to face sessions.	Neglect (inadequate/absent child restraint in motor vehicle)	Apparently accidental; Potentially preventable

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Case Number	Categorization	Family Characteristics	Family Characteristics Comments	Panel Determination	Other Qualifiers
NF-109-20-C	Neglect; Physical abuse	DCBS history; DCBS issues; Financial issues; Medical issues/ management; Other	Incident occurred in COVID restrictions - some virtual visits.	Neglect (medical); Physical abuse	
NF-110-20-C	Neglect; Overdose/ ingestion	DCBS history; DCBS issues; Bystander issues/ opportunities; Cognitive disability (caregiver); Criminal history (caregiver); Criminal history (in the home); Domestic Violence; Environmental neglect; Financial issues; Housing instability; Lack of treatment (mental health or substance abuse); MAT involvement; Mental health issues (caregiver); Other; Substance abuse (in home); Substance abuse by caregiver (current); Supervisional neglect; Unsafe access to deadly means	Incident occurred during COVID restrictions- some DCBS contacts virtual, virtual court, FPP, and other services.	Neglect (general - can include leaving child with unsafe caregiver); Neglect due to unsafe access to deadly/potentially deadly means; Supervisory neglect	Apparently accidental; Potentially preventable
NF-111-20-C	Burn; Neglect	DCBS issues; DCBS history; Criminal history (caregiver); Environmental neglect; Financial issues; Housing instability; Lack of treatment (mental health or substance abuse); Mental health issues (caregiver); Neglectful entrustment; Other; Out of State CPS History; Substance abuse (in home); Substance abuse by caregiver (current); Supervisional neglect; Substitute caregiver at time of event ; Unsafe access to deadly means; Statutory Issues; Criminal history (in the home)	COVID restrictions were in place prior to the incident, school based counseling for the index child had stops, and contact was made within COVID protocol.	Neglect (general - can include leaving child with unsafe caregiver); Supervisory neglect; Neglect due to unsafe access to deadly/potentially deadly means	Apparently accidental; Potentially preventable

Case Number	Categorization	Family Characteristics	Family Characteristics Comments	Panel Determination	Other Qualifiers
NF-112-20-C	Drowning/near-drowning; Neglect	Other; Bystander issues/ opportunities; Criminal history (caregiver); Criminal history (in the home); DCBS history; DCBS issues; Domestic Violence; Family violence; Financial issues; MAT involvement; Medical issues/management; Mental health issues (caregiver); Serial relationships; Statutory Issues; Substance abuse (in home); Substance abuse by caregiver (current); Supervisional neglect; Unsafe access to deadly means	Incident occurred during COVID restrictions. Communication and home visits occurred virtually and some referral services delayed.	Neglect due to unsafe access to deadly/potentially deadly means; Supervisory neglect	Apparently accidental; Potentially preventable
NF-113-20-NC	SUDI/near-SUDI/apparent life-threatening event; Neglect	Financial issues; Unsafe sleep (other); Other	The incident occurred during COVID restrictions leading to virtual home visits.	Neglect (unsafe sleep)	Apparently accidental; Potentially preventable
NF-114-20-C	Neglect; Overdose/ ingestion	DCBS history; Environmental neglect; Financial issues; Housing instability; Lack of treatment (mental health or substance abuse); Mental health issues (caregiver); Overwhelmed Caregiver; Supervisional neglect; Unsafe access to deadly means		Neglect (general - can include leaving child with unsafe caregiver); Neglect due to unsafe access to deadly/ potentially deadly means; Supervisory neglect	Potentially preventable; Apparently accidental
NF-115-20-C	Abusive head trauma; Physical abuse	Commonwealth/County Attorneys; Domestic Violence; Impaired caregiver; Medical issues/management; Mental health issues (caregiver); Other; Substance abuse (in home); Substance abuse by caregiver (current); Substitute caregiver at time of event	COVID restrictions affected investigation/ communication.	Physical abuse; Abusive head trauma; Sexual abuse	Potentially preventable

Case Number	Categorization	Family Characteristics	Family Characteristics Comments	Panel Determination	Other Qualifiers
NF-116-20-C	Natural causes/ medical diagnosis; Neglect	Bystander issues/ opportunities; Cognitive disability (caregiver); Cognitive disability (child); DCBS history; DCBS issues; Domestic Violence; Education/ child care issues; Environmental neglect; Family violence; Financial issues; Housing instability; Lack of treatment (mental health or substance abuse); Medical neglect; Mental health issues (caregiver); Mental health issues (child); Other; Overwhelmed Caregiver; Serial relationships; Substance abuse (in home); Supervisional neglect	COVID restrictions	Other	Apparently accidental; Potentially preventable
NF-117-20-C	Abusive head trauma; Physical abuse	Other; Criminal history (caregiver); Criminal history (in the home); DCBS history; DCBS issues; Domestic Violence; Evidence of poor bonding; Family violence; Financial issues; Housing instability; Lack of treatment (mental health or substance abuse); Law enforcement issues; Medical issues/ management; Medical neglect; Mental health issues (caregiver); Overwhelmed Caregiver; Perinatal depression (caregiver); Serial relationships; Substance abuse (in home); Substance abuse by caregiver (current)	Incident occurred during COVID and impacted case by necessitation many "virtual" contacts.	Abusive head trauma; Physical abuse; Torture	Potentially preventable

CASE REVIEWS FOR FISCAL YEAR 2019

Case Number	Categorization	Family Characteristics	Family Characteristics Comments	Panel Determination	Other Qualifiers
NF-118-20-C	Blunt force trauma - not inflicted MVC; Neglect	DCBS history; DCBS issues; Criminal history (caregiver); Criminal history (in the home); Domestic Violence; Financial issues; Housing instability; Impaired caregiver; Inadequate restraint; Lack of regular child care; Lack of treatment (mental health or substance abuse); Medical issues/management; Other; Substance abuse (in home); Substance abuse by caregiver (current); Supervisional neglect; Neglectful entrustment; Lack of Sleep Plan; Statutory Issues	Incident occur during COVID restrictions- visits were sometimes virtual.	Neglect (impaired caregiver); Neglect (inadequate/absent child restraint in motor vehicle); Neglect (general - can include leaving child with unsafe caregiver); Supervisory neglect	Apparently accidental; Potentially preventable
NF-119-20-NC	Neglect; Overdose/ ingestion	Criminal history (caregiver); Criminal history (in the home); Environmental neglect; Other; Perinatal depression (caregiver); Substance abuse (in home); Substance abuse by caregiver (current); Supervisional neglect; Unsafe access to deadly means; Mental health issues (caregiver)	COVID restrictions were in place during time of incident, limiting support for family and virtual home visits by DCBS.	Neglect due to unsafe access to deadly/potentially deadly means; Neglect (general - can include leaving child with unsafe caregiver); Supervisory neglect	Apparently accidental; Potentially preventable
NF-120-20-C	Blunt force trauma - not inflicted MVC; Neglect	Criminal history (caregiver); Criminal history (in the home); DCBS history; DCBS issues; Domestic Violence; Financial issues; Housing instability; Impaired caregiver; Inadequate restraint; Lack of regular child care; Lack of Sleep Plan; Lack of treatment (mental health or substance abuse); Neglectful entrustment; Other; Substance abuse (in home); Substance abuse by caregiver (current); Supervisional neglect	Incident occurred during COVID restrictions - some visits virtual.	Neglect (impaired caregiver); Neglect (general - can include leaving child with unsafe caregiver); Neglect (inadequate/absent child restraint in motor vehicle); Supervisory neglect	Apparently accidental; Potentially preventable

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