# 2015 Annual Report

# Child Fatality and Near Fatality External Review Panel

## EXECUTIVE SUMMARY

The Child Fatality and Near Fatality External Review Panel was created and established by Kentucky Revised Statutes 620.055 for the purpose of conducting comprehensive reviews of child fatalities and near fatalities suspected to be the result of abuse or neglect. The Panel is a twenty member multidisciplinary team of professionals including representatives from the medical, social services, mental health, legal, and law enforcement communities, as well as others who work with and on behalf of Kentucky's children. The Panel reviews official records and other relevant information received from a variety of sources: the Cabinet for Health and Family Services, the Department for Juvenile Justice, medical records including autopsy reports, law enforcement records and records held by any Family, Circuit or District Court. The purpose of these reviews is to become aware of systemic deficits and to make recommendations for improvements to help prevent child fatalities and near fatalities due to abuse and neglect.

This annual report is required 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 Health and Welfare Committee and the Judiciary Committee by December 1st of each year.

Throughout this year, the Panel met six times and reviewed cases from fiscal year 2014 (July 1, 2013 through June 30, 2014). The Panel reviewed 77 cases comprised of 31 fatalities and 47 near fatalities. Data was collected and summarized on 81 children by contracted case analysts and Justice Cabinet staff to expedite Panel discussion.

In addition to the recommendations for 2015, this report also provides an update of the progress made on the 2014 Panel recommendations.

Ultimately, it is only through an informed and engaged citizenry that the goals of systems improvement and prevention will be achieved. Therefore, Panel members encourage all interested citizens to read this report and to visit the Justice and Public Safety Cabinet's website (http://justice.ky.gov/Pages/Reports.aspx) to read the minutes from the Panel's meetings for a greater understanding of its work.

## 2015 RECOMMENDATIONS

The following 2015 Recommendations were developed after a review of the cases and thorough discussion from the Panel:

- The General Assembly should implement legislation allowing dependency, neglect, and abuse court proceedings to be opened to the public for the purposes of transparency, accountability, and systems improvement.
- The General Assembly should pass legislation requiring hospitals and birthing centers to provide prevention of Abusive Head Trauma training and Safe Sleep information to parents prior to an infant's discharge.
- Drug court participants, youth who are involved with the Court Designated Worker Program, and any person who is a party to any family court proceeding should be required to receive education on prevention of Abusive Head Trauma and Safe Sleep.
- As required by KRS 72.410(3)(a), coroners should make timely notifications to and gather necessary information from law enforcement, the Department for Community Based Services and the local health department upon notification of the death of a child under 18 years of age.
- Permit/require Multidisciplinary Teams on Child Sexual Abuse, established by KRS 431.600 and 620.040, to also review physical abuse cases.
- Law enforcement should actively enhance enforcement of the provisions of KRS 189.125 which require infants and children to be properly secured in child restraint systems and booster seats during transport in a motor vehicle.
- Department for Community Based Services (DCBS) should likewise consider inadequate restraint as an important indicator of neglect in an impaired driving incident or collision involving children, and include and weigh that information in their investigation and substantiation process.
- Ensure the Department for Community Based Services internal review process of child fatality or near fatality as mandated in KRS 620.050(12) is conducted in a manner consistent with the statute and it is part of a quality improvement process to address critical incidents within the child protection system. The review should include an examination of case best practice, policy compliance, staff training and experience, and a caseload analysis.
- The Department for Community Based Services should implement quality improvement practices to increase the timely completion of fatal and near fatal investigations. The annual report of child maltreatment fatalities and near fatalities that the DCBS produces should specifically identify the number of incomplete investigations at the time of release of the report so the public is aware of these preliminary figures and that they may increase significantly.
- The Department for Community Based Services should provide to the Panel information regarding the caseload, training, and experience levels on staff serving families in which a fatal or near fatal incident has occurred.

## 2015 IN REVIEW

The Panel has made a concerted effort to follow and document action related to the recommendations included in its 2014 Annual Report. A spreadsheet outlining those recommendations was created and individual recommendations were assigned to various Panel members to monitor and report progress. A summary of the progress of each recommendation begins on page nine of this report.

The biennial budget appropriation of $420,000 for FY 2014 and 2015 was largely used for personnel including Justice Cabinet staff, forensic medical case analysts and data analysts. Not all of the personnel were in place at the beginning of the availability of the funds and consequently approximately $250,000 was utilized. For the current fiscal year more contract personnel are anticipated to be used and for the entire budget period creating a more accurate expense picture.

The data collection tool created by a subcommittee of Panel members last year has been progressively enhanced through the year with the third version also available in electronic format and uploaded onto the SharePoint website.

A data analyst was consulted and concluded SharePoint was meeting the needs of the Panel as far as data collection was concerned. It was determined SharePoint is sufficient for exchanging case information securely, but it is not an adequate platform for data storage. Further, the Panel has determined the need to recruit a data expert to monitor collection and storage processes and assist with timely data analysis.

The Panel received 105 FY 2014 case records and one case from FY 2013 from the Department of Community Based Services (DCBS). All information was unredacted and was uploaded to the SharePoint website by DCBS. Approximately twenty (20) cases (four to five per group) per meeting were assigned for discussion to the four groups of Panel review members. Time constraints, criminal court circumstances, or requests for additional documentation sometimes tabled case reviews until subsequent meetings. Seventy-nine (79) cases were discussed at the scheduled Panel meetings this year with an additional two having been reviewed by the contracted analysts and Justice Cabinet staff.

Per statute, the Legislative Program Review and Investigations Committee conducts an annual evaluation of the Panel. That evaluation is currently on-going for 2015 with a tentative presentation date of December 10, 2015.

The Panel experienced a smooth transition at the end of the fiscal year as the statutorily required staggered terms of service necessitated replacement of some members. The Panel has also experienced some attrition as members have resigned or retired. By statute, many of the positions on the Panel require the member to be actively employed in a particular profession or with a specific organization or agency. The appointing agencies have been timely in supplying nominees for the vacant positions and naming individuals to serve.

## CASE REVIEW PROCESS

This year, due to the sheer volume of the cases – many of them with over a thousand of pages of records – the Panel contracted for the services of case analysts to review the records, create written summaries and timelines, and present the cases to the Panel at the meetings. These analysts are registered nurses or social workers with training and experience in pediatrics, forensics, and/or child protective services. This has facilitated the review of more cases and better data collection with the development of an expanded data collection tool. Some eighty-one (81) cases were reviewed by the analysts and seventy-nine (79) of those were presented to the Panel for discussion at meetings.

The following pages include the results of data analysis conducted on seventy-seven (77) cases. Two (2) of the cases provided to and reviewed by the panel did not meet the criteria for inclusion in the data: after review of each case, the Panel determined that the injuries sustained did not rise to the level of near fatality, so the cases were excluded from the data analysis.

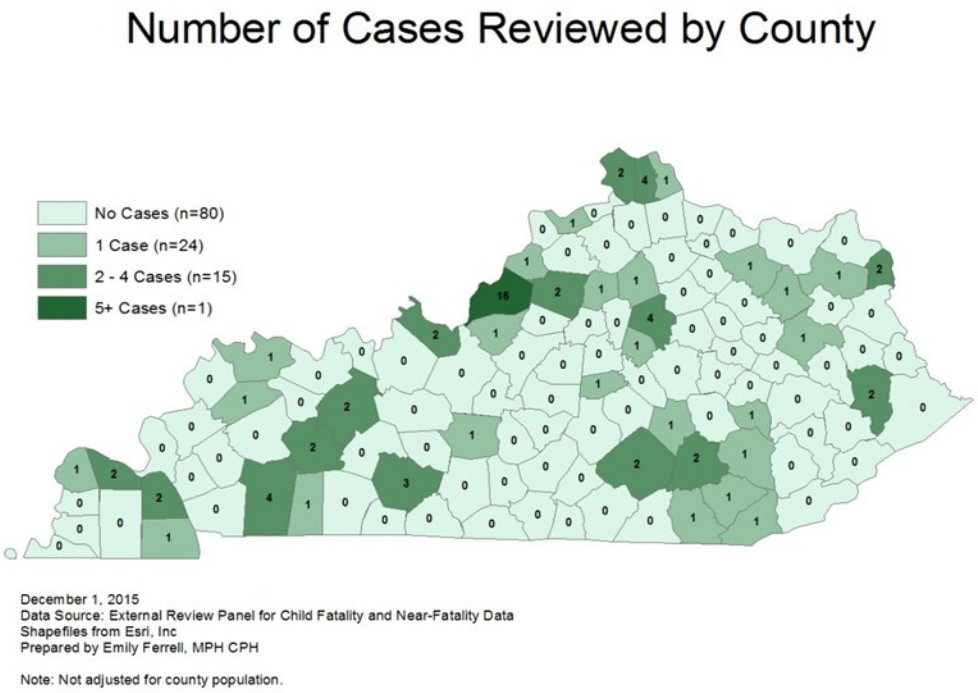
Data was input on an electronic data tool located on SharePoint, a cloud-based service that allows members of the panel to securely, easily and readily share documents. The data tool is where specific information about each individual case was input as a part of the case review process. Data from the 77 completed and reviewed cases were monitored and cleaned by staff throughout the data collection process. An Excel spreadsheet was used to maintain the data when securely pulled from SharePoint. Due to the nature of the data and the amount of completed and reviewed cases frequencies were run, using IBM SPSS Statistics 23, to obtain counts for individual variables. These variables included demographics, county, risk factors, categories, and panel determinations.

# DATA ANALYSIS

## METHODOLOGY

This report provides data elements relating to the child fatalities and near fatalities resulting from abuse and/or neglect for FY 2014. Included are the data variables county of incident, demographics, age of child victim, panel determinations and risk factors.

## COUNTY OF INCIDENT



## County of Cases (n=77) Reviewed by Child Fatality & Near Fatality External Review Panel for Fiscal Year 2014

| | Frequency | Percent |
|---|---|---|
| Ballard | 1 | 1.3 |
| Bell | 1 | 1.3 |
| Boone | 2 | 2.6 |
| Boyd | 2 | 2.6 |
| Boyle | 1 | 1.3 |
| Bullitt | 1 | 1.3 |
| Calloway | 1 | 1.3 |
| Campbell | 1 | 1.3 |
| Carroll | 1 | 1.3 |
| Carter | 1 | 1.3 |
| Christian | 4 | 5.2 |
| Clay | 1 | 1.3 |
| Fayette | 2 | 2.6 |
| Fleming | 1 | 1.3 |
| Floyd | 2 | 1.3 |
| Franklin | 1 | 1.3 |
| Hart | 1 | 1.3 |
| Henderson | 1 | 1.3 |
| Jefferson | 16 | 20.8 |
| Jessamine | 1 | 1.3 |
| Kenton | 4 | 5.2 |
| Knox | 1 | 1.3 |
| Laurel | 2 | 2.6 |
| Marshall | 2 | 2.6 |
| McCracken | 2 | 2.6 |
| Meade | 2 | 2.6 |
| Morgan | 1 | 1.3 |
| Muhlenberg | 2 | 2.6 |
| Ohio | 2 | 2.6 |
| Oldham | 1 | 1.3 |
| Owsley | 1 | 1.3 |
| Pulaski | 2 | 2.6 |
| Rockcastle | 1 | 1.3 |
| Rowan | 1 | 1.3 |
| Scott | 1 | 1.3 |
| Shelby | 2 | 2.6 |
| Todd | 1 | 1.3 |
| Warren | 3 | 3.9 |
| Webster | 1 | 1.3 |
| Whitley | 1 | 1.3 |
| Total | 77 | 100.0 |

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

## DEMOGRAPHICS

Race of Cases Reviewed by the Child Fatality and Near Fatality External Review Panel (n=77)
Fiscal Year 2014

| | Frequency | Percent |
|---|---|---|
| Black | 8 | 10.4 |
| White | 64 | 83.1 |
| Other | 5 | 6.5 |
| Total | 77 | 100.0 |

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

Gender of Cases Reviewed by the Child Fatality and Near Fatality External Review Panel (n=77)

Fiscal Year 2014

| | Frequency | Percent |
|---|---|---|
| Male | 52 | 67.5 |
| Female | 25 | 32.5 |
| Total | 77 | 100.0 |

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

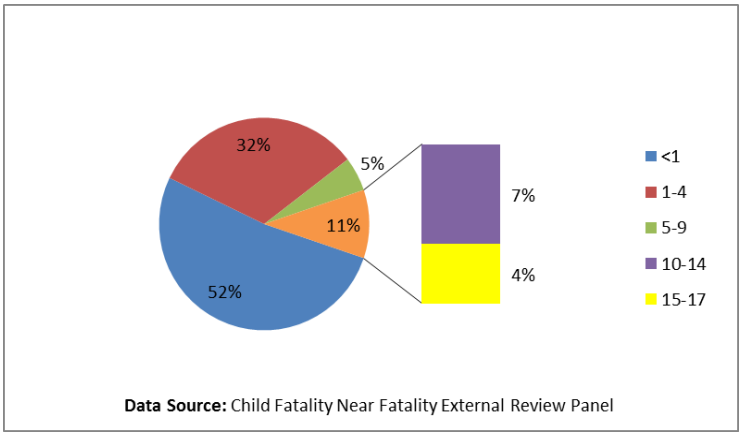
Ethnicity of Cases Reviewed by the Child Fatality and Near Fatality External Review Panel (n=77)
Fiscal Year 2014

| | Frequency | Percent |
|---|---|---|
| Hispanic | 4 | 5.2 |
| Non-Hispanic | 72 | 93.5 |
| Unknown | 1 | 1.3 |
| Total | 77 | 100.0 |

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

## AGE OF CHILD VICTIM

**Age in Years of All Cases Reviewed by the Child Fatality and Near Fatality Review Panel (n = 77)**
**Fiscal Year 2014**




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

| Age in Years | Frequency | Percent |
|---|---|---|
| <1 | 40 | 51.9 |
| 1-4 | 25 | 32.5 |
| 5-9 | 4 | 5.2 |
| 10-14 | 5 | 6.5 |
| 15-17 | 3 | 3.9 |
| Total | 77 | 100.0 |

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

## RISK FACTORS

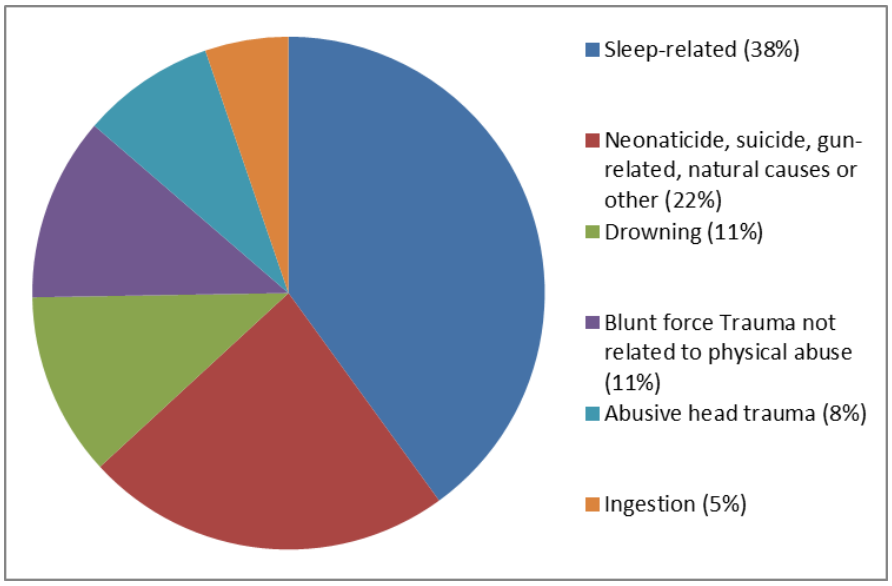
### Most Common Risk Factors Identified as Contributing to Fatality/Near Fatality Among Cases (n=77)

| Risk Factor | # Cases |
|---|---|
| Family Violence | 28 |
| Substance Abuse, Caregiver | 28 |
| Criminal History, Caregiver | 27 |
| Lack of Treatment – Mental Health or Substance Abuse | 27 |
| Mental Health Issues, Caregiver | 22 |
| Supervisional Neglect | 22 |
| Substance Abuse in Home | 21 |
| Impaired Caregiver | 20 |
| Substitute Caregiver at Time of Event | 17 |
| Unsafe Sleep (Bedsharing, Co-Sleeping/Non-Bed, Other) | 15 |
| Medical Neglect | 14 |

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

Other risk factors identified in cases include: Unsafe access to deadly means (9), Cognitive Disability, Child (5), Absence of Support System for Family (4), Cognitive Disability, Caregiver (4), Lack of Child Care (4), Mental Health Issues, Child (3)

## Panel Determinations for all Fatalities for Cases Reviewed (n = 37)




**Data Source:** Child Fatality and Near Fatality Review Panel FY 2014

## Final Categorization for Fatality Cases (N=37)+

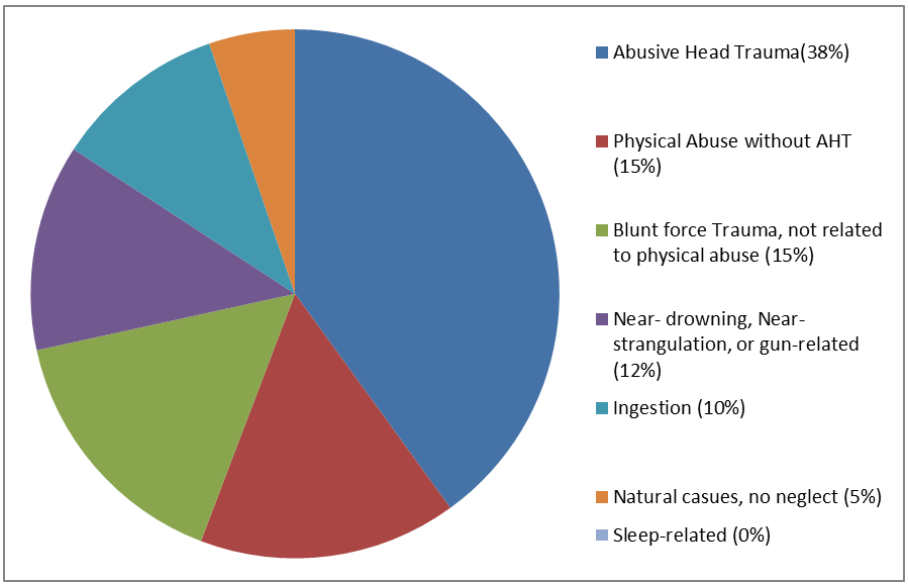
| Final Categorization | # cases | Percent |
|---|---|---|
| Sleep-related | 14 | 38 |
| Other* | 8 | 22 |
| Drowning | 4 | 11 |
| Blunt Force Trauma^ (unrelated to physical abuse) | 4 | 11 |
| AHT (with out without additional injury) | 3 | 8 |
| Physical Abuse (without AHT) | 2 | 5 |
| Ingestion | 2 | 5 |

+ 11/37 fatalities involved supervisional neglect (30%); 11/37 fatalities involved impaired caregivers (30%). There are 37 fatalities included in this data. Initially, the Panel received 33 fatality cases from DCBS. 31 of those cases were reviewed. Six (6) cases were labeled as near fatality cases but the child later died from the injuries sustained.

* Other = neonaticide, suicide, gun-related homicide, natural causes (with or without medical neglect)

^Of 4 cases of fatal blunt force trauma, 2 involved passengers in motor vehicle collisions. Both involved no restraint and impaired drivers.

## Panel Determinations for all Near Fatalities for Cases Reviewed (n = 40)




**Data Source:** Child Fatality and Near Fatality Review Panel FY 2014

## Final Categorization for Near Fatality Cases (N=40)+

| Final Categorization | # cases | Percent |
|---|---|---|
| AHT (with out without additional injury) | 15 | 38 |
| Blunt Force Trauma^ (unrelated to physical abuse) | 6 | 15 |
| Physical Abuse (without AHT) | 6 | 15 |
| Other* | 5 | 12 |
| Ingestion | 4 | 10 |
| Natural Causes, no evidence of neglect | 2 | 5 |
| Natural Causes, with medical neglect | 2 | 5 |
| Sleep-related | 0 | 0 |

+15/40 near fatalities involved supervisional neglect (38%); 9/40 fatalities involved impaired caregivers (23%)

*Other = near drowning, gun-related injury, or near-strangulation

^Of 6 cases of near fatal blunt force trauma, 4 involved passengers in motor vehicle collisions. Of those 4, all involved impaired drivers, and 3 had no information about restraint usage.

Child fatalities and near fatalities are tragic events and most often occur as a result of a complex set of circumstances, the results of which are not often predictable. However, lessons can and should be learned from every death. The Panel seeks out a broad and retrospective picture of these cases, a view not easily achieved by an individual agency. With the benefit of this perspective, and the advantage of hindsight, the Panel strives to discover opportunities where the timing and interactions of the agencies involved might have been improved and perhaps altered the course for the affected children and their families. Like patient safety efforts in the healthcare field, protecting children involves many agencies working as a team, with open and efficient lines of communication, and policies and practices that align and do not contradict each other. When the Panel's reviews find these opportunities in multiple cases, they become topics for further discussion and recommendations. The following are the recommendations from the 2015 Panel to strengthen our systems for protecting children in Kentucky.

## GENERAL ASSEMBLY:

**RECOMMENDATION:** The General Assembly should implement legislation that allows dependency, neglect, and abuse court proceedings to be opened to the public for the purposes of transparency, accountability, and systems improvement.

Proceedings for dependency, neglect, and abuse, "dependency cases," are the civil proceedings held in Family or District Court to determine child custody when a child has been found to be dependent, neglected or abused. The court acts in the best interest of the child by issuing protective orders that may allow a child to remain safely in the home, or alternatively determines whether the child should be removed from the home. In some cases reviewed by the Panel, the courts and Child Protective Services were not in agreement on the family's needs. In other cases, the decision of the court appeared inconsistent with the information presented in the case record.

In the interest of transparency, accountability, and systems improvement, the Panel endorses the concept of opening these dependency cases to the public. This recommendation was in the Panel's 2014 report. The public has a legitimate and compelling interest in the work of dependency courts. Open court proceedings increase public awareness of the critical problems faced by judges, county attorneys, guardians *ad litem*, and child welfare agencies and may enhance accountability in the conduct of these proceedings by lifting the potential veil of secrecy.

The Kentucky General Assembly has considered the issue of opening juvenile proceedings in multiple legislative sessions throughout the past several years. There have been amendments proposed in Kentucky, and legislation passed in other states, which effectively balance the public's interest in transparency and the needs of a child for protection from harmful public disclosure. This recommendation addresses dependency, neglect or abuse civil actions. The Panel expresses no opinion regarding opening of termination of parental rights, juvenile status offense, or juvenile public offense proceedings.

## GENERAL ASSEMBLY:

**RECOMMENDATION:** The General Assembly should pass legislation requiring hospitals and birthing centers to provide prevention of Abusive Head Trauma training and Safe Sleep information to parents prior to an infant's discharge.

Pediatric abusive head trauma continues to be the leading cause of physical abuse death in infants. Hospital-based education provided to the parents of newborns is a promising prevention practice. The goal of this approach is to assure every parent or caretaker receives information on the dangers of shaking their baby and strategies to soothe a crying baby before leaving the birthing hospital. This approach has been shown to reduce incidence of abusive head trauma by 47% (Dias *et al*., 2005). This program includes three primary components targeting caregivers: 1) a video addressing the dangers of shaking, 2) information on soothing an infant, and 3) signing a "don't shake" commitment statement. Currently 18 states have legislation requiring or encouraging statewide birthing centers to provide hospital based prevention training to the parents/caretakers of newborns.

Unsafe sleep practices were involved in at least 13 child fatalities in the cases reviewed by the panel this year. This does not encompass all sleep-related deaths in Kentucky, however, because not all of those deaths are submitted to the Panel for review. The Panel found inconsistent evidence of hospital and primary care physician education of families about Safe Sleep practices. Many, although certainly not all, of the sleep-related fatalities also involved co-sleeping or bedsharing with an impaired caregiver. The Panel has determined that Safe Sleep education is critical at the time an infant is discharged from the birth hospitalization, with special emphasis on the particular dangers of co-sleeping/bedsharing while impaired by alcohol, prescribed or illicit drugs, and/or physical exhaustion. Such education should continue to be reinforced by primary care physicians and other community service providers throughout infancy.

## DRUG COURT AND FAMILY/DISTRCT COURT:

**RECOMMENDATION:** Drug court participants, youth who are involved with the Court Designated Worker Program, and any person who is a party to any family court proceeding should be required to have education on prevention of Abusive Head Trauma and Safe Sleep.

Any time the court has contact with persons involved with substance abuse and/or violence in the home, whether youth or adults, it should be seen as an opportunity to educate the participants in prevention of Abusive Head Trauma (AHT) and infant Safe Sleep practices. While all of these persons may not be parents of infants, they may reside, short term or long term, in homes where there are infants present. The Panel has consistently documented cases where there has been prior court involvement with the parent or caregiver of infants. If these family members had been educated on these safe practices, vulnerable infants and children may have been kept from harm. The Panel has also reviewed many cases where it is not the birth parent that inflicts the abuse but rather a substitute caregiver: whether extended family, domestic partners, or friends/neighbors. The Panel sees the need for all of those additional people involved with caring for a child to understand the dangers of AHT and Infant Safe Sleep. Given that substance abuse is a contributing factor in a large portion of the cases the Panel reviews, there is an opportunity to reach these caregivers through the court system. The provision of this training would not be cumbersome and would likely involve a short video and accompanying materials.

## CORONERS:

**RECOMMENDATION:** As required by KRS 72.410(3)(a), coroners should make timely notifications to and gather necessary information from law enforcement, the Department for Community Based Services and the local health department upon notification to coroners of the death of a child under 18 years of age.

The Panel has observed that while such contacts are required by statute, in practice, notice to law enforcement, DCBS, and the local health department is inconsistently issued or not issued at all by coroners. When notifications from the coroner are timely, the agencies receiving the notifications are able to conduct scene investigations, share critical information regarding the family and assess safety of any other children who may be at risk (including children yet to be born into the family). Training through the Coroners Association would be a good first step in making new coroners aware of the statutory requirements as well as to improve the communication between coroners and state agencies concerned with the protection of children. In addition, coroners should be made aware of the KRS 72.029 requirement to file a report on every child death (under the age of 18) with the Department for Public Health. If training does not improve practice, efforts to measure and document performance may be necessary. The form is available on the Coroner's Association Website: http://coroners.ky.gov/NR/rdonlyres/6A9300B0-1DD3-42E0-A80E-E0AC1DDA505F/0KYCoroners_Child_fatality_reporting_form.pdf or from DPH: http://DCBS.ky.gov/NR/rdonlyres/5AA59568-249D-443D-B369-6D258A9D9B7E/0/CFR.pdf

## EXPANDING EXISTING INFRASTRUCTURE:

**RECOMMENDATION:** Permit/require Multidisciplinary Teams on Child Sexual Abuse, established by KRS 431.600 and 620.040, to also review physical abuse cases.

Multidisciplinary teams (MDTs) on child sexual abuse are required in all counties/jurisdictions in Kentucky. An MDT is comprised of the local prosecutor, the Children's Advocacy Center, law enforcement and DCBS social service workers. Other members may include mental health, medical and education professionals. Many of the members of the local MDT are also the same professionals who work on child physical abuse cases. Each local MDT team is required, by statute, to coordinate investigations of child sexual abuse and child human trafficking involving commercial sexual activity. By furthering the mandate to include or at least encourage teams to review child physical abuse cases, the child victim may benefit from the team approach to investigations. Minimally, the MDT should be involved in serious physical abuse and/or physical abuse of young children. These professionals utilize a team approach which ensures safety and protection for child victims as well as increases accountability of the service delivery system which allows quality investigations, prosecutions, and victim services and eliminates duplication of efforts in child sexual abuse cases. Child victims of physical abuse deserve the same protections.

## 2015 RECOMMENDATIONS AND DISCUSSIONS

### LAW ENFORCEMENT:

**RECOMMENDATION:** Law enforcement should actively enhance enforcement of the provisions of KRS 189.125 which require infants and children to be properly secured in child restraint systems and booster seats during transport in a motor vehicle.

In cases reviewed by the Panel from motor vehicle collisions, it is often unclear whether or not the child had been properly restrained in the vehicle. One factor in determining if there was child abuse or neglect is to know if the caregiver had properly used child safety restraints. The Panel has expressed concern about a lack of citations for improper restraints, particularly in these instances in which a child is injured. Panel members also expressed concerns that restraint data on crash victims may be inconsistently collected. Assessing additional data from the Kentucky Uniform Police Traffic Collision Report and comparing to Administrative Office of the Courts data on citations may help us understand the rate at which a collision with improper restraints results in citation. This may provide a larger data sample to verify or support the Panel's concern. This recommendation includes the need for further research to study the issues surrounding the failure to properly restrain children in appropriate child safety restraint systems.

Notification to DCBS in instances in which children are involved in vehicle-related crimes that potentially place them at significant risk of harm (reckless driving, DUI, possession of illicit substances, etc.) may enhance the system's ability to identify and protect children who are placed in such dangerous situations by caregivers. A number of cases reviewed by the Panel revealed a disconnect between law enforcement and DCBS investigations of children at risk due to vehicle-related offenses. While there is inadequate data at this time to make a formal recommendation for changes in policy regarding notification of DCBS, the Panel does recommend that law enforcement examine this issue.

### DEPARTMENT FOR COMMUNITY BASED SERVICES:

**RECOMMENDATION:** Department for Community Based Services (DCBS) should likewise consider inadequate restraint as an important indicator of neglect in an impaired driving incident or collision involving children, and include and weigh that information in their investigation and substantiation process. Substantiation of neglect in the setting of inadequate restraint when a child sustains injuries should be a given, if evidence supports it. (Please note: the substantiation of neglect does not necessarily result in a child's removal from the home.)

A number of cases involving motor vehicle collisions revealed inconsistent DCBS response regarding investigation and/or substantiation of neglect when a child was injured as a result of inadequate restraint. The Panel recognizes that a DCBS investigation of inadequate child restraint would present an unreasonable burden to the state. Therefore, the Panel will collect data in order to study the feasibility and efficacy of conducting neglect investigations when a child is found to be inadequately restrained during the course of investigation of a motor vehicle collision or other vehicle-related crime in which children are involved (DUI, reckless driving, etc.)

### DEPARTMENT FOR COMMUNITY BASED SERVICES:

**RECOMMENDATION:** Ensure the internal review process of child fatality or near fatality as mandated in KRS 620.050(12) is conducted in a manner consistent with the statute and is part of a quality improvement process to address critical incidents within the child protection system. The internal review should include an examination of case best practice, policy compliance, staff training and experience, caseload analysis, and other opportunities to engage in quality improvement.

The DCBS is required to conduct an "internal review" on any fatal or near fatal case in which there has been previous involvement with the family by the Department for Community Based Services (DCBS). The statute is clear – the DCBS is to conduct an internal review to address policy and personnel issues, in addition to a summary of the Cabinet's actions. A summary of internal review findings is to be included in the annual report released each September. A copy of the internal review is also to be provided to the Panel. The importance of the internal review is more than an issue of compliance with a statute. It is an opportunity for DCBS to engage in a quality assurance review process to inform improvements in DCBS practice, and support the Panel. The internal review process should allow DCBS (other agencies should also engage in similar processes) to analyze errors in service delivery, and examine root causes for these errors. The internal review process is not redundant to the Panel process, but represents an opportunity to examine agency practice in response to any critical incident. The Panel has noted internal reviews are not always provided to the Panel; those received lack detail and do not address statutorily required elements. Ideally staff not directly responsible for the casework should examine these cases and engage in an internal review process as required by statute. (The 2015 Cabinet report does document efforts to improve this process). This report may be found at http://DCBS.ky.gov/NR/rdonlyres/B2042949-9291-4E00-AC94-0BD37673B9AD/0/2015ChildFatalityandNearFatalityAnnualReport.pdf

## DEPARTMENT FOR COMMUNITY BASED SERVICES:

**RECOMMENDATION:** The Department for Community Based Services should implement quality improvement practices to increase the timely completion of fatal and near fatal child fatality investigations. The annual report that the DCBS produces should specifically identify the number of incomplete investigations at the time of release of the report so the public is aware of these preliminary figures and that they may increase significantly.

Pursuant to KRS 620.050 the DCBS is required to produce an annual report regarding the incidence of fatal and near fatal child maltreatment cases in Kentucky. Over the past several years, the Panel has noted that these reports contain misleading data, primarily a result of delay in completing investigations in a timely manner. As a result, the number of cases identified in the current year will increase significantly the following year (e.g. in the 2014 Report, the Cabinet reported 41 deaths or near deaths of children by abuse or neglect. In the 2015 report, the number for 2014 was increased by 26). While delays in case completion can be due to pending legal proceedings, Panel reviewers have noted delays are more often the result of failure to complete written case documentation. This delay in reporting causes inaccurate information to be provided to the public and misses an opportunity to raise awareness and promote prevention. Further, these delays can hamper the work of the Panel by delaying timely access to cases. In an effort to gather more data, the Panel has requested DCBS to provide with each case record the date the fatality/near fatality report was received and the date the investigation was finalized.

## DEPARTMENT FOR COMMUNITY BASED SERVICES:

**RECOMMENDATION:** The Cabinet for Health and Family Services should provide to the Panel information regarding the caseload, training, and experience levels on staff serving families in which a fatal or near fatal incident has occurred.

The Panel has repeatedly requested information from the CHFS on staff caseload, training, and experience levels of staff serving families in which a fatal or near fatal incident has occurred. This request has been made in an effort to examine anecdotal information presented to the Panel regarding the deleterious impact of high caseloads and staff turnover. Following its November meeting, the Panel sent a letter to the Secretary of the CHFS formalizing the request. This letter is found in Appendix B.

In the previous annual report, with this need in mind, the Panel had recommended a workload study be completed. The Commissioner of the Department for Community Based Services submitted a letter to the Panel regarding this recommendation, which is contained in Appendix A.

## UPDATE ON 2014 PANEL RECOMMENDATIONS

### Bed Sharing/Unsafe Sleep

The Panel recommended the Cabinet for Health and Family Services (CHFS) develop a state-wide public awareness campaign in collaboration with medical professionals, child care providers, parenting programs, early child home visiting programs, and other agencies. The information should provide tools for community professionals to discuss safe sleep with new parents, including the dangers of bed sharing, particularly when the caregiver may be impaired by exhaustion or sedating substances. When working with families of infants, staff of the Department for Community Based Services (DCBS) should include information on the dangers of bed sharing and impaired bed sharing—particularly during home visits with parents of infants.

The CHFS launched The *Safe Sleep Kentucky* campaign in October of 2015. This campaign was designed to let the public know how to ensure babies are sleeping safely. The "ABCs" of safe sleep informs that the safest way for babies to sleep is "Alone, on the Back, in a Crib." Kentucky has added a "D" to the messaging to point out the Dangers of impaired caregivers increasing the risks to the infant from unsafe sleep environments. A "tip sheet" for DCBS workers has been developed as part of the campaign as well as information specifically for home visitors, child care workers, babysitters and information for parents/grandparents.

The Panel recommended all birthing hospitals develop policies and practices to model safe sleep in their newborn, Neonatal Intensive Care Units (NICU), and pediatric care areas. Three hospitals in the state, Baptist Health Lexington, Norton Women's Hospital Louisville, and Kosair Children's Hospital have implemented policies to model safe sleep in their newborn and NICU areas. The Kentucky Hospital Association is partnering with the *Safe Sleep Kentucky* campaign to distribute information on the National Safe Sleep Hospital Certification Program to all Kentucky Birthing Hospitals.

### Substance-Related Impaired Caregivers

The Panel recommended development of a protocol for standardized, universal administration of drug tests of caregivers when children die unexpectedly in their care.

Drug testing of caregivers when children die unexpectedly in their care remains an issue under review by the Panel. Some have expressed concern about potential constitutional issues involved in this recommendation which may not easily be addressed by legislation. Law enforcement may request voluntary consent to perform a blood or urine test. If consent is not given, there is precedent in the state for courts to grant search warrants to secure biological samples for testing when probable cause to search AND exigent circumstances exist. The Panel will continue to collect data regarding this issue.

### Mental Health

The Panel recommended the Cabinet for Health and Family Services work to improve access to quality structured mental health assessments for caregivers of children in families found to be high risk, so mental health and substance abuse problems can be identified and addressed early in order to diminish the number of fatal or near-fatal events.

Since the Affordable Care Act and Medicaid expansion was implemented in Kentucky, more individuals are funded for substance abuse treatment and mental health assessments. This change offers an important and hopeful strategy to address this issue. The Department for Community Based Services (DCBS) can now refer parents for assessments without being placed on a waiting list. Prior to Medicaid expansion, parents were placed on a waiting list when referred for mental health services if they had no money to pay for those services. The Systems of Care grant via the Kentucky Department for Behavioral Health and Developmental and Intellectual Disabilities in Kentucky has been working with providers around the Commonwealth to build stronger capacity for quality mental health and substance abuse assessments and treatment. DCBS reports their ability to obtain these assessments has greatly improved and results are received in a more timely manner.

The DCBS also implemented a new assessment tool, the Assessment and Documentation Tool, which is intended to allow staff to be more targeted in their assessment of parents and improves their ability to know when and where to refer adults for assessments and treatment.

## UPDATE ON 2014 PANEL RECOMMENDATIONS

### Abusive Head Trauma

The Panel recommended multi-tiered prevention programming for abusive head trauma to be provided to parents by birth hospitals, healthcare providers, and home-visiting programs that include:

- the dangers of shaking an infant or young child;
- how to deal with infant crying, including soothing techniques;
- permission for caregivers to step away and take a break when feeling frustrated;
- choosing safe caregivers for infants and young children; and
- having an action plan for caregivers in the event of escalating frustration.

Efforts to address this recommendation have been made by Prevent Child Abuse Kentucky, the Department for Public Health, the State Injury Prevention Coalition, and Dr. Erin Frazier from University of Louisville and Kosair Children's Hospital, as well as others. In October, a letter from the Panel was sent to all birthing hospitals encouraging hospitals to implement evidence-based parent education and offering training and materials. This letter also addressed the issue of Safe Sleep. A copy of the letter is contained in Appendix D.

The Panel recommended ongoing education targeted to all professionals who work with children, as well as the community at large, about mandatory reporting requirements and recognition of early warning signs of child physical abuse, including specific education about bruising in infants.

Agencies represented on the Panel have continued to provide and update training addressing mandatory reporting requirements and recognition of early warning signs of child physical abuse. Some of these efforts include:

- Updating the prevention of Abusive Head Trauma Professional Training Curricula by partners from Kosair Charities Division of Pediatric Forensic Medicine at the University of Louisville, Prevent Child Abuse Kentucky, the Cabinet for Health and Family Services, and the University of Kentucky Pediatrics.
- Development of physician training mandated by the 2014 General Assembly through HB 157.
- Design of training resources to support the implementation of SB 119 passed in 2015.

### Coordinating Investigations

The Panel recommended law enforcement explore uploading information from Family and District Court protective and restrictive orders into the law enforcement database when those orders limit an adult's visitation opportunities with a child.

The law enforcement database to which this recommendation refers is called the LINK system (Law Enforcement Information Network of Kentucky) However, the LINK system is not a database but rather is a collaborative information sharing program that queries many different state/federal databases and provides structured results to authorized users in the law enforcement community. This system may access usable and secure databases in order to retrieve electronic records which must be in a format that would allow retrieval: scanned documents are not retrievable electronic records.

After study and further consideration, the Panel has determined this recommendation is not easily achieved and would require legislation in order to implement. The first hurdle to implementation is the fact that Family and District Court protective and restrictive orders are not currently stored in an electronic record format. Transferring these to an electronic record would first require enabling legislation allowing the records to be used in such a way as currently these records are from closed proceedings.

Additionally, implementation of a task of this magnitude would require legislative funding appropriations to cover the development of a new database system and workforce hours to create an electronic record from the court orders. In addition, the current LINK system would require funding to create interfaces to these other database sources of documentation to allow for easy search, retrieval, and presentation to the requestor.

The Panel recommended that the Department for Community Based Services, law enforcement, and coroners (in fatality cases) conduct joint investigations in cases where a child suffered a fatality or near fatality and there is reasonable suspicion to believe the cause may have involved abuse and/or neglect.

Justice and Public Safety Cabinet Secretary J. Michael Brown proposed holding a summit meeting to develop a better communication protocol addressing perceived and identified gaps in child fatality and near fatality investigations. That meeting was held at the Kentucky Coalition Against Domestic Violence facility in June 2015. Law enforcement, health care administrators, and DCBS attended to generate ideas on how to better share information among agencies. Coroners and local law enforcement were invited to participate but did not send representation.

## Coordinating Investigations (Continued)

The group recommended Multidisciplinary Teams (MDTs) on Child Sexual Abuse could also review cases of physical abuse (see 2015 Recommendations for more detail). When investigation issues arise, parties should consult with the local prosecutor to facilitate a group discussion. MDTs are required in all counties/jurisdictions in Kentucky. By furthering the mandate to include the review of physical abuse cases, the child victim may benefit from the team approach to investigations. Additionally, all of the members of the local MDT are also the same professionals who work on child physical abuse cases. These professionals utilize a team approach which ensures safety and protection for child victims as well as increases accountability of the service delivery system which allows quality investigations, prosecution, and victim services and eliminates duplication of efforts in child sexual abuse cases. Child victims of physical abuse deserve the same protections

## Wrap-around Services

The Panel recommended birthing hospitals assure linkage of high-risk infants to a medical home and needed community services prior to discharge.

This recommendation has been promoted at state-wide meetings on Neonatal Abstinence Syndrome. It is also recommended practice in the Kentucky Infant's Safe and Strong (KISS) hospital recognition program, a collaborative of the WIC program, Kentucky March of Dimes, and the Kentucky Perinatal Association. However, it is an optional step.

## Neonatal Abstinence Syndrome and Child Maltreatment

The Panel recommended the Cabinet for Health and Family Services (CHFS) develop best practice guidelines for recognition of Neonatal Abstinence Syndrome (NAS), including discharge guidelines for affected infants, and distribute them to all birthing hospitals.

Per KRS 211.676, all hospitals are now required to report NAS to the Department for Public Health. This should lead not only to improved recognition of NAS, but a better count of how often NAS babies are born in Kentucky, A form and guidance document for reporting are available from the Division of Maternal and Child Health in the Department for Public Health. http://chfs.ky.gov/NR/rdonlyres/F9860ECD-D0BD-4680-91DE-B5F4CA19B5F8/0/71514NASHospitalReportingGuidanceDocument.pdf

NAS Discharge Guidelines are in draft form for review and comment by professionals in the field. The draft guidelines were presented at a state-wide meeting on NAS in October, and are planned to be presented again as part of regional meetings of the Kentucky Perinatal Association beginning in January. Once all the feedback has been collected, they will be finalized and distributed to all the birthing hospitals.

In addition, CHFS has ongoing inter-departmental efforts on increasing substance abuse prevention and improving access to substance abuse treatment specifically targeting pregnant women, parenting women (through the child's first two years), and teens. These are the populations where cases reviewed by the Panel could be most impacted by increased access to treatment. Kentucky was one of 5 states invited to participate in a SAMHSA Policy Academy on Prescription Drug Abuse, was awarded an In-Depth Technical Assistance Grant from the National Center for Child Welfare and Substance Abuse, received a SAMHSA Grant for Targeted Capacity Expansion for Prescription Drug and Opioid Addiction, and is working with other state agencies on funds from the Attorney General's Office directed to Substance Abuse Treatment and Prevention for teens, and Neonatal Abstinence funds from SB 192. Kentucky was also represented on a Panel about NAS at the Appalachian Opioid Summit, an 8 state gathering in September 2015 to share best practices.

The Kentucky Perinatal Quality Collaborative has started a quality improvement project on improving care of NAS babies. There are 20 hospitals involved in implementing quality improvement protocols and projects around NAS.

## UPDATE ON 2014 PANEL RECOMMENDATIONS

### Open Courts

The Panel recommended opening dependency, neglect, and abuse court proceedings for purposes of transparency, accountability, and systems improvement

The Kentucky General Assembly considered the issue of opening juvenile proceedings in the 2014 General Assembly in Senate Bill 99. Senate Bill 99 would have amended KRS Chapter 21A requesting the Supreme Court of Kentucky institute a pilot project to study the feasibility and desirability of the opening or limited opening of court proceedings, except for proceedings related to sexual abuse, to the public. The proposed legislation included not only dependency, neglect and abuse proceedings but also termination of parental rights cases, juvenile status cases as well as some juvenile criminal cases.

This legislation was unsuccessful. The Panel continues to support opening dependency cases and have again made this one of its recommendations. The Panel expresses no opinion on termination of parental rights, juvenile status offense, or juvenile public offense proceedings.

### Department for Community Based Services Workloads

The Panel recommended the Cabinet for Health and Family Services conduct a workload study focusing on Department for Community Based Services frontline workers, including weighting the complexity of cases, and the impact of workloads on quality service delivery.

The Panel recommended DCBS conduct a workload study focusing on DCBS frontline workers, including weighting complexity of cases, and the impact of workloads on quality service delivery. The Department for Community Based Services has not conducted a workload study, and instead submitted the previously referenced letter contained in Appendix A of this report. The Panel has requested DCBS provide caseload data as part of submitting case records for review.

### Medical Training for Judicial and Other Court Staff

The Panel recommended developing and administering training conducted by medical professionals to Family/District Court Judges, county attorneys and staff on the medical indicators of abuse and neglect.

The Administrative Office of the Courts (AOC), the administrative arm of the Kentucky Court of Justice, has begun a multi-tiered process to address judicial training associated with this recommendation. In addition to addressing the need for training by medical professionals, the AOC is also creating other judicial education opportunities that will promote best practices in dependency, neglect, and abuse cases.

The initial implementation of this recommendation began with a judicial college held in September of 2015. Panel members and fellow judges were able to provide participants with details regarding the Panel's mission, purpose, and the need to provide the Panel with court documentation when requested. Additionally, the Panel members were able to inform participants of any systemic issues with the judicial handling of dependency cases that had been revealed through their review of the fatality and near fatality case review process.

The next phase of implementation of this recommendation will continue throughout 2016. The AOC is moving forward with various initiatives designed to ensure safety, permanency and well-being for children who have cases before the court. Specific curricula will be developed to provide training in these various initiatives:

- A Family Law Conference;
- Regional multidisciplinary training; and
- Continue to address the need to conduct medical and related training at the judicial colleges.

The Prosecutors Advisory Council is developing a webinar to address the medical training for prosecutors with physicians from the Kosair Charities Division of Pediatric Forensic Medicine at U of L. The AOC along with Panel staff will work in partnership to develop this webinar and to make it available for all judges and prosecutors across the state.

# FUTURE FOCUS

As the Panel continues its work in the upcoming year, the following items will continue to be a part of its focus:

- The Panel has identified "screening out" of reports by the Department for Community Based Services at intake as a practice area of concern. The National Commission to Eliminate Child Abuse and Neglect Fatalities has also identified this as an area requiring possible policy change. Potential policy improvements included requiring additional supervisory review of calls regarding young children, reports from medical professionals and/or reports involving families with multiple previous reports.
- The Panel has identified impaired driving and improper restraint as a significant contributor to childhood injury and death. Panel members and staff are currently working to assess the broader impact of this issue. In partnership with staff from the UK Kentucky Injury Prevention Center, data is being analyzed to assess the overall incidence of DUI accidents in which a minor is riding with an intoxicated caregiver. Panel staff is also working with Department of Transportation staff to analyze vehicle crash data to determine the incidence of children involved in crashes in which improper restraint was noted and a citation was issued.
- The Panel remains concerned about a lack of consistent protocol for drug screening in cases where substance abuse is an issue. In the case of a parent or caregiver alleged to be under the influence of a controlled substance at the time of the fatal/near fatal event, the Panel previously recommended across the board blood testing of that parent/caregiver. This issue may be best addressed with the development of consistent protocol so coroners, law enforcement officers and medical personnel will have standards in place and will know the best response when parental substance abuse is suspected. This issue may also apply to obtaining drug screens on child victims. The Panel has also documented cases where the child victim has ingested an illicit substance. In one case, medical personnel did not hold the blood sample for law enforcement to conduct the investigation. Best practice would have medical personnel and law enforcement in open communication and have protocols in place so that errors such as this may be avoided.
- The Panel receives cases from the Department for Community Based Services from the previous fiscal year. For instance, cases utilized for this report are from the Cabinet's 2014 fiscal year (July 2013 – June 2014), with some cases which were pending completion from the previous fiscal year. As a result, the Panel is reviewing and this report provides data on incidents which occurred minimally 17 months prior and more often two years in the past. In the coming year the Panel will identify strategies to make our case process more timely to the needs of the Commonwealth.
- As a follow-up to the letter sent to birthing hospitals regarding abusive head trauma and safe sleep parent education, the Panel will begin informing birthing hospitals when a child born at that facility is injured or dies as a result of abusive head trauma or unsafe sleep. The Panel will also indicate whether prevention of Abusive Head Trauma or Safe Sleep education is documented in the medical record. This information is intended to assist in educating providers about the need for and importance of prevention education.
- The Panel also has practical concerns with regards to its own data collection capacity. The Panel intends to recruit a staff person with the skills to perform the data collection, storage, and analytics required by the Panel. This goal can be achieved with current funding appropriated to the Panel. Despite the Panel's best efforts, data collection, storage, and analysis is an identified infrastructure weakness. For the Panel to be effective and use the data from the reviews for improving our systems, the Panel needs an enhanced capacity for data analytics and maintenance.

The Panel will continue to gather data and explore best practice recommendations to address system improvement opportunities.

## PANEL MEMBERS

Hon. Roger Crittenden, Chair
Retired Circuit Court Judge, 48th Judicial Circuit

Sen. Julie Raque Adams, Kentucky Senate
Senate Health and Welfare Committee Chair

Rep. Tom Burch, Kentucky House of Representatives
Health and Welfare Committee Chair

Dr. Melissa Currie, Child Abuse Pediatrician
University of Louisville School of Medicine

Sherry Currens, Executive Director
Kentucky Coalition Against Domestic Violence

Joel Griffith
Prevent Child Abuse Kentucky

Dr. Sabrina Jo Grubbs
Pennyroyal MR/MH Board

Honorable Brent Hall
Hardin Family Court Judge

Teresa James, Commissioner
Department of Community Based Services
Cabinet for Health and Family Services

Nicky Jeffries, Executive Director
CASA of Kenton and Campbell Counties

Dr. Blake L. Jones
University of Kentucky College of Social Work

Det. Sgt. Scott Lengle
Kentucky State Police

Dr. Stephanie Mayfield, Commissioner
Department for Public Health
Kentucky Cabinet for Health and Family Services

Dr. Owen Nichols
CEO, North Key Community Care

Jenny Oldham
Hardin County Attorney

Dr. Jaime Pittenger, Pediatric Hospitalist
University of Kentucky School of Medicine

Dr. William Ralston
Office of the Kentucky State Medical Examiner

Maxine Reid, Regional Program Manager
Family Resource and Youth Development Centers
Cabinet for Health and Family Services

Dr. Ruth Shepherd
Kentucky Public Health, State Child Fatality Review Team

Ed Staats
Citizen Foster Care Review Board

### Members who Left the Panel in 2015

Dr. Tracey Corey, Kentucky State Medical Examiner

Nathan Goins, State Chair, Citizens Foster Care Review Board

Major Eddie Johnson, Kentucky State Police

Dr. Kimberly McClanahan, CEO Pathways, Inc.

**CABINET FOR HEALTH AND FAMILY SERVICES**
**DEPARTMENT FOR COMMUNITY BASED SERVICES**
**Commissioner's Office**
**COA ACCREDITED AGENCY**

**Steven L. Beshear**
Governor

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**Audrey Tayse Haynes**
Secretary

November 10, 2015

Honorable Judge Roger L. Crittenden
Justice and Public Safety Cabinet
125 Holmes Street
2nd Floor
Frankfort, Kentucky 40601

Dear Judge Crittenden:

The Department for Community Based Services has been concerned about the caseload and staffing levels for the Protection and Permanency staff for the past three years. We have worked creatively and with the support of Casey Family Programs to explore the options that have been considered in other states with growing caseloads. Many state child welfare agencies across the country are presently struggling with recruitment and retention of social service investigators and ongoing staff. With reduced budgets and difficulty hiring and maintaining staff, states have seen child welfare caseloads increase, placing tremendous workloads on already stressed staff and resulting in children often lingering in foster care longer than necessary.

Kentucky's child welfare system is a part of this growing trend of agencies that are struggling to provide adequate staffing. Upon receiving the recommendations from the Child Fatality Review Panel to complete a workload study, DCBS began exploring options. The recommendations from the panel excluded any type of funding support for this caseload study thus DCBS attempted to try and explore options that could be managed within the present agency budget. One study was completed in Indiana by Deloitte for over $1M dollars and this resulted in the state requesting additional staff. DCBS explored the same option with Deloitte however; there were no readily available funds to cover the costs of the study.

DCBS has worked closely with Cabinet leadership to gather as much information as possible to assess the present caseload situation. The following measures have been initiated to mitigate the impact of increased caseloads while gathering data to support the budget request for additional staff.

1. Implemented monthly plan to complete a hand count of individual worker's caseloads in addition to the TWIST system generated caseload counts in an effort to provide an additional real time snapshot of individual staff caseloads.
2. Based on the above monthly snapshot caseload counts, the Director of Service Regions and the Commissioner held monthly calls with regional leadership to develop strategic plans to neutralize individual caseloads that were above 25 as to the best of our ability utilizing all available agency resources and staff from other regions to provide temporary support.
3. Implemented new procedure to insure that if an individual staff person was out of the office for more than two weeks on leave for any reason, that their entire caseload would be reassigned in TWIST to the social service worker who was providing case coverage. This would allow for us to give workers credit for the number of cases they were carrying with case responsibility.
4. TWIST monthly progress reports were created for regional leadership so that they could better assess the numbers of referrals, open cases, foster children, etc. This helped supervisors and regional leadership to more effectively triage the assignment of cases and investigations to workers.
5. Commissioner mandated that aggressive measures be taken to hire regional social service worker staff. This required staff to have registers out immediately once a position became vacant and to complete interviews weekly until the regional caps were achieved.
6. Utilized Interim staff positions to help support, coach and mentor regional social service workers in areas that were documented to have a large number of new staff and supervisors.
7. Coordinated a modified Regional Training for new staff in order to expedite new worker training by bringing training to the region and preventing staff from having to travel outside of the region for weeks at a time.
8. Central Office Department for Protection and Permanency performed an in-depth assessment of the trends in out-of-home care to consider ways in which to reduce caseloads. Clinical reviews were performed on cases open for 18 months to help make timely clinical case decisions towards permanency and implemented an adoption initiative to remove barriers to permanency for children whose biological parents had rights terminated and DCBS had an identified home waiting to adopt.
9. DCBS has worked with the State Personnel Cabinet to complete a salary comparison study of other state's social service staff. In addition, options were considered that might reduce caseloads and increase the ability to hire staff such as creating DCBS specific job classifications, creating fiscal incentives for critical positions that require an enhanced level of skill, expertise and experience, and considering an agency reorganization that was ultimately implemented this fall (see below).
10. DCBS completed reorganization via administrative order effective 10/16/15 which added 4 additional Service Region Administrators (SRA). Nine of the SRA's will be focused on Protection and Permanency and 4 SRAs will be focused on Family Support Services statewide. This will allow for more targeted regional management on issues such as caseload management, child risk and safety, staff morale and supervision and capacity building for service delivery system, etc.
11. DCBS leadership is working with the University Training Consortium and the Eastern Kentucky University Training Program to develop 9 Professional Management coaches to support the 9 service regional leadership teams. They will provide professional coaching and mentoring on management/leadership techniques for supervisors, service region associates (SRAA) and Service Region Administrators (SRA) in order to build a stronger clinical management leadership team.
12. DCBS is presently utilizing a consultant presently to assess the data fields in our SACWIS Data System in order to determine what types of management reports should be created to best meet the needs of specific groups: for workers, supervisors and management to assist with managing caseloads and other workload-related issues, trends identified, etc.

In closing, the Department for Community Based Services has presented data to the state legislature regarding the increases in the number of referrals for abuse and neglect being received by the department, the increases in the number of investigations and the increases in the number of children placed in out-of-home care. Based on the ongoing concerns about the Department's ability to meets its statutory mandate to investigate and intervene in cases of abuse and neglect of Kentucky's children. The Department's biennial budget includes an additional funding request that will address this serious issue. The department has asked for funding to support caseloads of 13 for investigative workers and caseloads of 18 for out-of-home and in-home workers. Without some form of relief in the next two years, the staff of this agency will continue to struggle to meet its statutory mandates.

The Department will continue to work aggressively on initiatives and strategies to address the caseload/workload issues and support the front line staff who daily care for Kentucky's children, their families and vulnerable adults.

Respectfully submitted,

Teresa C. James, LCSW
Commissioner, DCBS

# Child Fatality & Near Fatality External Review Panel

Justice & Public Safety Cabinet
125 Homes Street
Frankfort, Kentucky 40601
502-564-7554



Audrey Tayse Haynes, Secretary
Cabinet for Health and Family Services
Office of the Secretary
275 East Main Street
Frankfort, Kentucky 40621

Dear Secretary Haynes:

Thank you for your presentation at the November 16th meeting of the Child Fatality and Near Fatality External Review Panel. As was mentioned at the meeting, the panel has previously asked for Department for Community Based Services social service worker caseload information. At this time we would like to formalize this request in writing in the detail presented below.

For every fatality and near fatality the panel receives, the panel needs to know:

- The caseload of the worker assigned to investigate the fatal/near fatal incident. This should include active cases, as well as pending or past due cases. The caseload data should reflect a point-in-time caseload and a three month average for the assigned worker.

- If DCBS has provided previous ongoing casework or conducted investigations/assessments with the family in the twelve months prior to the fatal/near fatal event, any caseload information including active, or pending/ past due caseload of social service workers assigned to this family. Again, this caseload data should include a point-in-time caseload and a three month average for the assigned worker at the time the worker had caseload responsibility.

- The years of experience for workers and office/team supervisor assigned to investigate the fatal or near fatal incident and the years of experience of staff assigned to previous casework.

- County caseload data for the county where the incident occurred and/or where there was previous involvement by DCBS. The caseload data should be data at the time of the incident and caseload levels at the time of the request.

We anticipate Fiscal Year 2014 case information will be available prior to the

January 25, 2016 panel meeting. Thereafter, we would expect to see this information included in all case files from FY 2015 forward.

We appreciate your attention to this important matter as this information is vital to the work of the panel and our effort to support system improvement efforts. I, as well as other panel members or panel staff, will be glad to meet with you to discuss any questions to facilitate the preparation of this data for the January meeting.

Sincerely,

Roger Crittenden, Chair
Child Fatality and Near Fatality External Review Panel

# What Does a Safe Sleep Environment Look Like?

Reduce the Risk of Sudden Infant Death Syndrome (SIDS) and Other Sleep-Related Causes of Infant Death

Use a firm sleep surface, such as a mattress in a safety-approved* crib, covered by a fitted sheet.

Do not use pillows, blankets, sheepskins, or crib bumpers anywhere in your baby's sleep area.

Keep soft objects, toys, and loose bedding out of your baby's sleep area.

Do not smoke or let anyone smoke around your baby.

Make sure nothing covers the baby's head.

Always place your baby on his or her back to sleep, for naps and at night.

Dress your baby in sleep clothing, such as a one-piece sleeper, and do not use a blanket.

Baby's sleep area is next to where parents sleep.



Baby should not sleep in an adult bed, on a couch, or on a chair alone, with you, or with anyone else.

*For more information on crib safety guidelines, contact the Consumer Product Safety Commission at 1-800-638-2772 or www.cpsc.gov.

NIH Eunice Kennedy Shriver National Institute of Child Health and Human Development

kyhealthnow a advancing our state of wellness

SAFESLEEP KENTUCKY

# Safe Sleep For Your Baby

SAFESLEEP KENTUCKY
safesleepky.org

- Always place your baby on his or her back to sleep, for naps and at night, to reduce the risk of SIDS.
- Use a firm sleep surface, such as a mattress in a safety-approved* crib, covered by a fitted sheet, to reduce the risk of SIDS and other sleep-related causes of infant death.
- Room sharing—keeping baby's sleep area in the same room where you sleep—reduces the risk of SIDS and other sleep-related causes of infant death.
- Keep soft objects, toys, crib bumpers, and loose bedding out of your baby's sleep area to reduce the risk of SIDS and other sleep-related causes of infant death.
- To reduce the risk of SIDS, women should:
  - Get regular heath care during pregnancy, and
  - Not smoke, drink alcohol, or use illegal drugs during pregnancy or after the baby is born.
- To reduce the risk of SIDS, do not smoke during pregnancy, and do not smoke or allow smoking around your baby.
- Breastfeed your baby to reduce the risk of SIDS.
- Give your baby a dry pacifier that is not attached to a string for naps and at night to reduce the risk of SIDS.

*For more information on crib safety guidelines, contact the Consumer Product Safety Commission at 1-800-638-2772 or www.cpsc.gov.

- Do not let your baby get too hot during sleep.
- Follow heath care provider guidance on your baby's vaccines and regular health checkups.
- Avoid products that claim to reduce the risk of SIDS and other sleep-related causes of infant death.
- Do not use home heart or breathing monitors to reduce the risk of SIDS.
- Give your baby plenty of Tummy Time when he or she is awake and when someone is watching.

**Remember Tummy Time!**

Place babies on their stomachs when they are awake and when someone is watching. Tummy Time helps your baby's head, neck, and shoulder muscles get stronger and helps prevent flat spots on the head.

For more information about SIDS and the Safe Sleep KY Campaign, visit:

**SafeSleepKY.org**

September 2015

NIH *Eunice Kennedy Shriver* National Institute of Child Health and Human Development

SAFESLEEP
KENTUCKY
From the Kentucky Department for Public Health

kyhealthnow
advancing our state of wellness

# How to Respond

## when a caregiver says...

**"It will never happen to me."**

In Kentucky, we lose 1 baby every 5 days in a sleep-related death. Of the sleep-related deaths in 2013, 90% were in an unsafe sleep environment. Is it really worth the risk? Your baby needs to sleep alone, on its back and in a clean, clear crib.

**"Why can't I leave my baby in the car seat to sleep?"**

Car seats are designed for travel in a moving car and not as a sleep surface. If a baby is left in a car seat for extended periods of time, he or she can move into a dangerous position that blocks their breathing. Babies should always be removed from the car seat when arriving at your destination.

**"We used to do it this way."**

We used to do a lot of things before we learned they were dangerous. In the past, many babies died in car collisions because they weren't secure in a car seat. Now, we don't think twice about using car seats, and infant deaths from motor vehicle collisions are rare. In Kentucky, we know a baby is 70 times more likely to die in a sleep-related death than in a vehicle collision.

**"The ABC's are too hard to follow/ remember all the time."**

The ABC's refer to the simple steps of placing your baby alone, on their back and in a crib. A little planning is all it takes to protect your baby. Babies sleep a lot, so if you are going to be anywhere for naps or night time, just think ahead about where your baby can sleep safely. The planning is no different than remembering to pack diapers and an extra outfit.

**"Breastfeeding in bed promotes bonding."**

There is nothing wrong with breastfeeding in bed, but once you are ready to go back to sleep or are feeling drowsy, your baby needs to go back to his or her own Safe Sleep Space, alone and on their back, in a crib.

**"Co-sleeping is bonding. What's wrong with that?"**

Bonding does not occur while your baby is sleeping or when you are sleeping. Bonding happens when you and the baby are awake and are interacting during normal everyday activities like feeding, bathing and playing. Co-sleeping (bed-sharing) places your helpless baby at the mercy of an unconscious adult who moves around in bed without realizing it.

**"The doctor prescribed this medication."**

Taking medication as prescribed by your doctor or even some over-the-counter medications can cause drowsiness. If combined with alcohol or other medications, the effects can be even more dangerous. Because medications can have different effects on different people and cause different levels of impairment, it is even more important to follow the ABC's of Safe Sleep when taking medication, even when prescribed by your doctor.

SAFESLEEP KENTUCKY
From the Kentucky Department for Public Health

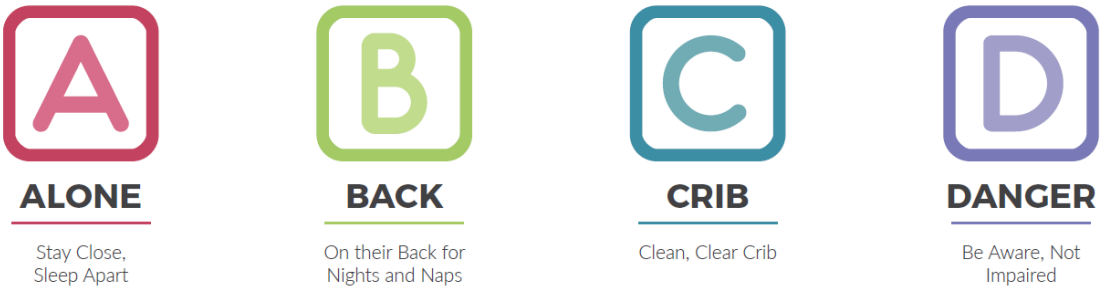
kyhealthnow
advancing our state of wellness

# Parents
## Guide to Safe Sleep

Every baby needs their own **Safe Sleep Space**.

A **Safe Sleep Space** is a crib, bassinet or pack & play that meets current guidelines, has a firm surface (mattress meant for that item) with nothing in the crib but a fitted sheet for that mattress. It is recommended that the crib be in the same room as the parents, but a baby should NEVER share a sleep surface with anyone else. This is very dangerous for the baby and increases the risk for SIDS. This guidance should be followed until the baby's first birthday.

### START WITH THE ABC'S




**Alone:** Babies should always sleep alone. There should never be anything else in a baby's sleep space except for the baby. A pacifier is permissible if the baby uses one, but if breastfeeding, please wait until breastfeeding is well established. Pacifiers should not be attached to a string, cord, stuffed animal or anything else.

**Back:** A baby should always sleep on his/her back for every sleep time both night and naps. Back sleeping on a firm surface decreases the risk of SIDS.

**Crib:** Babies should sleep in a clean, clear crib. A baby's crib should contain a fitted sheet only; no blankets, toys, pillows, bumpers, or other items that could cover a baby's face and suffocate them. Cribs, bassinets and pack & plays with firm mattresses are the only safe places for babies to sleep.

**Danger:** Drinking and drug use impair your ability to care for a baby, making bed-sharing and other unsafe sleep even more dangerous for the baby.

If you do not have a crib, bassinet or pack & play for your baby and cannot afford one, please check with Cribs for Kids at www.cribsforkids.org/find-a-chapter/,or call your local health department.

visit **safesleepky.org** for more information

## Important things to remember:

- Do not overheat a baby. If you are comfortable in light clothing, the baby will be too. Keep the room temperature at a comfortable setting for you.
- If your baby does require an extra layer for warmth, dress him/her in layers such as a onesie and a footed sleeper, or use a sleep sac over their clothing. Blankets should not be used in the bed for warmth.

- Keep a baby away from cigarette smoke, including e-cigarettes. This is a good time to make your home and car smoke free.
- A baby should never sleep in a car seat, swing, infant seat, adult bed, couch or chair, or any other item not designated for infant sleep.
- Provide "Tummy Time" for the baby every day, while they are awake and an adult is watching. This helps with muscle development.
- Be Aware, not Impaired. Drinking or drug use, even use of prescription drugs, can impair your ability to parent and increase the danger of SIDS for your baby. Always follow the ABC's (alone, on their back, in a crib) to keep your baby safe.
- Just as "designated drivers" protect people from the dangers of driving "under the influence," if you have to take a medication that you know can impair your judgment or reaction time, consider finding a "designated, dependable adult" to help you protect the baby from the dangers of unsafe sleep. Always follow the ABC's of Safe Sleep for your baby.

## If your baby won't sleep and cries continuously:

- Check to see if your baby is hungry, tired or needs changing
- Cuddle the baby in your arms
- Walk and sing with your baby
- Take your baby outside for a walk (weather permitting)
- Give your baby a warm bath
- Call a friend or family member to come watch the baby
- Talk to your baby's doctor
- NEVER, NEVER, NEVER shake a baby

Remember: Babies rely totally on adults for their safe care. A baby may not stop crying no matter what you try. No matter how frustrated you get, NEVER shake a baby. If you need to take time to calm yourself, place your baby in a safe sleep space (alone, on their back and in their crib) and check on them every 15 minutes.

For more information on Safe Sleep Kentucky, please visit our website at safesleepky.org or the national Safe to Sleep Campaign at safetosleep.nichd.nih.gov.

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# DANGER

## Be Aware, Not Impaired

Impairment affects your ability to drive a car; it can also affect your parenting. Right now in Kentucky, a baby is **70 times more likely to die from unsafe sleep** than from a motor vehicle collision. The risk of death from unsafe sleep is much higher in babies if the caregiver is impaired. Driving a car "under the influence" of alcohol, street drugs, or some prescribed medicines is unsafe and can even be deadly. Similarly, **caring for a baby while "under the influence" can be DANGEROUS for the baby.**

If an impaired parent or caregiver places a baby in an unsafe sleep space, the baby can die. In the Kentucky External Panel reviewing child abuse deaths, there have been several cases where impaired caregivers shared a bed with their baby and the baby died from SIDS, suffocation or strangulation—all common reasons for a baby to die if in an unsafe sleep environment. Many of these deaths would be preventable if the caregiver had followed the ABC's of Safe Sleep for the baby.

**Over half** of the sleep-related infant deaths in Kentucky in 2013 involved a person and a baby sleeping in the same bed, some with and some without impairment. This is an unsafe practice. Many of these infant deaths can be prevented.

### Why is impairment DANGEROUS?

When a person is impaired, his or her natural "ability to see, hear, walk, talk and judge distances" has been reduced. They may also have trouble paying attention or remembering. Impaired people often make bad or unsafe choices for themselves and others around them. Impairment is often caused by using alcohol and/or street drugs, but can also be from some prescription medications, especially those used to treat pain, anxiety, and depression, even if they are used as prescribed.

When a parent or caregiver of a baby is impaired, they may make **choices that are unsafe or dangerous for the baby.** One of the most dangerous of these bad choices is not following the ABCs of Safe Sleep. Whether you are impaired or sober, choosing unsafe sleep for a baby can be deadly.

## PROTECT babies from the dangers of impairment and unsafe sleep

Keep the babies in your life SAFE...ABCs of Safe Sleep - EVERY time an infant sleeps

**ALONE**: Stay Close, Sleep Apart—Share the room, not the bed.

**BACK**: On Your Back for Nights and Naps—A baby should always sleep on their back.

**CRIB**: Clean, Clear Crib—No blankets, toys, pillows, bumpers, or other items that could cover a baby's face and suffocate them.

**DANGER:** Be Aware, Not Impaired—Drinking and drug use impair your ability to care for a baby, making bed-sharing and other unsafe sleep even more dangerous for the baby.

***Designated Dependable Adult** —"Designated (sober) drivers" protect people from the dangers of driving "under the influence." So, if or when you know you will be impaired, think about finding someone to be your "designated, dependable (sober) adult." Ask this person to help protect the baby from the dangers of unsafe sleep and more.

## Other DANGERS of impairment

Because impairment can make people more easily frustrated, impaired caregivers are more likely to **accidentally hurt babies by shaking them.** This is very dangerous and often badly harms or even kills babies. If a baby will not sleep or stop crying, no matter what you try, **NEVER SHAKE a baby**! Check to see if the baby is hungry, tired, or needs changing. Cuddle, walk, or sing with the baby. Give the baby a warm bath. Call your doctor or a friend. If you feel yourself getting upset or angry, give yourself time to calm down by placing the baby in a safe sleep space (use ABCs) and walking into the next room. Go back and check on the baby about every 15 minutes. **NEVER, NEVER, NEVER shake a baby.**


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3. Eunice Kennedy Shriver National Institute of Child Health and Human Development. www.nichd.nih.gov/Pages/index.aspx


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# What DCBS Workers Need to Know About Safe Sleep


**ALONE**

Stay Close,
Sleep Apart


**BACK**

On their Back for
Nights and Naps


**CRIB**

Clean, Clear Crib


**DANGER**

Be Aware,
Not Impaired

As a DCBS worker, you work with families who are overburdened and have many challenges. Bringing a new baby home, although a joyful time, may also add to the family's stress. It is very important to the baby's safety that you educate your families with a new baby on preventing infant injury and even deaths. The two most common areas to emphasize are Safe Sleep and Prevention of Abusive Head Trauma.

Sleep-related deaths are the major cause of death in infants 1 month to 1 year of age. Many of these deaths are preventable by following the ABC's of Safe Sleep:

- Babies need their own Safe Sleep Space. A crib, bassinet or pack & play with a firm mattress (one designed for that device) and a snug fitting crib sheet.
- Babies should always sleep **ALONE.** Babies should sleep close to their parent by sharing a room, but not the bed. Sharing a bed with a sleeping adult puts the baby at high risk for suffocation or overlay.
- Babies should always be on their **BACK** for every sleep period, both nights and naps.
- The **CRIB** (includes a bassinet or pack & play) should not have anything in it but the baby — no added soft bedding such as blankets, pillows, bumper pads or toys.
- Babies should always use a footed sleeper, infant sleep sac or gown for added warmth if needed.
- Drinking and drug use (even some prescription drugs) impair one's ability to care for a baby, making bed-sharing and other unsafe sleep even more dangerous for the baby. In Kentucky's child abuse deaths, this a common finding among the infant deaths. Be sure families where there is substance abuse are counseled to always follow the ABCs and that they understand the potential consequences of not following them.

## Things for Families to Avoid

- Babies should not sleep in car seats, swings, infant seats or other items not designed for infant sleep.
- The baby's crib should not have bumper pads, blankets, pillows, toys or other items in the crib. These things are hazards and increase the risk of suffocation.

Visit **safesleepky.org** for more information

- **An adult bed is never a safe place for an infant to sleep**. Neither are a couch, recliner, or chair, with or without another person.
- Babies should NOT be placed on their side or stomach to sleep. This has been proven to be very dangerous and raises the likelihood of SIDS.
- Babies should never be around cigarette smoke, including e-cigarettes.
- Avoid overheating the baby. If the caregiver is comfortable, the baby needs no more than one layer more than the adults in the room.
- Never have the baby share a bed with another adult or child. Especially someone who has been using alcohol or drugs, even if the drugs are by prescription.

## Things You Can Do

Talk to your families and specially ask "Where does your child sleep?" Discuss why the ABC's (Alone, Back, Crib) of safe sleep are important.

- Use the "What does Safe Sleep Look Like?" Handout and explain the **ABC's** of Safe Sleep: Baby should always sleep **Alone**, on their **Back**, and in a clean, clear **Crib** (bassinet or pack & play).
- If families you work with don't have a crib or other Safe Sleep Space, you can check with the nearest Cribs or Kids program at www.cribsforkids.org/find-a-chapter/ or call your local health department. If the family has a crib check the safety of the crib on the Consumer Product Safety website: www.cpsc.gov/cribs.
- Drinking and drug use (even some prescription drugs) can impair a person's ability to care for a baby. Counsel your families about this.

Educate your families on the things that can trigger abusive head trauma and how to avoid it.

## To keep your baby safe when your baby won't sleep and cries continuously, the caregiver should:

- Check to see if the baby is hungry, tired or needs changing
- Cuddle the baby
- Walk and sing with the baby
- Take the baby outside for a walk (weather permitting)
- Give the baby a warm bath
- Call a friend or family member to come watch the baby
- Talk to the baby's doctor
- NEVER, NEVER, NEVER shake a baby.

Babies rely totally on adults for their safe care. A baby may not stop crying no matter what is tried. No matter how frustrated a caregiver gets, they should NEVER shake a baby. If a caregiver needs to take a time-out to calm themselves, the baby should be placed in their Safe Sleep Space using the ABC's (Alone, on their Back and in a Crib) and checked on every 15 minutes.

Free Safe Sleep information for families can be obtained at **The National Safe to Sleep Campaign**: safetosleep.nichd.nih.gov or the **Safe Sleep Kentucky Campaign**: SafeSleepky.org

If you would like information for families on prevention of pediatric abusive head trauma, another place where education families can save lives, contact us at SafeSleepKY@ky.gov or Prevent Child Abuse Kentucky at pcaky@pcaky.org

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# What Home Visitors Need to Know About Safe Sleep


**ALONE**

Stay Close,
Sleep Apart


**BACK**

On their Back for
Nights and Naps


**CRIB**

Clean, Clear Crib


**DANGER**

Be Aware,
Not Impaired

When your work with families includes visiting in the home, the Home Visitor has a unique opportunity to help families minimize the risk of SIDS (Sudden Infant Death Syndrome) for their baby. Unlike other providers, you are in the home and can see where the infant is sleeping and under what conditions. You can easily teach your families about the ABCs of Safe Sleep.

Before the baby is born, discuss the ABCs of Safe Sleep with families so they can prepare, find an appropriate crib, and not waste money on items that are not recommended for safe sleep. After the baby is born, you should ask to see where the baby sleeps and be sure it is appropriate (see handout: "What does Safe Sleep Look Like".) The baby should have their own bed (crib, bassinet, or pack & play) that is in good shape. Be sure the family is putting the baby down to sleep on their Back in a clean, clear Crib. For free handouts to provide to the family to reinforce safe sleep messages, go to SafeSleepky.org, or safesleep.nichd.nih.gov.

**Why is this important?**
Sleep-related deaths are the major cause of death in infants between 1 month to 1 year of age.

In Kentucky, every 5 days there is another baby who dies from unsafe sleep. Over half of these are sharing a bed with an adult, and others are sleeping in something not designed for infant sleep (soft, recliner, swing, etc.). Most of these deaths are preventable. Currently in KY, a baby is 70 times more likely to die from unsafe sleep than from a motor vehicle collision.

**Recommendations for Safe Sleep**

- Babies need their own **Safe Sleep Space.** A crib, bassinette or pack & play with a firm mattress (one deisgned for that device) and a snug fitting crib sheet, without any added soft bedding such as blankets, pillows, bumper pads, or toys.
- Babies should always sleep alone. Babies should sleep close to their parents by sharing a room, but not the bed. Sharing a bed with a sleeping adult puts the baby at

- Babies should always sleep on their back for every sleep period, both nights and naps.
- Babies should use a footed sleeper, infant sleep sac or gown for added warmth if needed.
- Drinking and drug use (even some prescription drugs) impair one's ability to care for a baby, making bed-sharing and other unsafe sleep even more dangerous for the baby. In Kentucky's child abuse deaths, this a common finding among infant deaths. Be sure families where there is substance abuse are counseled to always follow the ABCs.
- Babies need "Tummy Time" every day, while they are awake and an adult is watching them. This helps with muscle development when awake, not for sleep!

**Things for Families to Avoid:**

- Babies should not sleep in car seats, swings, infant seats or other items not designed for infant sleep.
- The baby's crib should not have bumper pads, blankets, pillows, toys, or other items in the crib. These things are hazards and increase the risk of suffocation.
- **An adult bed is never a safe place for an infant to sleep.** Neither on a couch, recliner, or chair, with or without another person.
- Babies should NOT be placed on their side or stomach to sleep. This has been proven to be very dangerous and raises the likelihood of SIDS.
- Babies should never be around cigarette smoke, including e-cigarettes.
- Avoid overheating the baby. If the caregiver is comfortable, baby needs no more than one layer more than the adults in the room.
- Never have the baby share a bed with another adult or child. Especially someone who has been using alcohol or drugs, even if the drugs are by prescription.

Be sure the families you work with have a safe sleep space for their baby—and that they use it correctly. Baby should always sleep Alone, on their Back, and in a clean, clear Crib (bassinet or pack & play). The only thing that can be in the bed with the baby is a pacifier (after breastfeeding is established).

Free information for families can be obtained at: The National Safe to Sleep Campaign www.safetosleep.nichd.nih.gov or Safe Sleep Kentucky Campaign SafeSleepky.org.

**Other Resources:**
If families you work with don't have a crib or other Safe Sleep Space, you can check with the nearest Cribs for Kids program at www.cribsforkids.org/find-a-chapter/ or call your local health department.

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# Child Fatality & Near Fatality External Review Panel

Justice & Public Safety Cabinet
125 Holmes Street
Frankfort, Kentucky 40601
502-564-7554

October 28, 2015



The Kentucky Child Fatality and Near Fatality External Review Panel is a legislatively established entity designed to recommend strategies for preventing child abuse related deaths and near deaths. We are seeking your assistance in addressing two primary causes of preventable death and critical injury in Kentucky infants and young children. We hope you share our optimism regarding how your voluntary participation will have a lasting impact on Kentucky's children.

Case review data indicates that Abusive Head Trauma (AHT) and Unsafe Sleep practices have been found to be primary precipitators in the death or near death of infants and young children in the hundreds of cases reviewed by the Panel. Both are preventable forms of childhood mortality and morbidity. The Panel has formulated recommendations to address these issues and we are seeking your support in implementing these recommendations.

Kentucky birthing hospitals offer the ideal opportunity to provide critical prevention-based information to the parents of newborns. The Panel is encouraging all birthing hospitals to provide evidence-informed prevention education to parents and caretakers addressing AHT and Safe Sleep. There are resources readily available to assist in implementing best practice prevention strategies.

Abusive Head Trauma: Our findings have documented 26 infants or young children who were killed or nearly killed in 2013; yet there are prevention models found to be effective. One such model involves the provision of hospital based education to the parents of newborns. This promising strategy involves assuring every parent or caretaker receives information on the dangers of shaking their baby, and strategies to soothe a crying baby before leaving the birthing hospital. This approach has been shown to reduce incidence of AHT by 47% (Dias et al., 2005). Training and other resources are readily available to assist Kentucky birthing hospitals in implementing this approach.

Safe Sleep: The Panel and other public health organizations have identified unsafe sleep practices as a primary cause of infant death. Bed sharing, particularly when caretakers were under the influence of alcohol or other drugs, was a significant risk factor in cases reviewed by the Panel. The Kentucky Department for Public Health, in collaboration with other community partners, has developed a state-wide public awareness campaign to address this issue. These materials are readily available for use, and can easily be included as part of routine discharge planning for all parents.

Due to the volume of families served from a large service area, you may not be aware when an infant born at your facility is injured as a result of AHT or unsafe sleep practices. We also recognize you understand the importance of receiving this information. In an effort to assist hospital staff in fully appreciating the potential impact of these proposed prevention efforts, the Panel will begin informing birthing hospitals when a child born at that facility is injured or dies as a result of AHT or Unsafe Sleep. We will also indicate whether or not AHT or Safe Sleep education is documented in the medical record.

I hope we can count on your leadership in providing AHT and Safe Sleep prevention education to the parents of all newborns prior to discharge. There are resources at-the-ready to assist in implementation. These resources are available through groups such as the Kentucky Safety and Prevention Alignment Network, the Kentucky Department for Public Health and Prevent Child Abuse Kentucky. In an effort to provide you or your staff a single point of contact, Joel Griffith with Prevent Child Abuse Kentucky will coordinate requests for information. Please contact Joel and he will assist in providing the information and resources you need to implement these important prevention strategies.

Joel Griffith
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801 Corporate Drive, Suite 120
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859-225-8879 ext. 224

Thank you in advance for your commitment to prevention education. Your involvement is critically important to the children of our Commonwealth.

Sincerely,

Roger Crittenden, Chair
Child Fatality & Near Fatality External Review Panel


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