2016 Annual Report

Child Fatality and Near Fatality External Review Panel

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

EXECUTIVE SUMMARY

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

The Panel reviews cases referred from the Department for Community Based Services (DCBS). The DCBS conducts their own investigation into the fatality or near fatality and determines whether to substantiate abuse or neglect. The Panel conducts its external review of all of these cases regardless of whether the DCBS substantiated abuse or neglect. The Panel may also review cases referred from other sources as long as the fatality or near fatality is suspected to be a result of abuse or neglect perpetrated by a parent, guardian or other person exercising custodial control or supervision.

As a part of this external review, other relevant information may be requested from a variety of sources and may include autopsy reports, medical records, law enforcement records and records held by any Family, Circuit or District Court. The purpose of these retrospective reviews is to 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 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. KRS 620.055(10).

Throughout 2016, the Panel met seven times including an extended multi-day session held in March 2016. Cases reviewed are from fiscal years 2014 and 2015 (July 1, 2013, through June 30, 2015). The Panel reviewed 142 cases comprised of 47 fatalities and 95 near fatalities. Of these, 26 cases are from incidents that occurred in fiscal year 2014 and 116 of the incidents occurred in fiscal year 2015. Two of the cases were referred from the Department for Public Health.

In addition to the recommendations for 2016, this report provides an update of the progress made on the recommendations that were presented in the 2015 Annual Report.

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

2016 PRIORITY RECOMMENDATIONS

-- **Address the substance abuse epidemic affecting families across the state.**

The Panel recommends:

- **Full implementation of and funding for Family Drug Courts in Kentucky;**
- **Plans of Safe Care and wrap-around services for infants with prenatal substance abuse exposure during and after discharge from the birth hospitalization; and**
- **Resources needed for substance abuse treatment.**

-- **Improve the social service delivery system by providing necessary funding to the Department for Community Based Services.**

The Panel recommends:

- **The Administration should propose and the General Assembly should assure the Department for Community Based Services is funded and resourced at the necessary level; and**
- **The Department for Community Based Services should examine and improve current practice addressing worker caseload and experience, including community partners in family team meetings, improved screening of reports of suspected child abuse and neglect, and continued improvement to the internal review process.**

Please see page 15 for a full discussion of these priority recommendations as well as the Panel's additional recommendations for 2016.

INTRODUCTION

Child fatalities and near fatalities are the most tragic result of child maltreatment. Unfortunately, in the fiscal year that ended June 30, 2016, the number of children in Kentucky who died or who suffered near fatal injuries dramatically increased. The Panel hopes that their work and this report will lay the framework for preventing child abuse and neglect in Kentucky. Preventing child abuse and neglect fatalities and near fatalities through retrospective review has received nationwide attention as well.

The Commission to Eliminate Child Abuse and Neglect Fatalities (CECANF) was created by United States Congress through the Protect Our Kids Act of 2012[1] to develop a national strategy and recommendations for reducing fatalities resulting from child abuse and neglect. After a two year review, the CECANF[2] issued their final report and recommendations.

The CECANF calls for systemic reform with a key component being the multidisciplinary review of child abuse and neglect fatalities and near fatalities which will help identify children and families most at risk. The CECANF publicizes that retrospective review identifies the family and systemic circumstances that led to maltreatment deaths and states that although we cannot identify who the next victim will be, we know a remarkable amount about the characteristics of the children who die and their families. The CECANF further suggests that the current approach of waiting until a child is severely injured before intervening with vital supports is reactive and does nothing to prevent these events from occurring.

Another national initiative focusing on the prevention of child fatalities is the Three Branch Institute to Improve Child Safety and Prevent Child Fatalities. Kentucky was recently selected to participate in this initiative sponsored by the National Governor's Association.[3] The legislative, executive, and judicial branches in Kentucky have partnered to prioritize needs, develop preliminary strategies, and will receive technical assistance and support under this initiative. Panel members and staff are involved in this process and data collected through the Panel's work will be used to help drive the efforts of systemic improvement in the prevention of the death and near death of our most vulnerable.

In 2016, the Panel's primary focus was on the thorough multidisciplinary review of cases referred to the Panel for review: the Panel reviewed nearly twice as many cases than in the previous year. This exhaustive process necessitated seven meeting dates, including an extended multi-day meeting. Data obtained inform of the risks contributing to the fatal and near fatal events and will assist in identifying the characteristics of these children and families.

The Panel reviewed 142 cases: 26 cases are from fatalities or near fatalities that occurred in fiscal year 2014 and 116 cases occurred in fiscal year 2015. Two cases from fiscal year 2015 were referred from the Department for Public Health.

[1] Public Law 112-275, H.R. 6655-112th Congress: Protect our Kids Act of 2012, https://www.govtrack.us/congress/bills/112/hr6655)
[2] See Appendix A for a Fact Sheet of the CECANF report or visit https://cybercemetery.unt.edu/archive/cecanf/20160323194611/https://eliminatechildabusefatalities.sites.usa.gov/files/2016/03/CECANF-final-report.pdf to download the full report.
[3] https://www.nga.org/cms/home/news-room/news-releases/2016--news-releases/col2-content/states-focus-on-improving-child.html

CASE REVIEW PROCESS

A SharePoint website is used to provide the case records and other relevant information to the panel members, case analysts and panel staff. The Department for Community Based Services (DCBS) initiates the case review by uploading the unredacted case record to the SharePoint site. Each case is assigned to a case analyst, an expert from the medical or social work field, who reviews the records and relevant information and prepares a case summary and timeline to facilitate the review process. If the case analyst determines that additional records are needed, staff assigned to the Panel will request these records from the source: law enforcement agencies, courts, medical providers, and any other agency that holds records related to the child or the fatality/near fatality investigation. Once the requested records are received, the staff will then upload the records to the SharePoint site for further review by the analyst. After completion of the analyst review, the case will be placed on the agenda for the next Panel meeting.

Panel members have the opportunity to review the case prior to the meeting using the SharePoint website. At the meeting, the case analyst provides an oral presentation to the full Panel who then conduct a thorough discussion of the case noting any systemic deficits, positive approaches, and develop recommendations for improvement.

The Panel makes findings in each case: designating the final categorization or type of case, identifying the risks that may have contributed to the fatality or near fatality and then making a final determination of whether abuse or neglect exists. These findings and other relevant Information are entered into a data tool that is stored on the SharePoint site. This data tool is used in the final analysis of the data and becomes the source for the recommendations that are found in this report.

This case review process has evolved over time and will continue to be improved upon in 2017. Exhaustive review and the sheer volume of the cases – many of them with over a thousand pages of records – is a daunting task and may require the Panel to begin a triage process for the review of fiscal year 2016 cases.

Tragically, the incidence of child fatalities and near fatalities suspected to be the result of abuse or neglect drastically increased during the timeframe of July 1, 2015 through June 30, 2016 (FY16). The DCBS reports that for FY16 there are nearly 160 cases that will be referred by the DCBS to the Panel, which is an increase of 44 fatalities/near fatalities from the previous year.

2016 IN REVIEW

The Panel has made a concerted effort to follow and document action related to the recommendations included in its 2015 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 15.

Extensive work was placed into the update of the data collection tool. A subcommittee of panel members and staff worked many hours enhancing this tool for the purpose of more extensive data collection. This tool will enter the testing phase in December, 2016 with an expected launch in the first week of January. Data from the FY16 cases will be collected using the new tool.

The Panel received 118 FY15 case records from the Department of Community Based Services (DCBS) and two cases from FY 15 from the Department for Public Health. All information was unredacted and was uploaded to the SharePoint website. Approximately twenty cases (four to five per group) per meeting were assigned for discussion to the four groups of Panel members. Time constraints or requests for additional documentation sometimes tabled case reviews until subsequent meetings. There were 146 cases discussed at the scheduled Panel meetings this year. Four of these cases were excluded from the data because the injuries suffered in those cases did not rise to the level of a near fatality.

Per statute, the Legislative Program Review and Investigations Committee conducts an annual evaluation of the Panel. That evaluation is on-going with a tentative presentation date of December 13, 2016.

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. However, one appointment was delayed as staff awaited additional documentation from the proposed panel members.

The Panel has requested the assistance of an expert from the University of Kentucky Department of Pediatrics as an additional resource to the Panel.

The Panel expanded its advocacy efforts this year through the live presentation of testimony from parents of a child who had suffered abuse at the hands of their caregiver. This expanded review was extremely informative to Panel members as they made the determination in that case.

The Panel requests additional documentation as needed from agencies including the courts, law enforcement, medical providers as well as others. Most agencies complied with the Panel's requests for additional documentation. Several entities have been nonresponsive to the request for records.

CASE REVIEW

DEMOGRAPHICS FISCAL YEARS 2014 AND 2015

COUNTY OF INCIDENT

Child abuse and neglect fatalities and near fatalities occur in every region of Kentucky. The chart below indicates the number of cases the Panel reviewed per county of incident. These data include cases for the complete fiscal year of 2014 and fiscal 2015.[3]

County of Incident Among All Cases Reviewed in FY14 and FY15

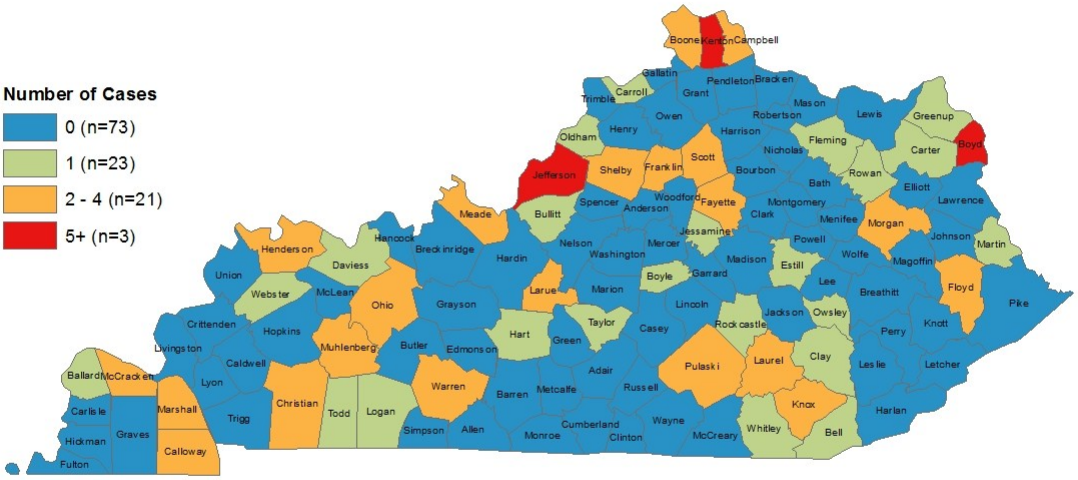
County	2014 # Cases	2015 # Cases
Adair	0	1
Allen	0	1
Anderson	0	1
Ballard	1	0
Barren	0	2
Bell	1	1
Boone	2	0
Boyd	5	3
Boyle	1	1
Breckinridge	0	1
Bullitt	1	2
Calloway	2	1
Campbell	2	1
Carroll	1	1
Carter	1	1
Christian	4	4
Clark	0	1
Clay	1	2
Daviess	1	4
Estill	1	1
Fayette	4	3
Fleming	1	0
Floyd	2	1
Franklin	2	1
Graves	0	2
Grayson	0	2
Greenup	1	0
Hardin	0	5
Harlan	0	2
Hart	1	0
Henderson	2	1
Jefferson	21	16
Jessamine	1	0
Knott	20	1
Knox	3	2
Larue	3	3
Laurel	3	5
Lincoln	0	1
Logan	1	1
Madison	0	4
Marion	0	2
Marshall	2	2
Martin	1	0
McCracken	2	3
McCreary	0	1
Meade	2	1
Monroe	0	2
Morgan	2	0
Muhlenberg	2	0
Nelson	0	1
Ohio	2	1
Oldham	1	0
Owsley	1	0
Pendleton	0	1
Pulaski	2	0
Rockcastle	1	0
Rowan	1	1
Scott	2	1
Shelby	2	0
Simpson	0	1
Taylor	1	2
Todd	1	0
Trimble	0	4
Union	0	2
Warren	3	6
Webster	1	0
Whitley	1	0
Total Cases	**104**	**116**

Data Source: Child Fatality and Near Fatality External Review Panel Data, Fiscal Years 2014 and 2015

[3] 77 cases from FY14 were reviewed and reported on by the Panel in its 2015 Annual Report. For demonstrative purposes, the Panel reports on the complete set of FY14 data relating to demographics.

COUNTY OF INCIDENT

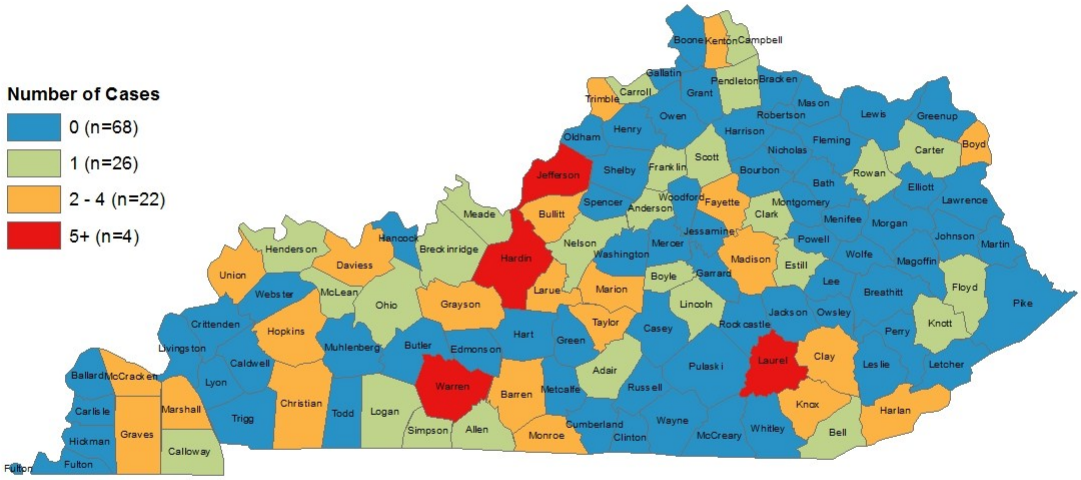
Cases Reviewed by County of Incident, 2014



December 6, 2016
Data Source: Child Fatality Near Fatality External Review Panel
Shapefiles from Kentucky Geography Network.
Prepared by Emily Ferrell, MPH CPH
104 cases total for this year.

Note: Not adjusted for county population

Cases Reviewed by County of Incident, 2015



December 6, 2016
Data Source: Child Fatality Near Fatality External Review Panel
Shapefiles from Kentucky Geography Network.
Prepared by Emily Ferrell, MPH CPH
116 cases total for this year.

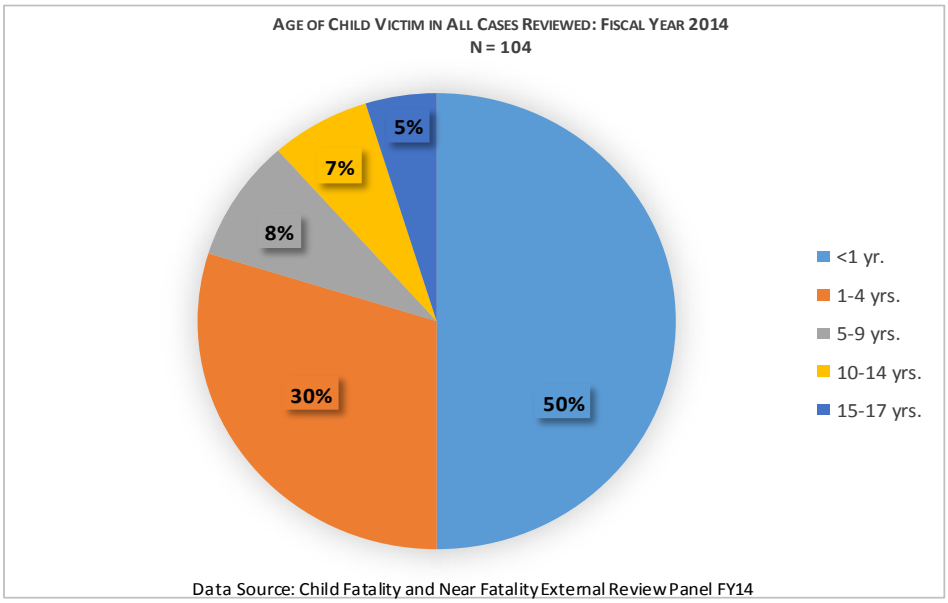
Note: Not adjusted for county population

DEMOGRAPHICS

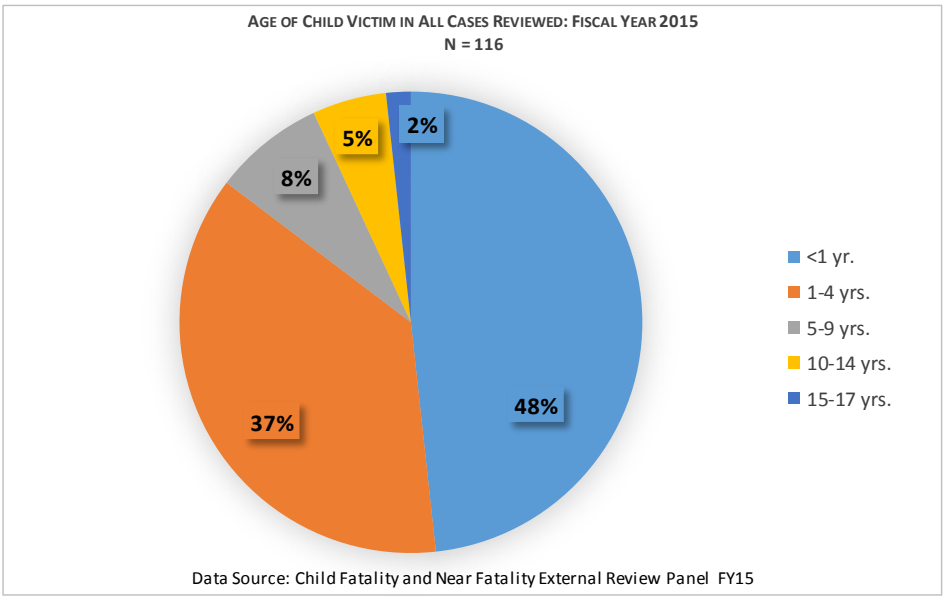
Age of Child Victim in All Cases Reviewed
Fiscal Years 2014 and 2015

AGE	2014		2015	
	# Cases	Percent	# Cases	Percent
< 1	52	50.00	56	48.28
1-4	31	29.81	43	37.07
5-9	9	8.65	9	7.76
10-14	7	6.73	6	5.17
15-17	5	4.81	2	1.72
Total	**104**		**116**	

Data Source: Child Fatality and Near Fatality External Review Panel Data FY14 and FY15



Data Source: Child Fatality and Near Fatality External Review Panel FY14



Data Source: Child Fatality and Near Fatality External Review Panel FY15

DEMOGRAPHICS

Gender of All Cases Reviewed FY14 and FY15

	2014		2015	
Gender	**# Cases**	**Percent**	**# Cases**	**Percent**
Male	69	66%	72	62%
Female	35	34%	44	38%
Total	104	100%	116	100%

Data Source: Child Fatality and Near Fatality External Review Panel Data, Fiscal Years 2014 and 2015

Race of All Cases Reviewed FY14 and FY15

	2015		2014	
Race	**# Cases**	**Percent**	**# Cases**	**Percent**
Black	11	9%	13	13%
White	90	78%	86	83%
Other	15	13%	5	5%
Total	116	100%	104	100%

Data Source: Child Fatality and Near Fatality External Review Panel Data, Fiscal Years 2014 and 2015

Ethnicity of All Cases Reviewed FY14 and FY15

	2015		2014	
Ethnicity	**# Cases**	**Percent**	**# Cases**	**Percent**
Hispanic	6	5%	4	4%
Non-Hispanic	110	95%	100	96%
Total	116	100%	104	100%

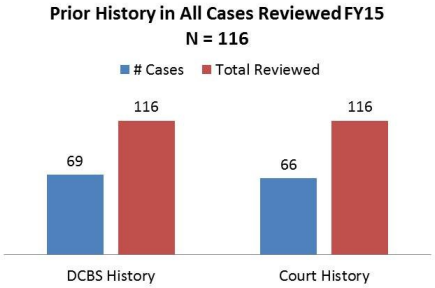
Data Source: Child Fatality and Near Fatality External Review Panel Data, Fiscal Years 2014 and 2015

Findings Specific to Fiscal Year 2015

FINDINGS AND DETERMINATIONS

After a thorough discussion of each case, the Panel makes findings and recommendations for systems and process improvements to help prevent child fatalities and near fatalities that are due to abuse and neglect. The Panel designates the final categorization or type of case, identifies the risks that may have contributed to the fatality or near fatality and makes a final determination of whether abuse or neglect exists. The following pages provide findings specific to fiscal year 2015 (FY15) case review.

Prior History



Data Source: Child Fatality and Near Fatality Review Panel FY15

In FY15, 59% of cases reviewed by the Panel had a prior history with child protective services (CPS) and 57% had a history in criminal and/or in a dependency, neglect, or abuse proceeding in Family/District Court. Among those with a CPS history, the number of prior contacts averaged 4.25. The history with the court system was 6.2 prior contacts among those with a prior court history.

Final Categorization All Cases FY15

Category	Fatalities	Near Fatalities	Total
Physical Abuse w/ Evidence of Abusive Head Trauma	6	27	33
Blunt Force Trauma Not Inflicted	6	10	16
Overdose/Ingestion	3	11	14
Sudden Unexplained Death of an Infant	10	0	10
Natural Causes/Medical Diagnosis	0	8	8
Physical Abuse/No Evidence of Abusive Head Trauma	1	6	7
Drowning	4	2	6
Undetermined Cause of Death/Near Death	4	2	6
Positional Asphyxia	4	1	5
Physical Abuse w/Evidence of Torture	1	3	4
Apparent Murder/Suicide	3	0	3
Gunshot Accidental	1	2	3
Failure to Thrive / Malnutrition	2	1	3
Traumatic Asphyxia	2	1	3
Neglect	0	3	3
Administration of Deadly Substance	1	1	2
Sexual Abuse	1	0	1
Smoke Inhalation/Fire	1	0	1
Burn	0	1	1
Attempted Murder	0	1	1

Data Source: Child Fatality and Near Fatality External Review Panel Data FY15

Findings Specific to Fiscal Year 2015

KEY FINDINGS FY15

→ Substance abuse was found to be the most common risk factor in all cases reviewed by the Panel.

→ The most common risk factors contributing to the fatality/near fatality in order of precedence for FY15 cases reviewed:

–substance abuse by a caregiver

–mental health issues, caregiver

–substance abuse in the home

–prior criminal history

–family violence

–prior history with child protective services

→ Physical Abuse and Abusive Head Trauma are the most frequent Panel determinations.

→ 59% of the cases reviewed from FY15 had a prior history with child protective services with an average of 4.25 prior contacts.

→ Nearly one half of all cases reviewed involve an infant under twelve months of age.

→ In cases where the Panel determination was neglect due to unsafe sleep, 59% of those involved substance abuse by the caregiver.

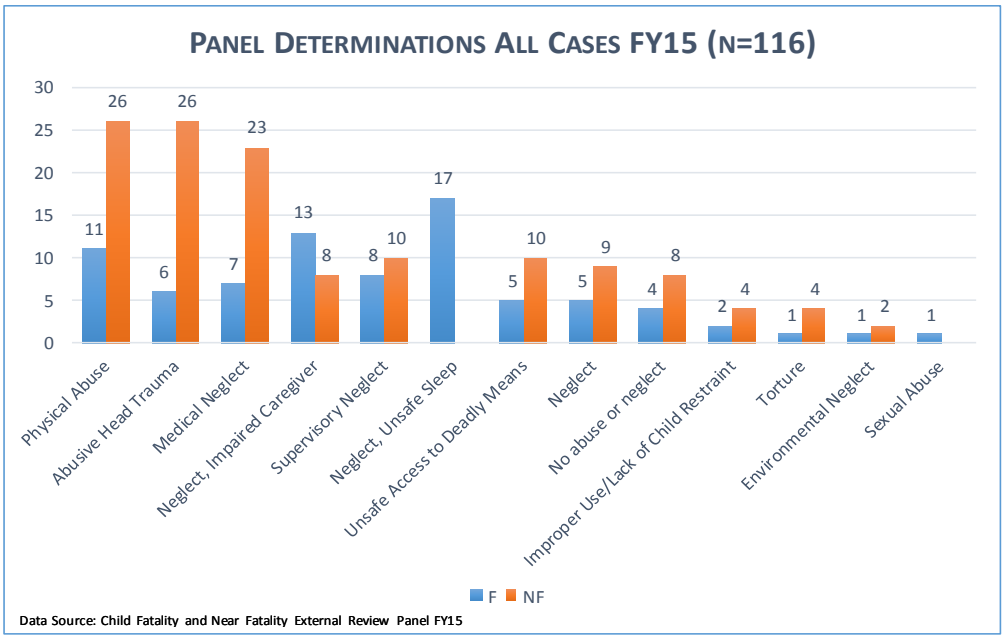
→ Over 85% of the cases reviewed were children under the age of four.

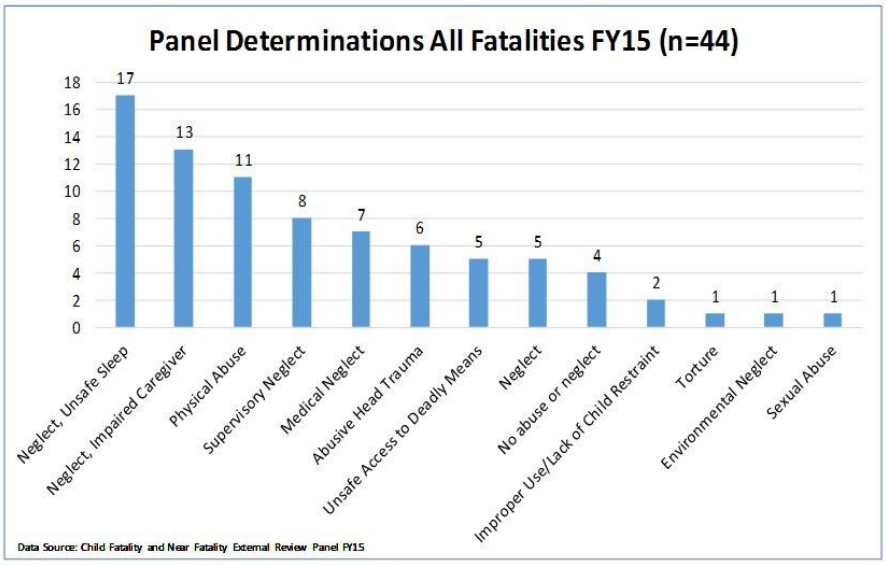
Panel Determinations All Cases FY15

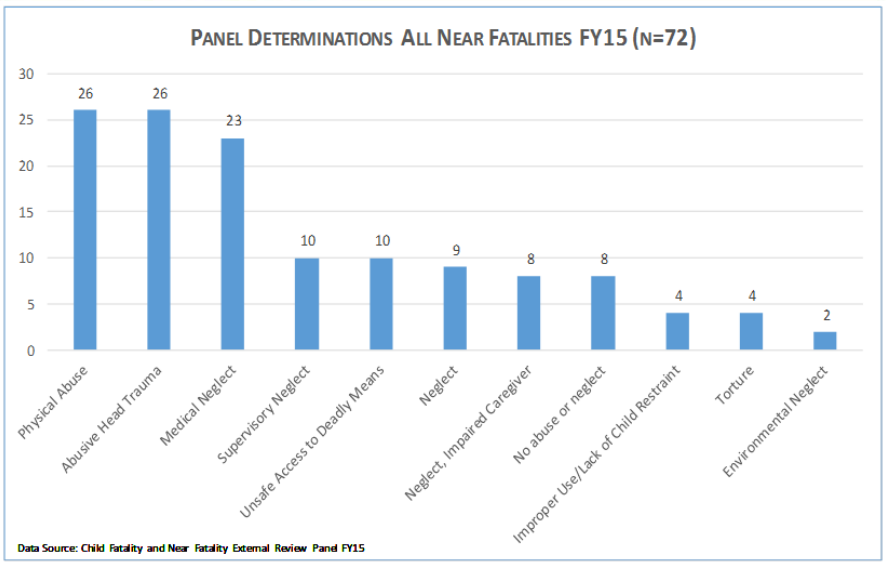
Determination	Fatalities	Near Fatalities	Total
Physical Abuse	11	26	37
Abusive Head Trauma	6	26	32
Medical Neglect	7	23	30
Neglect, Impaired Caregiver	13	8	21
Supervisory Neglect	8	10	18
Neglect, Unsafe Sleep	17	0	17
Unsafe Access to Deadly Means	5	10	15
Neglect	5	9	14
No abuse or neglect	4	8	12
Improper Use/Lack of Child Restraint	2	4	6
Torture	1	4	5
Environmental Neglect	1	2	3
Sexual Abuse	1	0	1

Data Source: Child Fatality and Near Fatality External Review Panel Data, FY 2015

Findings Specific to Fiscal Year 2015







Findings Specific to Fiscal Year 2015

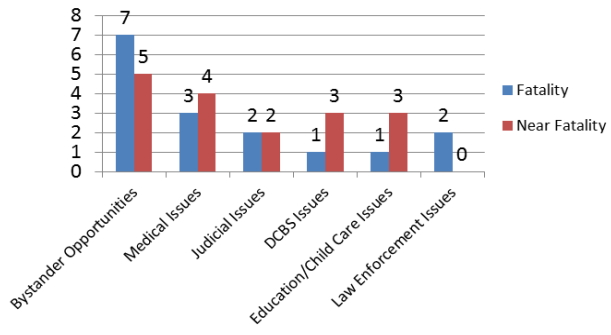
Risk Factors Contributing to the Fatality or Near Fatality

Most Common Risk Factors Identified as Contributing to the Fatality/Near Fatality Among All Cases FY15

Most Common Risk Factors	Fatality	Near Fatality	Total
Substance Abuse, Caregiver	18	25	43
Mental Health Issues, Caregiver	12	22	34
Substance Abuse in the Home	16	17	33
Criminal History Caregiver	17	15	32
Family Violence	12	17	29
DCBS History	10	14	24
Impaired Caregiver	12	10	22
Supervisional Neglect	10	9	19
Medical Neglect	3	13	16
Unless Access to Deadly Means	6	9	15
Lack of Substance Abuse/Mental Health Treatment	5	9	14
Substitute Caregiver	7	7	14
Financial	9	3	12
Bystander Opportunities	7	5	12
Medically Fragile/Neonatal Abstinence Syndrome	8	3	11
Neglectful Entrustment	4	6	10
Cognitive Disability Caregiver	3	6	9
Unsafe Sleep, Bedsharing	6	1	7
Medical Systems Issues	3	4	7
Absence Support System	2	3	5
Unsafe Sleep, Other	6	1	5
Judicial Issues	2	2	4
DCBS Systems Issues	1	3	4
Education/Child Care Systems Issues	1	3	4
Housing	2	2	4
Mental Health Issues, Child	2	1	3
Perinatal Depression	2	1	3
Serial Relationships	1	2	3

Data Source: Child Fatality and Near Fatality Review Panel FY15

Systems Issues Identified as Risk Factors that May Have Contributed to the Fatality/Near Fatality FY15 (N = 33)

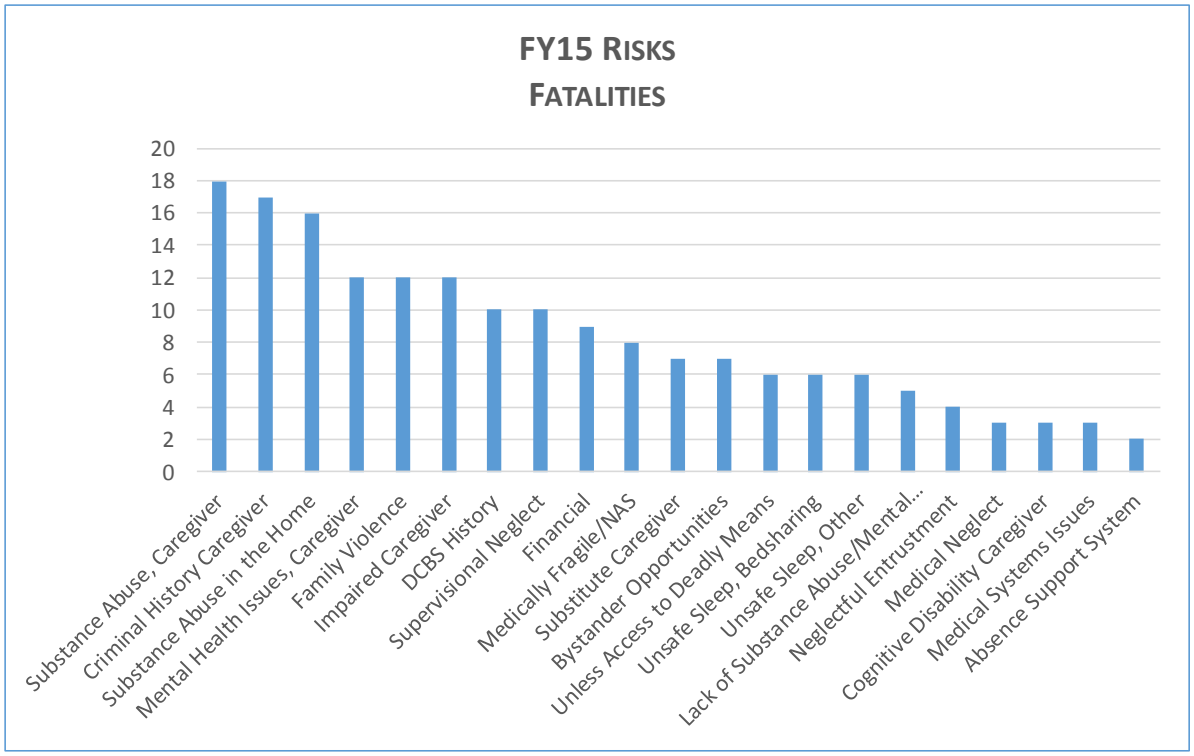


Data Source: Child Fatality and Near Fatality External Review Panel FY15

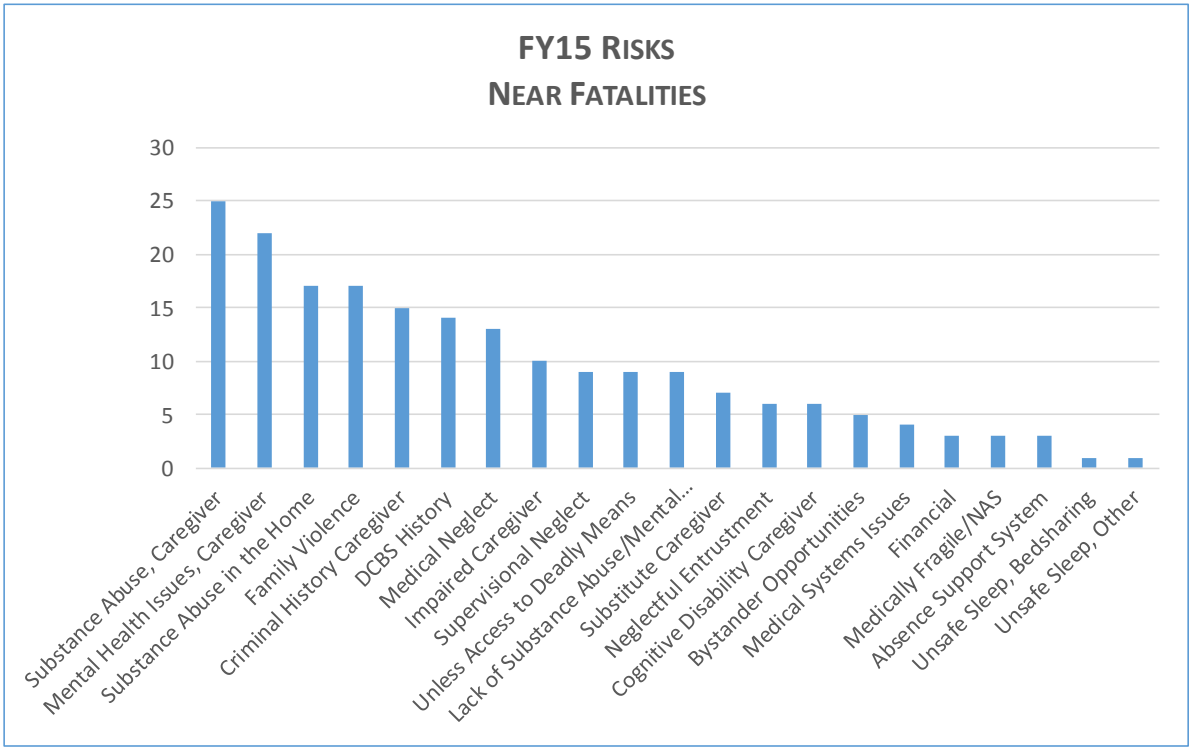
Among the 116 cases reviewed from FY15, systems issues that may have contributed to the fatality/near fatality were identified in thirty-three cases which represents 28% of the cases. The most common systems issue is bystander opportunities. Bystander opportunities occur when someone suspected abuse or neglect but failed to report to authorities. KRS 620.030 requires anyone who knows or has reasonable cause to believe that a child is abused or neglected, shall report to DCBS, to law enforcement, or to the Commonwealth's or county attorney. The next most common systems issue identified was medical issues: someone in the medical system failed to notice the indicators of abuse, failed to report the abuse, or failed to follow best practices/ follow up on high risk cases.

Findings Specific to Fiscal Year 2015

Most Common Risk Factors



Data Source: Child Fatality and Near Fatality External Review Panel Data, Fiscal Year 2015



Data Source: Child Fatality and Near Fatality External Review Panel Data, Fiscal Year 2015

Findings Specific to Fiscal Year 2015

In 2016, as a part of the determinations associated with any particular case, the Panel began identifying whether the circumstances in the case made the incident potentially preventable. The chart below shows the number of cases where the finding included circumstances that made the incident potentially preventable. Of the 44 cases involving a child fatality, the Panel determined that 45% of those deaths were potentially preventable. Among near fatality cases, 24% were determined to be potentially preventable.

Potentially Preventable Fatalities and Near Fatalities FY15
N = 116

	# Cases	Total	Percent
Fatalities	20	44	45%
Near Fatalities	17	72	24%
Total	37	116	32%

Data Source: Child Fatality and Near Fatality Review Panel FY15

Panel findings specific to Fiscal Year 2015 (FY15) include an in-depth analysis of the risk factors associated with the two most common Panel Determinations: Physical Abuse and Abusive Head Trauma. Cases included in this data are those with a date of incidence July 1, 2014 through June 30, 2015.

The chart below illustrates the most common risk factors identified as contributing to the fatality/near fatality with a Panel determination of Physical Abuse or Abusive Head Trauma. The most notable risks associated with these determinations in order of precedence: family violence, substance abuse by the caregiver, substance abuse in the home, and mental health issues of the caregiver.

Most Common Risk Factors Identified as Contributing to Fatality/Near Fatality Among Cases with a Panel Determination of Physical Abuse or Abusive Head Trauma (AHT) [n=46*]

Risk Factor	# Cases	% Cases
Family Violence	16	34.8
Substance Abuse, Caregiver	16	34.8
Substance Abuse in Home	14	30.4
Mental Health Issues, Caregiver	13	28.3
Criminal History, Caregiver	11	23.9
DCBS History	10	21.7
Substitute Caregiver	10	21.7
Bystander Opportunities	7	15.2
Financial Issues	7	15.2
Medical Neglect	7	15.2
Neglectful Entrustment	7	15.2

Data Source: External Review Panel for Child Fatality and Near Fatality Data, 2015
*23 cases had panel determinations for physical abuse and AHT; 14 were physical abuse only; 9 were AHT only
Other risk factors were identified in less than 10% of cases.

2016 RECOMMENDATIONS

PRIORITY RECOMMENDATIONS

I. Address the substance abuse epidemic affecting families across the state.

The most common risk factor among cases reviewed by the Panel was identified as substance abuse. Nationally, between 60-80% of child protection cases where abuse or neglect is substantiated involve substance abuse by the custodial parent or guardian.[4] In Kentucky, addiction has reached epidemic levels where painkillers and heroin abuse are rampant.[5] Cases reviewed by the Panel have revealed that child safety is at risk when substance abuse is present. To that end, the Panel makes this recommendation as a priority to address the substance abuse epidemic.

A. Provide funding for and full implementation of Family Drug Courts in Kentucky.

The National Association of Drug Court Professionals (NADCP) identifies the family drug court model among the most effective programs for improving substance abuse treatment initiation and completion in child welfare populations. Family drug courts were created to address the poor outcomes derived from traditional family reunification programs for substance abusing parents. The family drug courts have been shown to be effective in terms of treatment completion, family reunification and in the time children spend in out of home care as well as in cost effectiveness. Information from the NADCP retrieved: http://www.nadcp.org/sites/default/files/nadcp/Reseach%20Update%20on%20Family%20Drug%20Courts%20-%20NADCP.pdf

Prior to 2009, Kentucky had several family drug courts operating across the state that were funded primarily through various federal grant programs. These programs were not funded through a budget enactment of the state legislature and the federal funding eventually ran out.

The Panel strongly recommends this Administration propose and the General Assembly support a pilot project to determine the cost-effectiveness of fully funding family drugs courts on a statewide basis. Much of the infrastructure already currently exists in some jurisdictions to effectively use drug court for abuse and neglect petitions filed in Family Court and District Court. Use of drug court can prevent removals of children, reunify families more quickly (both of which save foster care dollars that can be redirected to child protection investigations) and may save children's lives. As evidenced from the positive outcomes and proven effectiveness in other areas of the country, this single initiative may save the lives of some of our most vulnerable children. Also see http://www.cffutures.org/files/publications/FDC-Guidelines.pdf for recommendations on developing family drug court guidelines from the Center for Child and Family Futures.

B. Address the needs of infants with Prenatal Substance Abuse Exposure.

The Panel has identified children under the age of one are the most at risk population for fatalities and near fatalities. In fiscal year 2015, 48 percent of the cases reviewed by the Panel involved infants under the age of one. The Panel was able to document prenatal substance abuse exposure in nearly 20% of those cases.

Medical service providers need to be aware of and address the unique needs of these infants through wrap-around services and plans of safe care. Cases where the DCBS should be involved need to be identified at birth in order to provide the services needed to ensure safety. Further, DCBS cannot and does not accept all of these cases. So in many cases, the mother and child leave the hospital with no services and no oversight. For these high-risk cases, wrap-around services, case management, and home visiting by providers when leaving the hospital is necessary.

The Child Abuse Prevention and Treatment Act (CAPTA)[6] requires states to develop plans of safe care for infants with prenatal drug or alcohol exposure.[7] Kentucky is one of the first states to address this provision which requires health care providers involved in the delivery and care of such infants to notify child protective services who then must implement a plan to provide appropriate services. Funding and resources are recommended to continue this implementation and to ensure services are in place.

C. Other recommendations surrounding substance abuse issues.

- Hospitals, Obstetricians, Pediatricians, Family Practice, and Nurse Practitioners need to know about the HANDS (Health Access Nurturing Development Services) program and make appropriate referrals. For more information on the HANDS program, See http://chfs.ky.gov/dph/mch/ecd/hands.htm.
- Providers of Suboxone and other medically assisted treatment providers need to consider safety of children at home and provide education/warnings to patients. The Panel identified several cases where children, including infants, obtained access to parents', grandparents' and other family members' medication that had been prescribed to address substance abuse. These fatal and near fatal incidents could have been potentially prevented with adequate safety and handling of these medications.
- Provide adequate resources for substance abuse treatment. According to the Kentucky Office of Drug Control Policy, tens of thousands suffer from substance abuse disorders. Although treatment availability has risen in recent years, there remains a provider gap of not enough licensed professionals available to meet demand. Resources are needed to close this provider gap and make substance abuse treatment more available.
- In all of the mentioned strategies to address substance abuse issues, collaboration is again a critical feature. The family drug court model as well as other identified strategies, depend upon combined efforts from a team of professionals working in collaboration to meet the needs of families and children.

[4] Young, *et al*, 2007 Dr. Nancy Young, Executive Director, Center for Child and Family Futures.
[5] Kentucky Office of Drug Control Policy: http://odcp.ky.gov/Pages/default.aspx
[6] Child Abuse Prevention and Treatment Act, Public Law 93-247 2010 amendment requiring policy /procedures for hospital notification to CPS and requires CPS to develop plan of safe care. 2016 amendment requires plan of safe care to address treatment needs of affected family or caregiver.
[7] See http://www.cwla.org/wp-content/uploads/2016/09/SuperSession_SEI_Part1_Final.pdf for Implementing Plans of Safe Care Presentation from 2016 Child Welfare League Conference

PRIORITY RECOMMENDATIONS

II. Improve the social service delivery system by providing necessary funding to the Department for Community Based Services.

A. The Administration should propose and the General Assembly should assure the Department for Community Based Services is funded and resourced at the necessary level.

The Child Fatality and Near Fatality External Review Panel strongly recommends that the Governor propose and the General Assembly assure adequate resources in the next budget session. From all indicators, the Department for Community Based Services (DCBS) is grossly underfunded, under-resourced and therefore unable to achieve its mission of protecting children from death or serious physical injury in some cases. This mission is not a luxury for Kentucky children. There should be adequate resources provided in order to deliver a full service array to Kentucky's families and children. It has been readily apparent to the Panel that there are missed opportunities within all aspects of the child protection systems. DCBS is not the only agency that is a part of the system in place to protect our children. However, despite this shared responsibility, DCBS is the agency statutorily accountable for child protection and is the proper agency in which to invest for our children's future protection.

B. The Department for Community Based Services should examine and improve current practice.

1. The Department for Community Based Services (DCBS) should examine the worker caseload and experience on all cases involving fatal or near fatal child abuse.

After making requests for several years, the Panel has recently received data regarding caseloads and worker experience. Based on initial review of this data, it is apparent many workers' caseloads vary and often greatly exceed recommended standards.

2. DCBS should review current practice, research best practice standards, and develop policies creating supervisory review of reports determined to be high risk.

Criteria should include indicators such as reports on children age three or under, families with multiple previous reports, reports from professional sources, etc. The administration should assure caseloads are addressed to allow for adequate staff to investigate reports, provide necessary supervisory oversight, and provide services to families found at risk.

3. DCBS "screening out" of referrals of suspected child abuse and neglect reports has been a concern noted in previous reports and is again of concern from the reviews conducted in 2016.

Of the cases reviewed by the Panel in 2016, 59% of cases had a prior history with DCBS. Of these cases, on average, there were 4.25 prior number of contacts with DCBS before the fatal/near fatal event. We found that some of these prior contacts had been "screened out," meaning an investigation was not conducted. The screening out of cases serves multiple purposes, many of which are appropriate. However, due to current caseloads and inadequate funding, the process for screening out cases may also serve to control workload. This practice can leave children at risk. Had some of the screened out reports actually been investigated, perhaps conditions would have been discovered that led to a different outcome for some of the children in the cases reviewed by the Panel. Current practice also appears to be inconsistent in various areas of the state. Additionally, screening out of reports has been identified as an area of practice needing improvement by the Commission to Eliminate Child Abuse and Neglect Fatalities.

4. The Panel recommends that DCBS continue to strengthen the internal review process required in KRS 620.050 as a part of its overall quality improvement efforts. The DCBS recently updated the internal review process in order to address recommendations made by the Panel. The Panel recommends that DCBS continue to strengthen this internal review process as a part of its overall quality improvement efforts.

5. To serve families effectively, DCBS must have the staff to partner with other community members, including mental health providers, medical service providers, law enforcement, the courts, schools, Family Resource and Service Centers (FRYSC), court appointed special advocates, foster parents, and others who come into contact with families with children.

Engaging families and their informal support systems is a critical best practice. Developing and engaging partners creates a greater safety net for at-risk children. Creation of a strong safety net also requires time, adequate funding and adequate staffing. Family team meetings should include community providers as part of the strong safety net. A family team meeting is a tool for engagement used to assist a family in achieving safety, permanency and well-being outcomes and sustainable family changes. This meeting should include family members and their informal support system, service providers, community representatives, the caseworker, the supervisor and possibly other resource staff from the child welfare agency. The Panel found Family Resource and Youth Service Centers to be well positioned to provide input into case planning for child safety. FRYSC Coordinators often have strong relationships with students and families that child protection service workers often investigate. FRYSC coordinators are in students' homes and are working with families to provide resources. They can often provide beneficial information to workers as cases are substantiated that will help workers uncover additional concerns with children.

2016 RECOMMENDATIONS

GENERAL ASSEMBLY

1. The Kentucky General Assembly should enact legislation creating easily accessible and low-cost access to background checks for parents considering utilization of unregulated child care providers. When legislation is enacted, the Cabinet for Health and Family Services should develop materials to educate parents on selection of safe caregivers and information on obtaining background checks. Review of case findings note incidents of children being fatally or near fatally injured at the hands of unregulated child care providers. In some cases, the unregulated provider had criminal or child protective services histories. Currently, there is no easily accessible and affordable means for parents seeking childcare to conduct criminal and child protective services background checks on potential childcare providers.

2. The General Assembly should consider enactment of enhanced penalties when a driver is convicted of a driving under the influence offense (DUI) with a minor in the vehicle. The Kentucky Department of Transportation and the Kentucky State Police should collect data regarding the incidence of DUI with children in a vehicle and develop an awareness campaign regarding the incidence of DUI accidents involving children and the need for bystander intervention. In 2016, and in previous reports, the Panel reviewed cases in which children have been fatally or near fatally injured in vehicular crashes while riding with an intoxicated parent or caregiver. In one case, the caregiver had received a DUI citation with a child in the car and no report was made to DCBS by law enforcement. Additionally, multiple cases have been reviewed in which bystanders witnessed the caregiver driving with the child and no effort to intervene was documented. National research has noted that 65% of children under the age of 15 that are killed in DUI incidents are riding with an adult caregiver.

MEDICAL PROVIDERS

3. The Kentucky Hospital Association and Kentucky Chapter of the American Academy of Pediatrics should promote awareness and use of the two Pediatric Forensic Medicine centers within Kentucky. Pediatric Forensic Medical centers are located within the University of Louisville as the Kosair Charities Division of Pediatric Forensic Medicine and the University of Kentucky Department of Pediatrics. Each of the departments employ specially trained and certified pediatricians who specialize in the recognition, treatment and prevention of child abuse. These centers are a valuable resource to not only social service delivery providers, but also exist as a resource for members of the medical community. Case reviews have noted missed opportunities within the medical community in the recognition and reporting of indicators of child maltreatment. The Panel recommends full utilization of these centers.

4. Hospitals should be required/encouraged/incentivized to model safe sleep and provide verbal face-to-face education regarding safe sleep and Abusive Head Trauma prevention education to parents of newborns. In fiscal year 2015, the Panel made findings of neglect due to unsafe sleep in 17 cases where unsafe sleep practices was a risk factor in the death of these infants. Of all of the cases reviewed by the Panel, unsafe sleep was the most lethal: among all cases in which the Panel determination was neglect due to unsafe sleep, 100% were fatalities. In 2015, the Panel recommended and the Department for Public Health implemented a public awareness campaign on safe sleep practices. This 2016 recommendation now appeals to medical providers to model safe sleep practices in their facilities and to provide face to face education regarding safe sleep. Abusive Head Trauma was the final case determination in 32 cases from FY15 reviewed by the Panel. As in previous reports, the Panel is recommending adoption of best practices for providing Abusive Head Trauma prevention education to the parents of newborns within all Kentucky birthing centers.

LAW ENFORCEMENT

5 Law enforcement officers need to treat each child fatality/near fatality under the "hypothesis" that the child may have been a victim of maltreatment. Preservation of the scene may lead to a different investigative conclusion. The Panel has reviewed several cases where a documented scene investigation had not been completed. Also, as the Panel is aware, many child maltreatment deaths have a delay between the time the child sustains the fatal injury and the subsequent death of the child. With this in mind, law enforcement officers need to document a scene, once identified, as quickly as possible.

Bill Walsh highlights the need for timely and thorough investigations in an article published in 2005: *Investigating Child Fatalities*.

> "Although most sudden and unexpected deaths of children are not caused by abuse and neglect, you should approach every investigation with the hypothesis that the child may have been a victim of maltreatment. Maintain this position until the investigation is completed and the evidence conclusively proves otherwise. With this open approach, you guard against jumping to unsubstantiated conclusions or focusing the investigation too narrowly on what first appears to be the cause of death. Although this approach may appear biased toward suspecting the worst of parents and caretakers, it will ensure that you preserve evidence and witness statements early in the investigation. Documenting the events in question will prove very important if the investigation finds that the case does involve maltreatment."

6. Law Enforcement should complete and/or submit a JC3 to the DCBS in situations where child neglect, abuse, and maltreatment are of concern, or should be of concern, to the officer. A JC3 is a reporting form used by law enforcement to notify the DCBS of suspected child maltreatment. Law enforcement may associate having to fill out a JC3 solely when they encounter actual or suspected domestic violence issues. Law enforcement officers need to be reminded JC3s can and should be filled out for suspected child abuse/endangerment and promptly reported to the DCBS.

2016 RECOMMENDATIONS

7. The Department of Criminal Justice Training and other Kentucky law enforcement training entities should assure all law enforcement officers are trained in best practices for safeguarding children. The Panel has identified missed opportunities within law enforcement in investigating allegations of fatal or near fatal maltreatment, and in opportunities to identify high risk situations prior to the occurrence of a critical incident. During arrests or other interventions, law enforcement officers are presented with the opportunity to identify at risk children and engage the child protective services system as needed. It is critical for law enforcement officers to understand this role, and be able to implement best practice. There are published protocol and training guides available to inform best practice in Kentucky. For example, the International Association of Chiefs of Police, with support from the U.S. Department of Justice, has developed model policies for safeguarding children when a parent is arrested. For more information regarding model policies, see: http://www.iacp.org/Portals/0/documents/pdfs/

COORDINATION OF INVESTIGATIONS

8. Require Multidisciplinary Teams on Child Sexual Abuse (MDTs), established by KRS 431.600 and 620.040, to also review serious physical abuse cases. The Panel has seen good examples of how joint investigations between law enforcement and DCBS have enhanced the outcome in the criminal case. The Panel has also noted how the breakdown in communication between counties and jurisdictions, and between law enforcements and DCBS has detrimentally affected outcomes in cases and may have contributed to the risk of fatalities and near fatalities. There are MDTs that currently review serious physical injury cases. In 2014, and 2015, the Panel recommended coordination of investigations through MDTs as permissive and now recommends this to be a required practice.

COURTS

9. Judges who hear dependency, neglect and abuse (DNA) cases should use the Administrative Office of the Courts (AOC) mandated DNA series of forms and should adhere to the statutory timeframes required in these cases. To the extent practicable, AOC should audit the judiciary's compliance in these cases and provide a reporting component to judges.

Compliance with statutory timeframes is in the best interest of children, and additionally carries a significant fiscal impact to the state.

The Adoptions and Safe Families Act (ASFA) was passed by U.S. Congress for the purpose of achieving timely permanency for children in out of home care (OOHC). Prior to ASFA, state child welfare agencies were required to make reasonable efforts to reunify families, leaving children in OOHC in a state of limbo and in a never ending cycle of foster homes. Once ASFA was passed in 1997, it allowed, for the first time, the state child welfare agency to also make reasonable efforts to finalize a permanency plan for children in OOHC.

Although the primary goal of this legislation was to achieve timely permanency for children in OOHC, the federal government held states accountable through Title IV-E funding. When judges fail to make the necessary findings of reasonable efforts at each stage of the process, states are subject to losing federal funding and reimbursement for the child's stay in OOHC.

The Panel has seen cases where judges have failed to make the necessary findings thus disqualifying the state for Title IV-E funding/ reimbursement.

The AOC DNA series of forms were developed to assist the judiciary in making these required findings at each stage in the process. The failure of judges to utilize the forms and make the appropriate findings leaves the child welfare agency with fewer resources to provide services to these children. Since the Panel has determined that funding for child welfare is a priority issue, the Panel recommends that AOC audit and report to the judiciary to aid compliance with the statutory timeframes. This will enhance DCBS's ability to provide necessary services to at risk children.

Progress on 2015 Panel Recommendations

→ Open Dependency, Neglect and Abuse Proceedings

In the 2016 legislative session, the General Assembly passed SB40. KRS 21A.190, which became effective July 15, 2016, allows the judiciary to conduct open dependency, neglect, and abuse proceedings in pilot project sites. The Administrative Office of the Courts continues to move forward on this project. Sites have been chosen. Guidelines and an assessment tool are being developed.

→ Require Abusive Head Trauma and Safe Sleep education before discharge from hospital

The General Assembly did not pass any legislation concerning this recommendation. However, the Panel continues to look at legislative alternatives and other avenues for building support. Additionally, the data tool which will be launched in January, 2017, will be helpful in tracking whether hospitals deliver this education. Plans are being made to routinely inform hospitals of fatalities/near fatalities that occur from abusive head trauma and unsafe sleep.

→ Require Abusive Head Trauma and Safe Sleep education in Drug Courts, the Court Designated Worker Program. and in Family Court

The Administrative Office of the Courts distributed the "Safe Sleep Kentucky" campaign materials to Court Designated Workers, Citizen Foster Care Review Board volunteers and Specialty Courts (Drug Court) personnel in January of 2016. The information was disseminated by program staff and volunteers to children, families and program participants. Information included "Safe Sleep During Winter" and "ABC's of Safe Sleep". Recently, in October of 2016, Safe Sleep Kentucky materials were distributed at the Circuit Judges College. Materials included guides for safe sleep and pediatric abusive head trauma education. Judges were provided with videos on safe sleep in both English and Spanish, along with a video to help caregivers understand and cope with infant crying. All of these materials will also be distributed at the 2017 Judicial Symposium on Addiction and Child Welfare.

→ Coroner notification to law enforcement, DCBS, and health departments upon death of a child under eighteen

The Office of the Kentucky Medical Examiner continues to address this issue by looking for an efficient tool to capture the appropriate information. A new coroner brochure, checklist and training on procedures are being planned.

→ Multidisciplinary Teams in Child Sex Abuse should review physical abuse cases

Panel members and staff are addressing this need with the statewide commission on child sex abuse. The commission is partnering on a planned survey to determine which teams currently review these physical abuse cases and criteria for selection of those cases.

→ Law Enforcement to enhance enforcement of child safety seats in motor vehicles

The Panel continues to study this issue by looking at various motor vehicle reports for a better understanding whether citations were issued for impaired driving and lack of restraint. Data collection is ongoing.

→ DCBS should consider inadequate use of child safety restraints as an indicator of neglect

Proper child restraint (in many respects a public health issue) may best be addressed through continued education efforts and through programs which intervene to provide access to child restraints. DCBS reports that it is not feasible for DCBS to consider inadequate restraint as an indicator of neglect. Law enforcement addresses these cases as part of investigating traffic accidents.

→ DCBS Internal Review Process should be consistent with the statute and used as a quality improvement process

A new internal review process was formalized and began mid FY 2015. The updated process has allowed consistency in analysis of prior reports, as well as a standardized way to troubleshoot areas of concern. The Panel will begin to see all new internal reviews when they begin reviewing FY 16 cases.

→ DCBS should timely complete investigations of fatality/near fatality cases

Timely completion of fatality/near fatality investigations is imperative. Beginning in January 2017, the Panel will begin tracking the length of time of an investigation from report to conclusion.

→ DCBS should clearly indicate the number of pending cases in its Child Fatality and Near Fatality Annual Report

The Panel identified a trend of numerous pending cases at the time of the publication of the DCBS Child Fatality and Near Fatality Annual Report. This causes a consistent under-reporting of fatality and near fatality cases. This data should be updated periodically in a location accessible by the public, and the Annual Report should clearly indicate 1) the final case numbers for the previous year's report, and 2) the number of pending cases at the time of publication of the current year's report.

→ DCBS should provide to the Panel caseload, training, and experience of staff when in fatal/near fatal cases

This process is becoming more formalized. DCBS now provides this information to the Panel with each case and has provided this information for FY 2013 to 2015 cases. The DCBS plans to provide this information on each case as it is provided to the Panel. DCBS staff will continue to work with Panel staff on refining this process.

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

Liz Croney, Executive Director
KVC Behavioral Health

Dr. Melissa Currie, Child Abuse Pediatrician
University of Louisville's Kosair Charities Division of
Pediatric Forensic Medicine

Sherry Currens, Executive Director
Kentucky Coalition Against Domestic Violence

Lee Emmons, Executive Director
CASA of McCracken County

Joel Griffith
Prevent Child Abuse Kentucky

Dr. Sabrina Jo Grubbs
Mountain Comprehensive Care

Honorable Brent Hall
Hardin Family Court Judge

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

Adria Johnson, Commissioner
Department of Community Based Services

Det. Sgt. Scott Lengle
Kentucky State Police

Jenny Oldham
Hardin County Attorney

Betty Pennington
Family Resource and Youth Development Centers

Dr. Jaime Pittenger, Pediatric Hospitalist
University of Kentucky Department of Pediatrics

Dr. Hiram Polk, Commissioner
Department for Public Health

Dr. William Ralston
Kentucky State Medical Examiner

Joyce Robl
Department for Public Health

Steve Shannon
Kentucky Association of Regional Programs, Inc.

Ed Staats
Citizen Foster Care Review Board

MEMBERS WHO LEFT THE PANEL IN 2016

Teresa James, Commissioner
Department of Community Based Services

Nicky Jeffries, Executive Director
CASA of Kenton and Campbell Counties

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

Dr. Stephanie Mayfield, Commissioner
Department for Public Health

Dr. Owen Nichols
CEO, North Key Community Care

Maxine Reid
Family Resource and Youth Development Centers

Dr. Ruth Shepherd
Department for Public Health

PANEL STAFF

Tim Havrilek, Justice and Public Safety Cabinet Administrator

Lyn Bruckner, Staff Attorney

Marlene Mundine, Executive Staff Advisor

COMMISSION TO ELIMINATE
CHILD ABUSE AND NEGLECT FATALITIES

FACT SHEET

Within Our Reach: A National Strategy to Eliminate Child Abuse and Neglect Fatalities

The Commission to Eliminate Child Abuse and Neglect Fatalities (CECANF) was established by the Protect Our Kids Act of 2012 to develop a national strategy and recommendations for reducing child fatalities resulting from abuse and neglect. The establishment of the Commission followed numerous congressional hearings, a Government Accountability Office (GAO) report reviewing this issue, as well as far too many stories highlighting these deaths as preventable. Beginning in 2014, twelve Commissioners, appointed by the president and Congress, began a two-year process of holding public hearings in 11 jurisdictions to hear from state leaders, local and tribal leaders, child protection and safety staff, advocates, parents, and more.

Key Findings:

• An estimated four to eight children a day, every day, die from abuse and neglect.

• Children who die from abuse and neglect are overwhelmingly young; approximately one-half are less than a year old, and 75 percent are under 3 years of age.

• A call to a child protection hotline is the best predictor of a child's potential risk of injury death before age 5.

• A number of children who die were not known to child protective services (CPS) but were seen by other professionals (e.g., health care), highlighting the importance of coordinated and multisystem efforts.

• Access to real-time information about families is vital to child protection efforts, but legal and policy barriers prevent this from occurring.

• We do not know the exact number of children who die from abuse and neglect, although we know it is critical to have these data to understand what works.

• We know a lot about what puts children at risk, but there are few promising solutions and only one evidence-based practice shown to reduce fatalities—the Nurse-Family Partnership.

Our report outlines a strategy for how to realign our organizations and communities to protect our children at highest risk of fatality from abuse or neglect. CPS agencies play a critical role, but waiting until a severe injury has occurred to allow CPS to intervene misses numerous opportunities to protect these children in their communities across this nation. By combining a proactive approach to child safety with a more strategic response, we hope to make prevention of fatalities from abuse and neglect standard practice.

All of our recommendations should be implemented as soon as possible, but we highlight 10 that lie at the heart of our strategy.

Recommendations to save children's lives today: We believe the following six recommendations should be implemented immediately:

1. States should undertake a retrospective review of child abuse and neglect fatalities from the previous five years to identify family and systemic circumstances that led to fatalities. Congress and the administration have significant roles in the implementation and oversight of this recommendation.

2. Every state should review their policies on screening reports of abuse and neglect to ensure that the children most at risk for fatality—those under age 3—receive the appropriate response, and they and their family are prioritized for services, with heightened urgency for those under the age of 1.

3. The administration should lead an initiative to support the sharing of real-time information among key partners such as CPS and law enforcement.

4. State receipt of funding from the Child Abuse Prevention and Treatment Act (CAPTA) should be contingent on existing child death review teams also reviewing life-threatening injuries caused by child maltreatment.

5. All other programs—such as Medicaid and home visiting programs—should be held accountable for ensuring their services are focused on reducing abuse and neglect fatalities.

6. Federal legislation should include a minimum standard designating which professionals should be mandatory reporters of abuse or neglect, and these professionals should receive quality training.

Recommendations that lay the groundwork for our national strategy: Large-scale reform does not happen overnight. Four additional recommendations are critical to begin now:

1. Elevate the U.S. Department of Health and Human Services' (HHS') Children's Bureau to report directly to the Secretary of HHS.

2. Using information from their review of fatalities, every state should be required to develop and implement a comprehensive state plan to prevent child abuse and neglect fatalities.

3. Congress should conduct joint committee hearings on child safety, provide financial resources to support states, and encourage innovation to reduce fatalities. While all Commissioners agreed that funding is needed to support these efforts, no consensus was achieved on the amount of funds to be provided.

4. Congress should support flexible funding in existing entitlement programs. Some high-cost interventions, such as long-term group care and generic parenting programs, have been demonstrated as less effective. Reinvesting resources might improve outcomes.

Throughout our process, we identified three groups of children who present unique challenges when it comes to preventing child abuse and neglect fatalities: children known to the CPS system today who are at high risk of an abuse or neglect fatality, American Indian/Alaska Native (AI/AN) children for whom little if any data exist, and African American children who die from abuse and neglect at a rate that is two-and-a-half times greater than that of white or Hispanic children. The following are key recommendations offered to Congress, the administration, and state and tribes to address these groups:

1. Analyze data from past fatalities to identify the children who are at greatest risk right now.

2. Improve and support data collection about child abuse and neglect fatalities of AI/AN children, and work to improve collaborative jurisdictional responsibility for these children's safety.

3. Conduct pilot studies of place-based intact family courts in communities with disproportionate numbers of African American child maltreatment fatalities.

A Public Health Approach to Child Safety: The Commission's recommendations reflect a public health approach to child safety that engages a broad spectrum of community agencies and systems to identify, test, and evaluate strategies to prevent harm to children based on three interrelated core components:

1. ***Leadership and Accountability*:** Strong leaders at every level—federal, state, local, and tribal—are needed.

2. ***Decisions Grounded in Better Data and Research*:** We need to collect, share, and utilize real-time, accurate data to ground child protection decisions.

3. ***Multidisciplinary Support for Families*:** Everyone has a role. Cross-system prevention and earlier intervention are critical to building and sustaining healthier families and communities.

Conclusion: The Commission's recommendations will support stronger CPS agencies that are better able to use data to identify and protect children with greater accountability. CPS agencies remain critical, leading the effort and responding quickly. But they share the responsibility for child safety with multiple partners that touch these vulnerable families in these communities. States, tribes, counties, and local communities play a critical role in eliminating fatalities from abuse and neglect, but the president and Congress have the opportunity to provide the necessary tools. For a copy of the full report, go to https://eliminatechildabusefatalities.sites.usa.gov.

Child Fatality and Near Fatality External Review Panel

CATEGORIZATION

Abusive head trauma
Physical abuse
Apparent murder-suicide (child perp or adult perp) [At least one other person was killed by an adult or child who then commits suicide]
Blunt force trauma - not inflicted (farming machinery, ATV, fall)
Blunt force trauma - not inflicted MVC
Burn
Carbon monoxide
Drowning/near-drowning
Failure to thrive/malnutrition
Gunshot – accidental
Gunshot – homicide
Natural causes/medical diagnosis
Neglect
Overdose/ingestion
Sexual abuse/ human trafficking
Smoke inhalation/fire
SUDI/near-SUDI/Apparent life threatening event (< one year of age)
Suicide (child)
Traumatic asphyxia
Undetermined (cause of death or near-death event)
Other _____

RISKS THAT MAY HAVE CONTRIBUTED TO F/NF

Bystander issues/opportunities _____
Cognitive disability, caregiver
Cognitive disability, child
Criminal history, caregiver
Criminal history in the home
DCBS history
DCBS issues _____
Deployment/redeployment in household
Education/childcare issues _____
Failure to thrive
Family violence
Financial struggles
Impaired caregiver (any indication)
Inadequate restraint
Judicial process _____
Lack of regular child care
Lack of support system for family
Lack of treatment-mental health or substance abuse
Law enforcement _____
Medical issues/management (improper, inadequate, lack of access, etc.)
Medical neglect
Medically fragile child (NAS, disability, autism, etc.)
Mental health issues, caregiver
Mental health issues, child
Military systems Issues_____
Neglectful entrustment
Perinatal depression, caregiver
Substance abuse in home
Substance abuse, caregiver (current)
Substance abuse, child
Substitute caregiver at time of event (a person who is not typically a caregiver on a regular basis)
Supervisional neglect
Unsafe access to deadly means
Unsafe sleep, bedsharing
Unsafe sleep, cosleeping/non-bed surface
Unsafe sleep, other
Unstable housing
Other _____

OTHER QUALIFIERS

Apparently accidental
Potentially preventable
Manner undetermined/foul play not ruled out

PANEL DETERMINATION

Abusive Head Trauma
Physical Abuse
Neglect, general (can include leaving child with unsafe caregiver)
Neglect, medical
Neglect due to impaired caregiver
Neglect due to inadequate/absent child restraint in a motor vehicle
Neglect due to unsafe access to deadly/potentially deadly means (includes ingestions, injury due to child's access to gun, unsafe access to car, ATV, or farm machinery, etc.)
Neglect due to unsafe sleep
No abuse or neglect
Sexual Abuse
Supervisory neglect
Torture
Other_____

The Commonwealth of Kentucky does not discriminate on the basis of race, color, religion, sex, national origin, sexual orientation or gender identity, ancestry, age, disability, political affiliation, genetic information or veteran status in accordance with state and federal laws.

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