Kentucky Board of Pharmacy Advisory Council

Kentucky Board of Pharmacy
via teleconferencing at
https://us02web.zoom.us/j/83613669515?pwd=RTgwMTdOZnRIU3ZoTDYxejBOWUdQdz09
Meeting ID: 836 1366 9515 Password: 0gpyZp

Dial by your location
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Meeting ID: 836 1366 9515 Password: 999250
June 18, 2020
1:00 p.m.

Agenda

I. Call to Order

II. Opening remarks by Chair Matt Martin

III. Approval of Minutes from June 11, 2020

IV. Discussion items:

A. Enhanced Safety Packaging
"**Child Fatality and Near Fatality Panel – Request for enhanced safety packaging [blister packs]** Larry Hadley and Katie Busroe presented a request from the Program Review and Investigations Committee at LRC for enhanced safety packaging for commonly used prescription drugs. Craig Martin moved to refer this to the Advisory Council. Peter Cohron seconded, and the motion passed unanimously. *The charge to the council is to review and consider the recommendations presented in the request from the Child Fatality and Near Fatality Panel.* John Fuller requested the council also consider the cost involved with the implementation of the enhanced safety packaging."

V. Adjournment

2019 Annual Report

Child Fatality and Near Fatality External Review Panel

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

EXECUTIVE SUMMARY

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

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

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

All statutorily required terms of members were replaced/reappointed during the fiscal year. Per statute, the Legislative Program Review and Investigations Committee conducted their annual review of the Panel and presented the report on July 12, 2019. The report recommended the General Assembly consider changing the due date of the Panel's annual report to February 1st to provide the Panel additional time to review all the cases from the previous fiscal year. It further recommended the Panel establish a policy for the destruction of electronic documents nearing the 5-year retention period and that the Panel's recommendations should be easily identifiable and clearly stated. Panel members support these recommendations. Extending the deadline for the annual report would allow members additional time to focus on the recommendations contained within their report. Panel staff worked with the Commonwealth Office of Technology and all electronic records will be automatically destroyed after the 5-year retention date.

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

Throughout 2019, the Panel met six (6) times including a two-day session in October.[1] Cases reviewed were from state fiscal year 2018 (July 1, 2017 through June 30, 2018). The Panel reviewed 136 cases comprised of 54 fatalities and 82 near fatalities. Of the 54 fatalities, 6 of the cases were reported to DCBS as near fatalities which ultimately resulted in a fatality. Fifteen (15) fatality cases were referred to the Panel from the Department for Public Health.

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

INTRODUCTION

The death or near death of a child is sentinel event that requires a multidisciplinary review to understand the risk factors and focus on recommendations to keep children healthy, safe, and protected. It is important to understand the Panel's philosophy regarding the case review process. The Panel examines cases from a systemic multidisciplinary lens. As part of the case review process, the Panel identifies concerns or missed opportunities as a tool to inform prevention and system improvement opportunities. The Panel examines system issues within the broad child welfare system, including the Department for Community Based Services (DCBS), law enforcement, the judicial system, mental health and medical providers, schools, and community members.

The review process continues to be refined by utilization of expert case analysts from the medical and/or social work field. The Justice and Public Safety Cabinet employs a full-time case analyst and contracts with medical analysts for these reviews. The analysts are responsible for presenting case summaries and triaging all cases for the Panel's review. This process has resulted in a more efficient use of Panel members' time and continues to allow them to review cases referred from other sources outside of DCBS.

The Panel recognizes there may be an appearance they place additional scrutiny on DCBS during these complex case reviews. While cases may be received from the Department for Public Health, those cases represent a mere 11% of the total cases reviewed. DCBS has the statutory responsibility to respond to every allegation of child abuse or neglect and is, therefore, involved in nearly every case that comes before the Panel. By virtue of that fact, there is an appearance of greater focus on that agency. This is a reflection of the type of cases brought before the Panel, not a result of an intentional focus on that specific agency.

Panel members, individually and as a group, have consistently acknowledged respect for the critical work carried out daily by the front-line social workers and their supervisors. It is a tireless and often thankless profession. Over the years the Panel has repeatedly recognized and discussed issues such as high caseload and worker burnout. The Panel has strongly advocated for additional resources for DCBS in prior annual reports and in testimony before the General Assembly. Additionally, the Panel has specifically asked DCBS leadership how the Panel's work can best support the agencies needs.

Unequivocally, the Panel believes missed opportunities or system failures found in reviews are never the result of an intentional or wanton act of any involved individual. System issues are not the fault of an individual, but failures of the system. The Panel does not seek to "blame" any agency and certainly not any individual. There are cases in which the Panel finds missed opportunities or concerns and these are opportunities for system improvements, not scapegoating of individuals.

The Panel recognizes difficult decisions are made by front line staff, in crisis situations, with limited information, and in the context of agencies beleaguered with staff shortages and limited resources. For several years the Panel has requested data to better understand the decision making process at the time of the event. The Panel has previously recommended DCBS develop quality assurance focused reviews, designed to identify the casual factors behind adverse events. After many years, DCBS has reported progress by implementing the Culture of Safety model. The Panel looks forward to integrating the Culture of Safety findings in their case review process to better understand the systemic issues facing their staff. DCBS leadership has also requested the opportunity for front line staff to join the Panel in case discussions. Panel members unanimously supported this idea, and look forward to developing a process to hear directly from front line staff, as well as other community stakeholders. The Panel is not interested in blaming individuals, but seeking accountability among policy and decision makers tasked with supporting the systemic changes required to keep children safe from abuse and neglect.

FEDERAL DATA COMPARISON

The objective of the Panel's work is to recommend system and process improvements to prevent child fatalities and near fatalities due to abuse and neglect. The Panel acknowledges its findings are based upon a small proportion of the 57,626 reports of maltreatment in Kentucky.[2] In an effort to assure Panel findings are representative of broader systems issues, the Panel has included data from Department for Health and Human Services reports. *Child Maltreatment*, 2017 (DHHS, 2018) is an annual report compiled from the National Child Abuse and Neglect Data System which analyzes state level data on child abuse and neglect. The Child and Family Services Reviews (CFSR) is a case review process structured to assist states in identifying strengths and areas of improvement within their agencies and programs. One of the three primary goals of CFSR parallel's with the Panel's goal, "to determine what is actually happening to children and families as they are engaged in child welfare services."[3]

Several data points from the *Child Maltreatment*, 2017 support findings in the Panel's annual report:

1. Kentucky screens out 49.1% of referrals which is higher than the national average of 42.4%.[4]
2. The youngest children are the most vulnerable to maltreatment. Nationally, states report that more than one-quarter (28.5%) of victims are younger than 3 years old.[5]
3. In Kentucky, 53.4% of child victims have substance abuse by a caregiver as a risk factor. The national average is 30.8%.[6]

In large part, the findings of the 2016 Child and Family Services Reviews are also consistent with the Panel's review of FY 2018 cases.

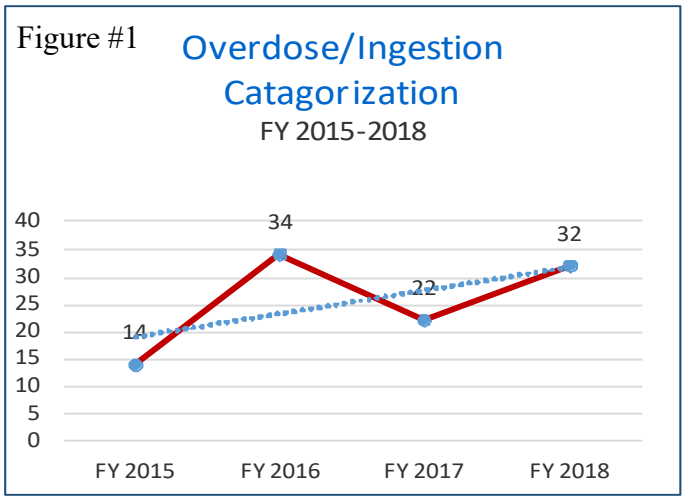
1. The CFSR noted, *"Case reviews indicated significant challenges in achieving safety and well-being outcomes in in-home services cases."* The report cites lack of quality case worker visits as a primary issue leading to inadequate assessments and insufficient safety planning.
2. Parents were not fully engaged in case planning and services were not provided.
3. Community partners identified staff turnover and high caseload as significant concerns. Changes in caseworkers within a single case were associated with delays in service delivery.
4. Assessment and stakeholder data indicated Kentucky lacks a functioning statewide quality assurance.
5. The Commonwealth's array of services is not adequate or accessible to children and families in all areas of the state.

It should be noted the CFSR sets very high standards and few states achieve substantial compliance. The Child and Family Services Reviews further state, "…because child welfare agencies work with our nation's most vulnerable children and families, only the highest standards of performance should be considered acceptable." [7]The Panel concurs with this sentiment. The similarity of findings between the CFSR and the Panel bolster the hope we can achieve improved outcomes for all children. By our in-depth reviews of these most tragic cases, the Panel advocates for systems reform with the goal of eliminating fatal and near fatal child abuse.

OVERDOSE/INGESTION CASES

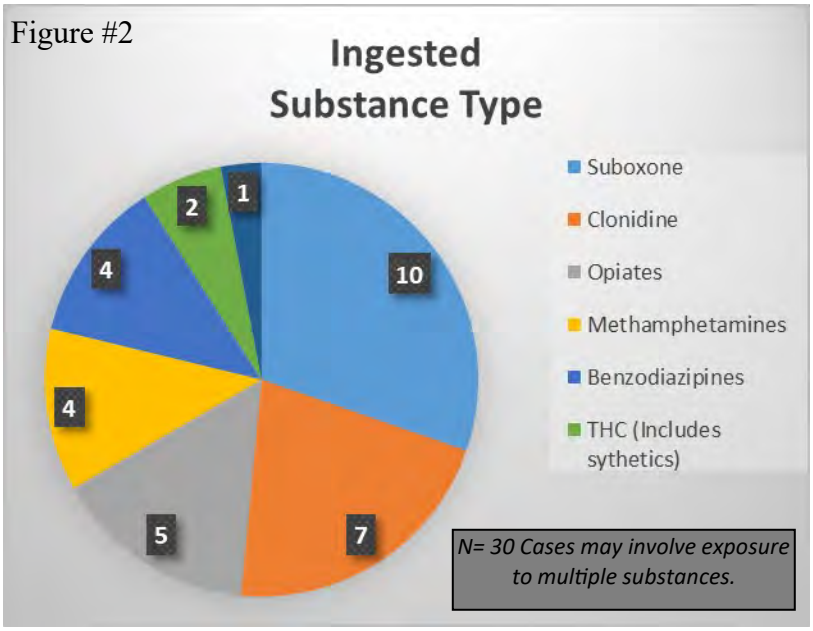
Overdose/ingestion cases have remained among the top three categories for the last four years. (Figure #1) It was the most frequent categorization in FY 2018. This categorization is a determination by the Panel as one of the "types of cases." Individual cases may have more than one type of categorization. For example, a case may be designated an overdose/ ingestion, as well as a neglect case. The overdose/ ingestion category captures both accidental and intentional ingestions. Intentional ingestions are rare occurrences among cases before the Panel, with only one of the cases being clearly documented as an intentional suicide attempt. Near fatal injury is the most likely outcome within this category, with only one of the 32 ingestion cases resulting in the death of a child. The large majority of children are young, with 90% of the cases involving children under age six.

Figure #1



Data Source: Child Fatality and Near Fatality External Review

Figure #2

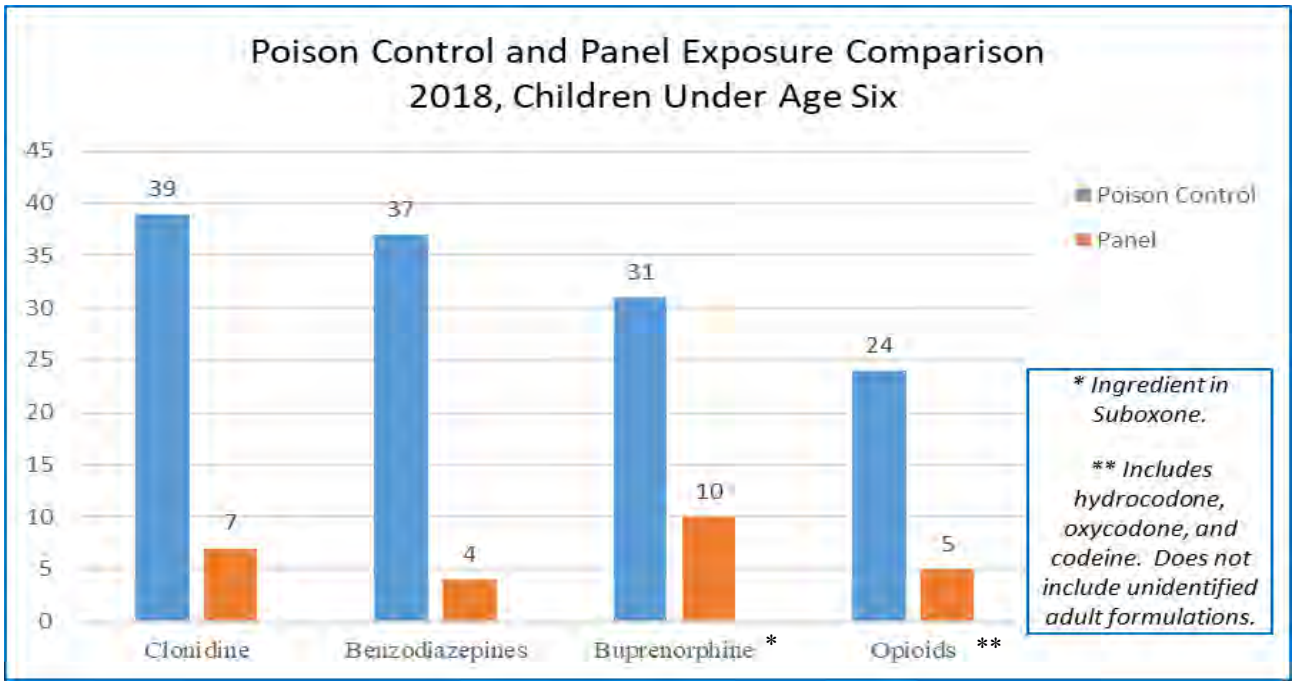


Data Source: Child Fatality and Near Fatality External Review

Ingestions and overdose can involve a wide range of drugs, (OTC, prescription, illicit substances). Also included is ingestion of other substances (household chemicals). Figure #2 identifies the type of substance exposure in ingestion cases reviewed by the Panel.

OVERDOSE/INGESTION CASES

The incidences of ingestion and overdose cases before the Panel are a subset of a much larger problem impacting Kentucky's children. To understand ingestion injuries in the broader context, Panel staff requested data from the Kentucky Poison Control Center (KPCC) and the Kentucky Injury Prevention and Research Center (KIPRC). In 2018, 4,977 pharmaceutical exposure inquiries involving children less than six years of age were received by the KPCC. The graph below compares exposures reported to the Poison Control Center, to the most common pharmaceutical exposures seen in Panel cases. This data indicates the actual incidence of children exposed to these drugs is much high than the number of cases seen by the Panel.



Data received from KIPRC is similar in demonstrating the true incidence of accidental drug ingestion is much higher than the cases reviewed by the Panel. In 2018, 897 children, birth to twelve years, were treated in emergency rooms due to drug overdose. Approximately 60% of these children were under age six; presumably the vast majority of the 12 and under group involved accidental ingestions.

The data from the Panel, supported by other sources, illustrates the seriousness of drug ingestion and overdose among young children in Kentucky. Hundreds of children each year are treated, if not seriously injured in these situations.

Evidence informed messaging regarding safe storage of medications should be developed for distribution through pharmacies, MAT facilities, as well as family practices and pediatrician offices. The Department for Public Health should convene collaborative forums with KIPRC, poison control center and other partners to identify opportunities to expand data collection to better inform prevention efforts. The Kentucky Board of Pharmacy should develop recommendations for enhanced safety packaging (e.g. blister packs) for prescription drugs most commonly ingested.

DEPARTMENT FOR COMMUNITY BASED SERVICES

The Panel has consistently paid close attention to staffing needs within DCBS. Previous annual reports have addressed workload issues and advocated for additional resources. Regretfully, there appears to have been little improvement over the years.

DCBS continues to struggle with high turnover and the tenure of the workforce is decreasing. In FY 2019, the turnover percentage for social service workers was 27%. The Department spends an average of $22,100 per employee exclusively for staff training. This equates to an average of $11,200,000 for employees leaving the Department. That cost does not reflect the loss of productivity, operating expenses, and adverse impact to the families the Department serves.

Case reviews continue to reflect what is most likely the aftermath of workforce issues. It is commonplace for multiple workers to be assigned to a single case over a period of mere months; leaving the newly assigned worker or remaining supervisor to piece together a case from notes left behind by a previous worker. Despite the determined efforts of frontline DCBS staff, these unplanned transitions result in compromised service delivery (lack of timely response, delays in assessment and service provision, etc.).

An inadequate workforce negatively impacts all families served by DCBS, not just those involved in Panel cases. Casey Family Programs compiled research in a 2017 report addressing the impact of staff turnover.[8] The report identifies the impact of high turnover on critical casework functions, including:

- Quality of service delivery,
- Family engagement, and
- Safety and permanency outcomes.

According to a 2016 article in *Governing*, the likelihood of a child reaching permanency if a single worker is involved is 74%. If the child has two workers, the chances drop to 17% and decreases another 5% if there are three workers.[9]

DCBS has advised the Panel, they are in the process of implementing additional support for their workforce to address secondary trauma. Social workers are at high risk for secondary trauma, which is a result of caring for, hearing about or witnessing the intense suffering of others. Overtime, the cumulative effect can result in an internalization of trauma, leading to compassion fatigue or burnout.[10] Up to 50% of social workers are at high risk for secondary trauma or related conditions of PTSD.[11] The Department should follow the guidelines of the National Child Traumatic Stress Network. The Department should strongly encourage their staff, including supervisors, to practice self-care and implement training to recognize the early signs of secondary trauma.

Addressing workforce supports is important to every family touched by the Department for Community Based Services and deserved by the dedicated professionals who entered the field with hopes of helping families in crisis. The Panel applauds the most recent efforts the Department has implemented to address their workforce issues. However, resolutions to these issues are largely dependent upon assuring DCBS receives adequate funding. The Governor's proposed biennial budget should recommend appropriations necessary to fully implement the workforce supports to address DCBS recruitment and retention efforts.

DEPARTMENT FOR COMMUNITY BASED SERVICES

The Family First Prevention Services Act of 2018, expanded the use of specified federal funds to enable states to provide services for children at risk of entering the child welfare system.[12] This Act allows the states to utilize federal funds to keep children with their families while receiving services in order to avoid the additional trauma of separating the child from their family and entering foster care. Historically, states could only access this funding for children in out of home care. The Department has informed the Panel, Kentucky has elected to be one of the first states to implement this opportunity.

The Commonwealth currently spends $18 million for preventive services, which equates to roughly $150,000 per county. In 2017, RAND researchers studied how children entered and flowed through the nation's child welfare system. The research suggested that expanding both prevention and treatment is required to reduce maltreatment and improve the outcomes of children. Expanding prevention and kinship supports will eventually pay for itself. [13]

The Department currently has several programs which are proving to be over 90% effective in keeping children safely in their homes. The Family Preservation Program (FPP) is designed to reduce abuse and neglect, maintain children safely in their home, improve parenting capacity, and facilitate the safe and timely return home for a child in out-of-home care. To qualify for FPP services, families must be at imminent risk of losing their child to out of home care or have a child in out of home care returning home. FPP service is available through a network of non-profit contract agencies. Kentucky Strengthening and Empowering Parents program (K-STEP) is an evidence informed intervention that stabilizes and supports families by providing intensive in-home services. K-STEP emphasizes collaboration between families, DCBS, and the community providers to achieve positive outcomes. K-STEP facilitates family engagement and involvement during the assessment and case planning process, which leads to empowerment of families and a reduction in high-risk behaviors. The Sobriety Treatment and Recovery Team (START) program improves child well-being, family functioning, and recovery. START provides comprehensive support services to families and ensures quick access to substance abuse treatment, improves treatment completion rates, and increases the county, region, and state's capacity to address co-occurring substance abuse and child maltreatment. The Panel strongly supports the Department's efforts to expand its Family Preservation Program (FPP), the Sobriety Treatment and Recovery Teams (START) program and the Kentucky Strengthening and Empowering Parents (KSTEP) program.

DEPARTMENT FOR COMMUNITY BASED SERVICES

Prior history with the Department of Community Based Services is a common characteristic noted when examining child deaths. In this reporting period, 78% of the cases reviewed by the Panel had prior DCBS history. The Panel's criteria for measuring prior contact is broad in comparison to department policy or federal measures. The Panel examines each case thoroughly to identify prevention or system improvement opportunities. When reviewing cases, the following questions regarding DCBS services to the family are addressed:

→ Was the child assessed for risk as part of the fatal or near fatal investigation?
→ Was the DCBS investigation of the event coordinated with law enforcement?
→ Was DCBS involvement restricted by law enforcement, courts, or other agencies?
→ Were there delays in conducting the investigation or missing information which was not clearly explained in the case record?
→ Did DCBS conduct an internal review of the case?
→ Was the prior referral not accepted for investigation?
→ Were there other issues of concern identified?

When considering prior involvement and opportunities for improvement, it is critical to understand the full context of prior DCBS involvement. Prior history does not equate culpability. Missed opportunities are identified at various points in the case history - before and/or after the occurrence of the event. In the latter, these opportunities would not be considered preventative and would not have likely impacted the outcome of the case. Importantly, missed opportunities were identified in roughly half (53%) of those cases with prior involvement by DCBS.

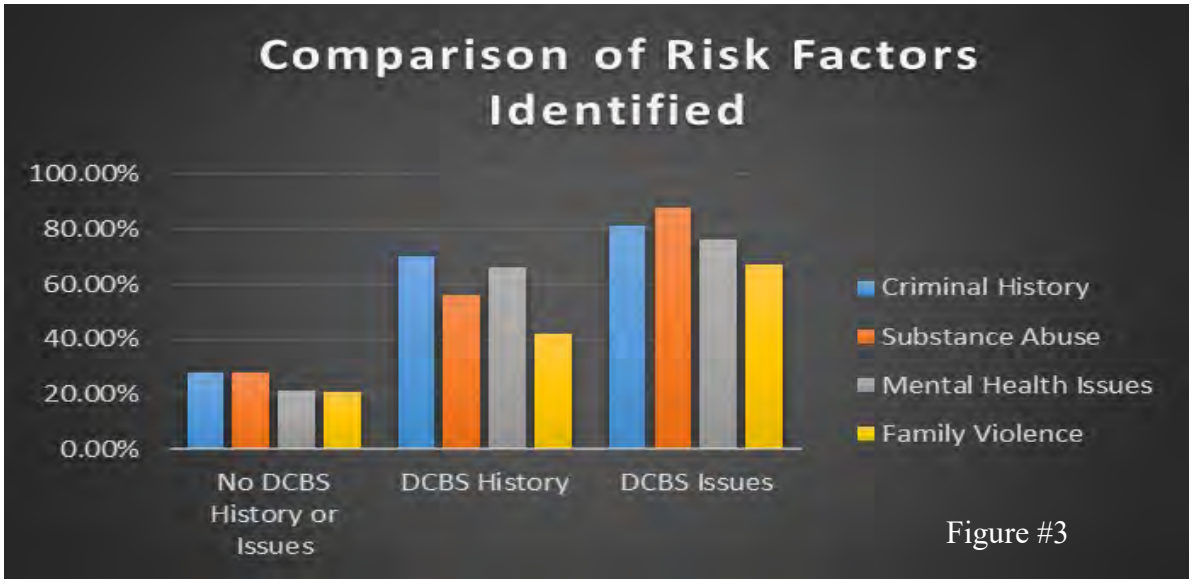


Figure #3

Data Source: Child Fatality and Near Fatality External Review Panel

Families served by DCBS are complex and often face multiple issues (substance abuse, family violence, mental health issues, and criminal history). Figure #3 compares the rate at which these risks occur among cases with *No DCBS History or Issues*, *DCBS History,* and *DCBS Issues* . Significantly, the rate of critical risks identification increases in cases with both prior DCBS history and DCBS issues.

As family complexity increases, so too does the need for effective intervention by other community partners. Other agencies are often intervening with families, prior to, or at the time DCBS is involved. In the vast majority of cases in which DCBS systems issues were identified, other system issues were identified as well. See Figure #4.

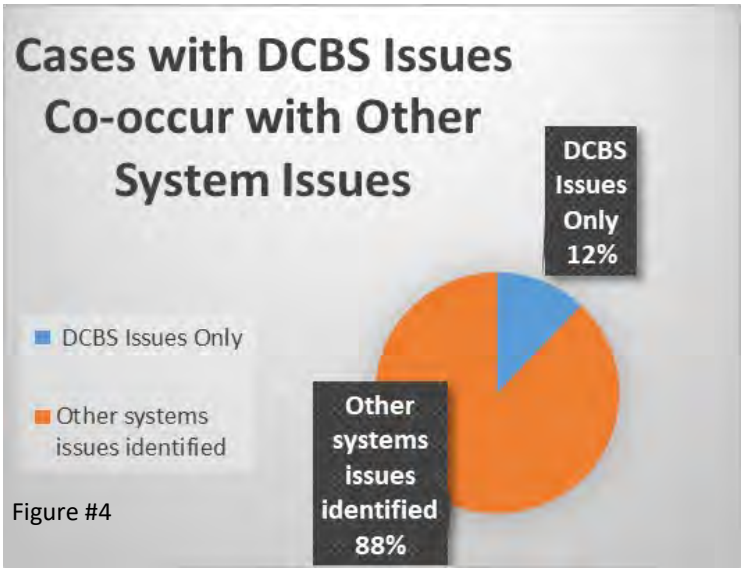


Figure #4

Data Source: Child Fatality and Near Fatality External Review

Examination of the number of systems issues, by discipline, provides a greater understanding of how an effective systemic response is needed. As seen in the Figure #5, every system, from bystanders to coroners, is responsible for preventing and responding to fatalities and near fatalities. It is readily apparent that all systems have opportunities for improvement.

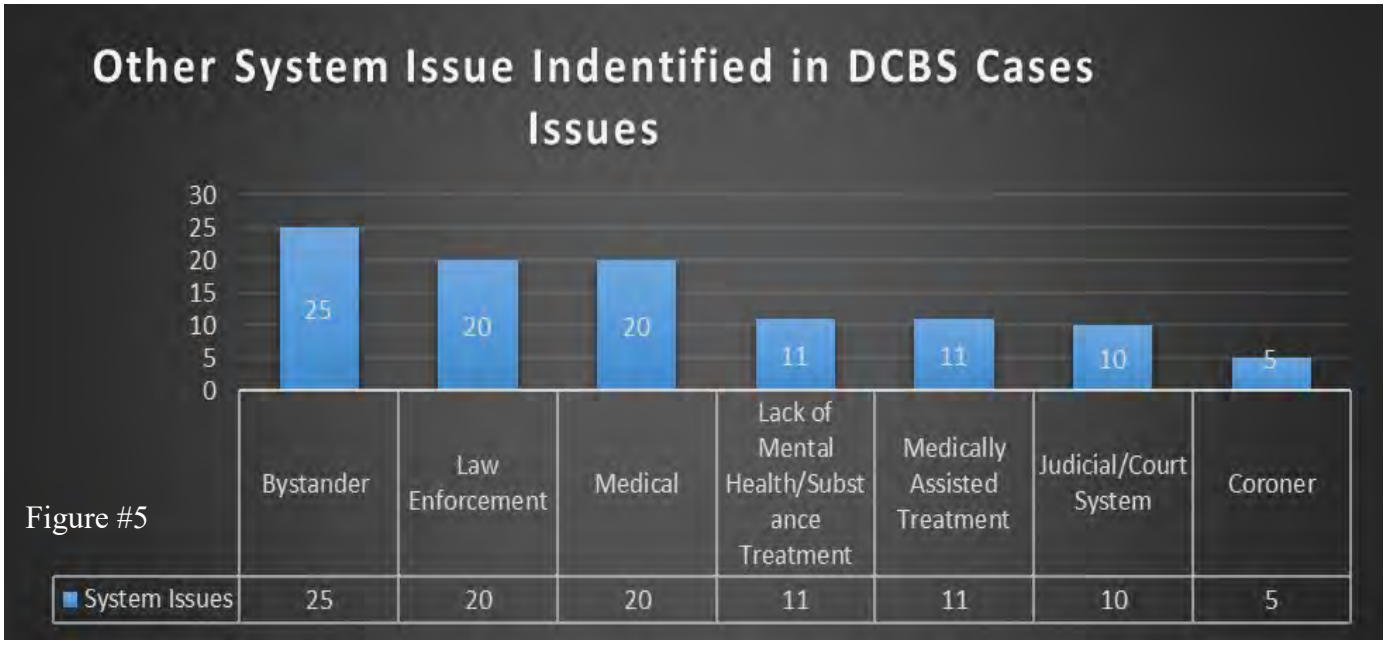


Figure #5

Data Source: Child Fatality and Near Fatality External Review

REPORTING SUSPECTED CHILD ABUSE OR NEGLECT

Kentucky law mandates any person who knows or has reasonable cause to believe a child is dependent, neglected, or abused shall immediately report it to a local law enforcement agency, the Kentucky State Police, the Cabinet for Health and Family Services, Commonwealth attorney or county attorney.[14] In 28% of the cases reviewed, the Panel identified a "bystander issue" for failing to make a report. Often times, family members and community members recognize the early signs of abuse and neglect but fail to report it until after a fatal\near fatal incident occurs.

F-14-18-C

While in the care of mother's paramour, the index child was fatally beaten to death. According to the autopsy and medical records, the child had fatal and non-fatal injuries in various stages of healing. The mother reported hearing the child being "punished" by the paramour, which resulted in the child vomiting and running a fever. The child was found dead the following day. The cause and manner of death was blunt force trauma and homicide. The paramour admitted to law enforcement he was too rough and threw the child, causing her head to hit the floor.

The extended family described numerous violent incidents and other concerns regarding the mother and paramour. The grandparents indicated the index child had marks on her face a year ago, but the grandmother thought the hospital had called CPS. The grandmother reported several previous injuries to the child and suspicious injuries to the mother. The grandfather had similar, and also unreported, concerns about the child's safety. He stated he saw a facial injuries in the days prior to the death. He questioned the mother, but she said it was none of his business.

In similar cases, reports are made but do not meet the Department's criteria to initiate an investigation. The issue of "Referrals Not Accepted for Investigation", commonly referred to as "reports screened-out" remains a significant concern to the Panel. National organizations, such as Casey Family Programs, have published recommendations regarding this issue. Those recommendations mirror those made by the Panel, particularly as it relates to addressing referrals regarding young children and professional reporting sources. Professional reporting sources, are individuals who encounter the child as part of their occupations, such as child daycare providers, educators, law enforcement officers, and medical staff. According to *Child Maltreatment 2017* report, 65.7% of reports are by professionals.[15]

During Panel discussions, the Department reported it will be implementing a "Safety Model" which will lead to consistent application of screening criteria and more appropriate screening-in of referrals. During this process the Department will engage in a screening threshold analysis that will determine the percentage of calls appropriately "screened in"; percentage of calls "screened in" where no maltreatment occurred; percentage of calls "screened out" correctly; and percentage "screened out" where maltreatment occurred within a specified timeframe. This analysis should allow DCBS to examine current acceptance criteria and make adjustments accordingly. The Panel applauds the department for these efforts and has encouraged them to share their findings with the Panel. Once the appropriate adjustments have been implemented into the screening criteria, DCBS should develop a training for reporting professionals.

PREVENTION PLANS

Prevention Plans, as described in DCBS Standards of Practice (SOP), are a tool to ensure the safety of children at high risk.[16] The plans are most often negotiated with families in the early stages of a CPS investigation and set parameters to provide for safety. Strategies utilized may include informal placement of children with other family members, requiring parents to have only supervised contact with the at risk children, requiring parents to remain sober, etc. Preventions plans must be short term; 30 days unless re-negotiated with the family. DCBS SOP indicates these plans are to not to substitute for court involvement when there are long term protection needs. When a caretaker signs the Prevention Plan, they are informed failure to comply can result in court action and/or foster care placement.

While Prevention Plans are well-intended, the Panel has noted significant concerns regarding the implementation of this practice. The Panel identified 58 cases with DCBS Issues; 18 (31%) of those cases involved concerns with the utilization of Prevention Plans. These concerns are best summarized by the following categories:

→ Inappropriate or unsafe placement or supervisory arrangements,
→ Lack of monitoring,
→ Lengthy informal placements,
→ Multiple placement moves between temporary caregivers, and
→ Lack of timely engagement of the courts.

F-009-18-C
The index child was born substance exposed, to methamphetamine. Mother presented with a history of substance abuse, mental health issues, and the loss of custody of an older sibling due to substance abuse issues. At the time of the index child's birth, DCBS developed a Prevention Plan requiring the father of the newborn to supervise mother's contact with the infant. The father, who was to provide supervision, had a criminal history of methamphetamine production and had lost custody of his biological child. When the infant was a week old, mother drug tested clean and a new Prevention Plan was completed removing the requirement for supervision of the mother. Five days later a home visit was made and no concerns were noted. A DNA petition was not filed. At one month and five days old, the index child died while co-sleeping with mother. The mother admitted to using methamphetamine for several days and being on a "meth crash" when the child died.

Cases were reviewed in which children were placed in circumstances without adequate home evaluations occurring prior to the placement. In several cases, after a Prevention Plan was implemented, the informal caregiver received few, if any, services. The lack of thorough assessment prior to placement and absence of monitoring after placement contributes to placement disruption and the occurrence of multiple placements. Prevention Plans involving informal placements were found to be in place for over six months without court engagement. Lack of engagement of the court was a common issue, occurring in 17 of the 18 cases with Prevention Plan concerns. Delay in filing DNA petitions is particularly alarming due the role the courts play in CPS cases. The courts provide the legal authority for placement of child, due process for the families impacted, and oversight regarding decisions made impacting the child.

Children placed in unsuitable and unmonitored homes, enduring multiple placements, without the oversight of the courts is deeply concerning. The breadth of the problem is unclear, as it appears there is no system to track how often these situations occur or how many placement changes are occurring as a result. DCBS should examine the drivers behind this current practice and implement changes to improve compliance with policy.

ACCESS TO CHILDCARE

"Lack of regular child care" is a family characteristic identified as a contributing risk factor. Among 2018 cases, the Panel identified this risk factor in 15 (11.1%) cases. When viewed in the context of other identified risks, the importance of accessible child care is reinforced. For instance, the following risks were co-occurring with lack of child care at the following rates:

*Financial Issues - 86.6%
*Mental Health Issues – 73.3%
*Substitute Caregiver - 60%

NF-058-18-C
The two month old index child sustained significant brain injury, skull fractures, rib fractures and bruising. Both parents worked and had difficulty finding regular child care. They utilized relatives when available. Multiple caregivers had been used in days before the injury occurred, making it difficult to identify the offender. In addition to lack of child care, the family struggled with financial issues, mental health issues and being overwhelmed with the care of a fussy infant.

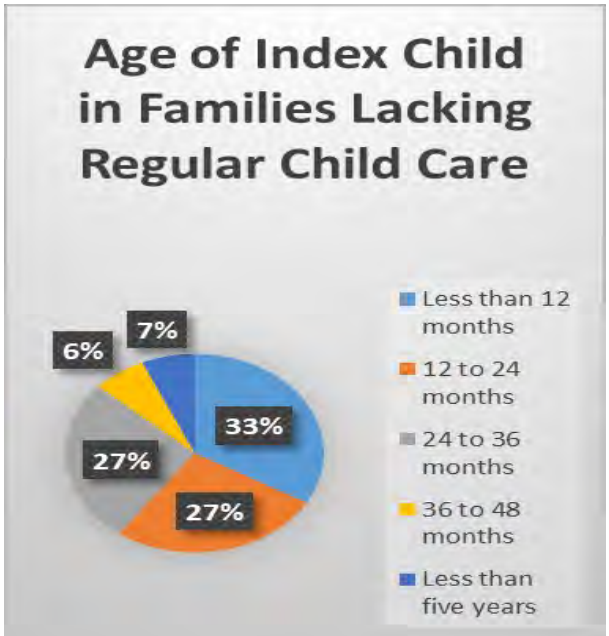


Figure #6

As evident in Figure #6, the majority of the child victims in these case were very young children.

Greater access to high quality child care is considered an important protective factor associated with reduced likelihood of child maltreatment and increases in school readiness.[17] The Colorado Department of Human Services *2018 Child Maltreatment Fatality Annual Report* identified over 200 incidents in a four year period which may have been prevented had affordable child care had been available. The report included recommendations for increased funding and greater access to child care subsidies for low income families.[18] Based on cases reviewed by the Panel, families need expanded access to affordable quality child care. This need is greater for families with additional risks such as poverty or mental health issues.

DCBS provides subsidized child protective or preventive services authorization for child care for at risk families. Kinship care providers, with children placed by DCBS, may also be eligible for child protective or preventive child care subsidies. The Department has the ability to waive co-pays for child protective or preventive service participants, but families may be required to pay the difference between the Child Care Assistance Program reimbursement rate and the provider's costs of care. Other systemic barriers include inadequate number of providers across the state (i.e., child care deserts), inadequate number of providers participating in the Child Care Assistance Program (CCAP), increasing need for nontraditional hours of operation, ability to serve children with special needs, increasing need for infant/toddler care, and child care staff recruitment and retention. Income eligible families can receive subsidies but co-pays may apply. Barriers associated with the child protective or preventive services authorization for childcare subsidies also impacts income eligible families. DCBS staff report implementing initiatives to address these identified barriers.

LAW ENFORCEMENT

The Panel identified law enforcement issues in 22% of the cases reviewed in FY18. As shown in Figure #7, the Panel tracks several issues of potential improvement for law enforcement agencies. The Panel continues to highly encourage law enforcement agencies to treat every child fatality and near fatality under the premise the child may have been a victim of abuse or neglect. Law enforcement agencies and social workers must maintain a mutual respect in order to accomplish a collaborative investigation. In 20% of the cases, it was noted the investigative law enforcement agency was not communicating with the CPS worker. Officers and social workers should be encouraged to discuss their roles prior to these events and conduct joint investigations. Furthermore over 63% of the cases identified to have a law enforcement issue, the responding agency failed to investigate the incident. An increasing trend the Panel has identified, is law enforcement agency's failure to investigate overdose/ingestion cases. Unfortunately, the Panel has not obtained a clear reason behind this trend. It could be the ingestion cases are being reported as "accidental" and\or it is often difficult to determine the individual responsible for allowing the child access to the medication. Without a proper investigation, social workers and doctors are left with more questions than answers which could potentially allow a child to remain in an unsafe environment. Law enforcement agencies need additional training on how to properly investigate overdose cases and a clearer understanding of the potential criminal charges applicable. Additional funds should be appropriated to allow law enforcement agencies to be fully staffed and train specialized detectives to handle these complex cases.

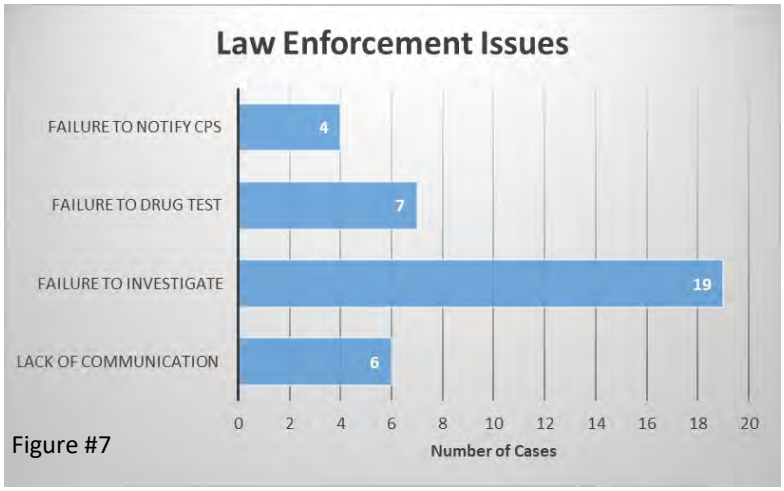


Figure #7

Data Source: Child Fatality and Near Fatality External Review

F-046-18-PH

The father discovered the infant not breathing and called 911. The child was subsequently pronounced dead. The child was found on an air mattress, face down with his face turned to the left. The twin sibling was sleeping in a car seat and the father on the floor. Father indicated he woke upon hearing the sibling crying. The SUDI form documented the home smelled of smoke and marijuana odor. The father denied recent marijuana use.

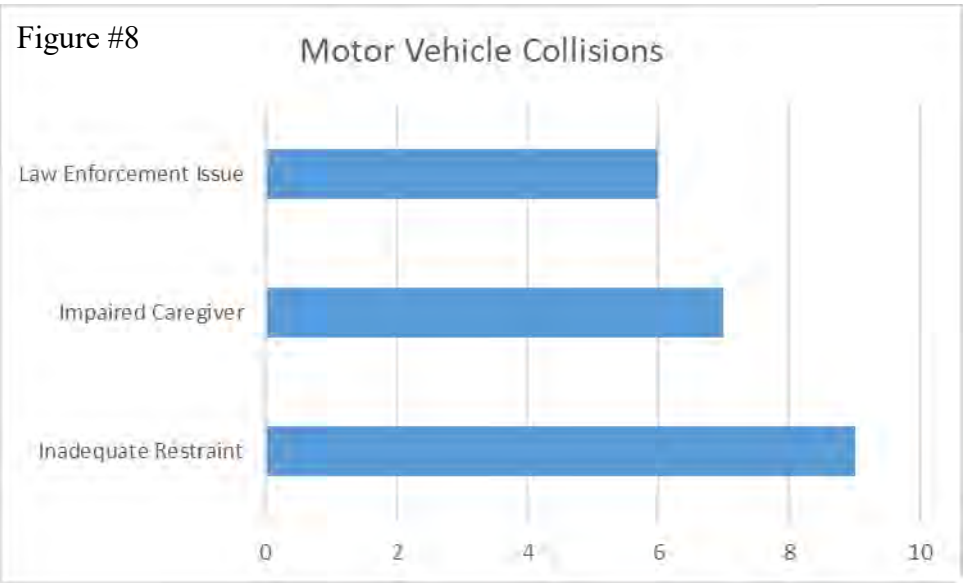
An autopsy was conducted and there was no identified natural disease. A focal subscalp hemorrhage over the left frontal skull was identified without fracture or intracranial injury. The cause of death was undetermined due to unsafe sleep conditions and focal subscalp hemorrhage.

The mother arrived home and became physically threatening to the father. Police intervened to prevent a physical altercation. The father was threatened (by mother and her boyfriend), so the law enforcement suggested he leave the residence. Law enforcement assisted him in getting bus ticket to visit family. It appears he left the state the night of the fatality. The police turned the surviving sibling over to the mother.

DCBS was contacted for assistance. Staff on the scene report being told by law enforcement their assistance was no longer needed as the surviving sibling was with mother. Mother moved to Kentucky from Missouri, along with the father approximately six months prior to the death. She had four other children, (5, 4, 3, and 2 years old) who were not in her care. Mother had a history of CPS involvement and a criminal charge for wanton engagement in Missouri.

MOTOR VEHICLE COLLISIONS

According to the Center for Disease Control and Prevention, motor vehicle injuries are the leading cause of death among children in the United States.[19] The Panel categorized fourteen (14) cases as Motor Vehicle Collisions (MVC) resulting in blunt force trauma injuries to the child. Even though two of the cases were categorized as MVC, one case involved an unrestrained child falling from a moving vehicle and one case involved a pedestrian versus a vehicle. In 64% of the MVC cases, the Panel found neglect by the operator for either inadequate or absent the proper child restraints while operating a motor vehicle. Equally noted, the Panel found law enforcement issues in 43% of the MVC cases. In more than half (67%) of those cases, the responding law enforcement agency failed to cite the operator for failing to use proper child restraint.



Data Source: Child Fatality and Near Fatality External Review

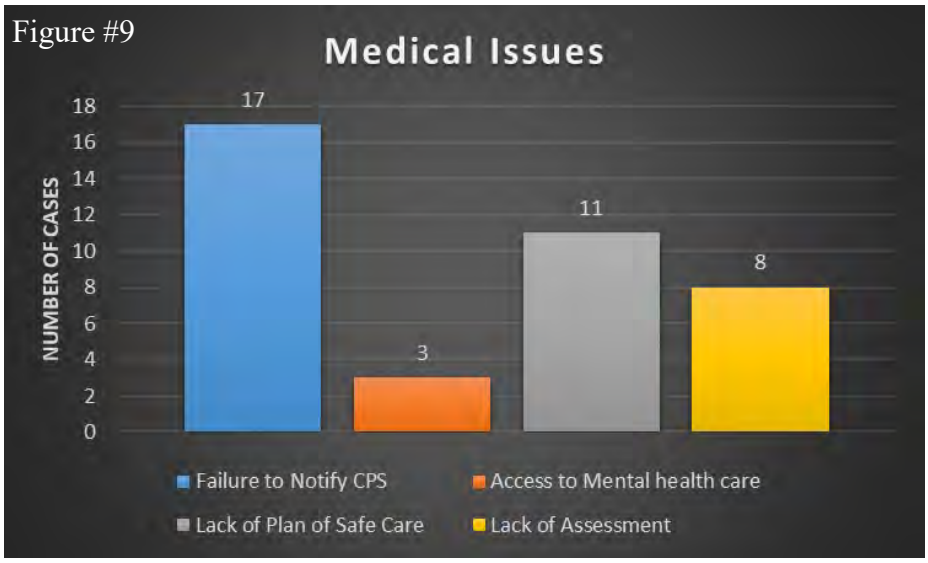
The Panel has noted the issues of MVC incidents as an area of concern in previous reports, with a variety of recommendations. As shown in Figure #8, 58% of the cases reviewed by the Panel noted an impaired caregiver at the time of incident. Law enforcement agencies need to remain diligent when enforcing child restraint laws and operating a motor vehicle while under the influence.

NF-17,18,19-C

This MVC incident involved mother (driver) and her five children. The initial report indicated mother was driving erratically, lost control resulting in the vehicle rolling over five times. All occupants were thrown from the vehicle. The mother and three of the children were seriously injured. The hospital record indicates law enforcement said the passengers were not restrained and there were not enough car seats in the vehicle for all the children. No indication the mother was cited for failure to use proper child restraints.

MEDICAL PROVIDERS

Identifying suspected child abuse and reporting reasonable suspicion to CPS can be one of the most challenging and difficult responsibilities for medical care providers. According to the American Academy of Pediatrics, there is evidence that physicians miss opportunities for early identification and intervention.[20] Twenty-three (23) percent of the cases reviewed by the Panel identified a missed opportunity by medical providers. In 55% of the cases with medical issues, the medical providers failed to notify CPS of various concerns. See Figure #9. Outlying hospitals in 26% of the cases failed to perform an adequate assessment, either on the victim or their surviving siblings. The Kentucky Hospital Association should continue to promote local hospitals to utilize the two Pediatric Forensic Medical centers to assist with a thorough assessment.



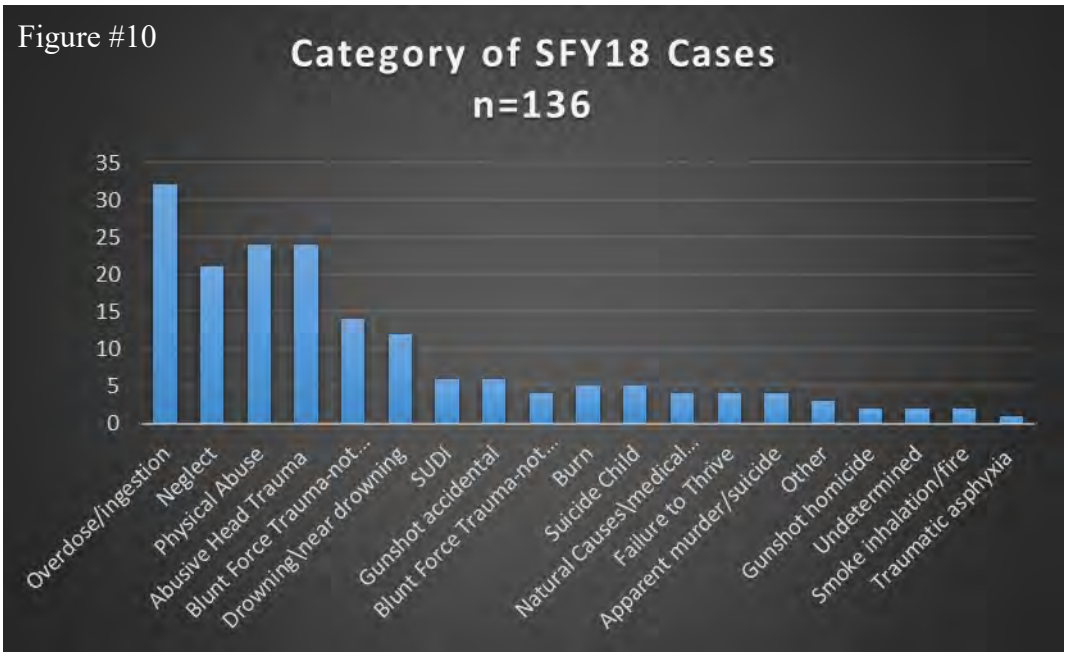
Data Source: Child Fatality and Near Fatality External Review

Furthermore, Kentucky should continue to promote the message of the TEN-4 rule to medical providers and the general public. This year, Governor Matt Bevin proclaimed TEN-4 day on October 4th. The TEN-4 rule means, for children under 4 years of age, bruising in the Torso, Ears, or Neck should cause concern and be reported.[21] Also, bruising on babies who are too young to walk or pull themselves up should be cause for concern. See Appendix A.

NF-21-18-NC

This case involves a two year old child who initially presented to the emergency department (ED) accompanied by his mother with vomiting, "shakes," a reported history of his ears turning purple. A "bruise on his ear from bed yesterday" was documented with no further explanation. He was diagnosed with otitis media (ear infection), given antibiotics, and discharged home from the ED to follow up with his primary care physician.

Mother returned to the ED later that day reporting the child had continued vomiting and was increasingly sleepy. Bruising of both ears, his back, thighs, and petechial of his back, neck. and jawline were documented. Mother reportedly stated he "may have hit the air conditioning unit" but had no definitive history to explain his injuries. Child was diagnosed with occipital and parietal bone skull fractures.

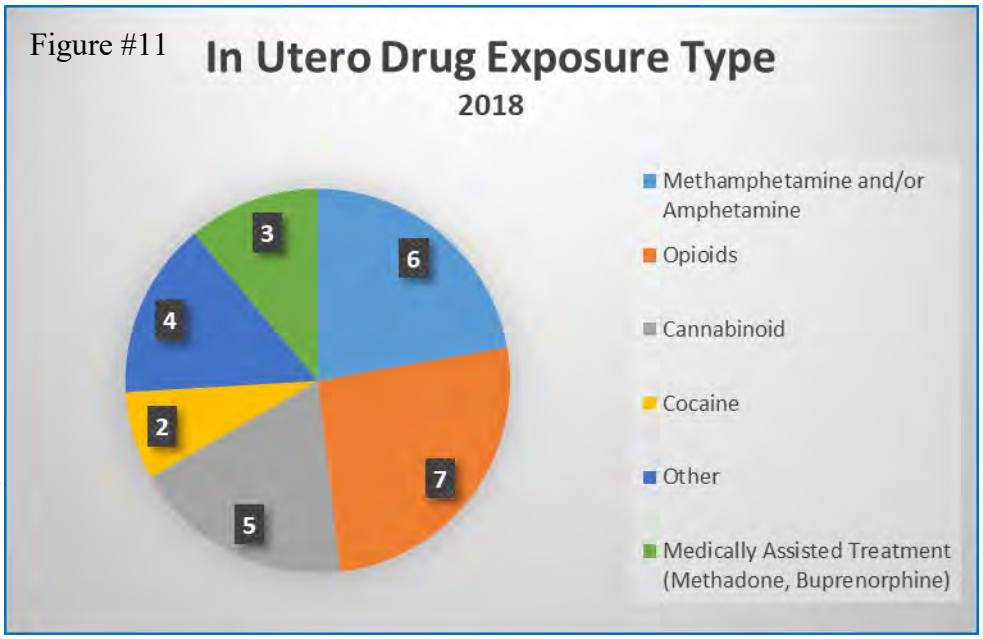


Data Source: Child Fatality and Near Fatality External Review

As in previous years, physical abuse and Abusive Head Trauma remain in the top categories of cases reviewed by the Panel. See Figure #10. In 73% of the cases categorized as Abusive Head Trauma, substance abuse by a caregiver was noted as a risk factor.

Substance abuse remains a significant risk factor among Panel cases, being identified as a family characteristics in 54% of cases. A subset of these cases situations involve children exposed to substances in utero and/or diagnosed with Neonatal Abstinence Syndrome (NAS). In 2018, the Panel documented 16 cases in which children were documented as having been exposed to substances prenatally. Five of these cases involved children diagnosed with NAS. In the case reviews noted with medical issues, 35% of those cases were identified as failing to establish a plan of safe care for these families.

These children were exposed to a variety of substances, often more than one type of drug. Figure #11 represents the type of drugs documented during pregnancy, either through screening or parental report. Alcohol, likely due to testing limitations, is not identified in this data. While MAT medications have been identified in three cases, through testing or parental self-report, case review data indicates five of the 16 families involved in this sample were receiving MAT services.



Data Source: Child Fatality and Near Fatality External Review

MEDICAL PROVIDERS

While these cases are complex and are ideally addressed through a collaborative multidisciplinary response. Families with substance abuse issues often struggle with a variety of additional barriers such as domestic violence, poverty, housing issues, mental health, etc. Multiple missed opportunities were found in numerous areas, including DCBS, medical, bystander, law enforcement, MAT providers and coroners. As illustrated in the highlighted case example, it is not unusual for multiple service providers to be engaged with these families and for service coordination to be lacking. Too often, there is also lack of communication among engaged providers.

The Department for Behavioral Health, Developmental and Intellectual Disabilities, in conjunction with the Department for Public Health, should explore programming necessary to assure implementation of Plans of Safe Care for NAS infants, as well as a coordinated service delivery model for other substance exposed infants. While DCBS should be "at the table," the mental health or public health system should be the primary lead in a specialized service delivery system.

The Commonwealth should focus on expanding access to Medication-Assisted Treatment (MAT) facilities for pregnant and postpartum women. Regulatory authorities should require MAT providers to require collaborative and holistic services to pregnant women, or mothers of infants, receiving MAT.

NF-013-18-C

The child was born substance exposed, testing positive for cocaine and methadone. Mother had been receiving MAT, and went in to residential drug treatment two days after the child's birth. She left treatment, with the baby, within 20 days. Mother's history included chronic substance abuse, domestic violence, housing instability, mental illness, poverty, prior CPS involvement, etc. A review of records indicated involvement by multiple service providers including the primary care physician, MAT and residential drug treatment provider, and DCBS; all appeared to be aware of the family history and current status. After leaving drug treatment, the child and mother were transient, before the child was near fatally injured less than two months later. There is no documentation of communication among providers or coordination of service delivery.

As shown in Figure #10, the Panel reviewed six cases which were categorized as Sudden Unexplained Death in Infancy (SUDI). Every case reviewed by the Panel was found to have unsafe sleep practices as a characteristic. The Panel continues to encourage medical providers and community partners to educate parents on safe sleeping environments. All infant caregivers should practice the ABCD of Safe Sleep; **A**lone, on their **B**ack, in a **C**rib, and **D**anger from impaired caregivers or distractions. The public is encouraged to visit www.safesleepky.org and https://pcaky.org/node/427 for additional information about safe sleep practices. See Appendix B.

CORONER

KRS 74.210 requires coroners to notify their local Department of Community Based Services, local public health, and law enforcement of any death of a child under the age of eighteen (18). The primary purpose of this statute is to support the exchange of information necessary to accurately determine the cause of death. Statute also encourages the coroners to conduct joint investigations and hold a local review of the child's death. The local Child Death Review team consist of first responders and community partners who have firsthand knowledge of the event and family. These local collaborative reviews allow the community to address any local needs to prevent future child fatalities. The Panel has noted an increase in the number of jurisdictions implementing local response teams. (Figure #12) This improvement appears to be directly related to support and technical assistance provided to localities by the Kentucky Department for Public Health staff. The Kentucky Medical Examiner has been a key support in this effort as well.

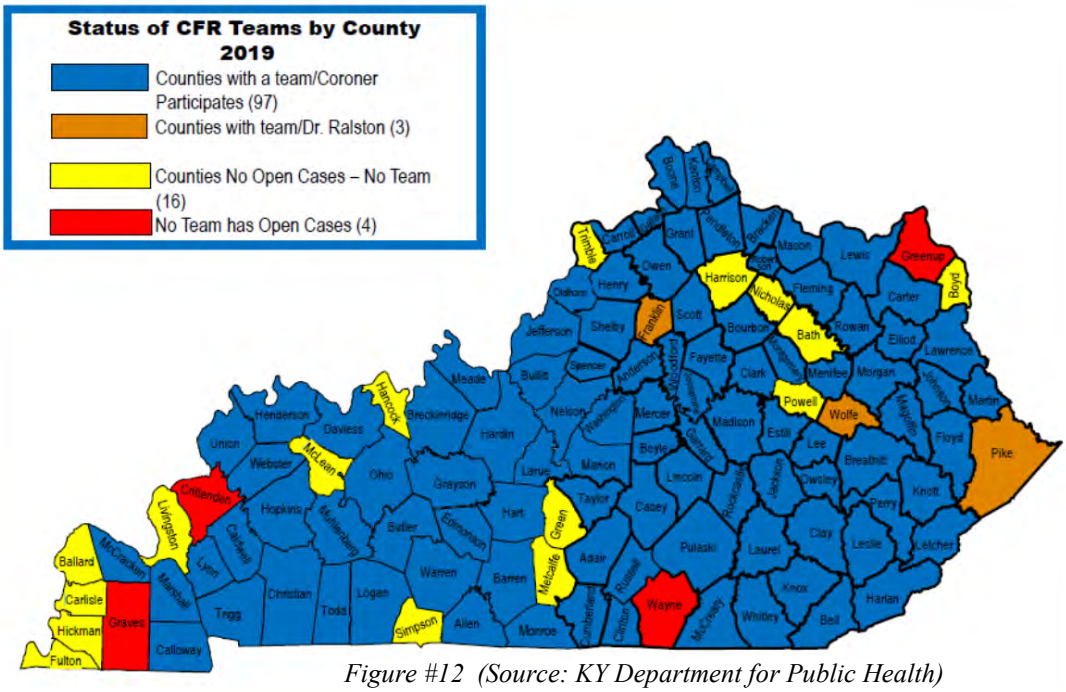


Figure #12 (Source: KY Department for Public Health)

Despite increasing local capacity, the Panel has noted a need for improvement. Coroner issues were identified in 10 of the 54 (18.5%) deaths reviewed by the Panel. The primary concerns identified within these cases involved poor communication, particularly in terms of providing timely communication with DCBS and public health. The lack of established protocol for incidents involving multiple jurisdictions is also an area of concern (e.g. injuries occurring on one county and child is pronounced at a hospital in a different county). The Kentucky Coroners Association should continue to encourage coroners to conduct local Child Fatality Reviews, complete the child death reporting forms recommended by the Department for Public Health and encourage joint investigations with local partners.

JUDICIAL PROCESS

For the purposes of Panel reviews, Judicial Process issues encompass the entire court system; judges, Guardian ad litems (GAL), county attorneys, CASA/FCRB, etc. Although the involvement by the courts is primarily within DNA actions, the Panel also examines the involvement of criminal and domestic violence actions.

The court system plays a critical role in monitoring and providing oversight of the services provided to the children before the DNA court. The case before the courts are complex; 75% of cases with Judicial Issues have substance abuse issues, as well as numerous other risk factors. These cases require timely and meaningful court reviews, involving input from DCBS staff and other players. There are multiple points within the court system at which decisions are made, some not in the best interest of families and children. Twelve cases were noted to have had Judicial Process Issues which were found to have occurred in three primary areas.

Those include the following:

→ Questionable decisions made regarding the placement of children, sometimes over the recommendations of DCBS.
→ Decisions regarding adjudicatory findings, either as a result of dismissal of cases or prosecution declination.
→ Lack of timely and/or thorough oversight of cases before the court.

F-023-18-C
A two month old died in what was considered neglectful circumstances, being left in his room for a least twelve hours prior to being found deceased. It was apparent he had been dead for several hours before being found dead. The home conditions were described as filthy. Both parents admitted to using methamphetamine prior to the death, and tested positive for this and THC. The autopsy indicated the manner of death was underdetermined, but noted concerns with suspicious history and parental drug use. DCBS substantiated neglect, but did not designate the case as fatal neglect. KSP presented the case to the Commonwealth Attorney and prosecution was declined. After successfully completed case planning, the DNA petition was dismissed by the DNA court.

Specifically, of concern is the practice amending DNA petitions to "dependency" findings, or dismissing petitions after the family has made progress in case planning. Panel members representing the courts expressed concern regarding this practice. These situation are potentially problematic in several areas; including understating the seriousness of the situation and impacting the family's level of cooperation with services, potentially requiring DCBS to change the finding resulting no record of the finding in the central registry, and impacting long term permanency planning or safety assessment due to the lack of a court finding surrounding a serious incident. Similar inconsistencies have been noted in the court system regarding criminal prosecution of cases.

As previously mentioned, when considering 54% of the case reviewed by the Panel involved substance abuse in the home, Family Drug Courts are the best recommended practice. Family Drug Courts increase the communication and information sharing of all agencies involved with the family. Due to the inconsistency discussed, the Administrative Office of the Courts should consider additional trainings throughout the judicial system.

ACCESS TO FIREARMS

In 2019, the Panel reviewed eleven (11) cases involving firearm injuries. Of these cases, eight (8) resulted in death and the remainder were near fatal incidents. Six (6) of the eleven (11) incidents were accidental in nature. Five (5) of the accidental injuries involve children under age seven. Three (3) of the incidents were children shot by caretakers in murder/suicide situations (two children in a single incident). Two cases involved suicides, both by teenagers.

The cases reviewed by the Panel are a subset of the total number of children killed or seriously injured in firearm incidents. Firearm injuries are a leading cause of child death in the U.S.[22] In the Child Fatality Review Program 2016 Annual Report, the Kentucky Department for Public Health reported 96 Kentucky children died in 2011-2016 years combined. Forty percent of those children were less than 15 years old.[23]

The common preventative factor in the majority of firearm incidents reviewed by the Panel is access to an unsecured firearm. Anecdotal data from the Panel indicate adults underestimate the risk of unsecured firearms. Parents believe hiding firearms will prevent access. However, 75% of children living in homes with firearms report knowing where they are stored.[24] Many adults believe teaching a child not to touch a firearm is effective (a theme seen during Panel review), but multiple studies have reported these trainings are largely ineffective. [25]

The US Government Accountability Office conducted a study of programs promoting safe firearms storage.[26] Findings from that study include:

→ In 2015, 6,900 children were treated for firearms injuries, and 1,500 gun related deaths of children were reported.

→ While safe storage devices reduce the risk of firearms injuries, over 25% of guns are stored loaded, and half of those are unsecured.

→ While there is minimal research (in part due to federal research appropriation limitations), some studies find distribution of firearm safety devices as promising practice.

→ Multiple programs exist which effectively engage partners with diverse perspectives in focusing on prevention education and gun lock distribution.

U.S. Gun-Related Injury Facts

* 1 in 3 families with children have at least one gun in the house. It is estimated there are more than 22 million children living in homes with guns.
* Most of the victims of unintentional shootings are boys. They are usually shot by a friend or relative, especially a brother.
* Nearly 40% of all unintentional shooting deaths among children 11-14 years of age occur in the home of a friend.
* Adolescents are at a higher risk for suicide when there is a gun in the home.

https://www.nationwidechildrens.org/research/areas-of-research/center-for-injury-research-and-policy/injury-topics/general/gun-safety

Statutory change has been found to be an effective prevention strategy. Studies have found states with child access prevention laws and firearm ownership requirements have lower rates of childhood gun injury and mortality rates. Specifically, states with strong child access prevention laws saw significantly lower self-inflicted and accidental firearm injuries.[27] A separate study found states with more strict gun laws and universal background check requirements had lower rates of pediatric firearms related mortality.[28]

RECOMMENDATIONS

1. The Panel recommends full implementation of the Culture of Safety model. The Panel further recommends the case specific learning points and recommendations developed be openly integrated into the Panel's case review process.

2. Evidence informed messaging regarding the safe storage of medications should be developed for distribution through pharmacies, MAT facilities, as well as family practice and pediatrician offices.

3. Department for Public Health should convene collaborative forums with KIPRC, poison control center and other partners to identify opportunities to expand data collection opportunities in an effort to better inform prevention efforts.

4. The Kentucky Board of Pharmacy should develop recommendations for enhanced safety packaging (e.g. blister packs) for prescription drugs most commonly ingested.

5. The Governor's proposed biennial budget should recommend appropriations necessary to fully implement recommended workforce supports to address DCBS staff recruitment and retention efforts.

6. The Kentucky General Assembly should critically review the proposed budget and assure the necessary appropriations are included.

7. The Child Welfare Oversight and Advisory Committee should review the DCBS proposal to address workforce issues, and monitor implementation of the plan through the 2021-2022 biennium.

8. The Biennial Budget should provide the funding necessary for DCBS to expand the FPP, K-STEP, and START programs statewide.

9. DCBS should ensure funding is properly allocated for the full implementation of the new "Safety Model". It is further recommended that the DCBS share the results of threshold hold analysis with the Panel and implement criteria which considers the age of the child, the number of prior referrals, and prioritization of referrals received from professional reporting sources.

10. DCBS should develop a data management system and supervisory case review process to track the use of Prevention Plans. DCBS should ensure when Prevention Plans are utilized they are in compliance with policy.

11. DCBS staff should examine protective child care programs to assess current utilization and identify barriers front line CPS staff may face when making child care referrals. Particular emphasis should be placed on utilization among high risk families.

12. The Child Welfare Oversight and Advisory Committee should review model programs and existing research regarding access to subsidized child care as a tool to enhance prevention and intervention services. Necessary recommendations for programmatic changes should be developed.

13. Law enforcement agencies should continue to treat every child fatality/near fatality under the premise the child may have been a victim of abuse or neglect.

RECOMMENDATIONS

14. Additional funding should be allocated to allow law enforcement agencies to reach full staffing capacity.

15. Law enforcement agencies should be encouraged to conduct joint investigations with CPS workers and local coroners.

16. The Department of Criminal Justice and Training and other law enforcement training entities should explore expanding their training curriculum in regards to properly investigating child overdose/ ingestion cases. Law enforcement officers should be provided with a clear understanding of the applicable criminal violations.

17. Law enforcement officers across the Commonwealth should consistently enforce child restraint violations.

18. Medical providers should remain diligent in reporting suspected abuse and neglect and utilizing the TEN-4 rule for young patients.

19. The Kentucky Hospital Association should continue to promote local hospitals to utilize the two Pediatric Forensic Medical centers to assist with a thorough assessment. Medical providers, DCBS, and law enforcement agencies are encouraged to consult with the Pediatric Forensic Medical centers.

20. All medical providers should continue to encourage and model safe sleep practices and consistent messaging regarding Abusive Head Trauma.

21. The Department for Behavioral Health, Developmental and Intellectual Disabilities, in conjunction with the Department for Public Health, should explore programming necessary to assure implementation of Plans of Safe Care for NAS infants, as well as a coordinated service delivery model for other substance exposed infants.

22. The Commonwealth should focus on expanding access to MAT facilities for pregnant and postpartum women.

23. Regulatory authorities should require MAT providers to require collaborative and holistic services to pregnant women, or mothers of infants, receiving MAT.

24. The Kentucky Coroner's Association should continue to encourage coroners to conduct local Child Fatality Reviews and complete the appropriate child death reporting forms recommended by the Department for Public Health.

25. The Kentucky Coroner's Association and the Department of Criminal Justice and Training should expand available coroner training regarding child death investigations.

26. As recommended in previous years, Family Drug Courts should be fully funded and implemented throughout Kentucky.

RECOMMENDATIONS

27. AOC should implement and/or explore other opportunities for improved practice, such a Model Court, throughout the Commonwealth.

28. AOC is encouraged to provide additional training throughout the state to ensure consistency regarding DNA findings and criminal prosecutions. The training should address how the judicial findings may impact DCBS.

29. DCBS should explore options to provide additional legal support to DCBS staff involved in DNA actions.

30. Department for Public Health in partnership with KIPRC, should support epidemiological data collection regarding firearm related injuries and deaths among Kentucky children. Department for Public Health should develop and distribute research based messaging regarding safe storage of firearms. These resources should be distributed through gun distributors, pediatric and family practice offices, child abuse prevention organizations, Kentucky Fish and Wildlife, law enforcement agencies, and school based parent organizations.

31. Exploration of funding partnerships to provide free or low cost trigger locks and/or locking gun boxes. These materials should be provided with research based educational materials and involve diverse partner groups

32. The Kentucky General Assembly should examine existing statutes with the goal of making amendments designed to reduce firearm related death and injuries among children.

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DEMOGRAPHICS

COUNTY OF INCIDENT

SharePoint allows the Panel to track demographic information for each case reviewed. The data shows fatal and near fatal events due to child abuse and neglect occur throughout every region of the Commonwealth. The chart below indicates the number of cases per county of incident. State Fiscal Year 2014, 2015, 2016, and 2017 have been combined, please refer to previous Annual Reports for a complete breakdown.

County of Incident Among All Cases Reviewed in SFY 14-17 and SFY18

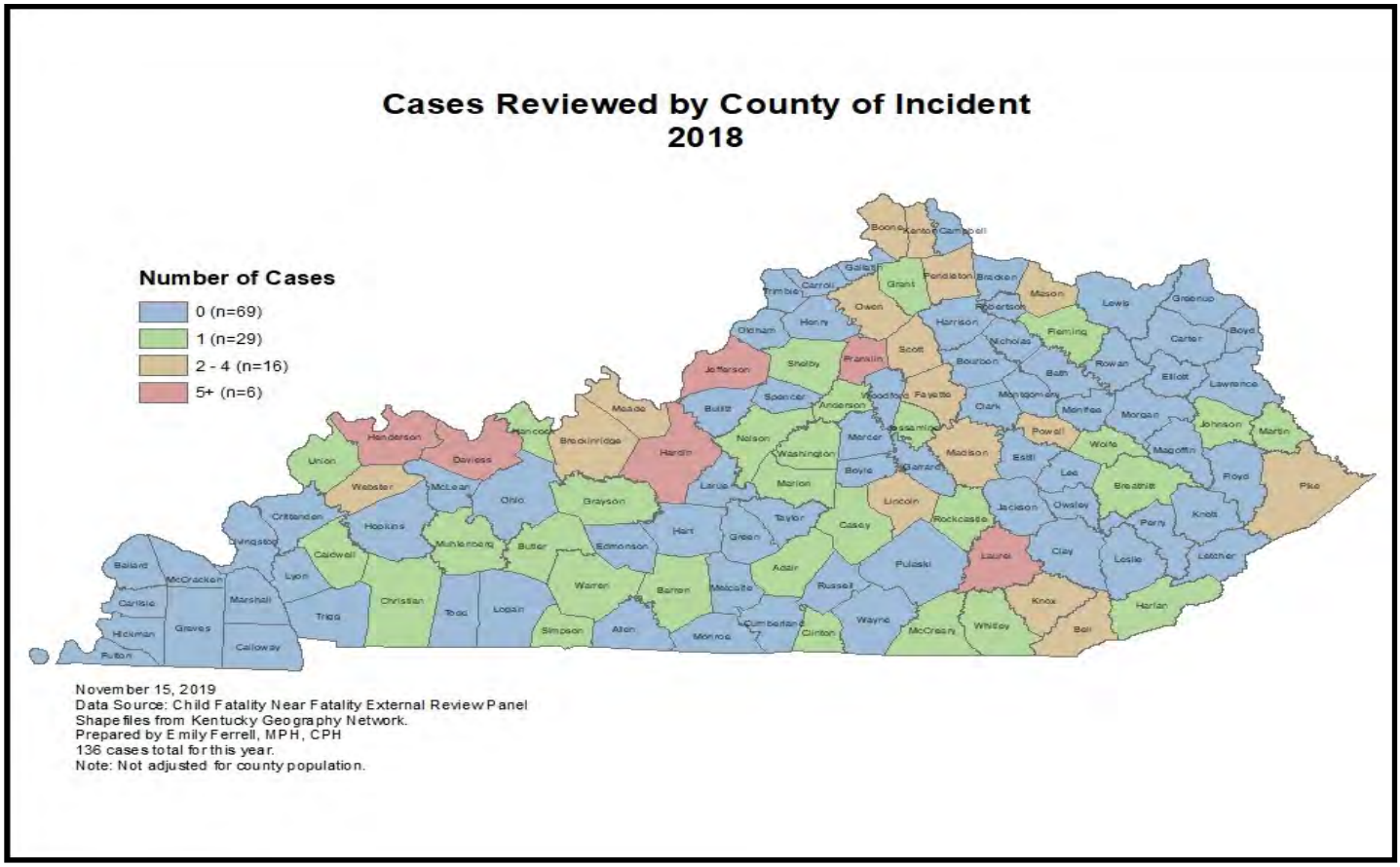
County	Combined SFY 14-17	SFY 2018
Adair	3	1
Allen	1	0
Anderson	1	1
Ballard	2	0
Barren	4	1
Bath	1	0
Bell	8	3
Boone	6	4
Bourbon	1	0
Boyd	14	0
Boyle	4	0
Bracken	1	0
Breathitt	0	1
Breckinridge	5	2
Bullitt	6	0
Butler	1	1
Caldwell	0	1
Calloway	3	0
Campbell	8	0
Carlisle	1	0
Carroll	3	0
Carter	2	0
Casey	3	1
Christian	11	1
Clark	4	0
Clay	9	0
Clinton	1	1
Crittenden	2	0
Cumberland	1	0
Daviess	14	6
Estill	3	0
Fayette	12	4
Fleming	3	1
Floyd	3	0
Franklin	8	5

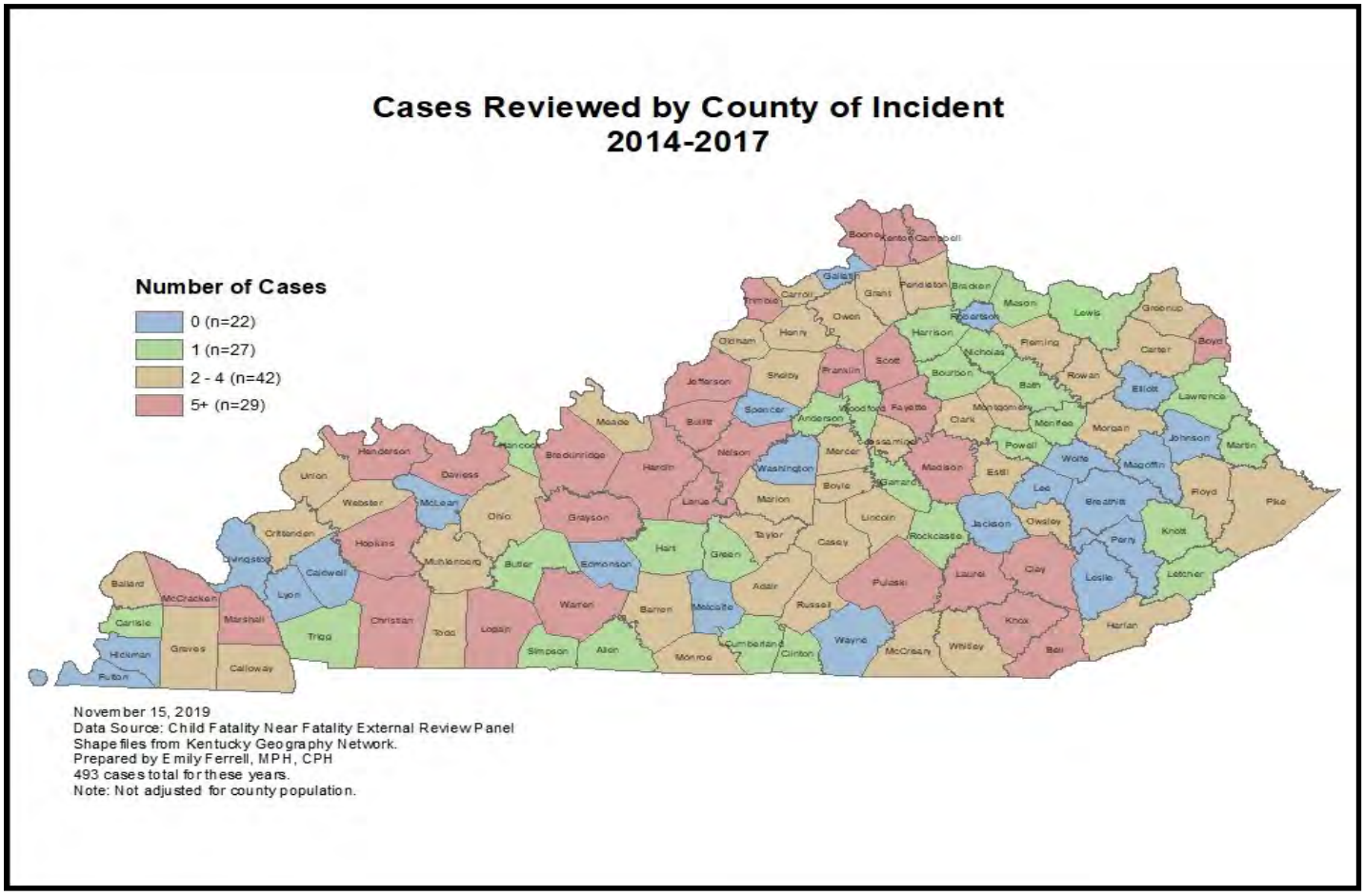
County	Combined SFY 14-17	SFY 2018
Garrard	1	0
Grant	2	1
Graves	3	0
Grayson	5	1
Green	1	0
Greenup	2	0
Hancock	1	1
Hardin	14	12
Harlan	4	1
Harrison	1	0
Hart	1	0
Henderson	8	7
Henry	2	0
Hopkins	6	0
Jefferson	87	30
Jessamine	4	1
Johnson	0	1
Kenton	19	3
Knott	1	0
Knox	7	2
Larue	8	0
Laurel	19	5
Lawrence	1	0
Letcher	1	0
Lewis	1	0
Lincoln	2	3
Logan	6	0
Madison	8	2
Marion	4	1
Marshall	8	0
Martin	1	1
Mason	1	2
McCracken	5	0
McCreary	4	1

County	Combined SFY 14-17	SFY 2018
Meade	4	2
Menifee	1	0
Mercer	2	0
Montgomery	2	0
Monroe	2	0
Morgan	3	0
Muhlenberg	2	1
Nelson	7	1
Nicholas	1	0
Ohio	3	0
Oldham	3	0
Owen	2	3
Owsley	2	0
Pendleton	2	4
Pike	3	2
Powell	1	2
Pulaski	11	0
Rockcastle	1	1
Rowan	2	0
Russell	2	0
Scott	6	2
Shelby	3	1
Simpson	1	1
Taylor	4	0
Todd	2	0
Trigg	1	0
Trimble	5	0
Union	3	1
Warren	17	1
Washington	0	1
Webster	4	2
Whitley	3	1
Wolfe	0	1
Woodford	1	0
Total Cases	**493**	**136**

Data Source: Child Fatality and Near Fatality External Review Panel

COUNTY OF INCIDENT





DEMOGRAPHICS

Gender of All Cases Reviewed SFY 2014—2018

	2014		2015		2016		2017		2018	
Gender	**# Cases**	**Percent**	**# Cases**	**Percent**	**# Cases**	**Percent**	**# Cases**	**Percent**	**# Case**	**Percent**
Male	69	66%	72	62%	86	57%	75	56%	87	64%
Female	35	34%	44	38%	64	43%	59	44%	49	36%
Total	**104**		**116**		**150**		**134**		**136**	

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

Race of All Cases Reviewed SFY 2014—2018

	2014		2015		2016		2017		2018	
Race	# Cases	Percent	# Cases	Percent	# Cases	Percent	# Cases	Percent	# Cases	Percent
Black	13	13%	11	9%	24	16%	22	17%	19	14%
White	86	83%	90	78%	109	72.67%	94	70%	95	70%
Asian					1	0.67%	0	0%	1	< 1%
Biracial					11	7.33%	7	5%	20	15%
Other	5	5%	15	13%	5	3.33%	11	8%	1	< 1%
Total	104		116		150		134		136	

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

*In 2014, rounding resulted in a value greater than 100%

Ethnicity of All Cases Reviewed SFY 2014—2018

	2014		2015		2016		2017		2018	
Ethnicity	# Cases	Percent	# Cases	Percent	# Cases	Percent	# Cases	Percent	# Cases	Percent
Hispanic	4	4%	6	5%	3	2%	12	9%	4	3%
Non-Hispanic	100	96%	110	95%	147	98%	122	91%	131	96%
Unknown									1	1%
Total	104	100%	116	100%	150	100%	134	100%	136	100%

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

DEMOGRAPHICS

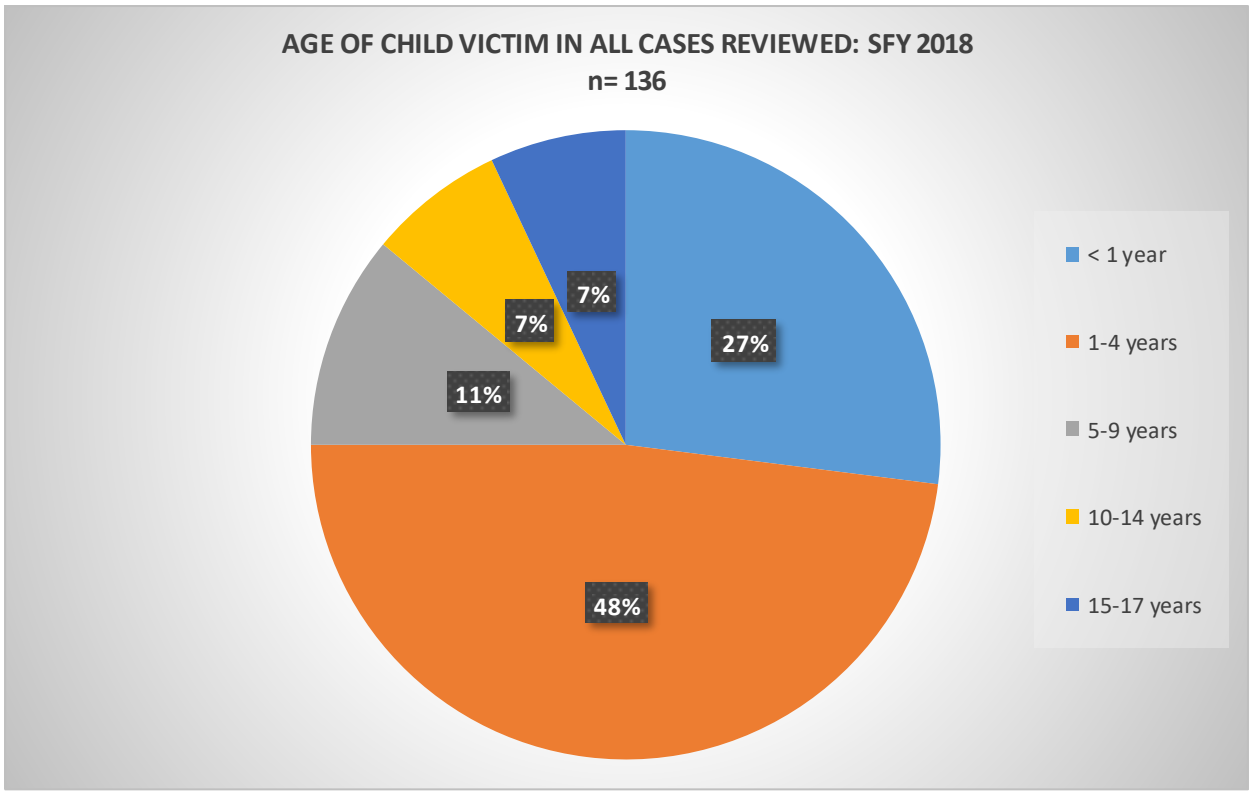
The Panel has continuously found that children four years of age or younger at higher risk for a fatal/near fatal event due to child maltreatment. Since 2014, 81% of all cases reviewed by the Panel were children four years or younger. Prevention efforts should continue to target these higher risk age groups.

Age of Child Victim in All Cases Reviewed

State Fiscal Years 2014—2018

Age	2014		2015		2016		2017		2018	
	# Cases	Percent	# Cases	Percent	# Cases	Percent	# Cases	Percent	# Cases	Percent
< 1 year	52	50	56	48.28	77	53	60	45	37	27%
1-4 years	31	29.81	43	37.07	49	32	48	36	65	48%
5-9 years	9	8.65	9	7.76	14	9	7	5	15	11%
10-14 years	7	6.73	6	5.17	5	3	11	8	10	7%
15-17 years	5	4.81	2	1.72	5	3	8	6	9	7%
Total	104		116		150		134		136	

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



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

Findings Specific to Fiscal Year 2018

FINDINGS AND DETERMINATIONS

The Panel designates the categorization or type of case, identifies the characteristics associated with 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 2018 (FY18) case reviews.

Final Categorization All Cases FY18

n= 136

Category	Fatalities	Near Fatalities	Total
Overdose/ingestion	1	31	32
Physical Abuse	3	21	24
Abusive Head Trauma	5	17	22
Neglect	6	15	21
Blunt Force Trauma-not inflicted MVC	7	7	14
Drowning\near drowning	10	2	12
SUDI	6	0	6
Gunshot accidental	3	3	6
Burn	0	5	5
Suicide Child	4	1	5
Blunt Force Trauma-not inflicted	0	4	4
Natural Causes\medical diagnosis	4	0	4
Failure to Thrive	0	4	4
Apparent murder/suicide	4	0	4
Other	3	0	3
Gunshot homicide	2	0	2
Undetermined	2	0	2
Smoke inhalation/fire	2	0	2
Traumatic asphyxia	1	0	1

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

*Cases may be captured in more than one category. "Other" includes infanticide (1) and hyperthermia (2).

Findings Specific to Fiscal Year 2018

KEY FINDINGS FY18

→ DCBS History continues to be the most common family characteristic in all cases reviewed by the Panel.

→ The most commonly found family characteristics in a fatality/near fatality in order of precedence for FY18 cases reviewed:

–DCBS History

–Financial Issues

–Criminal history (in the home and caregiver)

–Mental Health Issues (caregiver)

–Substance abuse (in home)

–Supervisional neglect

→ Neglect due to unsafe access to deadly means and supervisory neglect were the most common panel determinations.

→ 78% of the cases reviewed from FY18 had a prior history with child protective services

→ 75% of all cases reviewed involved a child four (4) year of age or younger

→ 58% of all cases with a panel determination of Neglect due to unsafe access to deadly means were overdose/ingestion cases.

→ 73% of Abusive Head Trauma cases involved substance abuse by a caregiver.

→ 71% of all Blunt Force Trauma – not inflicted MVC cases involved substance abuse by a caregiver.

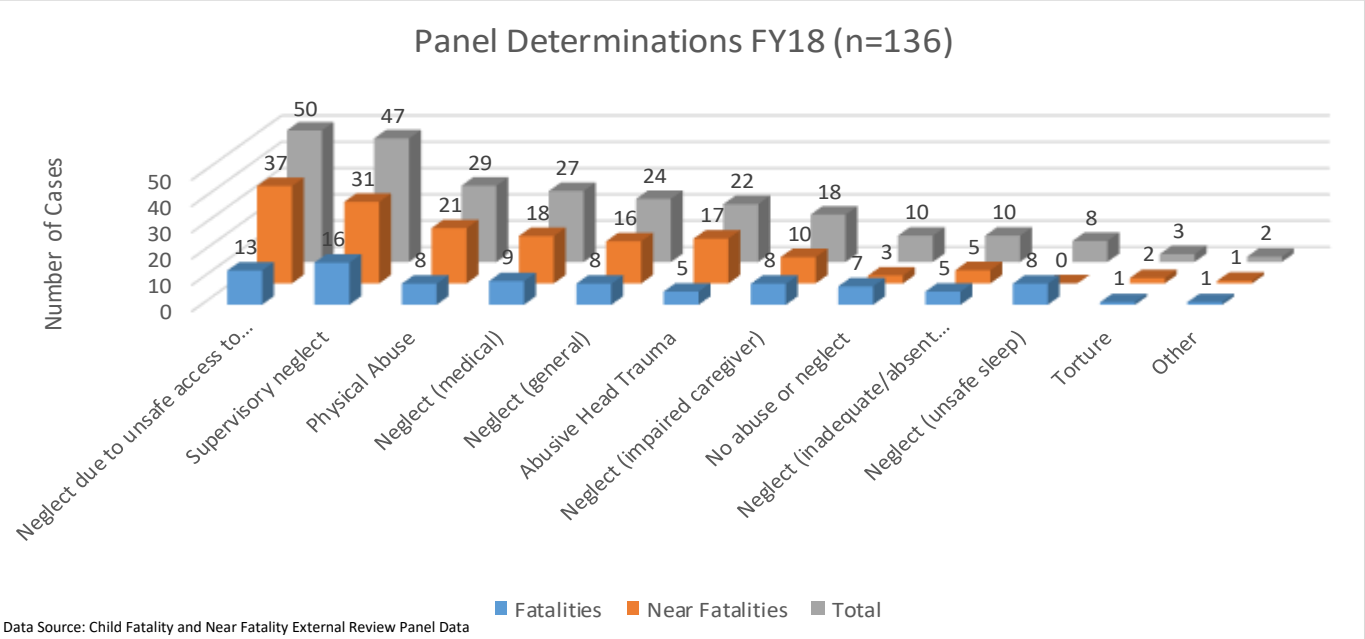
Panel Determinations All Cases FY18

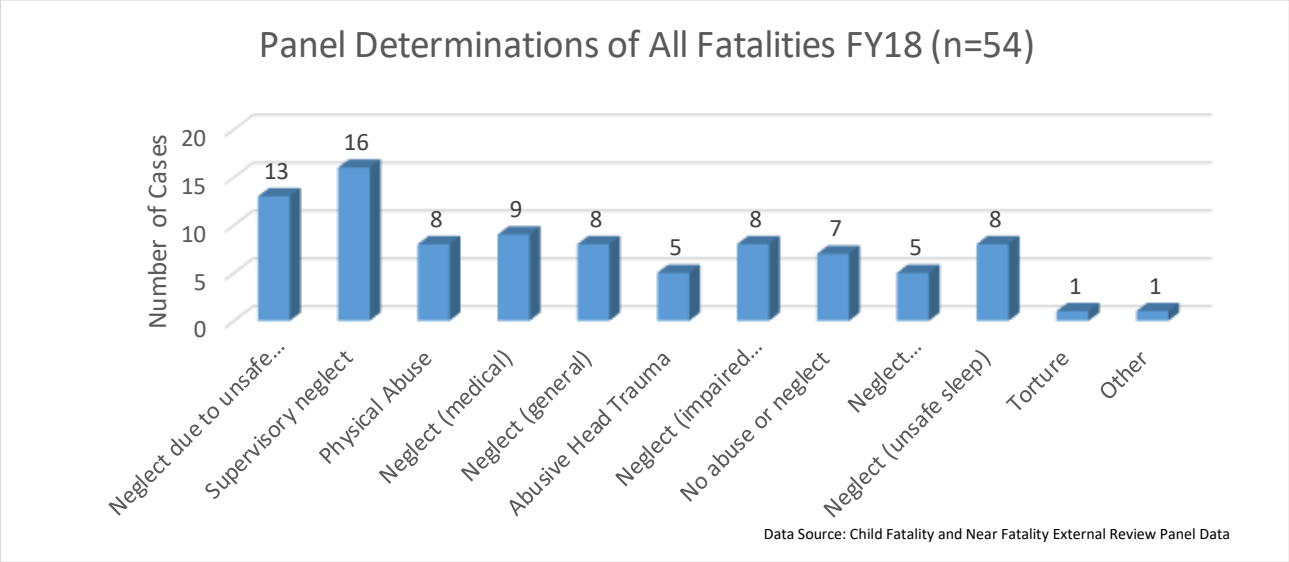
Panel Determinations	Fatalities	Near Fatalities	Total
Neglect due to unsafe access to deadly/potentially deadly means	13	37	50
Supervisory neglect	16	31	47
Physical Abuse	8	21	29
Neglect (medical)	9	18	27
Neglect (general)	8	16	24
Abusive Head Trauma	5	17	22
Neglect (impaired caregiver)	8	10	18
No abuse or neglect	7	3	10
Neglect (inadequate/absent child restraint in a motor vehicle	5	5	10
Neglect (unsafe sleep)	8	0	8
Torture	1	2	3
Other	1	1	2

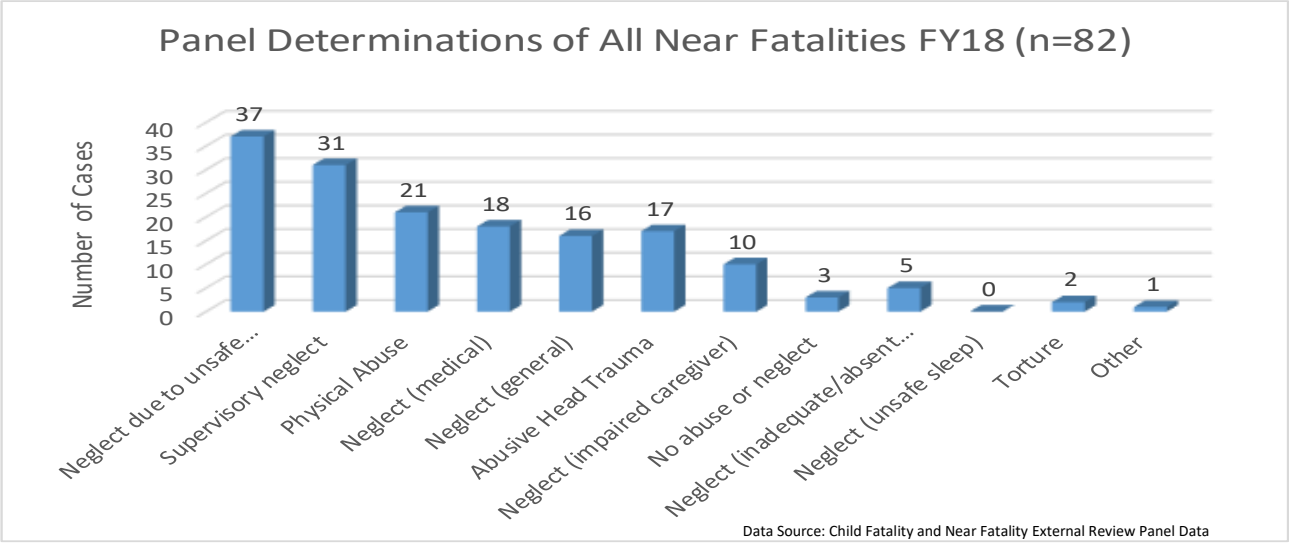
Data Source: Child Fatality and Near Fatality External Review Panel Data

*Cases may be represented in multiple categories.

Findings Specific to Fiscal Year 2018







Findings Specific to Fiscal Year 2018

Family Characteristics Contributing to the Fatality or Near Fatality

Family Characteristics	Fatality	Near Fatality	Total
DCBS History	44	62	106
Financial Issues	33	60	93
Criminal history (in the home)	31	50	81
Criminal History (caregiver)	29	48	77
Mental Health issues (caregiver)	30	46	76
Substance abuse (in home)	27	46	73
Supervisional neglect	27	43	70
Substance abuse (caregiver)	25	44	69
Family Violence	22	44	66
DCBS Issues	17	41	58
Unsafe access to deadly means	15	37	52
Housing Instability	18	33	51
Medically Fragile child	26	22	48
Impaired caregiver (any indication)	16	25	41
Medical neglect	11	28	39
Bystander issues/opportunities	16	22	38
Medical issues/management	10	21	31
Law Enforcement Issues	14	16	30
Other	7	21	28
Substitute caregiver at the time of event	8	18	26
Lack of treatment (mental health or substance)	11	13	24
Neglectful Entrustment	12	12	24
Environmental neglect	6	14	20
Serial Relationships	6	14	20
Mental Health issues (child)	8	8	16
Cognitive disability (caregiver)	4	12	16
MAT involvement	1	15	16
Lack of regular child care	7	8	15
Evidence of poor bonding	1	13	14
Judicial process	5	7	12
Coroner Issues	10	0	10
Cognitive disability (child)	5	6	11
Inadequate restraint	5	5	10
Unsafe sleep (other)	6	1	7
Education/childcare issues	3	3	6
Lack of Family Support System	1	4	5
Perinatal depression (caregiver)	1	4	5
Language/Cultural Issues	2	2	4
Failure to Thrive	2	2	4
Unsafe sleep (bed sharing)	2	1	3
Unsafe sleep (co-sleeping/non-bed surface)	1	1	2

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

Findings Specific to Fiscal Year 2018

The chart below shows the number of cases where the finding included circumstances that made the incident potentially preventable. Of the 54 cases involving a child fatality, the Panel determined that 89% of those fatalities were potentially preventable. Among the near fatality cases, 95% were determined to be potentially preventable. Overall the Panel found that 93% of these incidents may have been prevented.

Potentially Preventable Fatalities and Near Fatalities FY18
n = 136

	# of Cases	Total	Percent
Fatalities	48	54	**89%**
Near Fatalities	78	82	**95%**
Total	126	136	**93%**

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

Most Common Family Characteristics Identified in Fatality/Near Fatality Among Cases with a Panel Categorization of Overdose/ingestion (n=32)

Family Characteristics	# of Cases	% Cases
Unsafe access to deadly means	29	91%
Supervisional neglect	29	91%
DCBS history	26	81%
Financial Issues	24	75%
Substance abuse (in the home)	19	59%
Substance abuse (caregiver)	18	56%
Mental health issues (caregiver)	18	56%
Criminal history (in the home)	18	56%
Criminal history (caregiver)	17	53%
Family violence	15	47%
Housing instability	13	41%
Environmental Neglect	11	34%
Impaired caregiver	11	34%

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

Most Common Family Characteristics Identified in Fatality/Near Fatality Among Cases with a Panel Categorization of Physical Abuse (n=24)

Family Characteristics	# of Cases	% Cases
Financial Issues	18	75%
DCBS History	17	71%
Mental health issues, caregiver	16	67%
Substance abuse by caregiver	16	67%
Criminal history in the home	16	67%
Criminal history (caregiver)	16	67%
Bystander issues/opportunities	16	67%
Substance abuse (in home)	15	63%
Family violence	14	58%
DCBS issues	13	54%
Neglectful entrustment	11	46%
Medical neglect	11	46%
Medical issues/management	10	42%
Impaired caregiver	9	38%
Lack of regular child care	9	38%
Substitute caregiver	9	38%

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

Most Common Family Characteristics Identified in Fatality/Near Fatality Among Cases with a Panel Categorization of Neglect (n=21)

Family Characteristics	# of Cases	% Cases
DCBS history	20	95%
Financial issues	16	76%
Medical neglect	16	76%
Mental health issues, caregiver	16	76%
Criminal history (caregiver)	15	71%
Criminal history (in the home)	15	71%
Family violence	13	62%
Housing instability	13	62%
DCBS issues	11	52%
Medically fragile child	11	52%
Other	10	48%
Bystander issues/opportunities	9	43%
Evidence of poor bonding	9	43%
Substance abuse (in home)	9	43%
Substance abuse by caregiver	9	43%
Cognitive disability (caregiver)	8	38%

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

Panel Members

Hon. Melissa Moore Murphy, Chair

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

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

Elizabeth Croney, Executive Director
Board of Social Work

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

Angela Yannelli, Executive Director
Kentucky Coalition Against Domestic Violence

Lori Aldridge, Program Director
Tri –County CASA

Dr. Jaime Pittenger
Prevent Child Abuse Kentucky

Honorable Libby Messer
Fayette Family Court Judge

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

Elizabeth Epperson
Association of Addiction Professionals

Eric T. Clark, Commissioner
Department of Community Based Services

Detective Isaac Waters
Kentucky State Police

Hon. Dawn Blair
Hardin County Attorney

Betty Pennington
Family Resource and Youth Services Centers

Dr. Henrietta Bada,
Department for Public Health

Dr. William Ralston
Kentucky State Medical Examiner

Shelley Wood, RN
Department for Public Health

Steve Shannon
Kentucky Association of Regional Programs, Inc.

Linnea Caldon
Citizen Foster Care Review Board

Members Who Left The Panel in 2019

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

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

Rep. Addia Wuchner, Kentucky House of Representatives
Health and Welfare Committee Chair

Sherry Currens, Executive Director
Kentucky Coalition Against Domestic Violence

Shawna Kelly-Blair, Program Director
CASA of Eastern Kentucky

Honorable Paula Sherlock
Jefferson Family Court Judge

Lt. Scott Lengle
Kentucky State Police

Jenny Oldham
Hardin County Attorney

Angela Brown, RN
Department for Public Health

Panel Staff

Elisha Mahoney, Executive Staff Advisor

Justice & Public Safety Cabinet

Joel Griffith, Case Analyst

Justice & Public Safety Cabinet

THE MOST OVERLOOKED SIGN OF ABUSE: BRUISING

REMEMBER THE TEN-4 BRUISING RULE*

Watch for these signs of abuse that must be immediately evaluated:

Children age 4 and younger

Any bruising of the **T**orso, **E**ars or **N**eck

Infants – Any nonmobile infant under 1 year of age**

Any bruising **ANYWHERE** on a nonmobile infant under 1 year of age, or any infant who is not yet pulling up and taking steps. Those who don't cruise rarely bruise.

Normal bruising

In toddlers and older children who are mobile, bruises are typically on the front of the body and over bony areas like the forehead, elbows, knees and shins.

Is it abuse?

Even if you're not sure, you are required by law to report abuse or neglect.

In Kentucky, call **1-877-KYSAFE1** (1-877-597-2331) • In Indiana: **(800) 800-5556**

You may remain anonymous.

Forensic consultations 24 hour a day, 7 days a week • **(502) 629-6000**

* Pierce MC, Kazzer C, Aldridge S, Flynn J, Lorenz DJ. Bruising characteristics discriminating physical child abuse from accidental trauma. Pediatrics. 2010;125(1):67-74. Epub Dec 7, 2009. Erratum in Pediatrics. 2010;125(4):861.

** Sugar NF, Taylor JA, Feldman KW, et al. Bruises in infants and toddlers: those who don't cruise rarely bruise. Arch Pediatr Adolesc Med. 1999;153(3):332-4.

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NORTON Children's Hospital

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SAFESLEEP

KENTUCKY

Reduce the risk of SIDS (Sudden Infant Death Syndrome).

Follow the ABC's of Safe Sleep

ALONE—Stay Close, Sleep

On My BACK for Night and

In a Clean, Clear, CRIB

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.

www.safesleepky.org
Kentucky Department for Public Health

CASE REVIEWS FOR FISCAL YEAR 2018

Case Number	Categorization	Family Characteristics	Family Characteristics Comments	Panel Determination	Other Qualifiers
F-001-18-C	Physical abuse	Criminal history (in the home); Law enforcement issues		Physical abuse	Manner undetermined/foul play not ruled out; Potentially preventable
F-002-18-C	Drowning/near-drowning	DCBS history; Supervisional neglect; Unsafe access to deadly means; Criminal history (in the home); Financial issues		Neglect due to unsafe access to deadly/ potentially deadly means; Supervisory neglect	Apparently accidental; Potentially preventable
F-003-18-C	Suicide (child)	Criminal history (caregiver); Criminal history (in the home); DCBS history; DCBS issues; Deployment/ redeployment in household; Family violence; Financial issues; Medical neglect; Medically fragile child; Bystander issues/ opportunities; Medical issues/management; Mental health issues (caregiver); Mental health issues (child); Substance abuse (in home); Substance abuse by caregiver (current); Supervisional neglect; Unsafe access to deadly means; Lack of family support system		Neglect due to unsafe access to deadly/ potentially deadly means	Potentially preventable
F-004-18-NC	Blunt force trauma - not inflicted MVC	Supervisional neglect		Supervisory neglect	Apparently accidental; Potentially preventable
F-005-18-C	Gunshot (accidental)	DCBS history; Financial issues; Housing instability; Mental health issues (caregiver); Supervisional neglect; Unsafe access to deadly means; Lack of regular child care		Neglect due to unsafe access to deadly/ potentially deadly means; Supervisory neglect	Apparently accidental; Potentially preventable
F-006-18-NC	Apparent murder/suicide; Gunshot (homicide)	DCBS history; Mental health issues (caregiver); Mental health issues (child); Medical issues/management		Physical abuse	Potentially preventable
F-007-18-NC	Apparent murder/suicide; Gunshot (homicide)	DCBS history; Mental health issues (caregiver); Medical issues/management		Physical abuse	Potentially preventable

CASE REVIEWS FOR FISCAL YEAR 2018

Case Number	Categorization	Family Characteristics	Family Characteristics Comments	Panel Determination	Other Qualifiers
F-008-18-C	Gunshot (accidental)	DCBS history; Supervisional neglect; Unsafe access to deadly means		Neglect due to unsafe access to deadly/potentially deadly means	Apparently accidental; Potentially preventable
F-009-18-C	SUDI/near-SUDI/apparent life-threatening event	Bystander issues/ opportunities; Criminal history (in the home); DCBS history; DCBS issues; Impaired caregiver; Medical issues/ management; Mental health issues (caregiver); Substance abuse (in home); Substance abuse by caregiver (current); Unsafe sleep (bed sharing); Criminal history (caregiver); Financial issues; Lack of treatment (mental health or substance abuse); Medical neglect; Medically fragile child; Supervisional neglect		Neglect (impaired caregiver); Neglect (medical); Neglect (unsafe sleep)	Potentially preventable; Apparently accidental
F-010-18-C	Undetermined (cause of death or near-death event)	Bystander issues/ opportunities; Criminal history (caregiver); Criminal history (in the home); DCBS history; DCBS issues; Family violence; Financial issues; Housing instability; Impaired caregiver; Mental health issues (caregiver); Neglectful entrustment; Substance abuse (in home); Substance abuse by caregiver (current); Substitute caregiver at time of event ; Supervisional neglect; Unsafe sleep (bed sharing); Coroner issues; Lack of regular child care; Law enforcement issues		Neglect (general - can include leaving child with unsafe caregiver); Neglect (unsafe sleep)	Manner undetermined/foul play not ruled out
F-011-18-C	Abusive head trauma; Physical abuse	Bystander issues/ opportunities; Criminal history (caregiver); Criminal history (in the home); DCBS history; Impaired caregiver; Lack of regular child care; Neglectful entrustment; Substance abuse (in home); Substance abuse by caregiver (current); Supervisional neglect		Physical abuse; Abusive head trauma	Potentially preventable

Case Number	Categorization	Family Characteristics	Family Characteristics Comments	Panel Determination	Other Qualifiers
F-012-18-C	Other	Coroner issues; Criminal history (caregiver); Criminal history (in the home); DCBS history; DCBS issues; Family violence; Financial issues; Housing instability; Impaired caregiver; Medical neglect; Medically fragile child; Mental health issues (caregiver); Substance abuse (in home); Substance abuse by caregiver (current); Law enforcement issues; Lack of treatment (mental health or substance abuse)		Neglect (medical); Other	Potentially preventable
F-013-18-NC	Drowning/near-drowning	Other; Unsafe access to deadly means; Supervisional neglect; Medically fragile child	Parent overburdened by care of two medically fragile children and five year old sibling.	Neglect due to unsafe access to deadly/ potentially deadly means; Supervisory neglect	Apparently accidental; Potentially preventable
F-014-18-C	Abusive head trauma; Physical abuse	Criminal history (caregiver); Criminal history (in the home); DCBS history; DCBS issues; Family violence; Law enforcement issues; Medical neglect; Medically fragile child; Neglectful entrustment; Serial relationships; Substitute caregiver at time of event ; Financial issues; Lack of regular child care; Bystander issues/ opportunities		Abusive head trauma; Neglect (medical); Physical abuse; Torture	Potentially preventable
F-015-18-C	Blunt force trauma - not inflicted MVC	Criminal history (caregiver); Criminal history (in the home); DCBS history; Impaired caregiver; Inadequate restraint; Lack of treatment (mental health or substance abuse); Medical issues/management; Substance abuse by caregiver (current); Substance abuse (in home); Family violence; Neglectful entrustment		Neglect (impaired caregiver); Neglect (inadequate/absent child restraint in motor vehicle)	Potentially preventable; Apparently accidental
F-016-18-C	Drowning/near-drowning	Criminal history (caregiver); Criminal history (in the home); DCBS history; DCBS issues; Family violence; Housing instability; Medical issues/ management; Medically fragile child; Mental health issues (caregiver); Substance abuse (in home); Substance abuse by caregiver (current); Supervisional neglect; Coroner issues; Unsafe access to deadly means; Law enforcement issues		Supervisory neglect	Apparently accidental; Potentially preventable

Case Number	Categorization	Family Characteristics	Family Characteristics Comments	Panel Determination	Other Qualifiers
F-017-18-C	Blunt force trauma - not inflicted MVC	Bystander issues/ opportunities; Criminal history (caregiver); Criminal history (in the home); Impaired caregiver; Inadequate restraint; Mental health issues (caregiver); Substance abuse by caregiver (current); Substance abuse (in home); DCBS history		Neglect (impaired caregiver); Neglect (inadequate/absent child restraint in motor vehicle)	Apparently accidental; Potentially preventable
F-018-18-C	SUDI/near-SUDI/apparent life-threatening event	Criminal history (caregiver); Criminal history (in the home); DCBS history; Environmental neglect; Financial issues; Housing instability; Impaired caregiver; Judicial process issues; Medical issues/ management; Serial relationships; Substance abuse (in home); Substance abuse by caregiver (current); Unsafe sleep (other); DCBS issues		Neglect (impaired caregiver); Neglect (unsafe sleep)	Apparently accidental; Potentially preventable
F-019-18-C	Neglect; Natural causes/medical diagnosis	Bystander issues/ opportunities; Cognitive disability (caregiver); Criminal history (caregiver); Criminal history (in the home); DCBS history; Environmental neglect; Family violence; Financial issues; Impaired caregiver; Medical issues/ management; Medical neglect; Medically fragile child; Mental health issues (caregiver); Neglectful entrustment; Substance abuse (in home); Substance abuse by caregiver (current); Substitute caregiver at time of event ; Supervisional neglect; Unsafe sleep (other)		Neglect (general - can include leaving child with unsafe caregiver); Neglect (impaired caregiver); Neglect (medical); Neglect (unsafe sleep)	Apparently accidental; Potentially preventable
F-020-18-C	Drowning/near-drowning	DCBS history; Medically fragile child; Supervisional neglect; Unsafe access to deadly means; Coroner is-sues; Language/cultural issues		Neglect due to unsafe access to deadly/ potentially deadly means; Supervisory neglect	Apparently accidental; Potentially preventable

CASE REVIEWS FOR FISCAL YEAR 2018

Case Number	Categorization	Family Characteristics	Family Characteristics Comments	Panel Determination	Other Qualifiers
F-021-18-NC	Apparent murder/suicide	Cognitive disability (child); Family violence; Lack of treatment (mental health or substance abuse); Medically fragile child; Mental health issues (caregiver); Substance abuse (in home); Substance abuse by caregiver (current)		Physical abuse	
F-022-18-C	Apparent murder/suicide; Neglect	Bystander issues/ opportunities; Criminal history (caregiver); Criminal history (in the home); DCBS history; Family violence; Financial issues; Housing instability; Medical neglect; Mental health issues (caregiver); Mental health issues (child); Substance abuse (in home); Supervisional neglect; Lack of treatment (mental health or substance abuse)		Neglect (medical); Supervisory neglect	Potentially preventable
F-023-18-NC	Neglect; SUDI/ near-SUDI/ apparent life-threatening event; Undetermined (cause of death or near-death event)	Criminal history (in the home); Criminal history (caregiver); Environmental neglect; Financial issues; Housing instability; Impaired caregiver; Mental health issues (caregiver); Other; Perinatal depression (caregiver); Substance abuse (in home); Substance abuse by caregiver (current); Supervisional neglect; Unsafe sleep (other); Family violence; Judicial process issues	Overwhelmed parent	Neglect (unsafe sleep); Neglect (impaired caregiver); Supervisory neglect	Apparently accidental; Potentially preventable
F-024-18-C	Smoke inhalation/fire	Cognitive disability (caregiver); DCBS history; DCBS issues; Financial issues; Impaired caregiver; Lack of regular child care; Medically fragile child; Mental health issues (caregiver); Neglectful entrustment; Substance abuse (in home); Substance abuse by caregiver (current); Substitute caregiver at time of event ; Supervisional neglect		Neglect (general - can include leaving child with unsafe caregiver); Supervisory neglect	Apparently accidental; Potentially preventable

CASE REVIEWS FOR FISCAL YEAR 2018

Case Number	Categorization	Family Characteristics	Family Characteristics Comments	Panel Determination	Other Qualifiers
F-025-18-C	Drowning/near-drowning	Bystander issues/ opportunities; Cognitive disability (child); Criminal history (caregiver); Criminal history (in the home); DCBS history; MAT involvement; Medically fragile child; Mental health issues (caregiver); Substance abuse (in home); Substance abuse by caregiver (current); Substitute caregiver at time of event ; Supervisional neglect; Unsafe access to deadly means; Other	Overwhelmed caregiver.	Neglect due to unsafe access to deadly/ potentially deadly means; Supervisory neglect	Apparently accidental; Potentially preventable
F-026-18-NC	Drowning/near-drowning	Housing instability; Financial issues; Lack of regular child care; Medically fragile child; Supervisional neglect; Unsafe access to deadly means		Neglect due to unsafe access to deadly/ potentially deadly means; Supervisory neglect	Apparently accidental; Potentially preventable
F-027-18-C	Blunt force trauma - not inflicted MVC	Coroner issues; DCBS history; Financial issues; Inadequate restraint; Judicial process issues; Law enforcement issues; Medically fragile child; Substance abuse by caregiver (current); Supervisional neglect; DCBS issues; Education/ child care issues		Neglect (inadequate/ absent child restraint in motor vehicle)	Apparently accidental; Potentially preventable
F-028-18-C	Neglect	Bystander issues/ opportunities; Criminal history (caregiver); Criminal history (in the home); DCBS history; DCBS issues; Failure to thrive; Family violence; Financial issues; Housing instability; Medical neglect; Medically fragile child; Mental health issues (caregiver); Neglectful entrustment; Substance abuse (in home); Substance abuse by caregiver (current); Substitute caregiver at time of event ; Law enforcement issues; Environmental neglect; Lack of regular child care; Serial relationships; Unsafe sleep (other)		Neglect (medical); Neglect (general - can include leaving child with unsafe caregiver)	Potentially preventable; Manner undetermined/foul play not ruled out

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Case Number	Categorization	Family Characteristics	Family Characteristics Comments	Panel Determination	Other Qualifiers
F-029-18-NC	Drowning/near-drowning	Criminal history (caregiver); Criminal history (in the home); Financial issues; Medically fragile child; Supervisional neglect; Unsafe access to deadly means		Neglect due to unsafe access to deadly/ potentially deadly means; Supervisory neglect	Apparently accidental; Potentially preventable
F-030-18-C	Drowning/near-drowning	DCBS history; DCBS issues; Family violence; Financial issues; Housing instability; Impaired caregiver; Mental health issues (caregiver); Mental health issues (child); Substance abuse (in home); Substance abuse by caregiver (current); Supervisional neglect; Unsafe access to deadly means; Coroner issues; Law enforcement issues		No abuse or neglect	Apparently accidental; Potentially preventable
F-031-18-C	Gunshot (accidental)	Bystander issues/ opportunities; Cognitive disability (child); Criminal history (caregiver); Criminal history (in the home); DCBS history; DCBS issues; Environmental neglect; Failure to thrive; Impaired caregiver; Medical neglect; Mental health issues (caregiver); Mental health issues (child); Neglectful entrustment; Substance abuse (in home); Substance abuse by caregiver (current); Supervisional neglect; Unsafe access to deadly means; Judicial process issues; Lack of treatment (mental health or substance abuse); Law enforcement issues; Medical issues/ management; Medically fragile child		Neglect (impaired caregiver); Neglect due to unsafe access to deadly/potentially deadly means; Supervisory neglect	Apparently accidental; Potentially preventable
F-032-18-C	Other	Bystander issues/ opportunities; Cognitive disability (caregiver); Criminal history (caregiver); Criminal history (in the home); DCBS history; DCBS issues; Financial issues; Housing instability; Mental health issues (caregiver); Neglectful entrustment; Other; Supervisional neglect; Unsafe access to deadly means; Lack of treatment (mental health or substance abuse)	Overwhelmed parent	Neglect due to unsafe access to deadly/ potentially deadly means; Neglect (general - can include leaving child with unsafe caregiver); Supervisory neglect	Apparently accidental; Potentially preventable

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Case Number	Categorization	Family Characteristics	Family Characteristics Comments	Panel Determination	Other Qualifiers
F-033-18-C	Other	Criminal history (caregiver); DCBS history; Financial issues; Medically fragile child; Mental health issues (caregiver); Other; Supervisional neglect; Unsafe access to deadly means; Coroner issues	Overwhelmed parent	Neglect due to unsafe access to deadly/ potentially deadly means	Apparently accidental; Potentially preventable
F-034-18-PH	Drowning/near-drowning	Cognitive disability (child); Coroner issues; DCBS history; Supervisional neglect; Unsafe access to deadly means; Financial issues; Medical neglect; Medically fragile child; Mental health issues (caregiver)		Neglect due to unsafe access to deadly/ potentially deadly means	Apparently accidental; Potentially preventable
F-035-18-PH	Abusive head trauma	Language/cultural issues; Education/child care issues		Abusive head trauma	Potentially preventable; Apparently accidental
F-036-18-PH	SUDI/near-SUDI/apparent life-threatening event	DCBS history; Judicial process issues; Law enforcement issues; Family violence; Substitute caregiver at time of event ; Medically fragile child; Unsafe sleep (cosleeping on a non-bed surface)		Neglect (unsafe sleep)	Manner undetermined/ foul play not ruled out
F-037-18-PH	Neglect; Natural causes/medical diagnosis	Bystander issues/ opportunities; Cognitive disability (caregiver); DCBS history; DCBS issues; Environmental neglect; Evidence of poor bonding; Family violence; Financial issues; Housing instability; Medical neglect; Medically fragile child; Mental health issues (caregiver); Neglectful entrustment; Serial relationships; Lack of treatment (mental health or substance abuse); Law enforcement issues		Neglect (general - can include leaving child with unsafe caregiver); Neglect (medical)	Manner undetermined/ foul play not ruled out
F-038-18-PH	Suicide (child)	Criminal history (caregiver); DCBS history; Financial issues; Mental health issues (caregiver); Other; Coroner issues; Education/child care issues; Lack of treatment (mental health or substance abuse); Mental health issues (child)	Overwhelmed parent	Neglect (medical)	Potentially preventable

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Case Number	Categorization	Family Characteristics	Family Characteristics Comments	Panel Determination	Other Qualifiers
F-039-18-PH	Smoke inhalation/fire	Criminal history (caregiver); Criminal history (in the home); DCBS history; Housing instability; Impaired caregiver; Mental health issues (caregiver); Substance abuse (in home); Substance abuse by caregiver (current); Supervisional neglect; Coroner issues; Financial issues		Neglect (impaired caregiver)	Apparently accidental; Potentially preventable
F-040-18-PH	Blunt force trauma - not inflicted MVC	Criminal history (caregiver); Criminal history (in the home); DCBS history; Family violence; Financial issues; Housing instability; Inadequate restraint; Substance abuse (in home); Mental health issues (caregiver); Lack of treatment (mental health or substance abuse)		Neglect (inadequate/ absent child restraint in motor vehicle)	Apparently accidental; Potentially preventable
F-041-18-PH	Drowning/near-drowning	Medically fragile child; Law enforcement issues		No abuse or neglect	Apparently accidental; Potentially preventable
F-042-18-PH	Suicide (child)	DCBS history; Mental health issues (child)		No abuse or neglect	Potentially preventable
F-043-18-PH	Blunt force trauma - not inflicted MVC	Criminal history (caregiver); Criminal history (in the home); DCBS history; Family violence; Financial issues; Housing instability; Inadequate restraint; Substance abuse (in home); Lack of treatment (mental health or substance abuse); Mental health issues (caregiver)		Neglect (inadequate/ absent child restraint in motor vehicle)	Apparently accidental; Potentially preventable
F-044-18-PH	Overdose/ ingestion	Coroner issues; DCBS history; Law enforcement issues; Financial issues		No abuse or neglect	Apparently accidental; Potentially preventable
F-045-18-PH	Suicide (child)	Criminal history (in the home)		No abuse or neglect	
F-046-18-PH	SUDI/near-SUDI/apparent life-threatening event	Criminal history (caregiver); Criminal history (in the home); DCBS history; DCBS issues; Family violence; Financial issues; Housing instability; Law enforcement issues; Medically fragile child; Substance abuse (in home); Substance abuse by caregiver (current); Unsafe sleep (other); Supervisional neglect; Mental health issues (caregiver); Serial relationships		Neglect (unsafe sleep)	Apparently accidental; Potentially preventable

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Case Number	Categorization	Family Characteristics	Family Characteristics Comments	Panel Determination	Other Qualifiers
F-047-18-PH	Natural causes/ medical diagnosis	Criminal history (in the home); DCBS history; Family violence; Financial issues; Housing instability; Medically fragile child; Other; Substance abuse (in home); Substance abuse by caregiver (current)	Overwhelmed parent	No abuse or neglect	
F-048-18-PH	Neglect; Traumatic asphyxia	DCBS history; Criminal history (caregiver); Criminal history (in the home); Mental health issues (child)		Supervisory neglect; Neglect (general - can include leaving child with unsafe caregiver)	Apparently accidental; Potentially preventable
NF-001-18-C	Overdose/ ingestion	Criminal history (caregiver); Criminal history (in the home); DCBS history; DCBS issues; Family violence; Financial issues; Housing instability; Mental health issues (caregiver); Neglectful entrustment; Other; Substance abuse (in home); Supervisional neglect; Unsafe access to deadly means; Lack of treatment (mental health or substance abuse); Substitute caregiver at time of event	Overwhelmed parent	Neglect due to unsafe access to deadly/ potentially deadly means	Apparently accidental; Potentially preventable
NF-002-18-NC	Overdose/ ingestion	Supervisional neglect; Unsafe access to deadly means		Neglect due to unsafe access to deadly/ potentially deadly means	Apparently accidental; Potentially preventable
NF-003-18-C	Overdose/ ingestion	Criminal history (caregiver); Criminal history (in the home); DCBS issues; DCBS history; Impaired caregiver; Medical issues/ management; Medically fragile child; Supervisional neglect; Unsafe access to deadly means; Substance abuse (in home); Substance abuse by caregiver (current)		Neglect due to unsafe access to deadly/ potentially deadly means; Supervisory neglect	Apparently accidental; Potentially preventable
NF-004-18-C	Failure to thrive/ malnutrition; Neglect	Cognitive disability (child); DCBS history; DCBS issues; Evidence of poor bonding; Failure to thrive; Financial issues; Housing instability; Judicial process issues; MAT involvement; Medical issues/ management; Medical neglect; Medically fragile child; Other; Education/ child care issues	Overwhelmed parent	Neglect (medical)	Apparently accidental; Potentially preventable

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Case Number	Categorization	Family Characteristics	Family Characteristics Comments	Panel Determination	Other Qualifiers
NF-005-18-NC	Drowning/near-drowning	Financial issues; Unsafe access to deadly means; Supervisional neglect		Neglect due to unsafe access to deadly/ potentially deadly means; Supervisory neglect	Apparently accidental; Potentially preventable
NF-006-18-NC	Overdose/ ingestion	Supervisional neglect; Unsafe access to deadly means; Family violence; Financial issues; MAT Involvement		Neglect due to unsafe access to deadly/ potentially deadly means; Supervisory neglect	Apparently accidental; Potentially preventable
NF-007-18-C	Blunt force trauma - not inflicted (farm machinery, ATV, fall)	Criminal history (caregiver); Criminal history (in the home); DCBS history; DCBS issues; Family violence; Financial issues; Housing instability; Medically fragile child; Mental health issues (caregiver); Substance abuse (in home); Substitute caregiver at time of event ; Supervisional neglect; Unsafe access to deadly means		Neglect due to unsafe access to deadly/ potentially deadly means; Supervisory neglect	Apparently accidental; Potentially preventable
NF-008-18-NC	Overdose/ ingestion	Criminal history (in the home); DCBS history; Housing instability; Financial issues; Mental health issues (caregiver); Supervisional neglect; DCBS issues; Serial relationships; Unsafe access to deadly means; Lack of treatment (mental health or substance abuse)		Neglect due to unsafe access to deadly/ potentially deadly means; Supervisory neglect	Apparently accidental; Potentially preventable
NF-009-18-C	Abusive head trauma; Physical abuse	Criminal history (caregiver); Other; Law enforcement issues	Caregiver at the time had DCBS history and criminal history	Abusive head trauma; Physical abuse	Potentially preventable
NF-010-18-C	Overdose/ ingestion	Bystander issues/ opportunities; Criminal history (caregiver); Family violence; Impaired caregiver; Medical issues/ management; Supervisional neglect; Unsafe access to deadly means; DCBS history; DCBS issues; Financial issues; Mental health issues (caregiver); Substance abuse by caregiver (current)		Neglect due to unsafe access to deadly/ potentially deadly means; Supervisory neglect	Apparently accidental; Potentially preventable

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Case Number	Categorization	Family Characteristics	Family Characteristics Comments	Panel Determination	Other Qualifiers
NF-011-18-C	Burn; Neglect; Physical abuse	Bystander issues/ opportunities; Criminal history (caregiver); Criminal history (in the home); DCBS history; DCBS issues; Evidence of poor bonding; Family violence; Lack of family support system ; Lack of regular child care; Language/cultural issues; Law enforcement issues; Medical issues/management; Medical neglect; Mental health issues (caregiver); Judicial process issues; Serial relationships; Substitute caregiver at time of event		Physical abuse; Torture; Neglect (general - can include leaving child with unsafe caregiver)	Potentially preventable
NF-012-18-C	Overdose/ ingestion	Criminal history (in the home); DCBS history; Family violence; Substitute caregiver at time of event ; Medically fragile child; Supervisional neglect; Unsafe access to deadly means		Neglect due to unsafe access to deadly/ potentially deadly means; Supervisory neglect	Potentially preventable; Manner undetermined/foul play not ruled out
NF-013-18-C	Abusive head trauma; Physical abuse	Criminal history (caregiver); Criminal history (in the home); DCBS history; DCBS issues; Family violence; Housing instability; Impaired caregiver; Lack of regular child care; MAT involvement; Medically fragile child; Mental health issues (caregiver); Neglectful entrustment; Substance abuse (in home); Substitute caregiver at time of event ; Financial issues; Substance abuse by caregiver (current); Medical issues/ management		Abusive head trauma; Physical abuse	Potentially preventable
NF-014-18-NC	Overdose/ ingestion	Criminal history (caregiver); Criminal history (in the home); Impaired caregiver; Medical neglect; Mental health issues (caregiver); Substance abuse (in home); Substance abuse by caregiver (current); Supervisional neglect; Financial issues; Unsafe ac-		Neglect due to unsafe access to deadly/ potentially deadly means; Supervisory neglect	Apparently accidental; Potentially preventable
NF-015-18-C	Abusive head trauma	Criminal history (caregiver); Evidence of poor bonding; Family violence; Medical neglect; Medically fragile child; Criminal history (in the home); Law enforcement issues; Substance abuse by caregiver (current)		Abusive head trauma; Neglect (medical)	Potentially preventable

Case Number	Categorization	Family Characteristics	Family Characteristics Comments	Panel Determination	Other Qualifiers
NF-016-18-C	Blunt force trauma - not inflicted (farm machinery, ATV, fall)	Bystander issues/ opportunities; Criminal history (caregiver); Criminal history (in the home); DCBS issues; Deployment/ redeployment in household; Family violence; Housing instability; Impaired caregiver; Inadequate re-straint; Judicial process issues; MAT involvement; Medically fragile child; Mental health issues (caregiver); Mental health issues (child); Substance abuse (in home); Substance abuse by caregiver (current); DCBS history; Financial issues		Neglect (impaired caregiver); Neglect (inadequate/absent child restraint in motor vehicle)	Apparently accidental; Potentially preventable
NF-017-18-C	Blunt force trauma - not inflicted MVC	Criminal history (caregiver); Criminal history (in the home); DCBS history; DCBS issues; Family violence; Financial issues; Housing instability; Impaired caregiver; Inadequate restraint; Law enforcement issues; Medically fragile child; Substance abuse (in home); Substance abuse by caregiver (current); Supervisional neglect		Neglect (impaired caregiver); Neglect (inadequate/absent child restraint in motor vehicle)	Apparently accidental; Potentially preventable
NF-018-18-C	Blunt force trauma - not inflicted MVC	Criminal history (caregiver); Criminal history (in the home); DCBS issues; DCBS history; Family violence; Financial issues; Housing instability; Impaired caregiver; Inadequate restraint; Law enforcement issues; Medically fragile child; Substance abuse (in home); Substance abuse by caregiver (current);		Neglect (impaired caregiver); Neglect (inadequate/absent child restraint in motor vehicle)	Apparently accidental; Potentially preventable
NF-019-18-C	Blunt force trau-ma - not inflicted MVC	Criminal history (caregiver); Criminal history (in the home); DCBS history; DCBS issues; Family violence; Financial issues; Housing instability; Impaired caregiver; Inadequate restraint; Law enforcement issues; Medically fragile child; Substance abuse (in home); Substance abuse by caregiver (current); Supervisional neglect		Neglect (impaired caregiver); Neglect (inadequate/absent child restraint in mo-tor vehicle)	Apparently accidental; Potentially preventable

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Case Number	Categorization	Family Characteristics	Family Characteristics Comments	Panel Determination	Other Qualifiers
NF-020-18-C	Burn	DCBS history; Criminal history (in the home); Environmental neglect; Mental health issues (child); Financial issues; Housing instability; Cognitive disability (caregiver); Other; Substitute caregiver at time of event ; Unsafe access to deadly means	Overwhelmed parent	Neglect due to unsafe access to deadly/ potentially deadly means	Apparently accidental; Potentially preventable
NF-021-18-NC	Abusive head trauma; Physical abuse	Bystander issues/ opportunities; DCBS history; Financial issues; Housing instability; Substitute caregiver at time of event ; Serial relationships; Neglectful entrustment; Mental health issues (caregiver); Family violence; Medical issues/ management		Abusive head trauma; Physical abuse; Neglect (general - can include leaving child with unsafe caregiver)	Potentially preventable
NF-022-18-NC	Overdose/ ingestion	Criminal history (caregiver); DCBS history; Housing instability; Impaired caregiver; Family violence; Mental health issues (caregiver); Substance abuse (in home); Unsafe sleep (bed sharing); Criminal history (in the home); Environmental neglect; Financial issues; Lack of treatment (mental health or substance abuse); Substance abuse by caregiver (current)		Neglect (general - can include leaving child with unsafe caregiver)	Apparently accidental; Potentially preventable
NF-023-18-C	Abusive head trauma; Neglect	Criminal history (caregiver); DCBS history; Criminal history (in the home); Impaired caregiver; Medical neglect; Medically fragile child; Mental health issues (child); Substance abuse (in home); Substance abuse by caregiver (current)		Abusive head trauma; Neglect (medical)	Potentially preventable
NF-024-18-NC	SUDI/near-SUDI/apparent life-threatening event	Criminal history (caregiver); Criminal history (in the home); DCBS history; Family violence; Financial issues; Unsafe sleep (other); Neglectful entrustment		Neglect (unsafe sleep); Neglect (general - can include leaving child with unsafe caregiver)	Apparently accidental; Potentially preventable

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Case Number	Categorization	Family Characteristics	Family Characteristics Comments	Panel Determination	Other Qualifiers
NF-025-18-NC	Abusive head trauma; Physical abuse	Criminal history (in the home); DCBS history; Mental health issues (caregiver); Serial relationships; Substance abuse (in home); Substance abuse by caregiver (current); Substitute caregiver at time of event ; Unsafe sleep (other); Bystander issues/ opportunities; Criminal history (caregiver); Financial issues; Medical issues/ management		Abusive head trauma; Physical abuse	Potentially preventable
NF-026-18-NC	Overdose/ ingestion	DCBS history; MAT involvement; Substance abuse (in home); Substance abuse by caregiver (current); Supervisional neglect; Unsafe access to deadly means; Financial issues; Impaired caregiver		Neglect due to unsafe access to deadly/ potentially deadly means; Supervisory neglect	Apparently accidental; Potentially preventable
NF-027-18-NC					
NF-028-18-NC	Abusive head trauma; Physical abuse	Family violence; Financial issues; Mental health issues (caregiver); Substance abuse (in home); Substance abuse by caregiver (current); Medical neglect		Abusive head trauma; Physical abuse	Potentially preventable
NF-029-18-NC	Burn; Overdose/ ingestion	Supervisional neglect; Unsafe access to deadly means		Neglect due to unsafe access to deadly/ potentially deadly means; Supervisory neglect	Apparently accidental; Potentially preventable
NF-030-18-NC	Gunshot (accidental)	Criminal history (caregiver); Criminal history (in the home); DCBS history; DCBS issues; Family violence; Substance abuse (in home); Substance abuse by caregiver (current); Supervisional neglect; Mental health issues (caregiver); Unsafe access to deadly means		Neglect due to unsafe access to deadly/ potentially deadly means; Supervisory neglect	Apparently accidental; Potentially preventable
NF-031-18-C	Blunt force trau-ma - not inflicted (farm machinery, ATV, fall)	Bystander issues/ opportunities; DCBS history; DCBS issues; Financial issues; MAT involvement; Substance abuse (in home); Substance abuse by caregiver (current); Supervisional neglect; Criminal history (caregiver); Criminal history (in the home); Housing instability; Medical neglect; Medically fragile child; Family violence		Supervisory neglect	Apparently accidental; Potentially preventable

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Case Number	Categorization	Family Characteristics	Family Characteristics Comments	Panel Determination	Other Qualifiers
NF-032-18-NC	Overdose/ ingestion	Criminal history (caregiver); DCBS history; Lack of regular child care; MAT involvement; Mental health issues (caregiver); Substance abuse by caregiver (current); Substitute caregiver at time of event ; Supervisional neglect; Unsafe access to deadly means		Neglect due to unsafe access to deadly/ potentially deadly means; Supervisory neglect	Apparently accidental; Potentially preventable
NF-033-18-C	Physical abuse; Neglect	Cognitive disability (caregiver); DCBS history; Lack of regular child care; Mental health issues (caregiver); Neglectful entrustment; Serial relationships; Substitute caregiver at time of event ; Criminal history (caregiver); Criminal history (in the home); DCBS issues; Substance abuse by caregiver (current); Medical neglect		Neglect (general - can include leaving child with unsafe caregiver); Neglect (medical); Physical abuse	Potentially preventable
NF-034-18-C	Gunshot (accidental)	DCBS history; Criminal history (in the home); DCBS issues; Family violence; Financial issues; Substance abuse (in home); Supervisional neglect; Unsafe access to deadly means		Neglect due to unsafe access to deadly/ potentially deadly means; Supervisory neglect	Apparently accidental; Potentially preventable
NF-035-18-NC	Overdose/ ingestion	MAT involvement; Unsafe access to deadly means; Supervisional neglect		Neglect due to unsafe access to deadly/ potentially deadly means; Supervisory neglect	Apparently accidental; Potentially preventable
NF-036-18-C	Overdose/ ingestion	Criminal history (caregiver); Criminal history (in the home); DCBS history; DCBS issues; Family violence; Financial issues; Housing instability; MAT involvement; Mental health issues (caregiver); Substance abuse (in home); Substance abuse by caregiver (current); Supervisional neglect; Unsafe access to deadly means		Neglect due to unsafe access to deadly/ potentially deadly means	Apparently accidental; Potentially preventable
NF-037-18-C	Overdose/ ingestion; Sui-cide (child)	Criminal history (caregiver); Criminal history (in the home); DCBS history; Financial issues; Medical issues/management; Mental health issues (caregiver); Medical neglect; Mental health issues (child); Serial relationships; Substance abuse (in home); Supervisional neglect; Unsafe access to deadly means		Neglect (medical); Neglect due to unsafe access to deadly/ potentially deadly means; Supervisory neglect	Potentially preventable

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Case Number	Categorization	Family Characteristics	Family Characteristics Comments	Panel Determination	Other Qualifiers
NF-038-18-NC	Blunt force trauma - not inflicted MVC	Supervisional neglect; Inadequate restraint; Law enforcement issues		Neglect (inadequate/ absent child restraint in motor vehicle); Supervisory neglect	Apparently accidental; Potentially preventable
NF-039-18-NC	Abusive head trauma; Physical abuse	Bystander issues/ opportunities; Financial issues; Impaired caregiver; Medical neglect; Lack of treatment (mental health or substance abuse); Law enforcement issues; Mental health issues (caregiver); Substance abuse by caregiver (current); DCBS issues; Medical issues/ management; Substance abuse (in home)		Abusive head trauma; Neglect (medical); Physical abuse	Potentially preventable
NF-040-18-C	Physical abuse	Cognitive disability (caregiver); Cognitive disability (child); DCBS history; Financial issues; Medical neglect; Family violence		Neglect (medical); Physical abuse	Potentially preventable
NF-041-18-C	Neglect	DCBS history; DCBS issues; Evidence of poor bonding; Financial issues; Housing instability; Cognitive disability (caregiver); Medical issues/ management; Medical neglect; Mental health issues (caregiver)		Neglect (medical)	Potentially preventable
NF-042-18-C	Neglect	Cognitive disability (child); Criminal history (in the home); DCBS history; DCBS issues; Evidence of poor bonding; Family violence; Financial issues; Housing instability; Judicial process issues; Medical issues/management; Medical neglect; Medically fragile child; Mental health issues (caregiver); Mental health issues (child); Other; Serial relationships; Substance abuse (in home); Cognitive disability (caregiver)	Overwhelmed caregiver--index child was too much for PGGP and mother.	Neglect (medical)	Potentially preventable

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Case Number	Categorization	Family Characteristics	Family Characteristics Comments	Panel Determination	Other Qualifiers
NF-043-18-C	Overdose/ ingestion; Failure to thrive/ malnutrition	Bystander issues/ opportunities; Criminal history (caregiver); Criminal history (in the home); DCBS history; DCBS issues; Financial issues; Family violence; Housing instability; Impaired caregiver; Law enforcement issues; Medically fragile child; Mental health issues (caregiver); Serial relationships; Substance abuse (in home); Substance abuse by caregiver (current); Substitute caregiver at time of event ; Supervisional neglect; Medical issues/ management; Medical neglect		Neglect (medical)	Apparently accidental; Potentially preventable
NF-044-18-NC					
NF-045-18-C	Burn	Cognitive disability (caregiver); Criminal history (caregiver); Criminal history (in the home); DCBS history; DCBS issues; Family violence; Financial issues; Housing instability; Medical issues/management; Mental health issues (caregiver); Mental health issues (child); Other; Perinatal depression (caregiver); Serial relationships; Substance abuse (in home); Supervisional neglect; Unsafe access to deadly means	Overwhelmed parent and lack of health support system	Supervisory neglect; Neglect due to unsafe access to deadly/ potentially deadly means	Apparently accidental; Potentially preventable
NF-046-18-NC	Neglect	Bystander issues/ opportunities; Cognitive disability (caregiver); Criminal history (caregiver); DCBS history; DCBS issues; Medically fragile child; Mental health issues (caregiver); Medical neglect; Other; Financial issues	Overwhelmed parent	Neglect (medical)	Potentially preventable

Case Number	Categorization	Family Characteristics	Family Characteristics Comments	Panel Determination	Other Qualifiers
NF-047-18-C	Abusive head trauma; Physical abuse	Bystander issues/ opportunities; Criminal history (caregiver); Family violence; Financial issues; Housing instability; Lack of treatment (mental health or substance abuse); Mental health issues (caregiver); Substance abuse (in home); Substance abuse by caregiver (current); Criminal history (in the home); DCBS history; Lack of regular child care; Evidence of poor bonding; Medical neglect; Unsafe sleep (cosleeping on a non-bed surface)		Abusive head trauma; Physical abuse	Potentially preventable
NF-048-18-C	Abusive head trauma; Physical abuse	Bystander issues/ opportunities; Criminal history (caregiver); Criminal history (in the home); DCBS history; Financial issues; Housing instability; Impaired caregiver; Medically fragile child; Mental health issues (caregiver); Neglectful entrustment; Serial relationships; Substance abuse (in home); Substance abuse by caregiver (current); Substitute caregiver at time of event		Physical abuse; Abusive head trauma	Potentially preventable
NF-049-18-NC	Overdose/ ingestion	Cognitive disability (child); Criminal history (in the home); DCBS history; Environmental neglect; Mental health issues (caregiver); Supervisional neglect; Unsafe access to deadly means; Financial issues; Medical issues/ management; Mental health issues (child); Other; Substance abuse (in home); Substitute caregiver at time of event	Overwhelmed caregiver	Supervisory neglect; Neglect due to unsafe access to deadly/ potentially deadly means	Apparently accidental; Potentially preventable
NF-050-18-NC	Gunshot (accidental)	DCBS history; Supervisional neglect; Unsafe access to deadly means; Financial issues		Neglect due to unsafe access to deadly/ potentially deadly means; Supervisory neglect	Apparently accidental; Potentially preventable
NF-051-18-C	Blunt force trau-ma - not inflicted MVC	Criminal history (caregiver); DCBS history; DCBS issues; Impaired caregiver; Mental health issues (caregiver); Substance abuse by caregiver (current); Substitute caregiver at time of event ; Supervisional neglect; Law enforcement		Neglect (impaired caregiver)	Apparently accidental; Potentially preventable

Case Number	Categorization	Family Characteristics	Family Characteristics Comments	Panel Determination	Other Qualifiers
NF-052-18-C	Blunt force trauma - not inflicted MVC	Criminal history (caregiver); Criminal history (in the home); DCBS history; DCBS issues; Family violence; Financial issues; Impaired caregiver; Mental health issues (caregiver); Substance abuse (in home); Substance abuse by caregiver (current); Supervisional neglect		Neglect (impaired caregiver)	Apparently accidental; Potentially preventable
NF-053-18-C	Overdose/ ingestion	DCBS history; DCBS issues; Financial issues; Housing instability; Other; Medical neglect; Serial relationships; Substance abuse (in home); Substance abuse by caregiver (current); Supervisional neglect; Unsafe access to deadly means	The index child was not medically fragile, but two siblings were substance exposed.	Neglect due to unsafe access to deadly/ potentially deadly means	Apparently accidental; Potentially preventable
NF-054-18-NC	Overdose/ ingestion; Neglect	Bystander issues/ opportunities; Criminal history (caregiver); Criminal history (in the home); Environmental neglect; Family violence; Financial issues; Housing instability; Impaired caregiver; Medical neglect; Substance abuse (in home); Substance abuse by caregiver (current); Supervisional neglect; Unsafe access to deadly means; DCBS history		Neglect due to unsafe access to deadly/ potentially deadly means; Neglect (general - can include leaving child with unsafe caregiver); Neglect (impaired caregiver); Neglect (medical)	Apparently accidental; Potentially preventable
NF-055-18-NC	Overdose/ ingestion	DCBS history; DCBS issues; Financial issues; Housing instability; MAT involvement; Mental health issues (caregiver); Substance abuse (in home); Substance abuse by caregiver (current); Supervisional neglect; Unsafe access to deadly means; Environmental neglect; Judicial process issues		Neglect due to unsafe access to deadly/ potentially deadly means; Neglect (general - can include leaving child with unsafe caregiver); Supervisory neglect	Apparently accidental; Potentially preventable
NF-056-18-C	Overdose/ ingestion	Criminal history (in the home); DCBS history; Family violence; Law enforcement issues; Unsafe access to deadly means; Financial issues; Other	Overwhelmed caregiver	Neglect due to unsafe access to deadly/ potentially deadly means	Potentially preventable; Manner undetermined/foul play not ruled out

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Case Number	Categorization	Family Characteristics	Family Characteristics Comments	Panel Determination	Other Qualifiers
NF-057-18-C	Overdose/ ingestion	Criminal history (in the home); Criminal history (caregiver); DCBS history; Environmental neglect; Financial issues; Housing instability; Mental health issues (caregiver); Substance abuse (in home); Supervisional neglect; Unsafe access to deadly means; Other	Inappropriate caregiver expectations for child	Neglect due to unsafe access to deadly/ potentially deadly means; Neglect (general - can include leaving child with unsafe caregiver); Supervisory neglect	Apparently accidental; Potentially preventable
NF-058-18-C	Abusive head trauma; Physical abuse	Bystander issues/ opportunities; DCBS history; DCBS issues; Financial issues; Lack of regular child care; Mental health issues (caregiver); Other; Perinatal depression (caregiver); Criminal history (caregiver); Criminal history (in the home)	Parents overwhelmed with fussy baby.	Abusive head trauma; Physical abuse	Potentially preventable
NF-059-18-NC	Abusive head trauma; Physical abuse	Bystander issues/ opportunities; DCBS issues; Family violence; Impaired caregiver; Neglectful entrustment; Substance abuse (in home); Substance abuse by caregiver (current); Medical issues/management; Judicial process issues; Medical neglect		Abusive head trauma; Physical abuse	Potentially preventable
NF-060-18-C	Overdose/ ingestion	Environmental neglect; Housing instability; Substance abuse (in home); Substance abuse by caregiver (current); Bystander issues/ opportunities; Criminal history (in the home); DCBS history; Financial issues; Family violence; Mental health issues (caregiver); Supervisional neglect; Unsafe access to deadly means		Neglect (general - can include leaving child with unsafe caregiver); Neglect due to unsafe access to deadly/potentially deadly means; Supervisory neglect	Potentially preventable
NF-061-18-C	Overdose/ ingestion	DCBS history; DCBS issues; Financial issues; Impaired caregiver; Criminal history (caregiver); MAT involvement; Medically fragile child; Mental health issues (caregiver); Substance abuse (in home); Substance abuse by caregiver (current); Supervisional neglect; Unsafe access to deadly means; Other	Overwhelmed caregiver	Neglect due to unsafe access to deadly/ potentially deadly means; Supervisory neglect	Apparently accidental; Potentially preventable

Case Number	Categorization	Family Characteristics	Family Characteristics Comments	Panel Determination	Other Qualifiers
NF-062-18-C	Overdose/ ingestion; Neglect	Criminal history (caregiver); Environmental neglect; Family violence; Impaired caregiver; Lack of treatment (mental health or substance abuse); Mental health issues (caregiver); Substance abuse by caregiver (current); Supervisional neglect; Unsafe access to deadly means; DCBS history; Language/ cultural issues; MAT involvement		Neglect (general - can include leaving child with unsafe caregiver); Neglect (impaired caregiver); Neglect due to unsafe access to deadly/potentially deadly means; Supervisory neglect	Apparently accidental; Potentially preventable
NF-063-18-C	Abusive head trauma; Physical abuse	Criminal history (caregiver); Criminal history (in the home); DCBS history; DCBS issues; Family violence; Financial issues; Bystander issues/opportunities; MAT involvement; Medically fragile child; Mental health issues (caregiver); Perinatal depression (caregiver); Substance abuse (in home); Substance abuse by caregiver (current); Impaired caregiver;		Abusive head trauma; Physical abuse	Potentially preventable
NF-064-18-NC	Abusive head trauma; Physical abuse	Bystander issues/ opportunities; Criminal history (caregiver); Criminal history (in the home); Family violence; Financial issues; Neglectful entrustment; Medical neglect; Other; Substance abuse (in home); Substance abuse by caregiver (current); Medical issues/ management	Overwhelmed parents	Abusive head trauma; Physical abuse; Neglect (medical)	Potentially preventable
NF-065-18-NC	Blunt force trauma - not inflicted (farm machinery, ATV, fall)			No abuse or neglect	Apparently accidental
NF-066-18-C	Abusive head trauma; Physical abuse; Neglect	Bystander issues/ opportunities; Cognitive disability (caregiver); Criminal history (caregiver); Criminal history (in the home); DCBS history; DCBS issues; Education/child care issues; Evidence of poor bonding; Family violence; Financial issues; Impaired caregiver; Judicial process issues; Lack of treatment (mental health or substance abuse); Mental health issues (caregiver); Neglectful entrustment; Serial relationships; Substance abuse by caregiver (current); Substitute caregiver at time of event ; Other; Substance abuse (in home)	Overwhelmed caregiver	Abusive head trauma; Neglect (general - can include leaving child with unsafe caregiver); Physical abuse	Potentially preventable

Case Number	Categorization	Family Characteristics	Family Characteristics Comments	Panel Determination	Other Qualifiers
NF-067-18-C	Neglect	Cognitive disability (caregiver); Criminal history (caregiver); DCBS history; Family violence; Financial issues; Housing instability; Lack of family support system ; Lack of treatment (mental health or substance abuse); Medical neglect; Medically fragile child; Mental health issues (caregiver); Criminal history (in the home); Other	Parents had inappropriate expectation of the child	Neglect (medical)	Potentially preventable
NF-068-18-C	Overdose/ ingestion	Criminal history (caregiver); Criminal history (in the home); DCBS history; Environmental neglect; Family violence; Financial issues; Housing instability; Lack of family support system ; Neglectful entrustment; Serial relationships; Law enforcement issues; Substance abuse (in home); Supervisional neglect; Unsafe access to deadly means; Substance abuse by caregiver (current); DCBS issues; Medical neglect		Neglect due to unsafe access to deadly/ potentially deadly means; Physical abuse; Neglect (general - can include leaving child with unsafe caregiver)	Potentially preventable
NF-069-18-C	Abusive head trauma; Physical abuse	Bystander issues/ opportunities; DCBS history; DCBS issues; Evidence of poor bonding; Family violence; Financial issues; Impaired caregiver; Medical issues/ management; Substance abuse (in home); Substance abuse by caregiver (current)		Abusive head trauma; Physical abuse	Potentially preventable
NF-070-18-C	Natural causes/ medical diagno-sis	Bystander issues/ opportunities; Criminal history (caregiver); Criminal history (in the home); DCBS history; DCBS issues; Family violence; Impaired caregiver; Medically fragile child; Mental health issues (caregiver); Substance abuse (in home); Substance abuse by caregiver (current); Medical neglect		Neglect (medical)	Potentially preventable

Case Number	Categorization	Family Characteristics	Family Characteristics Comments	Panel Determination	Other Qualifiers
NF-071-18-C	Failure to thrive/ malnutrition; Neglect	Bystander issues/ opportunities; Cognitive disability (child); Criminal history (caregiver); Criminal history (in the home); DCBS history; DCBS issues; Evidence of poor bonding; Failure to thrive; Family violence; Financial issues; Housing instability; Medical issues/management; Medical neglect; Medically fragile child		Neglect (general - can include leaving child with unsafe caregiver); Neglect (medical)	Potentially preventable
NF-072-18-C	Physical abuse	Bystander issues/ opportunities; Cognitive disability (caregiver); Criminal history (caregiver); Criminal history (in the home); DCBS history; DCBS issues; Financial issues; Housing instability; Law enforcement issues; Medical issues/management; Medical neglect; Medically fragile child; Mental health issues (caregiver); Perinatal depression (caregiver); Substance abuse (in home); Substance abuse by caregiver (current)		Physical abuse	Potentially preventable
NF-073-18-C	Overdose/ ingestion	Cognitive disability (caregiver); Criminal history (caregiver); Criminal history (in the home); Environmental neglect; Lack of treatment (mental health or substance abuse); Substance abuse (in home); Substance abuse by caregiver (current); Unsafe access to deadly means; Supervisional neglect; DCBS history; Family		Neglect due to unsafe access to deadly/ potentially deadly means; Neglect (general - can include leaving child with unsafe caregiver); Supervisory neglect	Potentially preventable
NF-074-18-NC	Abusive head trauma; Physical abuse	Bystander issues/ opportunities; Cognitive disability (caregiver); Financial issues; Medical neglect; Mental health issues (caregiver); Environmental neglect; Evidence of poor bonding; Lack of treatment (mental health or substance abuse)		Abusive head trauma; Neglect (medical); Physical abuse	Potentially preventable
NF-075-18-C	Overdose/ ingestion; Ne-glect	DCBS history; Financial issues; Housing instability; Mental health issues (caregiver); Mental health issues (child); Other; Supervisional neglect; Unsafe access to deadly means	Overwhelmed parent	Neglect due to unsafe access to deadly/ potentially deadly means; Supervisory neglect	Apparently accidental; Potentially preventable

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Case Number	Categorization	Family Characteristics	Family Characteristics Comments	Panel Determination	Other Qualifiers
NF-076-18-NC	Burn	Family violence; Financial issues; Law enforcement issues; Criminal history (in the home); Criminal history (caregiver); DCBS history; Substance abuse (in home); Substance abuse by caregiver (current); Medical neglect; Substitute caregiver at time of event ; DCBS issues		Physical abuse; Neglect (medical)	Potentially preventable
NF-077-18-C	Overdose/ ingestion	Bystander issues/ opportunities; Criminal history (caregiver); DCBS history; DCBS history; DCBS issues; Family violence; Financial issues; Housing instability; Impaired caregiver; Medical issues/ management; Neglectful entrustment; Other; Mental health issues (caregiver); Substance abuse by caregiver (current); Substitute caregiver at time of event ; Supervisional neglect; Unsafe access to deadly means; Lack of treatment (mental health or substance abuse)	Grand parents over-whelmed with dealing with drug addicted daughter, two grandkids and aging mother.	Neglect due to unsafe access to deadly/ potentially deadly means; Neglect (general - can include leaving child with unsafe caregiver); Neglect (impaired caregiver); Supervisory neglect	Apparently accidental; Potentially preventable
NF-078-18-C	Abusive head trauma; Physical abuse	Criminal history (caregiver); Criminal history (in the home); DCBS history; DCBS issues; Family violence; Financial issues; Lack of regular child care; Lack of treatment (mental health or substance abuse); Law enforcement issues; Medical issues/management; Mental health issues (caregiver); Neglectful entrustment; Serial relationships; Substance abuse (in home); Substance abuse by caregiver (current); Substitute caregiver at time of event		Abusive head trauma; Physical abuse	Potentially preventable
NF-079-18-NC	Drowning/near-drowning	Unsafe access to deadly means; Supervisional neglect		Neglect due to unsafe access to deadly/ potentially deadly means; Supervisory neglect	Apparently accidental; Potentially preventable
NF-080-18-C	Blunt force trauma - not in-flicted (farm ma-chinery, ATV, fall)	Cognitive disability (child); DCBS history; Medically fragile child; Supervisional neglect; Financial issues; Other	Overwhelmed caregiver	Supervisory neglect	Apparently accidental; Potentially preventable
NF-081-18-C	Drowning/near-drowning				Apparently accidental

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Case Number	Categorization	Family Characteristics	Family Characteristics Comments	Panel Determination	Other Qualifiers
NF-082-18-C	Blunt force trauma - not inflicted MVC	Criminal history (caregiver); Criminal history (in the home); DCBS history; Family violence; Financial issues; Mental health issues (caregiver); Substance abuse (in home); Substance abuse by caregiver (current)		No abuse or neglect	Apparently accidental; Potentially preventable
NF-083-18-C	Blunt force trauma - not inflicted MVC	Criminal history (caregiver); Criminal history (in the home); DCBS history; Family violence; Financial issues; Mental health issues (caregiver); Substance abuse (in home); Substance abuse by caregiver (current)		No abuse or neglect	Apparently accidental; Potentially preventable
NF-084-18-C	Abusive head trauma; Physical abuse	Criminal history (caregiver); DCBS history; DCBS issues; Education/ child care issues; Evidence of poor bonding; Family violence; Financial issues; Impaired caregiver; Lack of regular child care; Lack of treatment (mental health or substance abuse); Mental health issues (caregiver); Neglectful entrustment; Substance abuse (in home); Substance abuse by caregiver (current); Criminal history (in the home)		Physical abuse; Torture; Abusive head trauma	Potentially preventable
NF-085-18-NC	Overdose/ ingestion	Criminal history (in the home); Financial issues; Supervisional neglect; Substance abuse (in home); Unsafe access to deadly means; Environmental neglect; Other	High risk house guest with substance abuse, criminal history and housing instability	Neglect due to unsafe access to deadly/ potentially deadly means; Neglect (general - can include leaving child with unsafe caregiver); Supervisory neglect	Apparently accidental; Potentially preventable
NF-086-18-NC	Neglect; Failure to thrive/ malnutrition	Cognitive disability (child); DCBS history; Evidence of poor bonding; Financial issues; Housing instability; Lack of family support system ; Law enforcement issues; Medical issues/ management; Medical neglect; Medically fragile child; Mental health issues (caregiver); Serial relationships; Criminal history (in the home); Other	Educational neglect and Emotional neglect	Neglect (medical); Other	Potentially preventable

CASE REVIEWS FOR FISCAL YEAR 2018

Case Number	Categorization	Family Characteristics	Family Characteristics Comments	Panel Determination	Other Qualifiers
NF-087-18-C	Overdose/ ingestion	Bystander issues/ opportunities; Criminal history (caregiver); Criminal history (in the home); DCBS history; DCBS issues; Family violence; Financial issues; Impaired caregiver; MAT involvement; Mental health issues (caregiver); Neglectful entrustment; Substance abuse (in home); Substance abuse by caregiver (current); Substitute caregiver at time of event ; Other; Supervisional neglect; Unsafe access to deadly means; Environmental neglect	Overwhelmed caregiver	Neglect (general - can include leaving child with unsafe caregiver); Neglect due to unsafe access to deadly/potentially deadly means; Supervisory neglect; Neglect (impaired caregiver)	Potentially preventable; Apparently accidental
NF-088-18-C	Neglect	Criminal history (caregiver); Criminal history (in the home); DCBS history; DCBS issues; Environmental neglect; Evidence of poor bonding; Family violence; Financial issues; Housing instability; Impaired caregiver; MAT involvement; Medical neglect; Medically fragile child; Mental health issues (caregiver); Substance abuse (in home); Substance abuse by caregiver (current)		No abuse or neglect	Potentially preventable

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