

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



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Department for Community Based Services
Cabinet for Health and Family Services
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In accordance with KRS 620.050 (12)(c), the Cabinet for Health and Family Services (CHFS/ Cabinet), Department for Community Based Services (DCBS/ Department) is required to submit an annual report of child abuse and neglect fatalities and near fatalities. A near fatality is defined by KRS 600.020 (40) as, “an injury that, as certified by a physician, places a child in serious or critical condition.” This report provides insights into the demographics of the children who were the victims of abusive or neglectful deaths and near deaths, and the circumstances around these events.

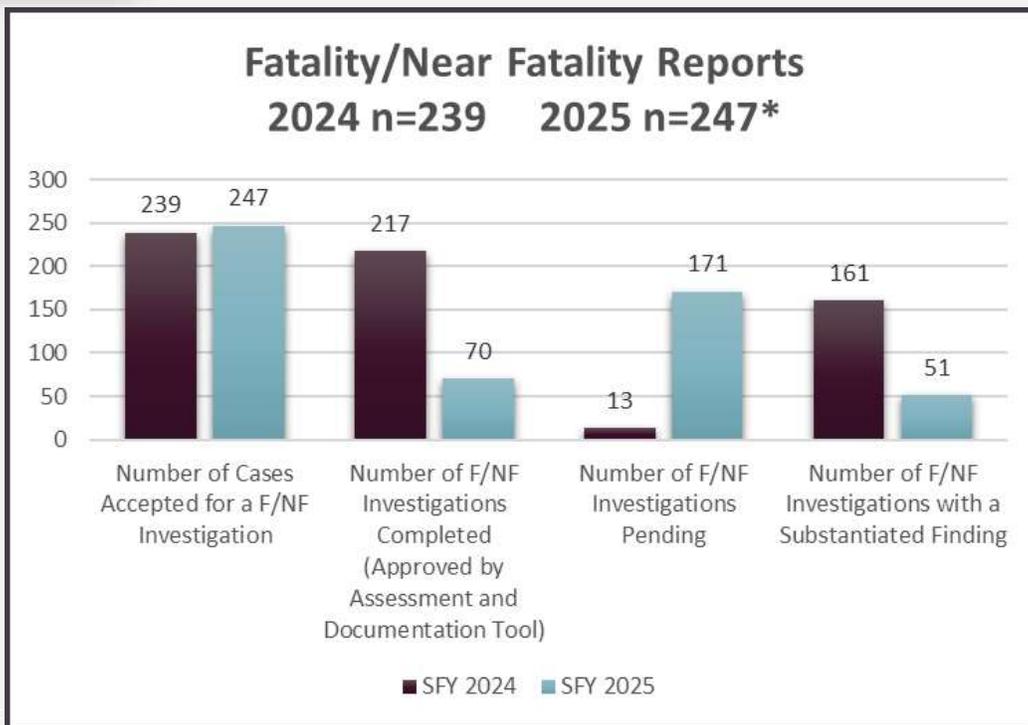
The report is organized into five sections. Historical data in this report spans five state fiscal years (SFYs) and includes only child abuse and neglect fatalities and near fatalities.



Section I: Comparative Referral Data



There is extensive work required in fatality and near fatality investigations of child maltreatment. Investigations are conducted jointly with law enforcement, require records collection, and include collaboration with other agencies, such as pediatric protection specialists and the medical examiner's office. This collaboration takes additional time, which contributes to the delay in finalization of some investigations.



Source:

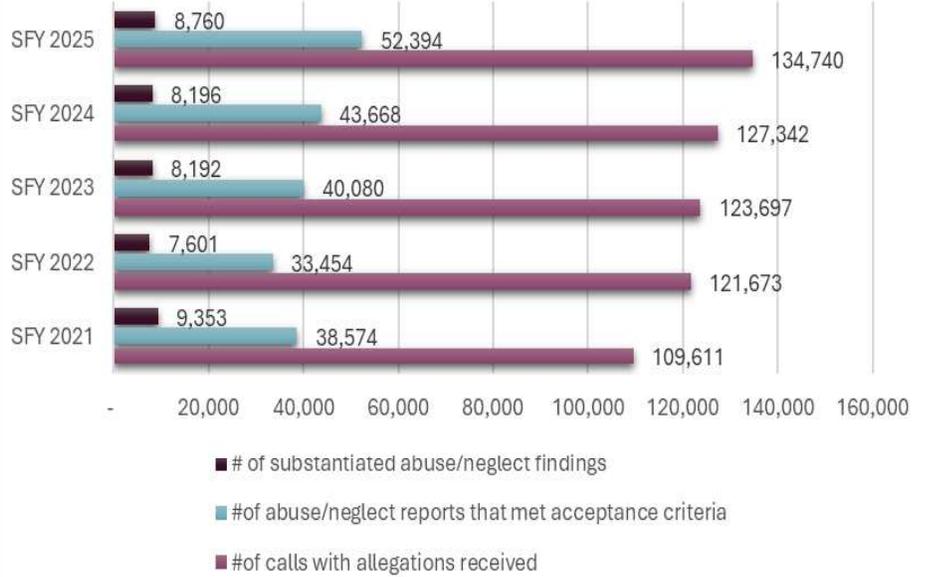
Source: SCIR data system

The graph above presents data from all investigations in SFY 2024 and 2025, including both completed and pending cases at the time of this report. The high number of pending investigations reflects the complex nature of these cases, which require specially trained, dedicated staff to complete. While staffing shortages have contributed to the backlog, steps have been taken to address this issue by deploying qualified staff from across the state during periods of high demand or reduced capacity. The number of substantiations reported for the prior year has been adjusted to account for investigations completed since the last reporting period.

* Indicates this number will change in the next year's annual report since the data is not complete due to pending investigations.

In SFY 2025, the Cabinet experienced an increase in referrals alleging child abuse and neglect compared to previous fiscal years. Referrals rose by 5.81% from SFY 2024, with a corresponding 19.98% increase in those meeting acceptance criteria. As a result, substantiated cases increased from 8,196 in SFY 2024 to 8,760 in SFY 2025. These trends underscore the need for continued analysis to better understand the underlying factors and inform targeted prevention and intervention strategies.

Statewide Child Maltreatment Reports



Source: TWS-M272F

Near Fatality Substantiation with Prior Involvement n=459 n=222



Source: SCIR data system

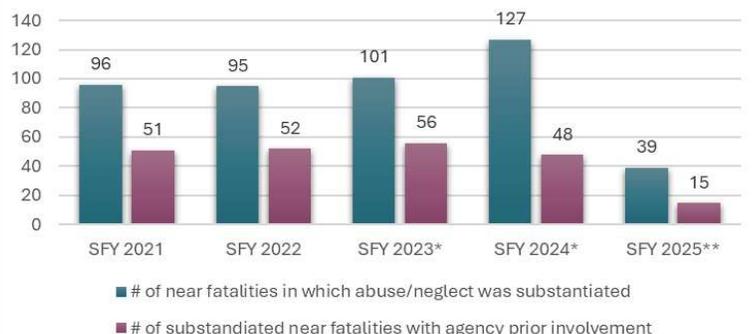
Based on the available data, there has been an increase in Near Fatality Substantiations from SFY 2023 to SFY 2024.

* Data from SFY 2023 and SFY 2024 reflect adjustments of substantiated findings due to completed investigations.
 **Data from SFY 2025 indicates incomplete data due to pending investigations.



There was an increase in fatality substantiations from SFY 2023 to SFY 2024.

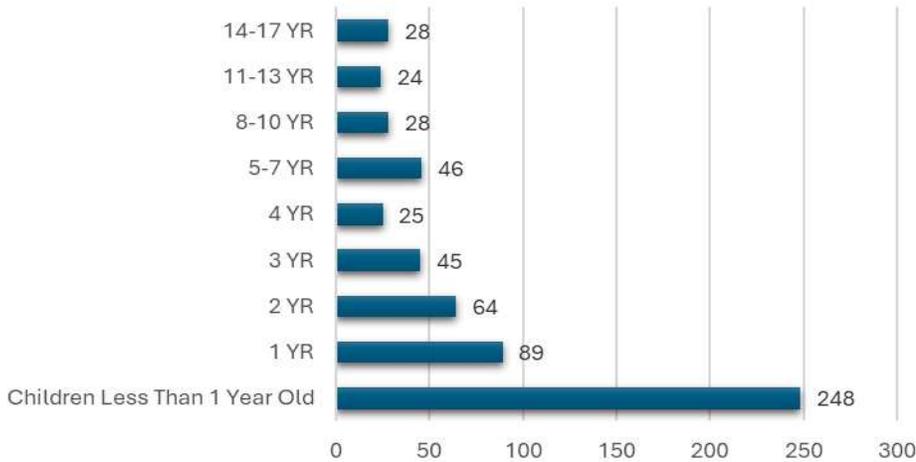
Near Fatality Substantiation with Prior Involvement n=459 n=222



Section II: Child Demographics

The data represented below is from SFY 2020 to SFY 2025

Age of Victim n=597



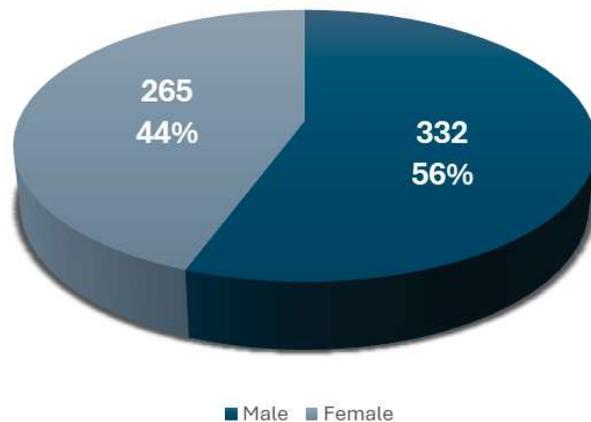
Children age four and under comprise approximately **79%** of all fatal and near fatal victims. Furthermore, children under the age of one represent **41.5%** of total victims.

Source: SCIR data system



As reported through previous years' data, males continue to be the majority of fatality/near fatality victims.

Gender of Victim n=597



Source: SCIR data system

The Census Bureau estimates, as of July 1, 2021, the Black or African American population comprises **8.6%** of the total Kentucky population. Black or African American children constitute **23%** of the 597 victims in substantiated fatal and near fatal investigations identified in the five year period.

Race of Victims n=597

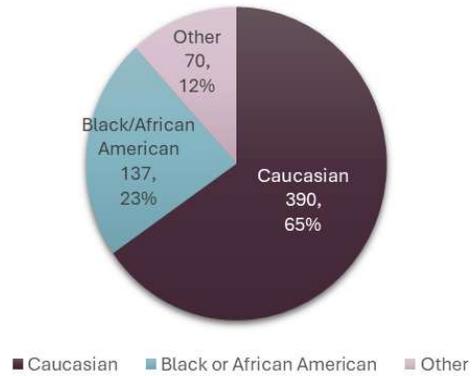


Chart below is pulled US Census Bureau at www.census.gov.

KY US Census Data 2020	
Caucasian/White Alone	87.1
Black or African American Alone	8.6
American Indian and Alaska Native	0.3
Asian Alone	1.7
Native Hawaiian and Other Pacific Islander	0.1
Two or More Races	2.2
Hispanic or Latino	4.2

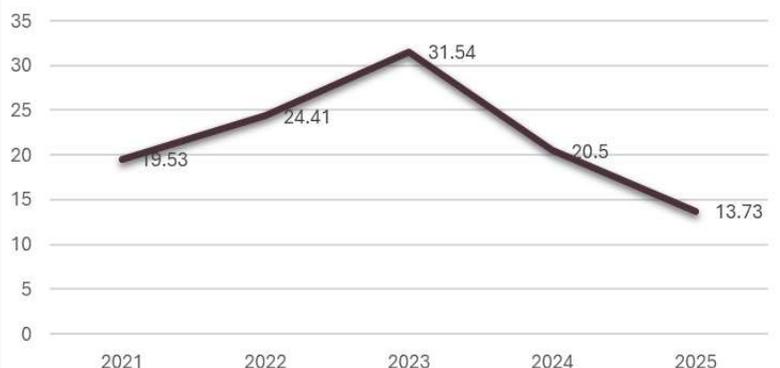


Source: SCIR data system

The African American population accounts for approximately 20% or greater of all fatal/near fatal reports received annually. The data shows a steady increase of these reports from 19.53 % in SFY 2021 to 31.54% in SFY 2023.

Note: The data presented in this table reflects information currently available. Please note that referrals for SFY 2024 and SFY 2025 remain pending and may impact the final data.

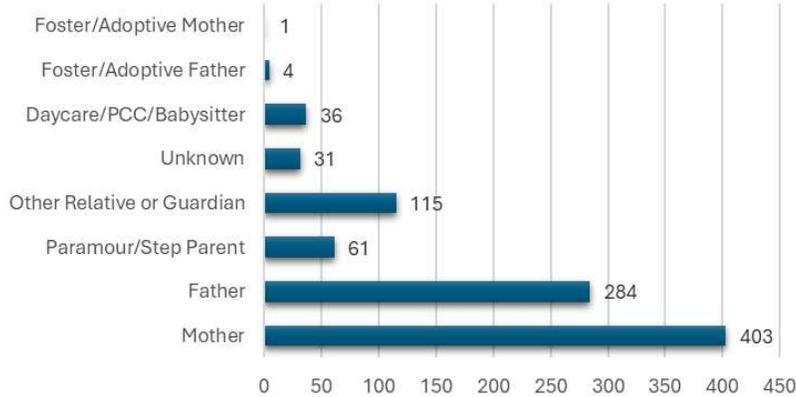
Percentage of FNF Referrals Accepted on Black/African American Children



Section III: Perpetrator and Maltreatment Demographics

Perpetrator Relationship to Victim

n=935



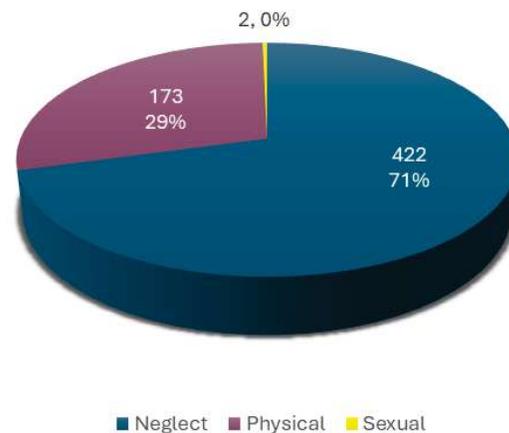
Parents remain the most common perpetrator identified in fatality and near fatality investigation findings. Of the 597 victims, there were 935 perpetrators identified. Many fatality/near fatality cases have more than one identified perpetrator.

Source: SCIR data system



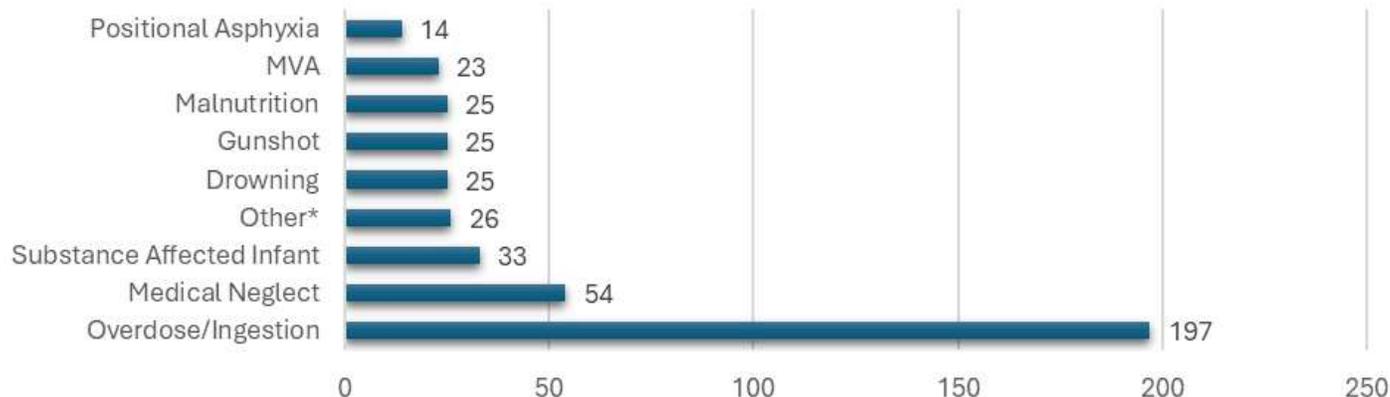
Neglect continues to be the leading type of maltreatment responsible for substantiated fatalities and near fatalities. There were two sexual abuse substantiations associated with a fatality designation.

Types of Maltreatment n=597



Source: SCIR data system

Types of Neglect n=422



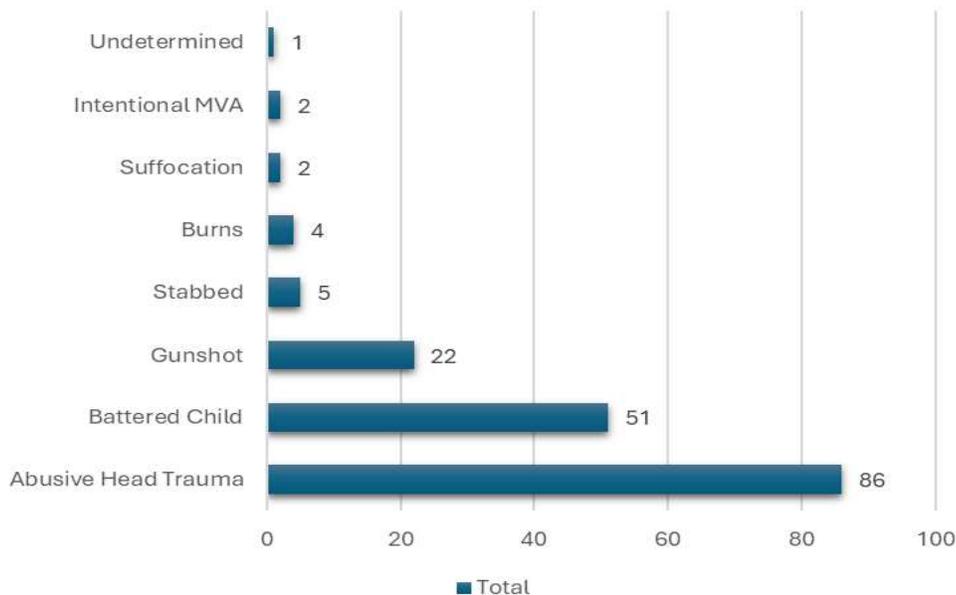
The leading cause of fatal/near fatal neglect is overdoses/ingestions cases. These incidents are typically the result of environmental or supervisory neglect, when prescribed or illegal drugs are left accessible to children. There continues to be an increase in ingestion of THC and/or other cannabinoids in edible form, which is packaged in a way that is appealing to children.

*'Other' category includes types of neglect that occurred 5 or less times including house fire, suffocation, and hyperthermia.

Abusive head trauma and battered child are the leading cause of fatalities and near fatalities from physical abuse.

The majority of these victims were four years of age and under.

Types of Physical Injury n=173



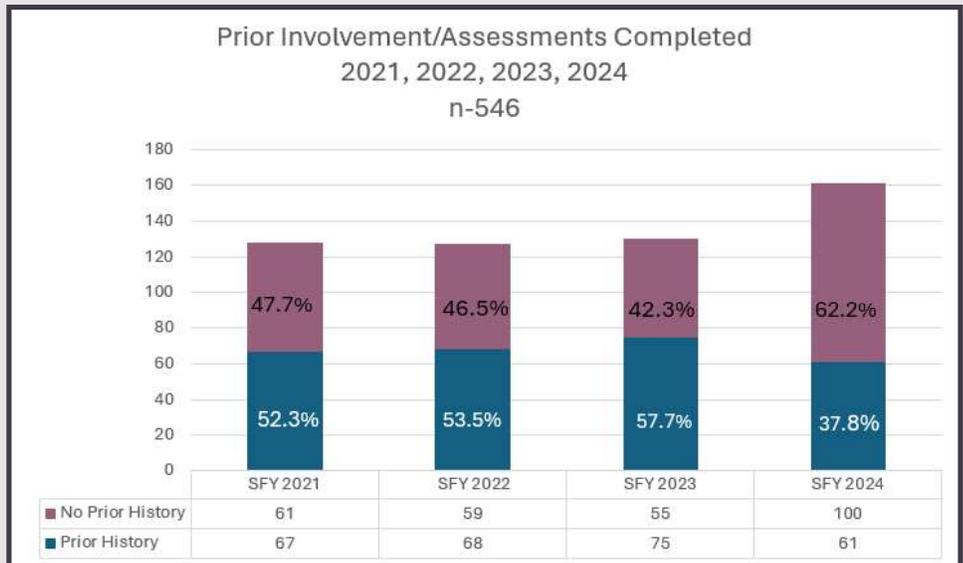
*MVA-Motor Vehicle Accident

Source: SCIR data

Section IV: Prior Department Involvement with Families of Fatality/Near Fatality (F/NF) Victims and Child Victims

Previous SFY data has maintained slightly more than a 50% average of previous DCBS involvement with substantiated fatality/near fatality investigations.

Please note that referrals for SFY 2024 and SFY 2025 remain pending and may impact the final data.

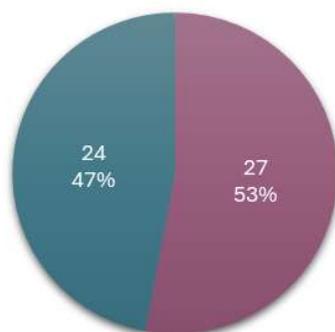


Source: SCIR data system



Data is collected on history with the agency specific to the Fatality/Near Fatality victim.

Child Victims Prior Involvement SFY 2025 n=51



■ No Prior Involvement ■ Prior Involvement/Assessment

Prior involvement with DCBS is defined as any report to DCBS. This includes substantiated and unsubstantiated reports, as well as reports that did not meet criteria for investigation or resource links.

Section V: Program Improvement Efforts

Internal Review

KRS 620.050 (12)(b) requires that the cabinet “conduct an internal review of any case where child abuse or neglect has resulted in a child fatality or near fatality and the cabinet had prior involvement with the child or family.” The statute also requires that the cabinet submit an annual report by September 1 to the Governor, the General Assembly, and the state child fatality review team that includes a summary of the internal reviews and an analysis of historical trends.



System Safety Review Process and Overview

Process Overview

The Department for Community Based Services (DCBS) continues its implementation of the System Safety Review (SSR) process for the internal review of all fatality, near fatality, and active fatality cases, as highlighted in previous annual reports. DCBS is entering into its seventh State Fiscal Year (SFY) since its initial implementation in October 2019. DCBS is committed to fostering a culture of safety, where staff can openly discuss how the system impacts their work. This approach moves beyond simply assigning blame and instead focuses on identifying and addressing the systemic barriers that affect casework. Maintaining a culture of safety better enables DCBS to identify systemic barriers to casework. The SSR team continues to produce valuable data on systemic influences effecting casework and presenting that empirical data to leadership with recommendations for systemic improvements. Leadership is committed to shared accountability. When barriers and challenges are identified, leaders will work with staff to address them and make systemic improvements. Previous processes of review have focused on reactionary pressures and the application of “quick fixes” that do not address the underlying barriers and challenges, but rather aggravate systemic pressures experienced by staff by creating new barriers and challenges. Only by working together to remove the systemic barriers and challenges influencing case decision-making may Team Kentucky be better able to improve outcomes for staff and the families they diligently serve daily.

*For a full description of the SSR process please, see the [System Safety Review Process Manual](#)

Process Results

The following recommendations reflect emerging themes identified through the SSR process and presented to leadership. Leadership has prioritized high-level systemic changes—such as process improvements, technological advancements, resource reallocation, and legislative support—over lower-level considerations.

While the primary focus is on system-wide impact, the SSR process also identifies lower-level opportunities for improvement. These have included refining policy language to eliminate vagueness or gaps, updating local or regional practices to enhance consistency, and improving the sharing of existing resources and processes across the agency.

Update on SFY 2024 Recommendations

Emotional Injury Process

- **Action:** The department evaluated barriers between policy and regulation for emotional injury assessments and provided staff with resources, including designated providers and payment methods.
- **Update:** Policy updates were implemented in SFY 2025 to address identified barriers. Service availability continues to present challenges, and efforts are ongoing to expand access.

Case Consultation

- **Action:** The department reviewed the frequency, redundancies, and resources associated with case consultation.
- **Update:** In partnership with a consultant, the department completed an evaluation of consultation and supervision practices. Recommendations were gathered and implementation has begun to strengthen consistency and support for staff.

Hiring Process

- **Action:** The department evaluated delays in the hiring process in coordination with the Office of Human Resource Management (OHRM).
- **Update:** Hiring procedures have been streamlined, and ongoing work is focused on identifying and addressing remaining barriers to improve efficiency.

Intimate Partner Violence (IPV)

- **Action:** The department assessed the availability of Batterer's Intervention Programs (BIP) and identified new opportunities to expand services with our community partners. DCBS also enhanced staff training and engaged the Administrative Office of the Courts (AOC) to address court orders, integrate agency recommendations, and promote shared accountability.
- **Update:** The court-related work has been incorporated into broader judicial collaboration efforts through the Judicial Engagement Committee. The agency convened a workgroup—including ZeroV staff—to review and update the IPV training curriculum for staff.

Evaluation Process

- **Action:** The department reviewed evaluation metrics from other systems to determine potential adoption.
- **Update:** The study is in progress, with findings to inform future evaluation improvements.

Medical Neglect / Complex Medical Conditions (CMC)

- **Action:** The department enhanced training curriculum for assessing and case planning in medical neglect and CMC cases. DCBS evaluated policy guidance for utilizing regional Nurse Consult Inspectors (NCI) and clarified roles and responsibilities.
- **Update:** The agency is actively collaborating with forensic medicine experts to strengthen assessment protocols and case planning practices.

SFY 2025 Recommendations

In SFY 2025, the SSR team presented review findings to DCBS leadership on January 7 and July 8, based on 265 cases (including 52 full reviews). Leadership focused on the following recommendations for action:

Technology Enhancements to Support Structured Decision Making (SDM) Processes

- Survey staff on functionality issues with current technology and identify needs.
- Consult with other jurisdictions and agencies on effective documentation systems.
- Pursue funding opportunities to upgrade databases and tools to improve field efficiency.
- Address connectivity challenges, particularly in rural areas.

Court Collaboration

- Establish a multidisciplinary taskforce to identify systemic barriers and create a collaborative plan for protective service cases.
- Engage representatives from DCBS, forensic medical teams, External Review Panel, Judicial Branch, and Office of Legal Services.
- Explore opportunities to expand Office of Legal Services support during court engagement.

Enhancing Agency Capacity

- Integrate dedicated, trained field trainers into the Training Branch's development plan.
- Deploy Rapid Response staff to provide immediate field training, building staff capacity to manage investigations and assessments from start to finish.

Kentucky Online Gateway (KOG) Notifications on Does Not Meet (DNM) Referrals

- Evaluate the impact of KOG notification technology on communication and field response.
- Adapt DCBS Standards of Practice (SOP) to incorporate clear guidance for staff related to DNM referrals on active cases.



Future annual reports will provide updates to actions steps taken by DCBS leadership on SFY 2025 recommendations, highlight any barriers or challenges to their implementation, and provide further recommendations drawn out of future emerging themes from the SSR process. Any needed updates from SFY 2024 will also be highlighted in future annual reports.

DID YOU KNOW?

Kentucky is a mandatory reporting state. If you suspect abuse or neglect of a child, you are required by law to make a report.

The Kentucky Abuse and Neglect Hotline

1-877-597-2331 or 1-800-752-6200

Referrals may also be made by using the web based reporting system at
<https://prd.webapps.chfs.ky.gov/reportabuse/home.aspx>



Remember the TEN-4 bruising rule

Children under the age of four should not have bruising to their
Torso, **E**ars, or **N**eck.

Non-mobile infants should not have any bruises.

Source-Norton Children's Hospital, UL Pediatric Forensics