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Acronyms contained in this report and their meanings:

CRP Citizen Review Panel

CFHS Cabinet for Health and Family Services

CPS Child Protective Services

SRA Service Region Administrator

QSR Quality Service Review

CQA Continuous Quality Assessment

DCBS Department for Community Based Services

SOP Standard Operating Procedures

FSOS Field Services Office Supervisor

FRYSC Family Resource and Youth Services Center

KRS Kentucky Revised Statute

SSW Social Services Worker

Eastern Mountain Citizen Review Panel

Laura Kretzer, Chair

*Ron Webb**	*Missie Quillen*	*Jenny Ward*
Bonnie Hale	*Deborah Clemons*	*Jean Rosenberg*
Rita Whicker	*Anita Cantrell*	
Charlotte Logan	*Mandy Stumbo*	

** DCBS Liaison*

PANEL RECOMMENDATION:

1. **The Eastern Mountain Citizen Review Panel strongly recommends implementation of a joint training effort between DCBS and FRYSC staff.**
2. **The Eastern Mountain Citizen Review Panel recommends development of an on-line service directory by region that is regularly updated.**

The Eastern Mountain Citizen Review Panel would highly encourage exploration of this model of joint meetings to include other professional groups integrally involved in the protection of children, including attorneys involved in family court cases, the law enforcement community, mental health, and judges with the same goals of increasing knowledge and communication.

The Eastern Mountain Citizen Review Panel encourages DCBS to consider how to outreach both to professionals and to the general public in a pro-active manner. Examples would include offering continuing legal education to attorneys, having booths at conferences and public events at state and local levels, and releasing positive stories to the media not during times of crisis.

CABINET RESPONSE

Jim Grace, Assistant Director, Division of Protection and Permanency, conducts an annual training for all new Family Resource and Youth Services Center (FRYSC) coordinators. There is discussion as to the FRYSC's role and relationship with DCBS. These events have been well received and are beneficial in establishing parameters in which to work. Commissioner Washington meets with the FRYSC Director to identify areas for joint training such as Family Team Meetings and Racial Disproportionality training.

The recommendation to create an on-line directory by region is an interesting concept. The DCBS contracted with Prevent Child Abuse Kentucky (PCAKY) for parenting classes and regional program/service directories. PCAKY has developed resource directories for each of the nine regions. The directories are complete and distribution is planned within a month.

The Cabinet was a co-sponsor of the *Kentucky Summit on Children* on August 27-29, 2007. Over 600 judges, county attorneys, prosecutors and other judiciary as well as social services personnel were in attendance. The Summit included presentations and workshops on the following:

- Timely adoptions vs. children lingering in foster care.
- Administrative procedures to help mitigate child maltreatment and juvenile delinquency.
- The confinement of status offenders.
- Professional development for guardian *ad litem*.
- How the substance abuse epidemic negatively affects families and the courts.
- How truancy impacts the future of our youth.
- Increasing communication and collaboration at the local and state levels.
- Disproportionality and disparate outcomes for children of color in the child welfare system.

- Understanding cultural diversity and how it affects our decision-making.
- Child abuse and domestic violence.
- Enhancing youth development and leadership opportunities.

Nine local summits will be held in each of the Department for Community Based Services' service regions. The purpose of the local summits will be to address areas of concern and best practices developed by the attendees of the statewide summit. Local practices will be developed that will implement reform in the child welfare and judicial systems.

The Kids Are Worth It Conference (KRWI) was held September 5-7, 2007 in Lexington. Each year this conference provides education for a multi-disciplinary audience. This year, a track of the conference was developed solely for judges, guardian *ad litem* and court appointed counsel in dependency, neglect, and abuse cases. The Administrative Office of the Courts will work closely with Prevent Child Abuse Kentucky to develop sessions that will improve the safety, permanency and wellbeing for Kentucky's children and families. The Cabinet was a sponsor of the conference.

The Cabinet awarded Children's Justice Act grant funds to the Administrative Office of the Courts (AOC). AOC will provide conferences which focus on advanced training for guardian *ad litem* (GAL). The GAL education initiatives will offer participants the opportunity to receive training in child protection law and best practice methods to utilize in dependency, neglect and abuse cases. These events will be designed for attorneys and other professionals who want to successfully navigate the state's District, Circuit and Family Court proceedings as they relate to children in state custody. All of the professionals who work in Juvenile and Family Court will be eligible to attend these conferences: judges, county attorneys, guardian *ad litem*, and social service workers.

Karen Glass, Web Manager with the Cabinet for Health and Family Services, provided information and web links pertaining to an on-line resource directory. The Cabinet currently has two sites which staff and the public can access for resource information. The Partners in Prevention internet site maintains links to a variety of programs and services for Kentucky families. Community Collaborations for Children, START, Child Abuse Recognition Education, Family to Family and the Youth Promise Program are examples of resource links. http://chfs.ky.gov/dcbs/partnersinprevention.htm.

The Faith Based and Community Initiatives (FBCI) link can be found on the ky.gov page or can be accessed through the above link. The site provides information regarding the FBCI office including staff and committees, the types of grants/funding that are available from the federal, state, and local governments, and information about Kentucky programs and services that work to help those in need. On the left of the page is the title Find Resources and Services. Clicking on this box will lead you to a statewide listing for programs and services in several categories.

The Kentucky Resource Market is an initiative of the state Department for Aging and Independent Living (DAIL) in the Cabinet for Health and Family Services. DAIL developed the Kentucky Resource Market in response to Kentuckians' need for a centralized, virtual system to address the needs of elders and people with disabilities. Resource Market information can be accessed on the Internet and by phone. When fully deployed, a central Resource Market for statewide inquiries and individual markets in each of the state's 15 Area Agencies on Aging will also offer face-to-face information.

Clients of the Kentucky Resource Market may receive counseling and recommendations covering all locally available care and support options as well as help accessing benefits and assistance programs for which they may be eligible.

Partners with DAIL in the Kentucky Resource Market include the state departments for Medicaid Services, Mental Health and Mental Retardation Services and Community Based Services; Area Agencies on Aging; service providers; aging and disabilities advocates; and consumers. Expansion of this program into other program areas is currently being considered.

Northeastern Citizen Review Panel

Sue Hill, Chair

Shari Stafford
Rhonda Sims
Sue Hill
Joyce Vance
Trudi Bravard
Douglas Jones
Jackie Sue Wright
**DCBS Liasion*

Cheryl Love
*Jackie Johnson**
Melissa James
Marilyn Slone
Scott Osborne
Kay Doughman

PANEL RECOMMENDATIONS:

Meth Review Team

Training should be more accessible to SSW. They need clarification on who transports the children. They need meth kits, sheets for the cars, drug screening for children and parents and access to state transportation since they have to share cars with other offices. **We recommend that the cabinet should require yearly updated trainings, and not just from the law enforcement branch.**

CABINET RESPONSE

Kathy Autrey with the Training Branch provided the following response:

"The Training Branch will consult with the Division for Protection and Permanency to determine support for Fiscal year budget expansion to provide yearly updates if indicated. Cabinet staff has continual access to the training calendar through the intranet web site. Registration can be completed on-line after approval from the Field Services Office Supervisor. On-line registration involves a logon by the SSW and then six mouse clicks to submit the registration. If a SSW experiences difficulty with the process, each region has two Regional Training Coordinators to provide assistance. Training has been acknowledged as a roadblock for some SSW to travel to training. Every effort is made to offer

training regionally. Some training is scheduled quarterly and rotate throughout the regions of the state. There is a procedure to request that a certain presentation be scheduled. The Regional Training Coordinator is available to facilitate this process."

(SEE SUPPORTING DOCUMENTS A)

There should be a requirement to take law enforcement on visits with suspected meth involvement. Workers should be given a digital camera and a cell phone that works. More and better involvement with law enforcement, pharmacists and mental health with inter-disciplinary trainings is needed. The workers asked for lists of possible trainings, refresher courses, protocol updates.

CABINET RESPONSE

DCBS policy indicates law enforcement should be involved in reports alleging methamphetamine use. The SSW is responsible for contacting law enforcement to inform them of the allegation and request assistance. SOP is available to all Cabinet personnel through the intranet site. The website provides current policy and staff receive prior notification of all changes.

Digital cameras will be provided to staffs in each region. The process for distribution has begun. The Cabinet leadership is aware of areas in the state where reception for cell phones is poor or nonexistent. Jason Dunn in the Commissioner's Office, stated the wireless contract is up for bid and quality of service is a critical feature. Fleet Management which oversees the state's motor pool, has issued a Request for Proposal for GPS systems in state vehicles. This is a result of the Boni Bill.

SOP 7B.5.1

(a) **When there are allegations of a Meth Lab, law enforcement should take the lead on home visits. This may be the Kentucky State Police (KSP), local law enforcement or the Sheriff's Department;**

REGIONAL RESPONSE

Investigation of Methamphetamine Cases

- Many issues related to policy appear to require a statewide exploration of the policy requirements (e.g., time frames, contaminated materials handling and disposal, provision of necessary resources/equipment, etc.).
- Many issues related to training appear to require a statewide examination of the training content and delivery.
- Consistency of coordination and enforcement of policy appears to require Central Office review.
- Knowledge and communication with Safety Workers appear to be a county/regional issue and able to be accomplished with local/regional information gathering and sharing.
- Local community cooperative agreements (DCBS/healthcare facilities/law enforcement) may need to be established to ensure best response in the investigation and service to Methamphetamine affected children/adults. This would need to be integrated into the statewide policy. County/regional implementation and coordination of agreements would follow such policy development.

SUPPORTING DOCUMENTS A

SOP 7B.5.1
R. 1/15/06

CHILD(REN) EXPOSED TO METHAMPHETAMINE PRODUCTION (METH LAB) INVESTIGATIONS

COA STANDARDS:

- **S10—Child Protective Services**

LEGAL AUTHORITY:

- **45 CFR Part 1355.34(b)(1)**
- **922 KAR 1:330**

PROCEDURE:

1. The SSW, in addition to following the procedures outlined in this Standard of Practice (SOP), follows applicable procedures in:
   (a) SOP 7B.1 Process Overview: Investigation/FINSA; and
   (b) SOP 7B.5 Child Neglect Investigation/FINSA.
2. **Reports of child(ren) exposed to the actual chemicals that are used to make methamphetamine, and reports of children who were exposed to an area where methamphetamine was made in the past or present are accepted as an imminent risk investigation and:**
   (b) **All attempts are made by the assigned investigative SSW to have face to face contact with the child(ren) within one (1) hour. The SSW, when possible, interviews the child(ren) at school or away from the home, however if this is not possible the SSW does not respond to the home without law enforcement;**
   (c) **When there are allegations of a Meth Lab, law enforcement should take the lead on home visits. This may be the Kentucky State Police (KSP), local law enforcement or the Sheriff's Department;**
   (d) **During the investigation the SSW determines if other children live in the home, including children who may not be present at the time of the investigation, and includes them in the current safety assessment; and**
   (e) **When the SSW is already in a home and suspects a Meth Lab, the SSW is to leave immediately and call law enforcement.**
3. **If an active Meth Lab is found:**
   (a) A Site Safety Officer should arrive on the scene and direct law enforcement as to best practice regarding the safety of all parties. The Site Safety Officer should also determine the manner in which the child is decontaminated.
   (b) The SSW cleanses the child if decontamination procedures are not available at the scene. This is for the protection of the SSW who may need to touch the child. Cleansing the child consists of the SSW wearing gloves, if possible, and cleaning the child's face, hands and hair with water. A protective covering (paper suit), if available, may be placed over the child's clothing for protection. The child's shoes are removed and left at the scene. The SSW may use a blanket, if available, to cover the car seat prior to placing the child

in a car for transporting. The child will still need to be decontaminated by the hospital or law enforcement. Only trained experts can decontaminate children.

(c) Staff DOES NOT TAKE ANY OF THE CHILD'S PERSONAL BELONGINGS (including shoes, blankets, toys, etc.) from the home due to possible contamination by dangerous toxins.

(d) The SSW requests that law enforcement take pictures of the overall conditions in the home, as well as, the chemicals used in the production of methamphetamine for court prosecution and documentation purposes.

4. **All children that have been exposed to methamphetamine, or the chemicals used to produce methamphetamine, shall be taken to an emergency room or appropriate medical facility for a complete medical assessment.**
   (a) **If the child(ren) is in physical distress or is exhibiting symptoms such as difficulty breathing, injuries or burns, EMS should transport the child to the Emergency Room (ER) for treatment. The SSW will need to determine how to proceed with custody. If necessary, law enforcement can take protective custody until the SSW is able to obtain an ECO.**
   (b) **If the child(ren) does not need emergency treatment, the SSW, law enforcement or an appropriate relative may transport the child(ren). The SSW should be extremely cautious in allowing a relative to take the child without a thorough assessment. The SSW must obtain an ECO, however, law enforcement may take protective custody of a child in imminent danger for twelve (12) hours without a court order, in accordance with KRS 620.040(5)(c). Law enforcement can then turn the child over to the SSW. An ECO must be obtained prior to the expiration of the twelve (12) hours if the child needs to remain in custody.**
5. **The SSW is responsible for assessing risk to the child and making placement decisions.**
6. **If law enforcement or a relative transports the child the SSW should arrive at the medical facility to explain the current situation to medical staff and requests the necessary lab tests. The SSW requests from the medical facility the following diagnostic testing:**
   (a) **Toxicology screening—including methamphetamine testing at a detection level; and**
   (b) **Diagnostic lab work to include CBC with differential, Chemistry Panel including BUN/Creatinine, and Liver Functions.**

   Additional tests should include Vital signs, X-ray, EKG, and Pulmonary Function Testing if clinically indicated. A thorough lung examination, including respiratory rate and oxygen saturation on room air, should be completed.
7. **The SSW notifies the Central Office Child Safety Branch at (502) 564-2136 of all substantiated investigations involving children exposed to methamphetamine production or the chemicals/area to produce methamphetamine.**

(Link to Methamphetamine Lab Medical Handout)

Kentucky Revised National Protocol for Medical Evaluation of Children Found in Methamphetamine Drug Labs with Addendum for Vulnerable Adults

for the Social Services Worker

Immediate Response

Assessment

- Assess the child or vulnerable adult for obvious injury or distress, if any of the below examples are noted, **ACTIVATE EMS IMMEDIATELY**

Examples include but are not limited to:

- Rapid breathing
- Difficulty breathing
- Appears ill
- Injuries that are worrisome such as burns
- Lethargy (sluggishness, apathy)
- Sommolence (sleepy or drowsy)
- If there is an explosion
- If there are active chemicals at the scene
- EMS, if contacted, will make decisions regarding need for emergent intervention including full decontamination

Cleansing or Containment

- Should occur prior to transport
- Gloves should be worn so as not to expose worker
- Clothing should be removed, if possible
- Cleanse the hair and skin of child or vulnerable adult. A warm shower is adequate and preferable to a bath.
- New clothing should be given to the child or vulnerable adult as all clothing inside the area where the methamphetamine lab is located is considered contaminated.
- If unable to cleanse, place a sheet on car seat for transport to acceptable facility.

Collect

- Collect urine from potentially exposed children and vulnerable adults as soon as possible, preferable within 2 hours of removal
- Urine should be screened quantitatively for drugs of abuse (this should indicate a number of particles found, not just positive or negative results)
- There are NO ACCEPTABLE levels of methamphetamine in children.

Kentucky Revised National Protocol for Medical Evaluation of Children Found in Methamphetamine Drug Labs with Addendum for Vulnerable Adults

for the Social Services Worker

Within 2-4 hours

Medical Examination

- The child or vulnerable adult should be evaluated in Emergency Room, Physician's Office, etc. by qualified medical professional.
- Include vital signs, a thorough lung examination, respiratory rate and oxygen saturation on room air.
- Blood Tests: CBS with differential, Chemistry Panel to include BUN and Creatinine, and Liver Panel.
- In children and vulnerable adults a chest x-ray, 12 lead EKG and pulmonary function tests if clinically indicated.

Within 72 hours

- If Liver Panel is elevated, Hepatitis B and C panels should be evaluated.
- Mental Health Evaluation.
- Dental Evaluation.
- For children, a developmental evaluation with special attention to speech, language and motor skills.

Follow-Up

- For children, repeat the medical examination in 30 days, 6 months and 1 year.
- Medical Examination follow-up for vulnerable adults is at the discretion of their medical practitioner as some vulnerable and elderly adults may be more sensitive to cardiac and respiratory effects of methamphetamine chemicals.
- For children, follow-up developmental recommendations as needed.
- In both children and vulnerable adults, follow-up mental health recommendations as needed.

For the Emergency Department or Physician's Office

Immediate Response:

Children should have at least a preliminary decontamination at the scene to include removal of clothing, if possible and cleansing of hair and skin at the scene before transport.

Medical Examination

Complete Medical Examination to assess Acute Medical Needs

- Urine for Toxicology (quantitative) COLLECTED AS SOON AS POSSIBLE, PREFERABLY WITHIN 2 HOURS
  Should be submitted a lab that screens and reports for the level of detection and not just NIDA standards
  Chain of evidence forms may be utilized or usual medical protocols for urine toxicology screens should be followed.
- Thorough Pulmonary Examination:
  (minimum standard for the symptomatic child)
  Vital signs
  Respiratory Rate
  O2 Saturation
  CXR
  - Labs: (can be done acutely or within 72 hours
    CBC with Differential
    Chemistry Panel to include BUN and Creatinine
    Liver Function Test

Vulnerable adults including the elderly may be more sensitive than children to cardiac and respiratory effects of toxins found in a methamphetamine lab.
O2 sats, ECG and CXR are recommended.

Kentucky Revised Statute

620.040 Duties of prosecutor, police, and cabinet -- Prohibition as to school personnel -- Multidisciplinary teams.

(1) (a) Upon receipt of a report alleging abuse or neglect by a parent, guardian, or person exercising custodial control or supervision, pursuant to KRS 620.030(1) or (2), the recipient of the report shall immediately notify the cabinet or its designated representative, the local law enforcement agency or the Department of Kentucky State Police, and the Commonwealth's or county attorney of the receipt of the report unless they are the reporting source.

(b) Based upon the allegation in the report, the cabinet shall immediately make an initial determination as to the risk of harm and immediate safety of the child. Based upon the level of risk determined, the cabinet shall investigate the allegation or accept the report for an assessment of family needs and, if appropriate, may provide or make referral to any community-based services necessary to reduce risk to the child and to provide family support. A report of sexual abuse shall be considered high risk and shall not be referred to any other community agency.

(c) The cabinet shall, within seventy-two (72) hours, exclusive of weekends and holidays, make a written report to the Commonwealth's or county attorney and the local enforcement agency or the Department of Kentucky State Police concerning the action that has been taken on the investigation.

(d) If the report alleges abuse or neglect by someone other than a parent, guardian, or person exercising custodial control or supervision, the cabinet shall immediately notify the Commonwealth's or county attorney and the local law enforcement agency or the Department of Kentucky State Police.

(2) (a) Upon receipt of a report alleging dependency pursuant to KRS 620.030(1) and (2), the recipient shall immediately notify the cabinet or its designated representative.

(b) Based upon the allegation in the report, the cabinet shall immediately make an initial determination as to the risk of harm and immediate safety of the child. Based upon the level of risk, the cabinet shall investigate the allegation or accept the report for an assessment of family needs and, if appropriate, may provide or make referral to any community-based services necessary to reduce risk to the child and to provide family support. A report of sexual abuse shall be considered high risk and shall not be referred to any other community agency.

(c) The cabinet need not notify the local law enforcement agency or the Department of Kentucky State Police or county attorney or Commonwealth's attorney of reports made under this subsection.

(3) If the cabinet or its designated representative receives a report of abuse by a person other than a parent, guardian, or other person exercising custodial control or supervision of a child, it shall immediately notify the local law enforcement agency or the Department of Kentucky State Police and the Commonwealth's or county attorney of the receipt of the report and its contents, and they shall investigate the matter. The cabinet or its designated representative shall participate in an investigation of non custodial physical abuse or neglect at the request of the local

law enforcement agency or the Department of Kentucky State Police. The cabinet shall participate in all investigations of reported or suspected sexual abuse of a child.
(4) School personnel or other persons listed in KRS 620.030(2) do not have the authority to conduct internal investigations in lieu of the official investigations outlined in this section.
(5) (a) If, after receiving the report, the law enforcement officer, the cabinet, or its designated representative cannot gain admission to the location of the child, a search warrant shall be requested from, and may be issued by, the judge to the appropriate law enforcement official upon probable cause that the child is dependent, neglected, or abused. If, pursuant to a search under a warrant, a child is discovered and appears to be in imminent danger, the child may be removed by the law enforcement officer.
(b) If a child who is in a hospital or under the immediate care of a physician appears to be in imminent danger if he or she is returned to the persons having custody of him or her, the physician or hospital administrator may hold the child without court order, provided that a request is made to the court for an emergency custody order at the earliest practicable time, not to exceed seventy-two (72) hours.
(c) Any appropriate law enforcement officer may take a child into protective custody and may hold that child in protective custody without the consent of the parent or other person exercising custodial control or supervision if there exist reasonable grounds for the officer to believe that the child is in danger of imminent death or serious physical injury or is being sexually abused and that the parents or other person exercising custodial control or supervision are unable or unwilling to protect the child. The officer or the person to whom the officer entrusts the child shall, within twelve (12) hours of taking the child into protective custody, request the court to issue an emergency custody order.
(d) When a law enforcement officer, hospital administrator, or physician takes a child into custody without the consent of the parent or other person exercising custodial control or supervision, he or she shall provide written notice to the parent or other person stating the reasons for removal of the child. Failure of the parent or other person to receive notice shall not, by itself, be cause for civil or criminal liability.
(6) To the extent practicable and when in the best interest of a child alleged to have been abused, interviews with the child shall be conducted at a children's advocacy center.
(7) (a) One (1) or more multidisciplinary teams may be established in every county or group of contiguous counties.
(b) Membership of the multidisciplinary team shall include but shall not be limited to social service workers employed by the Cabinet for Health and Family Services and law enforcement officers. Additional team members may include Commonwealth's and county attorneys, children's advocacy center staff, mental health professionals, medical professionals, victim advocates, educators, and other related professionals, as deemed appropriate.
(c) The multidisciplinary team may review child sexual abuse cases referred by

participating professionals, including those in which the alleged perpetrator does not have custodial control or supervision of the child or is not responsible for the child's welfare. The purpose of the multidisciplinary team shall be to review investigations, assess service delivery, and to facilitate efficient and appropriate disposition of cases through the criminal justice system.
(d) The team shall hold regularly scheduled meetings if new reports of sexual abuse are received or if active cases exist. At each meeting, each active case shall be presented and the agencies' responses assessed.
(e) The multidisciplinary team shall provide an annual report to the public of nonidentifying case information to allow assessment of the processing and disposition of child sexual abuse cases.
(f) Multidisciplinary team members and anyone invited by the multidisciplinary team to participate in a meeting shall not divulge case information, including information regarding the identity of the victim or source of the report. Team members and others attending meetings shall sign a confidentiality statement that is consistent with statutory prohibitions on disclosure of this information.
(g) The multidisciplinary team shall, pursuant to KRS 431.600 and 431.660, develop a local protocol consistent with the model protocol issued by the Kentucky Multidisciplinary Commission on Child Sexual Abuse. The local team shall submit the protocol to the commission for review and approval.
(h) The multidisciplinary team review of a case may include information from reports generated by agencies, organizations, or individuals that are responsible for investigation, prosecution, or treatment in the case, KRS 610.320 to KRS 610.340 notwithstanding.
(i) To the extent practicable, multidisciplinary teams shall be staffed by the local children's advocacy center.
Effective: June 26, 2007
History: Amended 2007 Ky. Acts ch. 85, sec. 331, effective June 26, 2007. -- Amended 2005 Ky. Acts ch. 99, sec. 665, effective June 20, 2005. -- Amended 2000 Ky. Acts ch. 14, sec. 63, effective July 14, 2000; ch. 144, sec. 6, effective July 14, 2000; and ch. 164, sec. 1, effective July 14, 2000. -- Amended 1998 Ky. Acts ch. 426, sec. 617, effective July 15, 1998. -- Amended 1996 Ky. Acts ch. 18, sec. 5, effective July 15, 1996. -- Amended 1994 Ky. Acts ch. 217, sec. 1, effective July 15, 1994. – Amended 1992 Ky. Acts ch. 434, sec. 2, effective July 14, 1992. -- Amended 1990 Ky. Acts ch. 39, sec. 1, effective July 13, 1990. -- Amended 1988 Ky. Acts ch. 258, sec. 3, effective July 15, 1988; and ch. 350, sec. 44, effective April 10, 1988. -- Created 1986 Ky. Acts ch. 423, sec. 65, effective July 1, 1987

Site Safety Officer *CPS* *APS*	An officer who has been trained to oversee safety during clandestine laboratory operations.

Protection and Permanency Employees
Staff Development Plan

New Employee Orientation:

- ☐ **Administrative Information**
- ☐ **Technology and Information Management**
- ☐ **Introduction to the Region**
- ☐ **Staff Development and Training**
- ☐ **Preventing Disease Transmission (web based)**
- ☐ **HIPAA (web based)**
- ☐ **Safety First (web based)*****
- ☐ **Americans with Disabilities Act (web based)**
- ☐ **Limited English Proficiency (web based)**
- ☐ **Random Moment Sampling (web based)**
- ☐ **Targeted Case Management (web based)**
- ☐ **Taking Care of Yourself**
- ☐ **Anti-Harassment Prevention (yearly)**
- ☐ **Understanding Substance Use Disorders in Ky. Families (web-based)**
- ☐ **Predictor Assessment (web based)**

Required before additional courses taken in program area:

- ☐ **Introduction to Community Based Services**

Academy Course 1 (3 graduate credit hours)+

- ☐ **The Foundations of the Ky Child Welfare**
- ☐ **Assessing Needs of Families and Children**
- ☐ **Case Planning**
- ☐ **TWIST WEEK 1 and TWIST Week 2 (taken in conjunction with Course 1)**
- ☐ **Medical Indicators (taken in conjunction with Course 1)**

Academy Course 2 (3 graduate credit hours)+

- ☐ **Meeting the Needs of Families and Children in Domestic Violence**
- ☐ **Meeting the Needs of Vulnerable Adults**

Academy Course 3 (3 graduate credit hours)+

- ☐ **Assessment and Case Management of Child Sexual Abuse and Follow-Up***

Additional Course Requirements:

- ☐ **Enhancing Safety and Permanency (3 graduate hours optional)***
- ☐ **Assessing CPS Referrals in Out of Home Care****
- ☐ **Elder Abuse (continuing education every 2 years)**
- ☐ **Working With Adult Guardianship****
- ☐ **Investigations in Alternate Care Facilities****
- ☐ **Serving Substance Abusing Families****
- ☐ **Cultural Competency (in revision status)**
- ☐ **Domestic Violence Continuing Education (every 2 years)**
- ☐ **TWIST (depending on function area)**
- ☐ **Workplace Violence Prevention (every 2 years- OHRM)*****

+ Graduate Credit awarded, exception MSW degreed may Audit
***Required for all except APS ONLY caseloads**
****Required based on job function**

This document is available to all staff at https://tris.eku.edu, Staff Development link.

Supervisors should review an employee's training record during interim evaluations.

NORTHEASTERN PANEL RECOMMENDATIONS CONTINUED

Child Fatality Review Team

CABINET RESPONSE

Sherry Rock, Internal Policy Analyst with the Child Safety Branch, has assumed responsibility for child fatality and near fatality work. The following responses were made by Ms. Rock. "It is up to the local coroner on how and when teams will meet. Many counties do not have local teams because the coroner chooses not to have them. KRS gives the coroner the ability to have a team, but does not mandate the formation of a team. There is literature available to the coroners on appropriate representatives to be on the team. It is highly recommended that along with the coroner, Local Health Department, and DCBS that there also is representation from all local law enforcement in the area, a pediatrician, EMS, County and/or Commonwealth Attorney, and other essential agencies. Some counties have representatives from child care, foster parents, and fire department along with EMS, local college or university personnel and other local hospital staff. The Leadership role for the fatality lies with the coroner, per KRS 211.686 (See Supporting Document B) which authorizes coroners to establish local child fatality response teams. Some counties do have a dual role with either the health department or DCBS in helping arrange the meetings, etc."

All counties across KY need to be following the same timeline and format in regards to the required meeting following a child fatality.

CABINET RESPONSE

There is no set format or timeline for conducting Child Fatality Review Team meetings; it is up to the discretion of the coroner of the jurisdiction. Child Fatality Review Teams are not mandated.

More representation should be included on each county's Child Fatality team such as the addition of a healthcare professional (i.e. MD or SANE nurse).

CABINET RESPONSE

There is no provision for who should or should not be on a team. KRS 211.686 does give examples of who should be present on the team. Many counties have a diverse make-up and the team makes decisions together about bringing in new team members. Many of the local teams have invited many healthcare professionals to be a part of the team. This would include pediatricians, ER nurses, and nursing instructors from nearby colleges or universities and EMS providers.

Documentation should be the same for all counties and documentation submission to Frankfort should be no less than 1 week following either the investigation and/or autopsy.

CABINET RESPONSE

Currently, coroners are the only ones actually required to submit paperwork. There is another form for coroners to use called the SUDII form, which has more information for the medical examiner. Not all coroners are using this form, but many of the medical examiners are requiring this form be filled out as much as possible before performing the autopsy. There was discussion at the State Child Fatality Team meeting and with some coroners, that getting information sent in no less than 1 week following the autopsy or investigation is sometimes not possible. While an autopsy might be completed within a few hours of the death, results of toxicology reports are sometimes taking up to 3 months or more because of the workload at the state lab. Some fatality investigations have taken several months or up to a year to complete.

The leadership role for the Child Fatality team in each county should be under the direction of a healthcare professional along with the county coroner; this should be a dual role.

CABINET RESPONSE

This would be the coroner's decision. The purpose of the review team is to analyze information to identify trends, patterns and risk factors and pass this

information to the State Team. Therefore, it may not be necessary to have a healthcare professional in a leadership role. It would be beneficial to have a healthcare professional as an active participant on the team.

Someone at Central Office of DCBS should be responsible to insure that the mandated Child Fatality meetings are taking place and that the proper documentation has been submitted with signatures from all the parties in attendance at the meetings.

CABINET RESPONSE

Child Fatality Review teams are not mandated. According to KRS 211.686, the proceedings, records, opinions and deliberations of the local team shall be privileged and shall not be subject to discovery or subpoena. The coroner has specific documentation to submit regarding the child's death, the Review Team does not. There is no provision in KRS for DCBS to be responsible for local Child Fatality Review Teams.

The various individuals who are on the Child Fatality team should be compensated by the state (Frankfort) for their travel time and any additional expenses (with submission of receipts) that they may have incurred while in the process of fulfilling their role on the team.

CABINET RESPONSE

The members of the team, aside from the coroner, are appointed by the agency the member is representing. It is that agency's responsibility to assume any costs for the member to attend. Generally, the teams meet during the business day. The majority of members are being "paid" for attending the meeting as part of their work day. Kentucky currently has no regional teams so travel would be within the member's county, unless a representing agency sends someone from another county or region. If this occurs, again it would be the responsibility of the participating agency to cover the costs. The Child Fatality Review Team is not a state mandated team, membership and participation is purely voluntary per

agency. Since this is voluntary for the coroner and participants, there is no funding source for travel or other activities.

REGIONAL RESPONSE LOCAL CHILD FATALITY REVIEW TEAM

Increased representation of healthcare professionals on Child Fatality Teams may be a desired improvement. Clear designation of Team leadership must be communicated and understood.

SUPPORTING DOCUMENT B

211.680 Legislative intent and findings for KRS 211.680 to 211.686 and KRS 72.029

The Kentucky General Assembly declares that the purpose of KRS 211.680 to 211.686 and KRS 72.029 is to reduce the number of child fatalities. The General Assembly finds that establishing priorities and developing programs to prevent child fatalities requires the:

(1) Accurate determination of the cause and manner of death;

(2) Cooperation and communication among agencies responsible for the investigation of child fatalities; and

(3) Collection and analysis of data to:

(a) Identify trends, patterns, and risk factors; and

(b) Evaluate the effectiveness of prevention and intervention strategies.

Effective: July 15, 1996

History: Created 1996 Ky. Acts ch. 347, sec. 1, effective July 15, 1996.

211.682 Interpretation of KRS 211.680 to 211.686 and KRS 72.029 with respect to laws relating to coroners.

The provisions of KRS 211.680 to 211.686 and KRS 72.029 shall not be interpreted to limit, restrict, or otherwise affect any power, authority, duty, or responsibility imposed by any other provisions of law upon any coroner, but rather shall be interpreted to aid, assist, and complement the coroner in the performance of those statutory duties.

Effective: July 15, 1996

History: Created 1996 Ky. Acts ch. 347, sec. 2, effective July 15, 1996.

211.684 Authorization to establish state child fatality review team -- Annual report on child fatalities.

(1) For the purposes of KRS Chapter 211:

(a) "Child fatality" means the death of a person under the age of eighteen (18) years; and

(b) "Local child fatality response team" and "local team" means a community team composed of representatives of agencies, offices, and institutions that investigate child deaths, including but not limited to, coroners, social service workers, medical professionals, law enforcement officials, and Commonwealth's and county attorneys.

(2) The Department for Public Health may establish a state child fatality review team. The state team may include representatives of public health, social services, law enforcement, prosecution, coroners, health-care providers, and other agencies or professions deemed appropriate by the commissioner of the department.

(3) If a state team is created, the duties of the state team may include the following:

(a) Develop and distribute a model protocol for local child fatality response teams for the investigation of child fatalities;

(b) Facilitate the development of local child fatality response teams which may include, but is not limited to, providing joint training opportunities and, upon request, providing technical assistance;

(c) Review and approve local protocols prepared and submitted by local teams;

(d) Receive data and information on child fatalities and analyze the information to identify trends, patterns, and risk factors;

(e) Evaluate the effectiveness of prevention and intervention strategies adopted; and
(f) Recommend changes in state programs, legislation, administrative regulations, policies, budgets, and treatment and service standards which may facilitate strategies for prevention and reduce the number of child fatalities.
(4) The department shall prepare an annual report to be submitted no later than November 1 of each year to the Governor, the Legislative Research Commission, the Chief Justice of the Kentucky Supreme Court, and to be made available to the citizens of the Commonwealth. The report shall include a statistical analysis of the incidence and causes of child fatalities in the Commonwealth during the past fiscal year and recommendations for action. The report shall not include any information which would identify specific child fatality cases.
Effective: July 14, 2000
History: Amended 2000 Ky. Acts ch. 14, sec. 61, effective July 14, 2000. -- Amended 1998 Ky. Acts ch. 426, sec. 311, effective July 15, 1998. -- Created 1996 Ky. Acts ch. 347, sec. 3, effective July 15, 1996.

211.686 Authorization for coroners to establish local child fatality response teams -- Confidentiality of team proceedings and records.
(1) A local child fatality response team may be established in every county or group of contiguous counties by the coroner or coroners with jurisdiction in the county or counties. The local coroner may authorize the creation of additional local teams within the coroner's jurisdiction as needed.
(2) Membership of the local team may include representatives of the coroner, the local office of the Department for Community Based Services, law enforcement agencies with investigation responsibilities for child fatalities which occur within the jurisdiction of the local team, the Commonwealth's and county attorneys, representatives of the medical profession, and other members whose participation the local team believes is important to carry out its purpose. Each local team member shall be appointed by the agency the member is representing and shall serve at the pleasure of the appointing authority.
(3) The purpose of the local child fatality response team shall be to:
(a) Allow each member to share specific and unique information with the local team;
(b) Generate overall investigative direction and emphasis through team coordination and sharing of specialized information;
(c) Create a body of information that will assist in the coroner's effort to accurately identify the cause and reasons for death; and
(d) Facilitate the appropriate response by each member agency to the fatality, including but not limited to, intervention on behalf of other children who may be adversely affected by the situation, implementation of health services necessary for protection of other citizens, further investigation by law enforcement, or legal action by Commonwealth's or county attorneys.
(4) The local team may:
(a) Analyze information regarding local child fatalities to identify trends, patterns, and risk factors;

(b) Recommend to the state team, and any other entities deemed appropriate, changes in state or local programs, legislation, administrative regulations, policies, budgets, and treatment and service standards which may facilitate strategies for prevention and reduce the number of child fatalities; and
(c) Evaluate the effectiveness of local prevention and intervention strategies.
(5) The local team may establish a protocol for the investigation of child fatalities and may establish operating rules and procedures as it deems necessary to carry out the purposes of this section.
(6) The review of a child fatality by a local team may include information from reports generated or received by agencies, organizations, or individuals that are responsible for investigation, prosecution, or treatment in the case.
(7) The proceedings, records, opinions, and deliberations of the local team shall be privileged and shall not be subject to discovery, subpoena, or introduction into evidence in any civil action in any manner that would directly or indirectly identify specific persons or cases reviewed by the local team. Nothing in this subsection shall be construed to restrict or limit the right to discover or use in any civil action any evidence that is discoverable independent of the proceedings of the local team.
Effective: July 14, 2000
History: Amended 2000 Ky. Acts ch. 14, sec. 43, effective July 14, 2000. -- Created 1996 Ky. Acts ch. 347, sec. 4, effective July 15, 1996.

The Lakes Citizen Review Panel

Ladonna Butler, Chairperson

*Peggy Meriedeth**	*Sonia Holmes*	*Gloria Olney*
Ralph Prince	*Cheryl Dodd*	*Kim Brand*
Wendy Lay	*Kathy Wilson*	*Linda Johnson*
Dr. Peggy Pittman-Munke	*Cindy Grahm*	*Ronald Pullen*
Julie Copeland	*Thomas Monroe*	*Theresa Shell*
Dianne Glasscock	*Evie Paschall*	*Jean Shipley*
Stephanie Hooper	*Maria Huntley*	*Renee Buckingham**
*Sherry Litchfield**	*Kristi Griffey**	

** DCBS Liaisons*

THE LAKES PANEL RECOMMENDATIONS TRANSITIONAL LIVING SERVICES

The Citizen Review Panel wishes to compliment the DCBS on the transitional living plan and wants to recommend continued support of the plan and ongoing education of all staff on the use of the plan.

The panel would like to **recommend a position be added to assist the Independent Living Coordinator** and the vital role he plays in the lives of foster children. The continuing growth of the population that is aging out warrants that a position should be added. Furthermore, the Lakes Region is a large and rural area which would be difficult for only one person to cover.

CABINET RESPONSE

Fawn Conley is the State Coordinator and Project Administrator for the Chafee Independence Program. She provided the following response to this recommendation:

"I wholeheartedly agree with the Citizen Review Panel that The Lakes Region

could use another Independent Living Coordinator. Ron Campbell has done an excellent job of handling a very large number of counties for a long time. However, there is no money in the Chafee Independence Program budget for another staff person at this time. I would recommend that The Lakes Region follow the example of the Salt River Trail and Jefferson Regions and convert one of their state employee positions to an Independent Living Coordinator. It seems to work very well in both of those regions and the staff turnover is less likely since they earn a higher salary than Eastern Kentucky University pays."

Current policy states that children aging out of foster care have six months to recommit: the recommendation is to extend this to a 12 month period to allow more time for this decision which has the potential to significantly impact their future. The panel will take an active role in contacting our legislators to impact the outcome of this piece of legislation. In order to be effective advocates it is imperative that DCBS establish ongoing communication regarding this issue with the Citizen's Review Panel.

CABINET RESPONSE

Ms. Conley stated "I would also support extending the time frame for a youth to return to the Cabinet for recommitment for 12 months rather than the current six month time frame. For most youth, six months is not enough time for them to figure out they cannot make it on their own. The Children's Alliance addressed this issue in the 2006 legislative session. It might be a good idea for the Citizen Review Panel to work with Bart Baldwin and his agency on this matter."

The number of committed children who are not suitable for academic or technical training is increasing. **The CRP would recommend that the Cabinet review existing policy, taking into account the unique needs of these adolescents. Policy should be revised by expanding the criteria of acceptable educational components beyond those carrying academic credit or certification. Resources need to be identified and/or developed locally that**

would enable these adolescents to qualify to extend their commitment by utilizing alternative means of education. An example would be on the job training accessible regionally.

CABINET RESPONSE

Ms. Conley further stated "I also agree with the Panel's recommendation that the criteria of acceptable educational/job training components for committed youth be expanded to include options for those youth who may not have the capability to complete a post seconddary education or certified job training program. There are a number of programs that exist that are not certified, but that would provide some good job training for those youth."

The CHFS leadership has been made aware of the panel's recommendations and Ms. Conley's response. They will determine how to proceed.

Jefferson Citizen Review Panel

Bryan Fantoni, Chair

*Laura Johnson**	*Carla Tyree Curry*	*Bonnie Swicegood*
Dwala Griffin	*Becky Lewis*	*Mary Lou Cambron*
Barbara Dempsey	*Sheila Nelson*	*Joanna Young*
Constance Ard	*Phillis Thompson*	*Barbara Carter*
Dr. Ann Swank		

**DCBS Liaison*

JEFFERSON PANEL RECOMMENDATIONS

Disproportionality Sub-Committee

1. **We recommend a public relations campaign by the Cabinet, Community Supporters in conjunction with media partners on the benefits of Adoption** highlighting:
   a. Cost of Adoption;
   b. Definition of Adequate Income (a requirement);
   c. Cabinet Support of families after Adoption;
   d. Financial Support by the Cabinet with emphasis on the Passport to Adoption Program: Medical, Education

CABINET RESPONSE

Mike Grimes, Branch Manager for the Adoptions Branch provided detailed information for each category mentioned above. "The Adoptions Branch continually attempts to promote adoptions and to include information regarding the Jefferson Panel's listed areas.

Potential adoptive parent/s are informed that the cost of adoption is minimal. The adoptive parent/s is required to have a doctor complete the DPP-107 form which verifies there is no mental or physical disability which would prohibit them from parenting. Attorney fees and court costs up to $1,000 is reimbursable through the Non-Recurring Adoption Expense Program.

The Cabinet has a public service announcement that was E-mailed to 128 radio stations statewide on June 25, 2007. It is available on the SNAP website at the following link: http://chfs.ky.gov/dcbs/dpp/Special+Needs+Adoption+Program+%28SNAP%29.htm.

Information regarding adoption benefits is also available in the Adoption Assistance Parent Handbook which is also available on-line at the following link: http://manuals.chfs.ky.gov/dcbs_manuals/dpp/docs/Adoption%20Assistance%20Parent%20Handbook%202005.doc. The handbook is currently being updated. There is a brochure which outlines adoption benefits. This is distributed at recruitment functions (i.e. conferences, state fair, etc.)

A Resource Home applicant is required to have a source of income that is sufficient to meet the applicant's household expenses and is separate from foster or resource home cares reimbursement or adoption assistance.

The Cabinet's Post Adoption Placement Stabilization Services (PAPSS) program allows adoptive parents to access residential treatment services for adoptive children up to ninety (90) days without having to relinquish custody of the child. Adoptive children can access the college tuition waiver which waives the tuition at any public Kentucky university or institution within the Kentucky Community and Technical College System (KCTCS). Children adopted at age sixteen (16) or older may also access the Educational Training Voucher (ETV). The ETV is up to a maximum of $5,000 per student per year. These funds can be used for any

expense related to keeping the student enrolled. Allowable expenses include but are not limited to: transportation, rent, day care, books, utilities and food.

Children who receive adoption assistance also receive Kentucky Medicaid. Kentucky's adoption assistance rates are in the top five in the U.S. There was an across the board raise in the rates of $3.00 per day which became effective on July 1, 2007. The Cabinet also provides reimbursement for services/items not covered by Medicaid through the Extraordinary Medical Expense Program. Allowable expenses include but are not limited to the following: day care, tutoring, respite, medication, counseling, eye glasses and transportation.

Prevent Child Abuse Kentucky (PCAKY) is gearing up for a statewide media campaign regarding recruitment of foster and adoptive parents. They will be using the 1-800-232-KIDS number on their print ads, billboards, radio and television spots."

REGIONAL RESPONSE

Our adoptions unit hosts multiple events throughout the year to highlight children available for adoption and the benefits (both tangible and non-tangible) of adoption. For example, during September 2007, there will be two grass roots fairs where data about removal of children, the number of children available for adoption and the number of resource and/or adoptive homes in two specific neighborhoods will be highlighted as part of a community event that will include games and refreshments. The two neighborhoods selected are those that have the highest rates of removal in the county.

Other recruitment/information events that we have held during the year include: Wednesday's Child Adopt-a-thon held every December on Channel 32. Information on how to become an adoptive parent is broadcasted along with appearances from several of our kids. Adoption staffs man the phones and provide information to interested families.

A booth is set up at the State Fair each year and staff work shifts with Wednesday's Child volunteers to provide information on becoming an adoptive parent.

During football and basketball season, booths are set up at specific games where staff sell posters of U of L players for one dollar to raise money for Wendy's Wonderful Recruitment and distribute information on how to become a foster/adoptive parent.

November is Adoption Month. We always have an "adoption day" where we highlight adoption efforts with the court and invite media partners.

The unveiling of the Shining Star Gallery always includes local media and the portraits travel to various community sites throughout the year.

Also, we have begun a partnership with local artists who will work with some of the children available for adoption to do a project that will be featured at local galleries along the Trolley Hop. Information on adoption is provided at the exhibits.

As a Family-to-Family Anchor Site, one of our strategies focuses on increasing both resource and adoptive homes. There is a strategy workgroup that focuses on this task with technical assistance from the Annie E. Casey Foundation. Among their tasks is community outreach and increased public awareness. This is an area in which we continue to apply innovative ideas and strategies.

2. African American children are disproportionately represented in the child protective services system. The Jefferson CRP supports the work of the Cabinet to address this fact and recommend the following actions to assist in this work.

- Alliance of Social Workers, First Responders and Community Partners to address issues revealed through research.
- Disseminate the research
- Continue Communications with Partners
- Provide Continuing Cultural Education for Workers
- Use CRPs to Educate the Community

CABINET RESPONSE

On April 3, 2007, Governor Ernie Fletcher and leaders from the Kentucky Cabinet for Health and Family Services (CHFS) announced a comprehensive project to target racial disproportionality and disparate outcomes in the child welfare system. The project targets 11 counties where African-American children are represented in state foster care at more than one and a half times the census rate. Delanor Manson, Executive Director of Quality Management with the Cabinet for Health and Family Services, has been actively involved with training of the Undoing Racism workshops.

On June 20, about 200 people gathered at Lexington's University of Kentucky campus for the "Race, Community and Child Welfare Summit: Addressing the Crisis in Fayette County." DCBS co-sponsored the event with LexLinc and UK's Office of Community Engagement. The event helped guests learn how race impacts the child welfare system, schools and the rest of the community.

Delanor Manson and Larry Michalczyk, DCBS' Community Partnership Consultant from the University of Louisville, presented information about disproportionality and disparate outcomes in Kentucky. Leaders in the judicial, law enforcement, health, media, faith-based organizations and social work fields are particularly encouraged to become involved. An excellent website is: http://www.jointheconversation.net.

The University Training Consortium, DCBS Training Branch, and regional representatives met on September 12, 2007 at Eastern Kentucky University. The purpose was to develop and enhance cultural diversity and anti-racism trainings for all front line staff and managers with the DCBS.

REGIONAL RESPONSE

Jefferson County is very proud of the work we have begun in trying to address disproportionality in child welfare. Our Undoing Racism workshops have been attended by our staff and a wide range of community partners. This workshop has led to the creation of an Alumni group that has formed workgroups to address specific issues related to disproportionality/racism in our community. We appreciate the CRP's support in our ongoing work to address this issue. We have also participated in the creation of the jointheconversation.net website that serves to inform and encourage discussion on the subject of disproportionality.

PANEL RECOMMENDATIONS

Child Sex Abuse Investigations

CPS should provide updated worker lists and phone lists to local law enforcement on, at a minimum, a quarterly basis by distributing lists through division commanders.

1. **CPS should consider mandating that ALL investigations into new allegations be controlled and handled by an investigative worker.**

2. **CPS should mandate that all sex or physical abuse investigations be handled by CPS workers assigned to CACU.**

CABINET RESPONSE

The Service Region Administrators are given the autonomy to make regional decisions as to service provision to families. They base best practice decisions on KRS, KAR and SOP. Professionals in the area of child maltreatment

investigations have varied opinions as to whether ongoing case SSW should conduct investigations on their open cases. There is the opinion that all new reports should be investigated by a professional on an intake/investigative team. It is felt this assures objectivity and does not compromise the role of the ongoing SSW with the family to whom they are providing services. However, some professionals believe low risk reports could be investigated by the ongoing SSW. These professionals believe the ongoing SSW knows the family and would be the best source of intervention for these low risk reports. Most all agree that the ongoing SSW should be informed when there is a new report of abuse and or neglect on an open case.

REGIONAL RESPONSE

Our CACU supervisor provides phone lists to his counterparts with LMPD (Louisville Metro Police Department) on a regular basis.

While we understand the concerns of workers conducting both investigations and carrying ongoing cases, Jefferson DCBS believes that the benefits to having a worker already involved with a family complete subsequent investigations outweigh the costs. When a worker has an open case and a new allegation is received, the ongoing worker is familiar with the family and their support system, so they are in a better position to complete a thorough investigation as well as coordinate services and resources for the family. Additionally, it is confusing for families to have multiple workers involved in their lives at the same time.

Serious physical abuse and all sexual abuse cases are assigned to the CACU team. If they are not able to take such a case for any reason, it is assigned to a worker on another investigative team who has experience at CACU. (CACU workers rotate regularly due to the potential stress involved in their caseloads and due to the intensity of the investigations.) When other physical abuse cases are assigned to workers who are not part of CACU, CACU is available to consult and assist as needed. Ideally, if we had additional staff, we would like to add a

second CACU unit. However, this would also require the commitment of the Louisville Metro Police Department to add additional detectives to work with our CACU staff.

2. **CPS should hire additional investigative social workers and enough supervisors to adequately supervise staff.**

CABINET RESPONSE

Governor Ernie Fletcher signed the "Boni Frederick Memorial Bill" into law at a ceremony in April at the Jefferson County Department for Community Based Services office. The law provides $6 million to improve safety for state human services social workers and to hire more staff. The Boni Frederick Memorial Law provides $3.5 million to fund security improvements at state child welfare offices, improve technology to provide for safe visitation for birth parents and their children in foster care. Another $2.5 million will be used to hire additional front-line staff. DCBS leadership is reviewing caseload and SSW ratios in order to strategically place new hires.

PANEL RECOMMENDATIONS:

1. **CPS should seek to address worker concerns promptly.**
2. **Identify areas within Jefferson County with disproportionately high turnover and target the retention of workers accordingly**
3. **Provide tools, training and financial incentive to retain staff.**

REGIONAL RESPONSE

Workers' concerns are addressed through our CQI process. We have also held or will hold several focus groups/forums with staff in recent months. (These were/are facilitated by training staff, not P&P workers, supervisors or managers.) Our statewide safety workgroup consists of frontline workers and supervisors and directly addresses concerns voiced by field staff through a workplace safety survey.

While we do experience high turnover, our vacancies tend to be spread throughout our units; there is not one particular area that has higher turnover than others. Within the past year, staffs have received cell phones and laptops; we will soon be distributing new digital cameras to our teams. We provide training on a regular basis and regularly introduce new trainings as they are needed.

Workers who begin their state careers with P&P are generally hired as Social Service Worker I. This position is a grade 13 in the state personnel system with a starting salary of $32,042.40 per year. After successfully completing probation (6 months) employees are eligible for a 5 percent raise which would take the salary to $33,644.64. After that time, annual raises are determined by the state legislature. After at least one year of experience, employees are possibly eligible for a reclassification to a Social Service Clinician I, which includes a 5 percent raise. In the past, there were other advancement opportunities for workers. However, several years ago, the job classification system was "updated" and several jobs within the social work series were collapsed into the same grade. For example, a Social Service Worker I and Social Service Worker II are now the same grade as are Social Service Clinician I, Social Service Clinician II and Social Service Specialist. (This also happened in the case management series in family support.) This has eliminated some of the financial incentives/promotional opportunities for workers who desire a career with P&P. The agency has recently reinstated an award system to recognize workers who go "above and beyond" or take on extra job responsibility. (See Supporting Documents C)

Retention incentives provided include stipend for staff to complete a Master's Degree in Social Work. Educational assistance may be provided for non-degreed staff to obtain a Bachelor's level degree.

PANEL RECOMMENDATIONS

TRAINING ON PHOTO TAKING IN INVESTIGATIONS:

1. **CPS should mandate training of all CPS workers, or at a minimum all investigative workers, involved with abuse allegations as to how to photographic injuries.**
2. **This training should encompass the proper method for taking photographs of differing injuries; the necessary and proper documentation of such photographs; the preservation of the photographs as evidence; the proper use of scale markers in photographs; the proper use of cameras to capture viable pictures of injuries.**

CABINET RESPONSE

Cameras have been provided to local DCBS offices in the past. Digital cameras were ordered in 2006 but the model was discontinued prior to the order being processed. They were reordered and upon delivery, the cameras will be distributed to the Service Regions. Some regions have received the cameras. The recommendation regarding training in the proper method for taking photographs is excellent. Staff in some local DCBS offices has worked collaboratively with local law enforcement for instruction in taking photos.

A tip sheet has been created by Debbie Dile, Child Safety Branch and Debbie Acker, Nurse Consultant in the Permanency and Protection Director's office. SOP may be needed to support the tip sheet. Debbie Acker, Nurse Administrator Consultant, is developing a training component on photo documentation. She anticipates the session will be 1 ½ hrs. The training will be part of the Medical Elements of Child Abuse and Neglect (MECAN) training.

REGIONAL RESPONSE

Our region has just received a shipment of new digital cameras. As part of the roll-out of this equipment, we plan to ask our forensic nurses to help us with training on how to appropriately photograph injuries.

PANEL RECOMMENDATIONS

SEXUAL ABUSE INVESTIGATIONS

1. **CPS should seek to initiate changes in the relevant policy/statutes to:**
   a. **eliminate the blanket one hour requirement for all sex abuse allegations.**
   b. **to allow an investigative worker and law enforcement personnel to jointly review all reports of sex abuse within one hour of their reporting to determine if the child is in immediate danger such to require immediate contact or CPS intervention.**
   c. **contact and intervention shall be done in as reasonable a time as necessary but never with a delay such to endanger the safety or welfare of a child.**

CABINET RESPONSE

The foundation of the Cabinet's policy is Kentucky Revised Statute and Kentucky Administrative Regulations. KRS defines the Cabinet's role and authorizes the Cabinet's intervention in cases of abuse and neglect. The statute pertaining to reports of child abuse and neglect can be found in Supporting Documents C.

The timeframes for initiation policy is covered in SOP 7B.1 which is the Process Overview for Investigations and FINSA. This policy is founded on KAR (Multiple Response) and KRS. Multiple Response created an avenue to intervene and provide services to families without the requirement of substantiating abuse or neglect. SOP 7B.9-Determination of Findings of Investigation or FINSA states: "If the SSW determines an investigation to be substantiated, but the case will be closed, an Aftercare Plan is completed and the case is closed. (Used for both

Substantiated and, Found and Substantiated.) If the SSW determines an investigation to be substantiated, and the case will be opened, a Prevention Plan is completed."

Supporting Documents C has the policy on timeframes, acceptance criteria for neglect and child sexual abuse and imminent risk is defined. There has been considerable discussion over the years regarding initiating a sexual abuse investigation within one hour. While sexual abuse is considered imminent risk to the child, the SSW does have some flexibility in initiation. When the SSW has determined that the alleged perpetrator does not have access to the child, the one-hour timeframe can be extended. It is the SSW responsibility to document in the CQA and Service Recordings how it was determined the alleged perpetrator did not have access. This has been reviewed by the Office of Legal Services who expressed the opinion that "the statute called for sexual abuse to be considered high risk and since SOP and the KAR did set out a timeframe then the timeframe must be followed."

The Cabinet intends to revise the Risk Matrix and to review the current policy on child sexual abuse for possible revisions. The Office of Legal Services has affirmed that it is "fine to change the SOP and of course the regulation (KAR) must be changed but deference must be given to KRS so that sexual abuse reports are given priority in investigation."

REGIONAL RESPONSE

On cases where there is imminent risk, the agency is required to initiate the investigation within one hour. KRS 620.060 defines imminent risk which may include sexual abuse allegations, although they are not necessarily defined as imminent risk in KRS. We are not required by KRS or SOP to initiate all sexual abuse investigations within 1 hour. However, that is a protocol put in place by Central Office. Staffs in Jefferson County agree with CRP that this one hour requirement should not be in place for every sexual abuse allegation. In many

cases, initiating within one hour can put a victim at risk (the perpetrator may be in the home when the investigator interviews the child) and can compromise the investigation (there isn't sufficient time to gather sufficient background information and/or form a strategy for the best investigative methods to use; we may not have access to a forensic interview in this short timeframe; the child may be more likely to recant if the investigation is not thought out well). In the long run, either of these consequences of a hasty initiation can be detrimental to the child and could place him/her at further risk. We support the current KRS/SOP requirement that the agency evaluate imminent risk and initiate investigations appropriately.

We believe that if the timeframes are reasonable and appropriate (i.e. imminent risk determination is made on a case-by-case basis), then workers can and should be held accountable for meeting these expectations.

2. **CPS should investigate their own policies and procedures which may seek to punish workers who fail to meet the statutorily mandated timeframe in situations where there is no danger or imminent threat to the victim.**

There is a concern that no one in the community is addressing issue of children (under age 12) perpetrating sexual abuse against another child. CPS identifies these cases as Family In Need of Services (FINSA) but if the parents do not want services, there are no repercussions. Neither perpetrators nor victims are required to get treatment. The police will not investigate and the Cabinet will not hold parents accountable for getting proper treatment for their children.

PANEL RECOMMENDATIONS:

1. **Cases should be open on all families involved and should not be considered FINSA cases.**

2. **Cases should be opened as on-going cases until both perpetrator and victims and their families have received proper treatment.**

CABINET RESPONSE

The foundation of the Cabinet's policy is Kentucky Revised Statute and Kentucky Administrative Regulations. KRS defines the Cabinet's role and authorizes the Cabinet's intervention in cases of abuse and neglect. KRS 510.020 and KRS 635.510 are pertinent to this issue. The entire statute pertaining to reports of child abuse and neglect can be found in Supporting Documents C.

Steve Hartwig, Internal Policy Analyst with the Child Safety Branch, has researched this issue. He found that Kentucky will substantiate on juveniles over the age of 12 if the juvenile sexually perpetrates/abuses a child(ren) while in a care-taking role. i.e. babysitting. Kentucky does not have a definition of consensual sex of children over the age of 13, however, per our SOP, a report is accepted as suspected sexual abuse when the reporting source has reason to believe that contacts or interactions have occurred in which the person having custodial control or supervision of the child or the responsibility for his welfare, uses, allows, permits, or encourages the use of the child for the purposes of sexual stimulation of the perpetrator or another person.

An SSW and a law enforcement officer conduct investigations of reports of suspected sexual abuse of a child. Additional Multi-disciplinary team members may be involved in the investigation per local protocol. Law enforcement determines if criminal charges will be filed against the juvenile, while the SSW determines whether or not we can substantiate our child protective services referral. When determining whether or not the sex between the juvenile/child was consensual we can review KRS 510.020 and KRS 635.510.

The Cabinet does have statistics on substantiated reports of sexual abuse where the perpetrator was 18 years of age or less at the time of the referral.

The following graph indicates the number of substantiated reports:

YEAR	NUMBER SUBSTANTIATED REPORTS
2003	56
2004	54
2005	49
2006	50

There were varied outcomes to the reports which included: criminal charges, criminal complaints and arrest; referral to Court Designated Worker and Department for Juvenile Justice; placement in treatment facility for sexual offenders; no contact orders; DCBS case opened; report closed as perpetrator has no access; victim removed from the home.

REGIONAL RESPONSE

While we agree that children in these situations need services, we don't believe that CPS involvement in child-on-child abuse is appropriate. CPS' charge is to investigate abuse and neglect by caregivers, and by definition a child under the age of 12 cannot be considered a caregiver. If there are potential neglect issues relating to the circumstances, we do open an investigation or designate the family as a FINSA (Family in Need of Services), and we will continue to offer resources to all families in these situations. We agree that there need to be more services for child perpetrators, particularly those who have not been adjudicated and would support CRP's advocacy for more services and increased public awareness.

Case Closure Sub-Committee

Based on positive feedback from social workers and supervisors, we found that the Jefferson County case closure team is effective in helping DCBS workers close cases to completion and move on to new cases. However, workers expressed a need for expansion or replication of this team to reduce the workload for ongoing teams.

PANEL RECOMMENDATIONS:

We recommend DCBS create additional positions, or another case closure team to reduce the workload for ongoing teams within Jefferson County and to help ensure that all cases are closed in a thorough and timely manner. We would like to see these positions and /or team formed by fall of 2007.

A mechanism needs to be developed by the fall of 2007 to track cases that re-enter the system. This needs to capture why cases re-enter the system so ongoing teams can begin to focus on the issues that impacts a possible increase in their workload.

REGIONAL RESPONSE

The closure team was created as a quality assurance tool. The additional oversight it provides help to ensure that cases cannot be closed if workers haven't taken all the necessary steps to assist the family. Currently, all ongoing cases for younger children (less than 12) are sent to the closure team and the medically fragile and adolescent teams have access to the services offered by the closure team. Jefferson's current plan is to increase the number of staff on the closure team by adding one permanent staff and placing one new employee on the team on a "host" basis. With this additional staff, we will be able to mandate that all Jefferson county cases be sent to the team prior to closing.

CABINET RESPONSE

Since November 2003, DCBS has been tracking the issue of re-entry into out of home care based on expectations from the federal government. Issues of re-entry are being closely followed and data is shared with management staff. In order to expand this tracking to all cases, we will need to define the specific elements that need to be tracked and the time parameters. This effort should include Central Office and local staff in order to determine the most meaningful

tracking mechanism possible. Based on the outcome of these discussions, we will need to create logic in order to incorporate this into existing TWIST data reports.

Jefferson County received a significant grant from the Annie E. Casey Foundation to study issues of re-entry. The study will encompass the entire Jefferson Region during 2007 – 2010. Since its inception in 1992, Family to Family has provided a common framework of child welfare reform for state and local partners and consultants across the United States. Initial work started in Alabama, Maryland, New Mexico, Ohio, and Pennsylvania. By 2000, we added sites in California, Colorado, Illinois, Kentucky, Michigan, New York, North Carolina, Oregon, and Tennessee. More recently, sites have been added in Alaska, Arizona, and Washington. Current programs operate in 17 states and nearly 80 individual sites. Starting in 2007, Family to Family is focusing on a select number of sites to fully implement the initiative and deepen Casey's system reform efforts. Our plan is to concentrate efforts in 15 sites and help them achieve comprehensive change in child welfare services. At the same time, we'll provide limited support to the remaining Family to Family sites to share, exchange, and disseminate their learning while improving the quality of child welfare services nationally. The designated anchor sites for intensive system reform efforts are: Cleveland, Ohio Denver, Colorado Detroit and Macomb County, Michigan Los Angeles, Orange County, Fresno, San Francisco, and Oakland, California Louisville, Kentucky Memphis, Tennessee New York City, New York Phoenix, Arizona Raleigh and Greensboro, North Carolina. For more information about the Family to Family initiative and these sites, contact familytofamily@aecf.org.

SUPPORTING DOCUMENTS C

3. **The following time frames established in administrative regulation 922 KAR 1:330 are used by the assigned SSW to initiate the Investigation or FINSA by making face to face contact with the:**
   (a) **Alleged victim(s) within one (1) hour if the report indicates imminent risk exists;**
   (b) **Alleged victim(s) and family within twenty-four (24) hours if the report indicates non-imminent risk of physical abuse exists; or**
   (c) **Alleged victim(s) and family within forty-eight (48) hours if the report indicates non-imminent risk not involving physical abuse exists.**

SOP 7A.2.3
R. 8/1/07

SEXUAL ABUSE

GENERAL PROVISIONS:

A sexual abuse report is accepted when the reporting source has reason to believe that the parent, guardian, or other person having custodial control or supervision of a child, uses, allows, permits, or encourages the use of the child for the purposes of sexual stimulation of the perpetrator or another person.

SOP 7A.2.2
R.8/1/07

NEGLECT

GENERAL PROVISIONS:

A report of neglect is accepted when the reporting source has reason to believe that the caretaker has failed to protect a child, or has by lack of action, placed a child at risk of harm.

A neglected child is one whose health or welfare is harmed or threatened with harm when his/her caretaker:

- Engages in a pattern of conduct that renders them incapable of caring for the immediate and ongoing needs of the child, including but not limited to, incapacity due to alcohol or other drug abuse;
- Abandons or exploits the child;
- Continuously or repeatedly fails or refuses to provide essential parental care and protection for the child, considering the age of the child;
- Does not provide the child with adequate care, supervision, food, clothing, shelter, education or medical care necessary for the child's well-being.

Imminent risk	Means immediate threat of injury or harm to a child when no interventions have occurred to protect the child. This may include requesting assistance from law enforcement for immediate removal of a child or petitioning the court for an emergency custody order. Additionally, the consults the FSOS and/or regional staff and take other actions to determine that a child is not in danger and that removal is not needed for the child's protection within 24 hours of the initial report. (1)The worker may use the following in determining imminent danger: (a)Children with serious injuries from physical abuse; (b)Children suffering from acute untreated medical condition(s) that demand urgent attention whose parent(s) is refusing to obtain treatment or cannot be located; (c) Self-referral from a parent or guardian who states they are currently unable to cope or feel they may harm their children; (d) Children who express fear of their current circumstances, serious sexual or physical abuse or neglect appear imminent; (e)Children presently receiving bizarre forms of punishment, e.g. locked in closets or tied to a chair or bed; (f)Children at risk of immediate harm from parents who are in a psychotic episode or are behaving in a bizarre manner; (g)Abandoned children who are currently without supervision of a responsible adult; (Abandonment is defined as leaving without any intent to return). (h)Children under 8 years of age who are currently without supervision by a responsible person; (The investigation shall determine the child's level of maturity, development and ability to function safely alone and whether the family has an established plan of action in case of emergency.) (i)Situations involving weapons; or, (h)Other situations which in the judgment of the FSOS and SSW constitute immediate risk to a child.

KRS 620.040 Duties of prosecutor, police, and cabinet -- Prohibition as to school personnel -- Multidisciplinary teams.

(1) (a) Upon receipt of a report alleging abuse or neglect by a parent, guardian, or person exercising custodial control or supervision, pursuant to KRS 620.030(1) or (2), the recipient of the report shall immediately notify the cabinet or its designated representative, the local law enforcement agency or the Department of Kentucky State Police, and the Commonwealth's or county attorney of the receipt of the report unless they are the reporting source.

(b) Based upon the allegation in the report, the cabinet shall immediately make an initial determination as to the risk of harm and immediate safety of the child. Based upon the level of risk determined, the cabinet shall investigate the allegation or accept the report for an assessment of family needs and, if appropriate, may provide or make referral to any community-based services necessary to reduce risk to the child and to provide family support. A report of sexual abuse shall be considered high risk and shall not be referred to any other community agency.

(c) The cabinet shall, within seventy-two (72) hours, exclusive of weekends and holidays, make a written report to the Commonwealth's or county attorney and the local enforcement agency or the Department of Kentucky State Police concerning the action that has been taken on the investigation.

(d) If the report alleges abuse or neglect by someone other than a parent, guardian, or person exercising custodial control or supervision, the cabinet shall immediately notify the Commonwealth's or county attorney and the local law enforcement agency or the Department of Kentucky State Police.

(2) (a) Upon receipt of a report alleging dependency pursuant to KRS 620.030(1) and (2), the recipient shall immediately notify the cabinet or its designated representative.

(b) Based upon the allegation in the report, the cabinet shall immediately make an initial determination as to the risk of harm and immediate safety of the child. Based upon the level of risk, the cabinet shall investigate the allegation or accept the report for an assessment of family needs and, if appropriate, may provide or make referral to any community-based services necessary to reduce risk to the child and to provide family support. A report of sexual abuse shall be considered high risk and shall not be referred to any other community agency.

(c) The cabinet need not notify the local law enforcement agency or the Department of Kentucky State Police or county attorney or Commonwealth's attorney of reports made under this subsection.

(3) If the cabinet or its designated representative receives a report of abuse by a person other than a parent, guardian, or other person exercising custodial control or supervision of a child, it shall immediately notify the local law enforcement agency or the Department of Kentucky State Police and the Commonwealth's or county attorney of the receipt of the report and its contents, and they shall investigate the matter. The cabinet or its designated representative shall participate in an investigation of non custodial physical abuse or neglect at the request of the local law enforcement agency or the Department of Kentucky State Police. The cabinet

shall participate in all investigations of reported or suspected sexual abuse of a child.
(4) School personnel or other persons listed in KRS 620.030(2) do not have the authority to conduct internal investigations in lieu of the official investigations outlined in this section.
(5) (a) If, after receiving the report, the law enforcement officer, the cabinet, or its designated representative cannot gain admission to the location of the child, a search warrant shall be requested from, and may be issued by, the judge to the appropriate law enforcement official upon probable cause that the child is dependent, neglected, or abused. If, pursuant to a search under a warrant, a child is discovered and appears to be in imminent danger, the child may be removed by the law enforcement officer.
(b) If a child who is in a hospital or under the immediate care of a physician appears to be in imminent danger if he or she is returned to the persons having custody of him or her, the physician or hospital administrator may hold the child without court order, provided that a request is made to the court for an emergency custody order at the earliest practicable time, not to exceed seventy-two (72) hours.
(c) Any appropriate law enforcement officer may take a child into protective custody and may hold that child in protective custody without the consent of the parent or other person exercising custodial control or supervision if there exist reasonable grounds for the officer to believe that the child is in danger of imminent death or serious physical injury or is being sexually abused and that the parents or other person exercising custodial control or supervision are unable or unwilling to protect the child. The officer or the person to whom the officer entrusts the child shall, within twelve (12) hours of taking the child into protective custody, request the court to issue an emergency custody order.
(d) When a law enforcement officer, hospital administrator, or physician takes a child into custody without the consent of the parent or other person exercising custodial control or supervision, he or she shall provide written notice to the parent or other person stating the reasons for removal of the child. Failure of the parent or other person to receive notice shall not, by itself, be cause for civil or criminal liability.
(6) To the extent practicable and when in the best interest of a child alleged to have been abused, interviews with the child shall be conducted at a children's advocacy center.
(7) (a) One (1) or more multidisciplinary teams may be established in every county or group of contiguous counties.
(b) Membership of the multidisciplinary team shall include but shall not be limited to social service workers employed by the Cabinet for Health and Family Services and law enforcement officers. Additional team members may include Commonwealth's and county attorneys, children's advocacy center staff, mental health professionals, medical professionals, victim advocates, educators, and other related professionals, as deemed appropriate.
(c) The multidisciplinary team may review child sexual abuse cases referred by participating professionals, including those in which the alleged perpetrator

does not have custodial control or supervision of the child or is not responsible for the child's welfare. The purpose of the multidisciplinary team shall be to review investigations, assess service delivery, and to facilitate efficient and appropriate disposition of cases through the criminal justice system.

(d) The team shall hold regularly scheduled meetings if new reports of sexual abuse are received or if active cases exist. At each meeting, each active case shall be presented and the agencies' responses assessed.

(e) The multidisciplinary team shall provide an annual report to the public of nonidentifying case information to allow assessment of the processing and disposition of child sexual abuse cases.

(f) Multidisciplinary team members and anyone invited by the multidisciplinary team to participate in a meeting shall not divulge case information, including information regarding the identity of the victim or source of the report. Team members and others attending meetings shall sign a confidentiality statement that is consistent with statutory prohibitions on disclosure of this information.

(g) The multidisciplinary team shall, pursuant to KRS 431.600 and 431.660, develop a local protocol consistent with the model protocol issued by the Kentucky Multidisciplinary Commission on Child Sexual Abuse. The local team shall submit the protocol to the commission for review and approval.

(h) The multidisciplinary team review of a case may include information from reports generated by agencies, organizations, or individuals that are responsible for investigation, prosecution, or treatment in the case, KRS 610.320 to KRS 610.340 notwithstanding.

(i) To the extent practicable, multidisciplinary teams shall be staffed by the local children's advocacy center.

Effective: June 26, 2007

History: Amended 2007 Ky. Acts ch. 85, sec. 331, effective June 26, 2007. -- Amended 2005 Ky. Acts ch. 99, sec. 665, effective June 20, 2005. -- Amended 2000 Ky. Acts ch. 14, sec. 63, effective July 14, 2000; ch. 144, sec. 6, effective July 14, 2000; and ch. 164, sec. 1, effective July 14, 2000. -- Amended 1998 Ky. Acts ch. 426, sec. 617, effective July 15, 1998. -- Amended 1996 Ky. Acts ch. 18, sec. 5, effective July 15, 1996. -- Amended 1994 Ky. Acts ch. 217, sec. 1, effective July 15, 1994. – Amended 1992 Ky. Acts ch. 434, sec. 2, effective July 14, 1992. -- Amended 1990 Ky. Acts ch. 39, sec. 1, effective July 13, 1990. -- Amended 1988 Ky. Acts ch. 258, sec. 3, effective July 15, 1988; and ch. 350, sec. 44, effective

KRS 510.020 Lack of consent.
(1) Whether or not specifically stated, it is an element of every offense defined in this chapter that the sexual act was committed without consent of the victim.
(2) Lack of consent results from:
(a) Forcible compulsion;
(b) Incapacity to consent; or
(c) If the offense charged is sexual abuse, any circumstances in addition to forcible compulsion or incapacity to consent in which the victim does not expressly or impliedly acquiesce in the actor's conduct.
(3) A person is deemed incapable of consent when he or she is:
(a) Less than sixteen (16) years old;
(b) Mentally retarded or suffers from a mental illness;
(c) Mentally incapacitated;
(d) Physically helpless; or
(e) Under the care or custody of a state or local agency pursuant to court order and the actor is employed by or working on behalf of the state or local agency.
(4) The provisions of subsection (3)(e) of this section shall not apply to persons who are lawfully married to each other and no court order is in effect prohibiting contact between the parties.
Effective: July 12, 2006
History: Amended 2006 Ky. Acts ch. 182, sec. 30, effective July 12, 2006. -- Amended 1988 Ky. Acts ch. 283, sec. 10, effective July 15, 1988. -- Created 1974 Ky. Acts ch. 406, sec. 82, effective January 1, 1975.

KRS 635.510 Criteria for classification as juvenile sexual offender -- Juvenile sexual offender assessment.
(1) A child, thirteen (13) years of age or older at the time of the commission of the offense, shall be declared a juvenile sexual offender if the child has been adjudicated guilty of an offense listed in KRS 635.505(2)(a), (b), (c), (d), (e), or (f).
(2) (a) A child, less than thirteen (13) years of age, may be declared a juvenile sexual offender if the child has been adjudicated guilty of an offense listed in KRS 635.505(2).
(b) Any child, thirteen (13) years of age or older, may be declared a juvenile sexual offender if the child has been adjudicated guilty of an offense listed in KRS 635.505(2)(g).
(3) Upon final adjudication by the juvenile court under subsection (2) of this section, the juvenile court judge shall order a juvenile sexual offender assessment to be conducted on the child by the Department of Juvenile Justice treatment program or by a qualified professional approved by the program which shall recommend whether the child be declared a sexual offender and receive sexual offender treatment. Upon receipt of the findings of the assessment, the juvenile court judge shall determine whether the child shall be declared a juvenile sexual offender, and, if so, shall initiate a referral to the Department of Juvenile Justice treatment program for treatment.
Effective: July 12, 2006
History: Amended 2006 Ky. Acts ch. 182, sec. 54, effective July 12, 2006. -- Amended 2004 Ky. Acts ch. 160, sec. 7, effective July 13, 2004. -- Amended 2002 Ky. Acts ch. 263, sec. 9, effective July 15, 2002. -- Amended 1998 Ky. Acts ch. 538, sec. 15, effective April 13, 1998. -- Amended 1996 Ky. Acts ch. 358, sec. 62, effective July 15, 1997. -- Created 1994 Ky. Acts ch. 94, sec. 7, effective July 15, 1994.

635.505 Definitions for chapter.

As used in this chapter, unless the context otherwise requires:

(1) The "treatment program" means a continuum of services provided in community and institutional settings designed to provide early intervention and treatment services for juvenile sexual offenders.

(2) A "juvenile sexual offender" as used in this chapter means an individual who was at the time of the commission of the offense under the age of eighteen (18) years who is not actively psychotic or mentally retarded and who has been adjudicated guilty of or has been convicted of or pled guilty to:

(a) A felony under KRS Chapter 510;

(b) Any other felony committed in conjunction with a misdemeanor described in KRS Chapter 510;

(c) Any felony under KRS 506.010 when the crime attempted is a felony or misdemeanor described in KRS Chapter 510;

(d) An offense under KRS 530.020;

(e) An offense under KRS 530.064(1)(a);

(f) An offense under KRS 531.310; or

(g) A misdemeanor offense under KRS Chapter 510.

(3) A "juvenile sexual offender assessment" means an assessment of the child's adolescent social development, medical history, educational history, legal history, family history, substance abuse history, sexual history, treatment history, and recent behaviors, which shall be prepared in order to assist the courts in determining whether the child should be declared a juvenile sexual offender, and to provide information regarding the risk for reoffending and recommendations for treatment.

(4) "Mentally retarded" as used in this section means a juvenile with a full scale intelligent quotient of seventy (70) or below.

Effective: July 12, 2006

History: Amended 2006 Ky. Acts ch. 182, sec. 66, effective July 12, 2006. -- Amended 2002 Ky. Acts ch. 263, sec. 8, effective July 15, 2002. -- Amended 1998 Ky. Acts ch. 538, sec. 14, effective April 13, 1998. -- Created 1994 Ky. Acts ch. 94, sec. 6, effective July 15, 1994.

Governor Fletcher Announces Project Targeting Racial Disparity in Child Welfare System

By Anya Armes Weber

On April 3, Governor Ernie Fletcher and leaders from the Kentucky Cabinet for Health and Family Services (CHFS) announced a comprehensive project to target racial disproportionality and disparate outcomes in the child welfare system. The project targets 11 counties where African-American children are represented in state foster care at more than one and a half times the census rate. These children have on average poorer outcomes in the Chile Welfare System.

The child welfare system includes the community, its people and systems that report abuse and neglect to child protective services and those that respond and provide services.

"We are concerned about the high representation of African-Americans in out-of-home care," Governor Fletcher said. "By studying this inequity and mapping a course to address it, we can ensure that more families are able to improve their home lives and ultimately stay together. "

The Community, Race and Child Welfare Initiative is the result of a two-year effort conducted by the Jefferson Service Region and the Cabinet's Office of Quality Management.

"The significant number of minority children in the child welfare system is a national concern," CHFS Secretary Mark D. Birdwhistell said. "Although this is a complex issue, we are already taking many positive steps to educate staff and community partners to dispel the problem."

To research the disparity, CHFS has worked closely with the nonprofit Casey Family Programs Foundation, a private, national organization that supports child and family organizations.

The studies show that rates of abuse referrals and substantiations and out-of-home care entries for African-American children are higher than would be expected based on state census numbers.
This is particularly true in larger communities. For example, Anglos make up 77 percent of Jefferson County's child population. But only 55 percent of referrals to DCBS in Jefferson County involved Anglo children; 41 percent were African-American and 1 percent was Hispanic. And only 43 percent of out-of home care placements involved Anglo children, while 53 percent were African-American and 3 percent were Hispanic.

Tom Emberton Jr., CHFS' undersecretary for Children and Family Services, said the cabinet will provide cultural competency training for all DCBS staff as one of its first steps.

"In our efforts to keep children safe, we need to be acutely aware of any unintended outcomes for minority families when our studies show their safety risks are the same or even lower than those of Anglo families," he said. "We will take this opportunity to educate staff in cultural diversity, cultural competency and undoing racism."

"These changes will help make all of us more aware of the reasons for and consequences of unintentional racism in the human services system," Emberton said.

CHFS has targeted 11 counties where African-American children are represented in out-of-home care at more than one and a half times the census rates. The counties are: Boyle, Christian, Daviess, Fayette, Graves, Hardin, Jefferson, Kenton, Madison, McCracken and Warren.

Staff from the People's Institute, a national group that provides anti-racism training across the country, will lead seminars in the targeted counties, and will offer the workshop several times in Jefferson County.

The seminars are designed to help participants understand several factors, including the influence of race in determining whether a child is placed in out-of-home care; the factors that affect what services are accessible to black families; and the actual and perceived needs of black families.

The seminars are intended for all human services providers, including community partners, law enforcement, agency contractors and members of local governments. Remaining slots are open to the general public.

For more information on racial disparity and the workshops, log on to http://www.jointheconversation.net/.

"Our struggle for change begins with education," Emberton said. "We'll take our message to the communities most affected by this problem."

Other facets of the plan include expanding the use of parent advocates to mentor families and collaborating with state universities to provide continuing educational opportunities on "How Race Matters."

Emberton said his office has proposed a 2007 budget of $500,000 to provide for administrative costs, education and community outreach materials, training contracts and data management services for the project.

"This is a necessary investment to make the kind of cultural changes that will ensure we equitably treat all families involved with our community based services," he said.

Southern Bluegrass Citizen Review Panel

Jennifer Brown
Nancy Shinn
Heather Schill
Eileen O'Malley
Pam Black
Brandon Rayford
Cynthia Kay
Ellen Burke
Ryan Koch
*Kristen Krebs**
Roseanne O'Connor
Darlene Thomas
Kathleen Cleary
Melanie Tyner-Wilson
Terry Goldfarb

** DCBS Liaison*

The Southern Bluegrass Citizen Review Panel was formed in January of 2007 and had its first meeting on March 2, 2007. The Panel has used the first part of the year to focus on issues which impact the Southern Bluegrass region. A variety of guest speakers have visited with the Panel, including Commissioner Mark Washington, Bruce Linder, Jim Grace, Dr. Ruth Huebner, and Debbie Acker. The Panel has learned about many of the programs being implemented by the Cabinet, including the Child and Family Services Review, new drug and alcohol treatment initiatives, and a special medical training of workers involved in investigating the physical signs of child abuse. The Panel met on August 17, 2007 in Berea to plan their activities for 2007-08.

CABINET RESPONSE

The Cabinet is enthusiastic about the development of the new Southern Bluegrass Panel. The panel shows diversity and has expressed interest in continuing to pursue this as a goal. Panel members have been thorough in their orientation process and have worked to develop a foundation from which to develop projects for the upcoming year. We look forward to continuing to support their efforts through the DCBS Liaison for the panel, Central Office staff support and assistance and through the partnership with the University of Kentucky.