I. Immediate Danger to Home Visitor at Home Visit

II. Family Has History of Domestic Violence / Substance Abuse and Home’s Safety is in Question
   - Power and Control Tactics Characteristic of Domestic Violence Towards Women
   - Common Symptoms of Drug Intoxication
   - Meth Guidance

III. Supervised Visits with a CPS Worker

IV. If Family Regains Custody of Child from CPS

V. Firearms and Ammunition/Weapons

VI. Suicidal Thoughts / Actions

VII. Homicidal Thoughts / Actions

VIII. Mental Illness / Psychiatric Emergencies
   - Bed Bug Guidance

IX. General Safety Guidelines of Home Visitors

Page 1 of 11
Page 1 of 11
Page 2 of 11
Page 2 of 11
Page 3 of 11
Page 4 of 11
Page 4 of 11
Page 4 of 11
Page 4 of 11
Page 4 of 11

Page 7 of 11
Page 8 of 11
Page 9 of 11
Page 10 of 11

Section 8:
HOME VISITATION HEALTH & SAFETY
Section 8: HOME VISITATION HEALTH & SAFETY

Each HANDS Staff should review this section on an annual basis, in conjunction with annual completion of the Code of Ethics.

Each site should have a protocol in place to ensure the safety of Home Visitors (i.e., worker contacting the Supervisor or a designee to report that last visit is complete, if after LHD/agency hours or worker is not required to return to site after last visit; daily schedule available to Supervisor; etc.)

It is of the utmost importance that each staff providing home visitation services gather as much information as possible to determine the safety of themselves and the families. By constantly assessing their surroundings and being provided with any known information (current history and circumstances) that could be considered potentially dangerous, home visitors are better equipped to make decisions that will ensure their immediate safety, as well as the families they serve.

I. When the home visitor feels there is immediate danger at a home visit, he/she must:

   A. LEAVE IMMEDIATELY;

   B. IMMEDIATELY Call:
      1. “911” to request assistance from law enforcement;
      2. CPS (Child Protective Services), if children are in danger;
      3. APS (Adult Protective Services), if an adult is in danger; and
      4. Their HANDS Supervisor to advise him/her of the situation.

   C. Follow up with the family:
      1. As safety permits (after consultation with HANDS Supervisor) to ensure that everyone is safe; and
      2. To assure the parents that you will continue to work with them, if possible, within program guidelines.

II. When a family has a history of domestic violence / substance abuse and the home’s safety is in question, the Supervisor and home visitor will discuss any current threat of violence / substance abuse to determine if the home is a safe environment; and

   A. If the threat of danger is suspected / is uncertain; in which case:
      1. Visits can be staggered between a neutral site and the home until further assessment of safety is determined; and
      2. Must be justified in the chart.

      Note: No more than 25% of the total visits can occur outside the home and cannot occur long term. If documentation continues to indicate that the home is an unsafe environment, then exiting the family from services could occur. The supervisor must be involved in this decision.

   B. If no immediate threat of danger is suspected, but domestic violence / substance abuse is an issue; in which case:
      1. Visits can occur with the family in their home; and
      2. The home visitor can:
         a. Provide the family with local domestic violence / substance abuse resources; and
         b. Make appropriate referrals; and
         c. Encourage the victim to establish outside sources of support to ensure their safety.
8.3 - Power and Control Tactics characteristic of domestic violence towards women:

**USING COERCION AND THREATS**
- Making and/or carrying out threats to do something to hurt her
- Threatening to leave her, to commit suicide, to report her to CPS, Medicaid, KTAP, etc.
- Making her drop charges
- Making her do illegal things

**USING INTIMIDATION**
- Making her afraid by using looks, actions, gestures
- Smashing things
- Destroying her property
- Abusing pets
- Displaying weapons

**USING EMOTIONAL ABUSE**
- Putting her down
- Making her feel bad about herself
- Calling her names
- Making her think she’s irrational
- Playing mind games
- Humiliating her
- Making her feel guilty

**USING ISOLATION**
- Controlling what she does, who she sees and talks to, what she reads, where she goes
- Limiting her outside involvement
- Using jealousy to justify actions

**MINIMIZING, DENYING and BLAMING**
- Making light of the abuse and not taking her concerns about it seriously
- Saying the abuse didn’t happen
- Shifting responsibility for abusive behavior by saying she caused it

**USING CHILDREN**
- Making her feel guilty about the children
- Using the children to relay messages
- Using access visits to harass her
- Threatening to take the children away

**USING PRIVILEGE**
- Treating her like a servant
- Making all the big decisions
- Acting like the master of the castle
- Being the one to define roles
- Putting her down because of race, gender or disability

**USING ECONOMIC ABUSE**
- Preventing her from getting or keeping a job
- Making her ask for money
- Giving her an allowance
- Taking her money
- Not letting her know about or have access to family income

Resource: Domestic Abuse Intervention Project, Duluth, MN.

8.4 - Common symptoms of drug intoxication (Some of these symptoms are often signs of other issues besides substance use):

- Balance problems, difficulty walking, and falls
- Change in mental status
- Changes in mood, personality or behavior
- Diminished reflexes
- Drowsiness or excessive energy
- Impaired balance and coordination
- Impaired judgment and memory
- Impaired vision
- Nausea with or without vomiting
- Pupil size changes
- Slurred speech; excessive talking

Resource: http://www.localhealth.com/article/drug-abuse/symptoms; Better Medicine for Healthgrades, Harvard School of Medicine

Top of the Document
8.5 - Meth Guidance

Methamphetamine is a dangerous drug that poses serious health and environmental dangers. The drug can be manufactured cheaply and easily using household and agricultural chemicals that are very toxic and can explode or ignite without warning. Individuals who work in or near homes where a meth lab is present are extremely vulnerable and at risk for injury. Meth labs can be set up nearly anywhere, but are most commonly found in motel rooms, apartments, and rental properties.

What to Look For:

- Odors
  - Ether-like: aromatic, sweet odor often accompanied by a sweet taste, sometimes described as a ‘hospital’ odor. Nasal irritant.
  - Solvent-like: sweet odor from common solvents used in paint thinners, paint removers, adhesives, and cleaning fluids. Type of odor often found in an auto body shop. Eye and nasal irritant.
  - Ammonia-like: an intense, sharp irritating odor similar to but much stronger than that from wet diapers, glass cleaners, cattle feedlots or fertilizers. Eye and nasal irritant.
- Large amounts of household products:
  - Cold and allergy medicines
  - Anhydrous ammonia
  - Lithium batteries
  - Gas-line additive
  - Table or rack salt
  - Matchbooks
  - Sidewalk deicer
  - Drain cleaner
  - Staring fluid
  - Camping fuel
  - Iodine
- Reddish or purple stained coffee filters
- Plastic soda bottles with chalky substance inside and/or tubing stemming from the caps
- Windows blacked out or covered
- Chemical burns or stains on carpet, linoleum, walls and other household surfaces.

General Safety Precautions:

- If you enter a home and see evidence of a meth lab, leave immediately.
- Home visitors are encouraged to bring a stool along with them on visits. During interaction with the family, it is recommended that the home visitor use the stool rather than sitting on the carpet or furniture.
- Carry disinfectant wipes and/or hand sanitizer, use after the visit, preferably before touching anything in the car.
- Transport items taken in and out of the home in a plastic bag/tote.
- Wipe off items used during the visit, such as toys, materials, etc. with a disinfectant wipe prior to placing them in the bag before departure. Home visitors should explain to the family that the use of disinfectant wipes is a general precaution on all visits to limit the spread of germs.
- Use a plastic tote with a secure lid to transport items in the car to contain materials taken in and out of the home.
- Home Visitors should always have an extra pair of clothes and shoes available. This is helpful in the event the Home Visitor believes he/she has encountered a hazardous material of any type.

Contact exposure to methamphetamines is very slim since “cooking” during a home visit is very unlikely. However, Home Visitors that believe they are at risk for methamphetamine exposure or feel as if they have been exposed are advised to contact their Supervisor immediately and follow the guidelines of the agency.

Resources:
- Meth Abuse: [http://www.meth-abuse.com/Signs Of a Meth Lab.htm](http://www.meth-abuse.com/Signs Of a Meth Lab.htm)
- Meth Information.org: [http://www.methinformation.org/index.html](http://www.methinformation.org/index.html)
Section 8: HOME VISITATION HEALTH & SAFETY

III. When visiting a family during supervised visits with a CPS worker:
   A. The visit may take place at a neutral site; and
   B. The home visitor must document the reason an alternate location for visits is necessary.

IV. If a family regains custody of their child from CPS:
   A. The home visitor and Supervisor should discuss any current threat of violence to determine if the home is a safe environment; and
   B. If the home visitor and Supervisor suspect potential violence in the family’s home:
      1. Visits should occur at a neutral site until the home visitor can assess his/her well being is safe in the home;
      2. The home visitor and Supervisor should discuss the reasons for the unsafe home assessment during weekly supervision sessions;
      3. The home visitor must document the reason an alternate location for visits is necessary; and
      4. The Supervisor can accompany the home visitor on the initial visit upon the baby’s return to the home to help assess the safety of the home.

           Note: No more than 25% of the total visits can occur outside the home and cannot occur long term. If documentation continues to indicate that the home is an unsafe environment, then exiting the family from services could occur. The Supervisor must be involved in this decision.

   C. If the home visitor and Supervisor suspect no threat of violence, visits should occur in the family’s home.

V. When the home visitor views firearms and ammunition/weapons:
   A. Out in the open, and has concerns for his/her own safety, he / she should LEAVE IMMEDIATELY, and follow the protocol outlined in I.A and I.B-2-4 (not B1, unless it is deemed necessary).
   B. In a cabinet that is obviously not locked or the family informs the home visitor that they are not locked, provide education and resources to the parents in regards to keeping firearms and ammunition locked up.

VI. When suicidal thoughts/actions of a family member are a concern of the home visitor:
   A. Follow the protocol outlined in I. A – C, if immediate danger is detected.
   B. For a suicide attempt:
      1. Call “911” for law enforcement assistance;
      2. Apply first aid as appropriate;
      3. Ensure safety of children; and
      4. Consult with supervisor immediately.

---

8.5 - The Childproofing Checklist (ACH-308) is an excellent resource to assist with educating the family if the above circumstance arises. The FSW can use the circumstance as a teachable moment to introduce or revisit the Childproofing Checklist and provide additional resources to the family. It is highly recommended that gunlocks be shared with families if possible (check with your local Sheriff Department, if not available at Health Department site).
Section 8: HOME VISITATION HEALTH & SAFETY

C. For suicidal ideation:

1. Ask the family member if he/she is considering harming him/herself; and

   NOTE: Remember that asking a person about suicide does not make someone more likely to do it.

2. If the participant indicates that he/she feels like harming his/herself, the Home Visitor should ask the participant if he/she has a plan or the means to do so; and,

   a. If the participant reports a plan and has a realistic means (i.e. states that he/she has a gun or pills); and

      1. The Home Visitor has concerns for his/her own safety, he/she should:
         a. Leave immediately; and
         b. Call “911” for law enforcement assistance and DCBS; and
         c. Request that law enforcement and/or a Mental Health Specialist be sent to the participant’s home; and
         d. Report all actions to the Supervisor immediately; and
         e. Document actions on the Service Record (CH 3A).

   2. The Home visitor does not have concerns for his/her own safety:

      a. He/she should inform the participant of the need to contact the regional/statewide hotline or Mental Health Specialist during the visit; and

         1. When the participant accepts the referral, the Home Visitor should:
            a. Assist the participant with contacting the local hotline; and
            b. Stay with the participant during the call; and
            c. As needed, assist the participant with the follow-up suggested by the crisis worker; and
            d. Report all actions taken to the Supervisor within 24 hours; and
            e. Document on the Service Record (CH 3A)

         2. When the participant declines the referral, the Home Visitor should:
            a. Call 911 and DCBS;
            b. Report all actions to the Supervisor immediately; and
            c. Document actions on the Service Record (CH 3A).
Section 8: HOME VISITATION HEALTH & SAFETY

8.6 - PV Process Form A: Family Rights states that HANDS Home Visitors are expected to keep all information provided by the family confidential, with exception (by law) when the participant is:

- Hurting him/herself
- Hurting someone else
- Being hurt by someone
- Needing a referral to First Steps

If the hotline or Mental Health Specialist is not able to provide assistance, call 911.

If phone service is not available at the home, the Home Visitor needs to go where contact with the hotline is possible and return to the home as soon as possible to be with the participant until someone arrives at the location.

b. If he/she does not have plans or means available, and:

1. Has no therapist, discuss importance of this and offer a referral; or
2. Has a mental health provider, have him/her contact the provider immediately and tell therapist about suicidal ideation; and
3. Consult HANDS Supervisor immediately to discuss the situation; and

8.7 - Facts about Suicide

- In the past decade an average of 600 Kentucky citizens have died by suicide annually.
- Kentucky loses three times as many citizens to suicide as to homicide.
- Kentucky’s suicide death rate is the twenty-third highest in the nation (down from tenth in 2007).
- Suicide is the second leading cause of death for Kentuckians who are 15 to 34 years of age.
- Suicide is the fourth leading cause of death for persons who are 35 to 54 years of age.
- 75% of suicide deaths in Kentucky were caused by firearms.
- 90% of those who die by suicide are believed to have a diagnosable psychiatric disorder or substance abuse issue at the time of their death.
- Undiagnosed untreated, or under treated depression is the leading cause of suicide death.
- 60% of those who die by suicide are not in treatment.

Suicide Myths and Facts

**MYTH**
No one can stop suicide, it is inevitable.
Confronting a person about suicide will only make them angry and increase the risk of suicide.
Only experts can prevent suicide.
Suicidal people keep their plans to themselves.
Those who talk about suicide don’t do it.
Once a person decides to complete suicide, there is nothing anyone can do to stop them.

**FACT**
If people in a crisis get the help they need, they will probably never be suicidal again.
Asking someone directly about suicidal intent lowers anxiety, opens up communication and lowers the risk of an impulsive act.
Suicide prevention is everybody’s business, and anyone can help prevent the tragedy of suicide.
Most suicidal people communicate their intent sometime during the week preceding their attempt.
People who talk about suicide may try or even complete an act of self-destruction.
Suicide is the most preventable kind of death and almost any positive action may save a life.
8.8 - Suicide Clues and Warning Signs

Direct Verbal Clues – May include statements like "I've decided to kill myself.", "I wish I were dead.", "I'm going to commit suicide.", "I'm going to end it all.", "If (such and such) doesn't happen, I'll kill myself."

Indirect Verbal Clues – May include statements like "I'm tired of life, I just can't go on.", "My family would be better off without me.", "Who cares if I'm dead anyway.", "I just want out.", "I won't be around much longer.", "Pretty soon you won't have to worry about me."

Behavioral Clues – May include any previous suicide attempt; acquiring a gun or stockpiling pills; co-occurring depression, moodiness, hopelessness; putting personal affairs in order; giving away prized possessions; sudden interest or disinterest in religion, drug or alcohol abuse or relapse after a period of recovery; unexplained anger, aggression and irritability.

Situational Clues – May include being fired or being expelled from school; a recent unwanted move; loss of any major relationship; death of a spouse, child or best friend, especially if by suicide; diagnosis of a serious or terminal illness; sudden unexpected loss of freedom / fear of punishment; anticipated loss of financial security; loss of a cherished therapist, counselor or teacher; fear of becoming a burden to others.

Referral Options

National Suicide Prevention Lifeline 1-800-273-TALK / 1-800-273-8255
Community Mental Health Center and Psychiatric Hospital Crisis Line
Local Survivor of Suicide (SOS) Group

Above information for MHMR Power Point Presentation: Question, Persuade & Refer – QPR:
Suicide Prevention Skills Ask a Question, Save a Life (Jan Ulrich)
NOTE: Updated via information on KY. Suicide Prevention Web Site (June 2013)

VII. When homicidal thoughts/actions of a family member are a concern of the home visitor:

A. For homicidal ideation:
   1. If a family member indicates that he/she feels like harming another person, ask him/her if he/she has a plan or the means to do so; and
      a. If he/she reports a plan or has realistic means (i.e. statements he/she has a gun, poison or other means to kill someone):
         1. Leave immediately (even when home visitor does not think there is immediate harm to self);
         2. Call “911” for law enforcement assistance;
         3. Request that a police officer and/or mental health specialist be sent to the home; and
         4. Consult supervisor immediately to discuss the situation.
      b. If he/she does not have a plan; and
         1. Has a mental health provider, have him/her contact the provider immediately and tell therapist about homicidal ideation.
         2. Has no therapist, discuss importance of this and offer a referral.
   2. Regardless of whether the family member has a plan or means to harm another:
      a. The Home visitor must contact his/her HANDS Supervisor immediately; and
      b. The Home visitor has a duty to warn the potential victim:
         1. By contacting law enforcement immediately and providing them with any information they may have about the potential victim (if known).
Section 8: HOME VISITATION HEALTH & SAFETY

VIII. When mental illness / psychiatric emergencies of a family member are a concern of the home visitor:

A. Follow the protocol outlined in I. A – C, if immediate danger is detected

B. **Never transport a person in a mental health crisis.**

C. If home visitor has prior knowledge of mental illness:
   1. A signed release to talk with the person’s treating mental health specialist should be obtained so that the home visitor can get information on the illness, risks, symptoms, etc.
   2. And a crisis occurs:
      a. Follow the protocol outlined in I. A - C, AND
      b. Alert the treating therapist if you have a signed consent.
   3. And there is no immediate danger:
      Encourage the family member to contact his/her therapist.
      a. Make the necessary referrals for a professional assessment if
      b. he/she does not already have a therapist/psychiatrist

D. If there is immediate danger to the child(ren) in the home or others in the family, contact CPS.

---

8.9 - Signs and Symptoms of Acute Mental Instability and Possible Risk:

1. Suicidal ideation, threats, attempts.
2. Homicidal ideation, threats, attempts.
3. Hallucinations: auditory, visual, or tactile (voices, visions, or sensations that are internal only but perceived as coming from an external source)
4. Delusions (unshakeable, persistent belief that something is true even in the face of evidence that it is not true, or even impossible).
5. Severely disorganized or bizarre behavior.
6. Extreme lethargy, catatonic state (unresponsive).
7. Severe deterioration in day-to-day hygiene and functioning.
8. Significant change in eating and/or sleeping patterns.
9. Loss of interest in daily activities.
10. Feelings of hopelessness, helplessness.
11. Severely disorganized or bizarre speech, incoherence, pressured speech.
12. Very rapid mood changes and extremes of mood (e.g. excessive crying).
13. Dangerous or severely risky behavior.
15. Self-injurious behavior.
16. Use of drugs and/or alcohol with prescribed medications or in place of medications.
17. Stopping medications without MD knowledge or approval.

Some of these symptoms may be present as part of illness, but if they are new, worse, or in any way frightening, then the home visitor should assume that there is a risk and follow procedures outlined in I. A – C (page 1).

---

**THE HOME VISITOR SHOULD DISCUSS FEARS OR CONCERNS FOR SAFETY IN ANY OTHER REGARD WITH A SUPERVISOR. The Home Visitor’s safety is another reason why weekly supervision sessions are of great importance.**
8.10 - Bed Bug Guidance

There has been a resurgence of bed bugs in recent years. Based on reports from local Health Departments and pest control operators, bed bug infestations have occurred in hotels, nursing homes, public housing, apartment complexes, moving vans, jails, furniture rental stores, dormitories and other multi-unit dwellings, as well as single-family homes. The bugs are efficient hitchhikers and usually transported on luggage, clothing, beds, furniture or other items. Acquiring secondhand beds, couches and furniture is another way that the bugs are transported into previously non-infested dwellings. Bed bugs can also be carried in on a person’s clothing or shoes, resulting in an infestation. As Home Visitors, it is important to take preventative measures to decrease the chances of transporting bed bugs into your work place and/or home.

**General Facts:**
- Bed bugs are not known to spread disease, and therefore should not be considered a medical or public health hazard.
- Bed bugs are wingless, they do not fly or jump like fleas.
- Their presence is not determined by the cleanliness of the living conditions where they are found.
- Infestations usually occur around or near the areas where people sleep.
- They can live several months without a blood meal.
- The best way to prevent bed bugs is regular inspection for the signs of an infestation.

**What to Look For:**
- Bugs about ¼ inch long with reddish-brown, oval flattened bodies (easily mistaken for ticks or roaches)
- Bite marks on the face, neck, arms and hand (may take as long as 14 days to show up) or any other body parts while sleeping
- Rusty-colored blood spots due to their blood-filled fecal material that they excrete on the mattress or nearby furniture
- A sweet musty odor

**General Precautions:**
- Home visitors are encouraged to bring a stool or a blanket with them on visits. During interaction with the family, it’s recommended that the home visitor use the stool or blanket to sit on rather than the carpet or furniture.
- Light colored clothing should be worn.
- Items taken in and out of the home should be transported in a sealable plastic bag/tote.
- Items used during the visit such as toys, materials, etc. should be wiped with a disinfectant wipe prior to placing them in a bag before departure. Home visitors should explain to the family that this is done as a general precaution to limit the spread of germs, bugs, etc. (Disinfectant wipes will not prevent the spread of bed bugs unless they wipe off any eggs the object may have come in contact with.)
- Only take the items needed for the visit into the home. Things should be taken out as needed, keeping additional items stored in a sealable plastic bag/tote while not in use.
- A plastic tote with a secure lid should be used to transport items in the car to contain items taken to and from the home.
- Home visitors are encouraged to use a metal or plastic clipboard for paperwork.
- Home visitors should briefly inspect their shoes and clothing upon returning to their car after the visit.
- Home visitors should have an extra pair of clothes and shoes available, in their car, in the event they believe they have come into contact with an infestation.

**Exposure Protocol:**
- Home visitors that believe they are at risk for beg bug exposure should notify their supervisor immediately and follow the guidelines of their agency.

**Resources:**
Guidelines for Reducing the Risk of Transporting Bed Bugs for Social Service Employees Who conduct Home Visits


Reducing the Risk of Transporting Bed Bugs – guidelines for Home Visits

UK Cooperative Extension Service; Bed Bugs [http://www.ca.uky.edu/entomology/entfacts/ef636.asp](http://www.ca.uky.edu/entomology/entfacts/ef636.asp)


Safety precautions must be considered when making home visits to families in your community. Always act in accordance with your agency’s policies and HANDS policies for home visitation. Refer to Kentucky statutes that address your right to protect yourself: KRS 503.050 and KRS 503.070 (see following pages).

When making home visits, consideration should be given to the following:

- Develop a plan for your home visits and gather as much information as possible about the family and their support system. Get specific instructions from the family in regards to entry prior to the visit.
- Let someone in your agency know your schedule and expected duration for each home visit. If your schedule changes, let someone in your agency know of your change in plans.
- If the home is in an unsafe area, go in daylight hours and have specific instructions as to the location of the home. Leave a copy of specific directions to the home with your supervisor or appropriate office staff.
- Dress conservatively and carry an ID.
- Lock your purse in the car and carry a cell phone.
- Park your car as close as possible to the home. Park with the vehicle heading out, so exiting location will not require backing out or turning around; but will facilitate quicker departure. Make sure to carry your car key ring in the palm of your hand with the key projecting through your fingers. Consider placing a whistle on your key ring.
- Always be aware of your surroundings. On arrival to the visits: stop and listen; always knock and announce your name, agency, and reason for the visit; wait to be invited into the home; be respectful. Take note of exit routes. Find out who is in the home during the visit. Use all your senses to determine potential safety hazards in the home.
- Be cautious of animals, dogs, etc., even if they appear to be restrained in some manner. Pay attention to ‘Beware of Dog’ signs. If an animal(s) is loose when arriving at / leaving home visit and pose(s) a threat to your safety, ask that the animal be restrained / removed so visits can take place.
- Monitor body language. Signs of anger, anxiety, or paranoia can be signs of personal instability and a potential danger to your safety. Maintain a safe distance.
- If you suspect any illegal activity prior to your home visit, report it to the proper authorities. Ask a law enforcement official to accompany you on the visit.
- Tactfully remove yourself from the home immediately if you are in doubt of your safety (i.e. “I need to get something from my car.”)
- Be prepared for emergencies (i.e. place a first aid kit, disposable gloves, blanket, etc. in your car).
- Report safety concerns to appropriate agencies.
  a. Your local Health Department administrator and immediate supervisor
  b. Cabinet for Health and Family Services
  c. Police Department
  d. Fire Department
  e. Landlords/property owners

NOTE: Do not attempt to inspect the trash bags on the premises. If you are in the process of the home visit and the members of the household exhibit unsafe behavior, or if you identify any of the above, leave immediately.
KRS 503.050
Use of physical force in self-protection – Admissibility of evidence of prior acts of domestic violence and abuse.

(1) The use of physical force by a defendant upon another person is justifiable when the defendant believes that such force is necessary to protect himself against the use or imminent use of unlawful physical force by the other person.

(2) The use of deadly physical force by a defendant upon another person is justifiable under subsection (1) only when the defendant believes that such force is necessary to protect himself against death, serious physical injury, kidnapping, sexual intercourse compelled by force or threat, felony involving the use of force, or under those circumstances permitted pursuant to KRS 5403.055.

(3) Any evidence presented by the defendant to establish the existence of a prior act or acts of domestic violence and abuse as defined in KRS 403.720 by the person against whom the defendant is charged with employing physical force shall be admissible under this section.

(4) A person does not have a duty to retreat prior to the use of deadly physical force.

Effective: July 12, 2006

KRS 503.070
Protection of another.

(1) The use of physical force by a defendant upon another person is justifiable when:
   (a) The defendant believes that such force is necessary to protect a third person against the use of imminent use of unlawful physical force by the other person; and
   (b) Under the circumstances as the defendant believes them to be, the person whom he seeks to protect would himself have been justified under KRS 503.050 and 503.060 in using such protection.

(2) The use of deadly physical force by a defendant upon another person is justifiable when:
   (a) The defendant believes that such force is necessary to protect a third person against imminent death, serious physical injury, kidnapping, sexual intercourse compelled by force or threat, or other felony involving the use of force, or under those circumstances permitted pursuant to KRS 503.050 and 503.060 in using such protection.
   (b) Under the circumstances as they actually exist, the person whom he seeks to protect would himself have been justified under KRS 503:050 and 503.060 in using such protection.

(3) A person does not have a duty to retreat if the person is in a place where he or she has a right to be.

Effective: July 12, 2006