



Kentucky Child Fatality And Near Fatality External Review Panel

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2017 Annual Update

Program Review And Investigations Committee

Kentucky Legislative Research Commission

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Kentucky Child Fatality And Near Fatality External Review Panel

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Abstract

KRS 6.922 requires that the Program Review and Investigations Committee conduct an annual evaluation of the Child Fatality and Near Fatality External Review Panel. The panel, which has 15 voting and 5 ex officio members, is attached administratively to the Justice and Public Safety Cabinet. The independent panel's charge is to conduct comprehensive reviews of child fatalities and near fatalities reported to the Cabinet for Health and Family Services that are suspected to be a result of abuse or neglect. The panel is in compliance with its governing statutes. Lack of staff has hampered the panel's capacity to aggregate trend data from a large volume of records and information. This concern has been addressed by an appropriation by the 2014 General Assembly of \$420,000 per fiscal year that will be dedicated to the panel beginning July 1. The panel appears to be distinctive in terms of its organizational structure and mission compared to other states.

Foreword

Numerous people provided assistance throughout the study. Program Review staff acknowledge specifically the valuable help provided by

- members of the Child Fatality and Near Fatality External Review Panel, especially Chair Roger Crittenden;
- panel facilitator Tom Cannady;
- staff and officials of the Cabinet for Health and Family Services, especially Commissioner Teresa James, Colleen Hagan, Dana Nickles, Dr. Ruth Shepherd, and Tina Webb; and
- Corey Buckman of the Commonwealth Office of Technology.

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Legislative Research Commission
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Summary

Beginning in 2014, the Program Review and Investigations Committee is required by KRS 6.922 to evaluate the Child Fatality and Near Fatality External Review Panel annually.

The panel was codified by the General Assembly as of June 2013 in KRS 620.055(1), which says
An external child fatality and near fatality review panel is hereby created and established for the purpose of conducting comprehensive reviews of child fatalities and near fatalities, reported to the Cabinet for Health and Family Services, suspected to be a result of abuse or neglect. The panel shall be attached to the Justice and Public Safety Cabinet for staff and administrative purposes.

The panel has not determined its definition of *near fatality*. KRS 600.020(38) defines a *near fatality* as an injury that, as certified by a physician, places a child in serious or critical condition.

This initial Program Review report focuses on describing the background and organization of the panel, the panel's compliance with its governing statutes, and how it has done its work so far. The panel's 2014 annual report, due in December, and its impact will be evaluated as part of next year's Program Review study.

The panel, attached to the Justice and Public Safety Cabinet for staff and administrative purposes, has 15 voting members and 5 ex officio nonvoting members. Ten voting members are appointed by the attorney general, all but one from a list of names provided by specified entities.

The panel is in compliance with its governing statutes. The panel noted in its *2013 Annual Report* that its recommendations should be based on trend data gathered from reviewing a large number of cases. The panel's ability to formalize its process and tasks has been hampered by a lack of staff to assist it. The volume of material associated with each case has made it difficult for panel members to consider how best to create the necessary process for analyzing case information. The volume of material provided by the Cabinet for Health and Family Services (CHFS) is, however, vital to the panel's assessment of case trends. This concern has been addressed by an appropriation by the 2014 General Assembly of \$420,000 per fiscal year that will be dedicated to the panel beginning July 1. Thus, the panel's capacity will change significantly this year with the use of staff dedicated to assisting with its charge.

Panel members use an electronic case management system to read, comment on, and discuss cases with other panel members online. The system—SharePoint—is a secure site that panel members can access from their own computers. CHFS uploads its case records, both substantiated and unsubstantiated, into SharePoint. Statute requires that CHFS provide the records in unredacted form and that it provide additional unredacted records, upon panel request, from a lengthy list in KRS 620.055(6). In FY 2013, CHFS investigated 115 cases of child fatalities or near fatalities suspected to be due to abuse or neglect. The panel is currently continuing to review selected cases from that group.

Kentucky also has a State Child Fatality Review Team, which was established by the Department for Public Health. In comparison to that team and teams in seven states selected for review, the Kentucky Child Fatality and Near Fatality External Review Panel appears to be distinctive in terms of its organizational structure and mission. Colorado does have a team with a similar mission.

Kentucky Child Fatality And Near Fatality External Review Panel

In July 2012, Governor Beshear issued an executive order creating a Child Fatality and Near Fatality External Review Panel. The panel's purpose was to conduct comprehensive reviews of child fatalities and near fatalities determined to be due to child abuse or neglect. Statute defines *near fatality* as an injury that, as certified by a physician, places a child in serious or critical condition. The panel did not determine whether to use a different operational definition. The independent review panel was attached to the Justice and Public Safety Cabinet for staff and administrative purposes (E.O. 2012-585).

The General Assembly established a Child Fatality and Near Fatality External Review Panel in 2013.

In June 2013, the General Assembly codified the panel and its structure under House Bill 290. It established a Child Fatality and Near Fatality External Review Panel to conduct comprehensive reviews of child fatalities and near fatalities that are reported to the Cabinet for Health and Family Services and suspected to be a result of abuse or neglect. The independent review panel continued to be attached to the Justice and Public Safety Cabinet for staff and administrative purposes (KRS 620.055(1)).

Major Conclusions

This report has three major conclusions.

This report has three major conclusions.

- The Child Fatality and Near Fatality External Review Panel is complying with its governing statutes.
- The panel appears to be distinctive in terms of its organizational structure and mission.
- The \$420,000 annual appropriation to the panel, to be used primarily for staff, should allow the panel to review cases and make recommendations more effectively.

About This Report

Beginning in 2014, the Program Review and Investigations Committee is required by statute to evaluate the panel annually.

Beginning in 2014, the Program Review and Investigations Committee is required by KRS 6.922 to evaluate the Child Fatality and Near Fatality External Review Panel annually. At its December 11, 2013 meeting, the committee voted to undertake the evaluation as one of its studies.

The capability of the panel will change significantly this year with the addition of panel staff. This initial Program Review report will focus on describing the background and organization of the panel, the panel's compliance with its governing statutes, and how it has done its work so far. The panel's report for 2014 is not due until December. That report and its impact will be evaluated as part of next year's Program Review study.

There will be major issues related to evaluating the panel in future years. First, the Kentucky Child Fatality and Near Fatality External Review Panel appears to be distinctive, with limited similar organizations for comparison.

Second, any child fatality or near fatality is a tragedy, but as shown in Table 1, they are rare relative to the thousands of cases of reported abuse and neglect. It will often be the case that factors involved in a fatality or near fatality will also be factors in a large number of other cases. This makes the task of preventing fatalities and near fatalities especially difficult. The rarity of fatalities and near fatalities will also affect any evaluation of the work of the panel in the short term. Ultimately, the success of the panel—or any preventive measure—will be a reduction in the number of fatalities and near fatalities. Because they are rare, however, the number of fatalities and near fatalities in any state can vary significantly by year. An increase or decrease in a single year is unlikely to be a valid measure of a preventive measure's level of success.

Table 1
Kentucky Fatalities And Near Fatalities Resulting From Substantiated Abuse Or Neglect
Fiscal Year 2009 To Fiscal Year 2012

	2009	2010	2011	2012	Average
Fatalities	29	35	31	32	32
With Protection and Permanency history	15	23	17	11	17
Near fatalities	60	51	48	44	51
With Protection and Permanency history	35	26	25	28	29
Children involved in cases with substantiated abuse and neglect	14,475	15,092	15,510	15,699	15,194
% of cases with fatality or near fatality	0.61%	0.57%	0.51%	0.48%	0.54%

Source: Compiled by Program Review staff from Kentucky. Cabinet for Health and Family Services. Division of Protection and Permanency. *Child Abuse and Neglect Annual Report of Fatalities and Near Fatalities*. Sept. 1, 2013.

Organization Of The Panel

The panel, attached to the Justice and Public Safety Cabinet for staff and administrative purposes, has 15 voting members and 5 ex officio nonvoting members. Ten voting members are appointed by the attorney general, all but one from a list of names provided by specified entities.

The Child Fatality and Near Fatality External Review Panel is an independent panel attached to the Justice and Public Safety Cabinet for staff and administrative purposes (KRS 620.055(1)).

Members

The panel has 15 voting members and 5 ex officio nonvoting members. Panel members are not paid. Initial terms were staggered to provide continuity.^a Upon expiration of these initial terms, successors will serve terms of 2 years. Nonvoting members are eligible for reappointment, and vacancies are filled in the same manner as the original appointments (KRS 620.055(3)).

The five ex officio nonvoting panel members are

- the chairs of the House and Senate Health and Welfare Committees,
- the commissioner of the Department for Community Based Services,
- the commissioner of the Department for Public Health, and
- a family court judge appointed by the chief justice of the Kentucky Supreme Court (KRS 620.055(2)).

Table 2 provides information on the 15 voting panel members. Ten voting members are appointed by the attorney general, all but one from a list of names provided by specified entities. Appendix B lists current panel members.

^a Five voting members were appointed for terms of 1 year, five voting members were appointed for terms of 2 years, and five voting members were appointed for terms of 3 years.

Table 2
Voting Members Of The Child Fatality And Near Fatality External Review Panel

Title	Appointing Authority	Qualifications
At-large representative who shall serve as chair	Secretary of state	
Pediatrician from Univ. of Ky. Dept. of Pediatrics	Attorney general from a list of three names provided by the dean of the Univ. of Ky. School of Medicine	Licensed and experienced in forensic medicine relating to child abuse and neglect
Pediatrician from Univ. of Louisville Dept. of Pediatrics	Attorney general from a list of three names provided by the dean of the Univ. of Louisville School of Medicine	Licensed and experienced in forensic medicine relating to child abuse and neglect
The state medical examiner or designee		
Director of Court-Appointed Special Advocate (CASA) program	Attorney general from a list of three names provided by the Ky. CASA Assn.	
Peace officer	Attorney general from a list of three names provided by commissioner of State Police	Experience investigating child abuse and neglect fatalities and near fatalities
Representative from Prevent Child Abuse Kentucky Inc.	Attorney general from a list of three names provided by president of board of directors of Prevent Child Abuse Kentucky Inc.	
Practicing local prosecutor	Attorney general	
Executive director of Ky. Domestic Violence Assn.		
Chair of State Child Fatality Review Team		
Practicing social work clinician	Attorney general from a list of three names provided by Board of Social Work	
Practicing addiction counselor	Attorney general from a list of three names provided by Ky. Assn. of Addiction Professionals	
Representative from Family Resource and Youth Services Centers	Attorney general from a list of three names submitted by Cabinet for Health and Family Services	
Representative of a community mental health center	Attorney general from a list of three names provided by Ky. Assn. of Regional Mental Health and Mental Retardation Programs Inc.	
Member of a citizen foster care review board	Chief justice of Ky. Supreme Court	

Source: KRS 620.055(2)

Independence

Although the panel is attached administratively to the Justice and Public Safety Cabinet, and the cabinet has been providing existing cabinet staff to assist the panel, the cabinet states that it takes no role in panel operations.¹

A memorandum of understanding between the Justice and Public Safety Cabinet and the Child Fatality and Near Fatality Review Panel states that the panel was established to be external to the Justice and Public Safety Cabinet and independent of the executive branch. The document describes ways in which the panel's independence is guaranteed.

“Memorandum of Understanding Between the Justice and Public Safety Cabinet and the Child Fatality and Near Fatality Review Panel,” adopted by the panel at its May 19, 2014, meeting, states that the panel was established to be external to the Justice and Public Safety Cabinet and independent of the executive branch. The memorandum of understanding (MOU) recognizes that several agencies within the Justice and Public Safety Cabinet may have had involvement in cases reviewed by the panel. In addition, some panel members are also cabinet employees. Thus, the panel’s case reviews could involve scrutinizing the actions of Justice and Public Safety Cabinet employees as well as other employees of state and local government. Cabinet employees sometimes perform tasks for the panel and may be asked to attend closed sessions the panel might hold. The MOU establishes that discussions that occur during closed sessions will not be divulged by cabinet employees.²

The MOU describes ways in which the panel’s independence is guaranteed.

- KRS 620.055 describes the panel as “external.”
- The panel is a multidisciplinary group of individuals from each branch of state government, from local government, from private nonprofits, from universities, and from the community.
- No panel members are appointed by the governor or secretary of the Justice and Public Safety Cabinet.
- Any Justice and Public Safety Cabinet employee assigned to assist the panel performs those responsibilities solely under the direction of the panel chair.
- The panel has control over its information technology equipment and use and works directly with the Commonwealth Office of Technology.
- The panel uses a letterhead that reflects its position as an independent entity with independent authority and responsibilities.³

The MOU provides for the need for administrative information to be provided to the cabinet by the panel, including budget requests and financial expenditures. The panel will provide its budget request to the Justice and Public Safety Cabinet. The cabinet will operate as a pass-through and will submit the panel’s budget to the

Office of the State Budget Director without prioritization. The panel is responsible for demonstrating its budgetary needs to the executive branch and to the General Assembly.⁴

One provision of note in the MOU is that the panel agrees to give advance notice to the secretary of the Justice and Public Safety Cabinet of any appearances by a panel representative to testify before a legislative or other policy-creating body concerning panel activities. The MOU states that “the notice will be provided in a manner that ... will not disturb the panel’s independence.”⁵

Another area relating to the panel’s independence is the overlap between panel members and several state government cabinets. Two panel members—the state medical examiner and a peace officer from the State Police—are employees of the Justice and Public Safety Cabinet. Panel members employed by the Cabinet for Health and Family Services (CHFS), which provides the cases the panel reviews, are the chair of the State Child Fatality Review Team and a representative from the Family Resource and Youth Services Centers. The commissioner of the CHFS Department for Community Based Services (DCBS) and the commissioner of the CHFS Department for Public Health are ex officio nonvoting members, but they participate in reviewing cases from CHFS as part of the panel’s routine review process.

Panel members, including those not associated with the cabinets, indicated that the panel’s composition and diversity are strengths because they help panel members determine what information might be missing from materials and what might still be needed to clarify cases.⁶ Another panel member connected to CHFS noted that the panel is considered a panel of experts, not just an external panel, and thus it remains independent because CHFS staff members are simply contributing their expertise in their role as panel members. Both panel members and cabinet-level staff noted the value of this external review panel in which experts can share information.⁷

CHFS staff noted that the DCBS commissioner’s role on the panel is to be transparent about the challenges the agency faces and to be a resource for the panel. The DCBS commissioner can educate the panel about the work of the department and how to work collaboratively with it, thus providing additional expertise to other panel members.⁸

Panel members and CHFS staff expressed the hope that the panel will identify needed systemic changes. Cases often do not involve

a single agency; a chain of events can involve courts, police, pediatricians, schools, and others and is thus a community-level problem. The panel has already identified trends. For example, better outcomes occur when DCBS and police work together more effectively. Such insights from a variety of panel members can help ensure that this information sharing takes place in regions statewide.⁹

The chair of the Department for Public Health's State Child Fatality Review Team noted that the department is eager to review case surveillance. The state review team chair's membership on the committee facilitates

- coordination of the work of the State Child Fatality Review Team with that of the panel and
- coordination in determining a consensus definition of child abuse, which would in turn help the Department for Public Health in its determination of the number of child deaths due to abuse.¹⁰

Compliance With Governing Statutes

Purpose

Statute requires that the panel conduct "comprehensive reviews of child fatalities and near fatalities, reported to the Cabinet for Health and Family Services, suspected to be a result of abuse or neglect."

The statutory requirements for the Child Fatality and Near Fatality External Review Panel's charge, codified in June 2013 by KRS 620.055, are few and broadly stated. What the panel should accomplish is mostly at the panel's discretion.

Statutory requirements are that the panel shall

- conduct "comprehensive reviews of child fatalities and near fatalities, reported to the Cabinet for Health and Family Services, suspected to be a result of abuse or neglect" (KRS 620.055(1)) and
- "publish an annual report ... consisting of case reviews, findings, and recommendations for system and process improvements to help prevent child fatalities and near fatalities that are due to abuse and neglect" (KRS 620.055(10)).

Much of the panel's work to date has involved identifying how best to meet this broad purpose. The panel has developed a systematic process for assigning the review of specific cases closed by CHFS to one of four groups of panel members. Panel members discuss all assigned cases in detail at formal panel meetings held every other month.

The panel has engaged in extensive discussions at its meetings as to how best to systematize a process for assessing trends and patterns in the cases that come before it. Such a process will enable the panel to recommend specific and systemic changes needed to reduce the number of child fatalities and near fatalities due to abuse or neglect. The panel has not yet formally adopted recommendations concerning this process other than the recommendations contained in its 2013 report.

The panel's ability to formalize its process and tasks has been hampered by a lack of staff to assist it. This concern has been addressed by an appropriation by the 2014 General Assembly of \$420,000 per fiscal year that will be dedicated to the panel beginning July 1. These funds will be used to hire staff to review case material, determine which cases the panel should review, develop methods for analyzing data, and aggregate trend data for the panel's use.

The panel's ability to formalize its process and tasks has been hampered by a lack of staff to assist it. Panel members are volunteers, most of whom have full-time positions in other capacities. The volume of material associated with each case has made it difficult for panel members to keep up with its case reviews while considering how best to create the necessary process for analyzing case information in the aggregate. The volume of material provided by CHFS is, however, vital to the panel's assessment of cases.

This concern has been addressed by an appropriation by the 2014 General Assembly of \$420,000 per fiscal year that will be dedicated to the panel beginning July 1, 2014. These funds will primarily be used for panel staff to review all case material, determine which cases the panel should review, develop methods for analyzing data, and aggregate trend data for the panel's use. No formal decisions have been made about staffing, but the panel anticipates that relevant staff will

- be able to abstract data from the complex cases to create summary information for the panel's review process,
- be able to read and interpret medical or social service records,
- be knowledgeable of medical data and information that is significant in identifying child abuse, and
- have experience with child protection and law enforcement investigations and reports.¹¹

Meetings

Statute requires the panel to meet at least quarterly. The panel has exceeded this requirement.

The panel is required to meet at least quarterly (KRS 620.055(4)). The panel has exceeded this requirement by meeting at least every other month since June 2013.^{b 12}

^b In 2013, the panel met in July, September, November, and December. In 2014, it met in January, March, and May and is scheduled to meet in July, September, and November.

The panel is required to post updates after each meeting to the Justice and Public Safety Cabinet's website regarding case reviews, findings, and recommendations. It has done so for all 2013 meetings by posting the minutes of panel meetings. Minutes for the panel's 2014 meetings are available from the panel facilitator but cannot be posted to the cabinet's website as it undergoes revision.

The panel is required to post updates after each meeting to the Justice and Public Safety Cabinet's website regarding case reviews, findings, and recommendations (KRS 620.055(8)). It has done so for all 2013 meetings by posting the minutes of panel meetings, which contain the requisite information.¹³ Minutes for the panel's 2014 meetings are available from the panel facilitator but have not yet been posted on the cabinet's website. The website is under revision at the state level, meaning minutes cannot be posted at this time.¹⁴

The panel is required to report a summary of its discussions and proposed or actual recommendations to the Interim Joint Committee on Health and Welfare monthly or at the request of a committee co-chair (KRS 620.055(9)). At present, the panel posts the summaries on the Justice and Public Safety Cabinet website. It is unclear whether the online posting of the meeting summaries fulfills this requirement. Statute calls for a summary to be reported monthly, but the panel is required to meet only quarterly.

The panel has posted summaries on the Justice and Public Safety Cabinet website of each of its 2013 meetings through November. The December 2013 publication of the panel's annual report and its subsequent presentation of that report to the committee may be considered to have fulfilled the summary requirement for its December 2013 meeting. Summaries of the panel's 2014 meetings are available from the panel facilitator but have not yet been posted on the cabinet's website because the website is under revision at the state level, meaning summaries cannot be posted at this time.¹⁵

Annual Report

The panel is required to publish a report by December 1 of each year consisting of case reviews, findings, and recommendations for system and process improvements to help prevent child fatalities and near fatalities that are due to abuse and neglect. The panel has met this requirement.

The panel is required to publish a report by December 1 of each year consisting of case reviews, findings, and recommendations for system and process improvements to help prevent child fatalities and near fatalities that are due to abuse and neglect. The report must be submitted to the governor, the secretary of CHFS, and the director of the Legislative Research Commission for distribution to the Health and Welfare Committee and the Judiciary Committee (KRS 620.055(10)).

The panel met this requirement with its *2013 Annual Report*. The panel was scheduled to present the report's results to the Interim Joint Committee on Health and Welfare in December 2013. That meeting was canceled, so the panel presented the report to the House Standing Committee on Health and Welfare on January 9, 2014.¹⁶

Destruction Of Case Records

Statute requires that all copies of information and records provided to the panel involving an individual case must be destroyed by the Justice and Public Safety Cabinet.

At the conclusion of the panel's examination, all copies of information and records provided to the panel involving an individual case must be destroyed by the Justice and Public Safety Cabinet (KRS 620.055(11)).

All FY 2013 and FY 2014 case information is in electronic form. Once the panel has made a final determination regarding a case, case files will be permanently removed from SharePoint, software used by panel members to review cases. At present, the panel's comments are expected to be left in SharePoint. So far, no cases have been removed from SharePoint because the panel has not voted on findings for FY 2013 or FY 2014 cases. The panel facilitator anticipates that case information will not be removed from SharePoint until late 2014 because the panel is still working with FY 2013 cases and has not made recommendations for its annual report for 2014.¹⁷

The first cases reviewed by the panel after its creation by executive order were from FY 2012. Because all were in paper form, it was more expedient to allow individual panel members to shred those documents at their offices than to arrange to return them to a central location. The panel facilitator distributed a document for panel members to sign attesting to when they destroyed their first year's review work and cases.¹⁸

Confidentiality And Transparency

Statute allows all information obtained by the Cabinet for Health and Family Services (CHFS) regarding both substantiated and unsubstantiated reports of suspected child abuse or neglect to be divulged to the panel in unredacted form. The panel may also receive unredacted information from other specified sources.

Kentucky statute allows all information obtained by CHFS regarding both substantiated and unsubstantiated reports of suspected child abuse or neglect to be divulged to the Child Fatality and Near Fatality External Review Panel in unredacted form. It also allows all information developed by a children's advocacy center regarding cases that come to its attention to be disclosed to the panel in unredacted form. Further, it allows the panel to receive unredacted identifying information from oral or written reports of suspected child abuse or neglect made to a local law enforcement agency, the Kentucky State Police, CHFS, or a commonwealth's attorney or a county attorney (KRS 620.050(5), (6), (11); KRS 620.030).

Statutory requirements related to handing of information and meetings are in KRS 620.055(11) to 620.055(14).

Information and records received by the panel that are confidential under state or federal law are not considered to be the panel's information and records. Thus, they do not lose their confidential status or become public records.

Information and records received by the panel that are confidential under state or federal law are not considered to be the panel's information and records. Thus, they do not lose their confidential status or become public records subject to the Kentucky Open Records Act as a result of being provided to the panel. Open records requests for the information must be made to the appropriate agency responsible for maintaining the original information and records used to generate the copies provided to the panel.

Portions of the panel meetings during which an individual child fatality or near fatality case is reviewed or discussed by panel members may be in closed session, which may occur only following the conclusion of an open session.

Portions of the panel meetings during which panel members review or discuss an individual child fatality or near fatality case may be in closed session, which may occur only following the conclusion of an open session. At the conclusion of the closed session, the panel must immediately convene an open session and give a summary of what occurred during the closed session. The panel has conducted no closed sessions.

Any panel member, any person attending a closed panel session, and any person presenting information or records on an individual child fatality or near fatality to the panel shall not release information or records to the public that are not available under the Kentucky Open Records Act.

Panel members addressed concerns about information provided by those who come before the panel in closed sessions being subject to legal discovery or subpoena in future civil or criminal cases. The consensus was that such information would not be subject to subpoena because the panel is not the official custodian of the information. The panel's role does not include reinvestigating cases. If the panel were to uncover a situation requiring further investigation by some other body, it would refer the situation to that body. The panel's purpose is to look at the system, process, and procedures.¹⁹

A panel member cannot be prohibited from making a good faith report to any state or federal agency of any information or issue that the panel member believes should be reported or disclosed in an effort to facilitate effectiveness and transparency in Kentucky's child protective services (KRS 620.055(14)).

Budget And Staff

The panel has been an unfunded mandate absorbed by the Justice and Public Safety Cabinet. The panel facilitator, an employee of the cabinet, has been using cabinet staff, including himself and legal department staff, for administration of the panel. The time spent on panel activities by cabinet staff is unknown. The only panel-related costs of significance before July 1, 2014, were staff salaries.²⁰

In 2014, the Secretary of the Justice and Public Safety Cabinet asked the Governor and the General Assembly to fund \$420,000 per year for the next two fiscal years for the panel. The Governor's budget recommendation included this request.²¹ According to the cabinet secretary, the panel chair, and the panel's *2013 Annual Report*, the funds are to be used primarily for staff to assist the panel in reviewing, tracking, and aggregating trend data for the cases sent to it by CHFS.²²

The General Assembly approved the requested amount. There is no specific line in the budget that addresses this item, but it is included in the overall appropriation for Justice Administration. It will be included in the Budget of the Commonwealth documents when they are produced.

Beginning July 1, the panel will pay for the use of SharePoint, software used by panel members to review cases. Total costs are uncertain but may be up to \$7,200 annually.

It appears that beginning July 1, 2014, the cost for the panel's use of SharePoint will be paid from the \$420,000 appropriation. SharePoint provided its service to the panel without any initial or annual charges beginning July 18, 2013. A new rated service has been authorized to begin July 1, 2014, with a rate of \$25 per user per month plus storage charges. With 24 registered panel users, that would be \$600 per month, or \$7,200 annually. As the Commonwealth Office of Technology integrates SharePoint infrastructure and users from all Kentucky cabinets, the rate is expected to drop significantly.²³

Staff Requirements

The panel has identified a pressing need for additional panel staff to filter cases. Issues that drove the panel's 2014 budget request to fund staff dedicated to the panel's work included

- the volume of cases the panel receives from CHFS,
- the hundreds of pages of information for a typical case, and
- the need to gather and aggregate trend data.²⁴

The panel received 115 cases for FY 2013. A case typically involves hundreds of pages, including law enforcement, medical, court, medical examiner, mental health assessment, and behavioral records.

For FY 2012, the panel received 114 cases in paper form. Each case included approximately 400 to 500 pages of material.²⁵ The panel officially reported on 55 of those cases in its *2013 Annual Report*.²⁶ For FY 2013, the panel received 115 cases via SharePoint.²⁷ One case typically involves review of hundreds of pages of information.²⁸ Cases include not only many pages of reports, documentation, and other information maintained by CHFS during its investigation, but also extensive pages of law enforcement, medical, court, medical examiner, mental health assessment, substance abuse, and behavioral records. During its November 2013 meeting, the panel determined that those records are vital to its case reviews and requested that CHFS provide all such records routinely, even for cases not closed by the June 25, 2013, effective date of the KRS 620.055(6) requirements.²⁹

With regard to trend data, panel members reported a need for a tool to collect information on key risk factors for child fatalities and near fatalities, such as substance abuse or a significant emotional shift in an at-risk household, in order to track statistics. This level of analysis requires trained staff dedicated to this task.³⁰

At present, the panel is discussing staff requirements, job descriptions, and the possibility of contracting for temporary staff while the formal hiring process is ongoing. No formal actions have been taken or adopted.

Case Review

SharePoint

The panel members use the software SharePoint to read all case information, make notes and comments, and discuss cases with other panel members online. The server is on a secure site maintained by the Commonwealth Office of Technology.

SharePoint is a Microsoft software product that creates a secure online location for the panel's use. Panel members use SharePoint to read all case information, make notes and comments, and discuss cases online with other panel members outside of meetings. The server is on a secure site maintained by the Commonwealth Office of Technology. Panel members must use passwords, which change frequently, to obtain access to SharePoint, whether from a state government computer or from their own computers.³¹

Panel members are divided into groups of four, each of which is assigned specific cases for review.

Panel members are divided into four groups. The panel tries to have each group include members with different expertise. Each case to be reviewed is assigned to one of the four groups. The panel facilitator emails each panel member as a case is assigned to the group. The facilitator also flags cases on SharePoint so that a

panel member can see the list of cases assigned to the group as they are added.

At present, the panel facilitator sorts through the cases received from CHFS to find those that seem most in need of panel review. As appropriate panel staff are added, that initial review process will be formalized and a staff member will review every case prior to determining which cases the panel should review.³²

One panel member at a time can “check out” a case online. A link in SharePoint allows panel members to comment on a case. Other panel members can still read a case while it is checked out but cannot comment on it.

FY 2012 cases are not in SharePoint because SharePoint was not instituted until after the panel was created statutorily in June 2013. FY 2012 cases are considered closed by the panel. SharePoint will eventually enable the panel to track statistics for cases it has reviewed, although that capability does not exist yet.

Information Provided By CHFS

DCBS oversees Kentucky’s Child Protection Hotline and the online Kentucky Child/Adult Protective Services Reporting System through its Division of Protection and Permanency.³³ When an allegation of abuse or neglect related to a child fatality or near fatality is made, the DCBS central office in Frankfort tracks the case through the investigative process. Once the investigation is closed, a full copy of all files related to the case is sent to Protection and Permanency.

Once a case of abuse or neglect related to a child fatality or near fatality is closed, the Department for Community Based Services’ (DCBS) Division of Protection and Permanency loads scanned information into the SharePoint system to be used by the panel.

Protection and Permanency personnel organize the case, create a table of contents, scan the case information into a PDF file, and upload the scanned file into the SharePoint system to be used by the panel.³⁴ The file includes all information often referred to as “the hard file,” which is paper documentation not loaded into DCBS’s online The Worker Information SysTem (TWIST). This means that both substantiated and unsubstantiated case files are included in the upload into SharePoint for the panel’s review.³⁵

Protection and Permanency personnel assign each case a number, complete a Case Review Summary Form created by the panel, and upload the form as the first page of each case file.³⁶ A copy of the most recent version of the Case Review Summary Form is shown

in Appendix C.^c This draft version provides an idea of statistical data the panel will gather in a formalized fashion once panel staff are in place.

Statute requires CHFS to provide to the panel within 30 days, upon request, a lengthy list of information and records in unredacted form. This list may include information that was not on file with CHFS during its investigation of a case.

As of June 2013, KRS 620.055(6) requires CHFS to provide to the panel within 30 days, upon request, a lengthy list of information and records in unredacted form. This list may include information that was not on file with CHFS during its investigation of a case. The information required to be provided by statute is as follows:

- CHFS records and documentation regarding the deceased or injured child and the child’s caregivers, residents of the home, and persons supervising the child at the time of the incident, including
 - all prior and ongoing investigations, services, or contacts;
 - any and all records of services to the family provided by agencies or individuals contracted by CHFS; and
 - all documentation of actions taken as a result of child fatality internal reviews
- Licensing reports from the CHFS Office of Inspector General if an incident occurred in a licensed facility
- All available records regarding protective services provided out of state
- All records of services provided by the Department for Juvenile Justice regarding the deceased or injured child and the child’s caregivers, residents of the home, and persons involved with the child at the time of the incident
- Autopsy reports
- Emergency medical service, fire department, law enforcement, coroner, and other first responder reports, including photos and interviews with family members and witnesses
- Medical records regarding the deceased or injured child, including
 - primary care records, including progress notes; developmental milestones; growth charts that include head circumference; all laboratory and X-ray requests and results; and a birth record that includes a record of delivery type, complications, and initial physical exam of the baby;
 - in-home provider care notes about observations of the family, bonding, others in the home, and concerns;
 - hospitalization and emergency department records;
 - dental records;
 - specialist records; and
 - all available photographs of injuries of the child

^c It is still being revised by panel members and has not been formally adopted by the panel.

- Educational records of the deceased or injured child, or other children residing in the home where the incident occurred, including
 - attendance records,
 - special education services,
 - school-based health records, and
 - documentation of any interaction and services provided to the children and family
- Head Start records or records from any other child care or early child care provider
- Records of any family, circuit, or district court involvement with the deceased or injured child and the child's caregivers, residents of the home, and persons involved with the child at the time of the incident including
 - petitions;
 - court reports by DCBS, guardians ad litem, court-appointed special advocates, and the Citizen Foster Care Review Board;
 - all orders of the court, including temporary, dispositional, or adjudicatory; and
 - documentation of annual or any other review by the court
- Home visit records from the Department for Public Health or other services
- All information on prior allegations of abuse or neglect and deaths of children of adults residing in the household
- All law enforcement records and documentation regarding the deceased or injured child and his or her caregivers, residents of the home, and persons involved with the child at the time of the incident
- Mental health records regarding the deceased or injured child and his or her caregivers, residents of the home, and persons involved with the child at the time of the incident

Protection and Permanency staff attempt to include all records from this list in their initial upload into SharePoint. It is unclear whether panel members find it necessary to or are able to distinguish via SharePoint whether CHFS had records during its investigation or whether records were added to the file after CHFS closed a case but before the file was uploaded into SharePoint by Protection and Permanency. CHFS staff may have had access to some of this information during its investigation via personal contact with individuals or organizations even if full records were not on file at the time the case was officially closed. That information would be included in CHFS notes that would be provided to the panel.³⁷

If the panel determines that it needs further records, it requests that the case be placed as pending. The panel requests the necessary records, through DCBS, from the entities involved.

The agencies listed above do not always send the required information to CHFS. In addition, information uploaded into SharePoint for cases closed before KRS 620.055 took effect on June 25, 2013, might not contain records the panel determines it needs to review a case.³⁸

If the panel determines that it needs records from either the requisite or other entities to effectively review the case, it requests that the case be placed as pending. The panel requests the necessary records directly from the entities involved. DCBS sends the requests via a form letter on panel letterhead. The entities send the requested records directly to the panel facilitator, who scans them into SharePoint if they are in paper form or transfers them electronically into SharePoint if they are in electronic form. Such records display in SharePoint as separate links and are distinguishable from the original case file uploaded by Protection and Permanency.³⁹

If the panel were to receive a case that had not been investigated by CHFS, it is unclear whether the panel would request the necessary records through DCBS or on its own. An example of such a case would be one referred directly to the panel from the State Child Fatality Review Team, which is part of CHFS.

If the panel were to receive a case that had not been investigated by CHFS, it is unclear whether the panel would request the necessary records through DCBS or on its own.⁴⁰ An example of such a case would be one referred directly to the panel from the State Child Fatality Review Team. The team is statutorily authorized under KRS 620.055(1) to refer cases to the panel because it is under the Department for Public Health, a department of CHFS.

Other cases could potentially come to the State Child Fatality Review Team through local child fatality review teams and Child Advocacy Centers. Such referrals would provide more cases per fiscal year, enabling a larger sample from which to look for trend data.⁴¹ Such referrals have not happened because the panel has not had the staff to handle them. At present, there is no established process.⁴²

Case Categories

Cases reviewed by the panel may be categorized as

- cases involving a child fatality,
- cases involving a child near fatality,
- substantiated cases,
- unsubstantiated cases,
- cases in which CHFS was involved before the child fatality occurred, and
- cases in which CHFS was not involved before the child fatality occurred.

This can happen because all child fatalities must be reported to the Department for Public Health whether or not they involved abuse or neglect. If CHFS determines that the fatality occurred because of abuse or neglect, it investigates the case and the case file will ultimately be sent to the panel.⁴³

The panel reviews substantiated and unsubstantiated cases.

The panel decided to review substantiated and unsubstantiated cases. Panel Chair Crittenden noted that language in the panel's enabling statute, KRS 620.055, says that the panel's purpose is to conduct reviews of "child fatalities and near fatalities ... suspected to be a result of abuse or neglect." He interpreted *suspected* to include substantiated and unsubstantiated cases.⁴⁴

The Kentucky Child Fatality and Near Fatality External Review Panel has not determined its definition of a near fatality. Kentucky statute defines a near fatality as an injury that, as certified by a physician, places a child in serious or critical condition (KRS 600.020(28)).

2013 Annual Report

The Child Fatality and Near Fatality External Review Panel's *2013 Annual Report* contains all cases the panel reviewed for FY 2012; FY 2013 cases were still not closed by CHFS at that point. The panel's 2014 annual report, due in December, will contain the panel's findings on cases for FY 2013.

During the panel's presentation of its 2013 report to the House Health and Welfare Committee, Panel Chair Crittenden reported that the panel concluded that at least some of the cases it reviewed were preventable. The panel next intends to create a system for reviewing cases and to collect data and analyze trends. The panel should base its recommendations on trend data from a large number of cases. To that end, the panel needed the ability and funding to add staff with the expertise and time to review all case material and gather and analyze trend data in the aggregate.⁴⁵

According to the panel, the process for selecting and reviewing cases will be as critical as the recommendations the panel makes in future annual reports.

The panel noted that the process for selecting and reviewing cases will be as critical as the recommendations the panel makes in future reports. More efficient use of the voluntary panel members' limited schedules can be made by providing them with case summaries put together by professional staff dedicated to analyzing and interpreting child fatality and near fatality data. The panel can then focus on developing solutions for reducing child fatalities and near fatalities. Acquiring staff dedicated to the work

of the panel specifically for case and data analysis was deemed critical for the panel to achieve its goals.⁴⁶

The 2013 Annual Report covered 55 FY 2012 cases. Based on the limited number of cases read by the panel in its first year, it identified preliminary issues worthy of further study and review.

The report covered 55 known cases completed by CHFS from its FY 2012 cases. All FY 2012 cases were received in paper copy form with redacted information. The panel found these cases difficult to read due to the inconsistent redactions, missing files, and inconsistent format.^{d 47}

Based on the limited number of cases read by the panel in its first year, it identified preliminary issues worthy of further study and review. While the issues were not formulated into specific recommendations, they were issues the panel planned to explore during the coming year. The panel was mindful of not forming premature conclusions from the first wave of case reviews but also noted the emergence of patterns that might ground future observations and recommendation once a more systematic review of records is under way.⁴⁸

The preliminary issues of concern listed in the report are

- common risk factors;
- opportunities to increase awareness;
- a lack of affordable and readily accessible mental health services for families;
- a lack of coordination with law enforcement and courts;
- communication and training of medical providers;
- communication, capacity, and resources of Child Protective Services; and
- coordination with related programs and systems.

The report listed seven preliminary issues of concern.

- **Common risk factors:** These included issues of domestic violence, criminal history, and substance abuse by caretakers and family members.
- **Opportunities to increase awareness:** These included the need to design and implement targeted awareness campaigns. The need for increased awareness regarding suspected child abuse and neglect was mentioned as an especially critical need.
- **Lack of mental health services:** The lack of affordable and readily accessible mental health services for families was a common theme in the cases reviewed. Such services are particularly critical for the high-risk families served by the child protective services system.
- **Communication and capacity with investigative responses (law enforcement and courts):** A lack of coordination among the various entities and tools involved in child abuse cases raised a number of issues. The panel noted a lack of inclusion of law enforcement records and court records in the vast majority of cases it had reviewed, and it said that it was taking steps to ensure that such records are routinely provided to it.
- **Communication and training of medical providers:** The panel identified concerns such as ineffective communication between medical care providers and investigative agencies, a lack of adequately trained medical staff, and the lack of capacity of

^d As of June 2013, KRS 620.055 codified a requirement that the panel receive unredacted files, but the panel decided not to review the FY 2012 cases again. The panel began with FY 2013 cases.

medical care providers to provide effective aftercare support to high-risk children in cooperation with other community providers.^e

- Communication, capacity and resources for child protective services: A recurring theme the panel found during its case reviews and subsequent discussions addressed the workload, training, experience level, and supervisory support within DCBS. Independently of the panel, DCBS has also identified these as areas of focus for the agency. The panel will work to gather trend data on these issues.
- Coordination with other related programs and systems: The panel noted the existence of Kentucky review or response teams that deal with different aspects of child fatality responses. Examples include the State Child Fatality Review Team administered by the Department for Public Health and investigative responses to unexpected child deaths led by coroners. The panel noted that it hopes to develop a process by which cases from these efforts can be referred directly to the panel as provided in KRS 620.055. In addition, the panel hopes to develop a protocol for coordinating exchange of trend data with the Kentucky Injury Prevention and Research Center, the Kentucky Violent Death Reporting System, Kentucky All Schedule Prescription Electronic Reporting, and the Kentucky Health Information Exchange.⁴⁹

Case Statistics

CHFS tracks its case records by fiscal year; however, its count of fiscal year cases does not end on June 30. Cases that have been reported by June 30 but are still undergoing investigation will be counted as cases in the fiscal year in which they were reported, even if they were not closed until some point in the following year. A “closed” or “completed” case is one for which CHFS has made a finding and for which its investigation has officially ended. A “pending” case is one for which CHFS is still in the process of collecting evidence and information in order to determine a finding.⁵⁰

^e HB 157, enacted in the 2014 regular session, amended KRS 311.601 to require the State Board of Medical Licensure to include in its continuing medical education requirements training on the recognition and prevention of pediatric abusive head trauma for pediatricians, radiologists, family practitioners, and emergency medicine and urgent care physicians.

The panel's 2014 annual report will consider FY 2013 cases.

The panel's 2014 annual report, due in December 2014, will reflect its review of CHFS cases reported in FY 2013. These cases have been uploaded by CHFS into SharePoint on an ongoing basis. All FY 2013 CHFS cases involving a child fatality or near fatality due to abuse or neglect have now been closed.

For FY 2013, CHFS investigated 115 cases of child fatalities or near fatalities suspected to be due to abuse or neglect. All have been uploaded into SharePoint for the panel's review. Of the 115 cases, 42 involved a fatality; 73 involved a near fatality.

For FY 2013, CHFS investigated 115 cases of child fatalities or near fatalities suspected to be due to abuse or neglect. All have been uploaded into SharePoint for the panel's review. Of the 115 cases, 42 involved a fatality; 73 involved a near fatality.⁵¹

CHFS makes a finding of "substantiated" or "unsubstantiated" when it closes a case. A CHFS administrative regulation defines a "substantiated" case as one involving

- an admission of abuse or neglect by the person responsible,
- a judicial finding of child abuse or neglect, or
- a preponderance of evidence that abuse or neglect was committed by the person alleged to be responsible (922 KAR 1:330 Sec. 1).

An "unsubstantiated" case is defined as one in which there is insufficient evidence, indicators, or justification present for substantiation of abuse or neglect (922 KAR 1:330 Sec. 1).

Of the 115 cases investigated by CHFS for FY 2013, 68 were substantiated and 47 were unsubstantiated. Of the 68 substantiated cases, 19 involved a fatality and 49 involved a near fatality. Of the 47 unsubstantiated cases, 23 involved a fatality and 24 involved a near fatality.⁵²

National Statistics

National statistics on fatalities and near fatalities due to child abuse or neglect in each state are not directly comparable. Keeping in mind that these comparisons are approximations, Kentucky's rate of fatalities due to maltreatment relative to its child population is worse than average. However, the number of reports of child abuse and neglect in Kentucky is among the highest in the US. As a percentage of these reports, Kentucky's fatality rate due to maltreatment is better than average.

National statistics comparing the numbers of fatalities and near fatalities due to child abuse or neglect in each state are not directly comparable. State laws define child abuse differently and may also differ in how information is reported to the national data compiler. Thus, the information provided here is an approximation of how states compare.

States, the District of Columbia, and US territories have child abuse and neglect reporting laws mandating that certain professionals and institutions report suspected maltreatment to a child protective services agency. Each state has its own definitions of child abuse and neglect that are based on standards set by federal law. Federal law provides a foundation for states by identifying a set of acts or behaviors that define child abuse and

neglect as, at a minimum, “any recent act or failure to act on the part of a parent or caretaker, which results in death, serious physical or emotional harm, sexual abuse or exploitation, or an act or failure to act which presents an imminent risk of serious harm” (42 USC Sec. 5101).

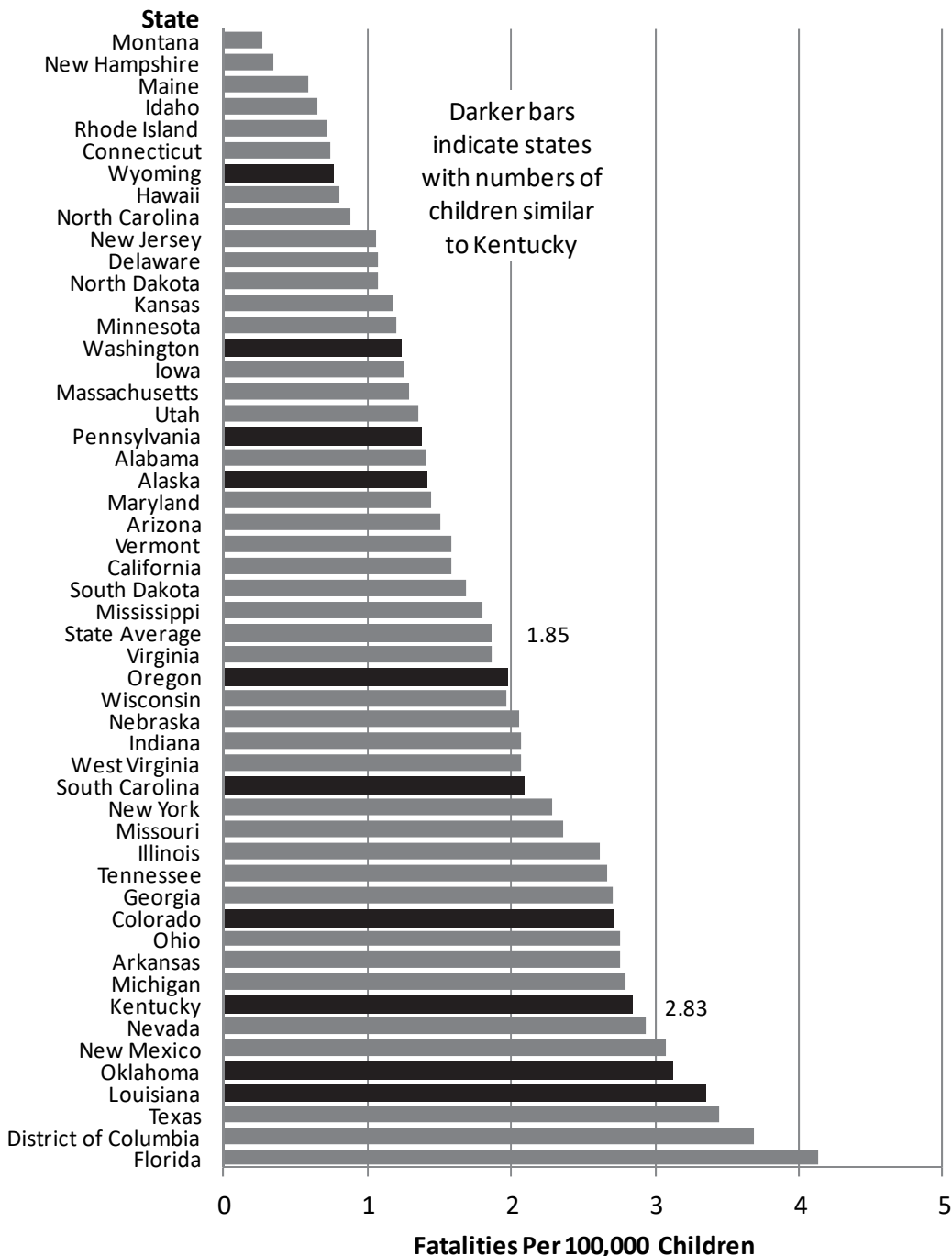
The National Child Abuse and Neglect Data System is a federally sponsored effort that collects and analyzes annual data on child abuse and neglect that is submitted by states, the District of Columbia, and US territories. The US Children’s Bureau collects and analyzes the data.⁵³

Figures A and B show the average annual child fatality rate due to maltreatment per state over a 5-year period.^f Figure A indicates the number of such fatalities per 100,000 children in the state. The state average is 1.85 fatalities per 100,000 children. Kentucky’s rate of 2.83 is above average. The darker bars indicate the states with a similar number of children as Kentucky.

As shown in Figure B, the fatality rate in Kentucky is relatively low with respect to the number of reports of abuse and neglect. For federal fiscal years 2008 to 2012, Kentucky averaged 1,667 reports of abuse or neglect per 100,000 children. Only the District of Columbia, Massachusetts, and New York had higher reporting rates. In Kentucky, 0.17 percent of such reports involved a fatality. The national average was 0.25 percent. To put that difference in perspective, Kentucky averaged 29 fatalities per year over the 5-year period. If Kentucky’s fatality rate per report were the same as the national average, there would have been 14 more fatalities per year.

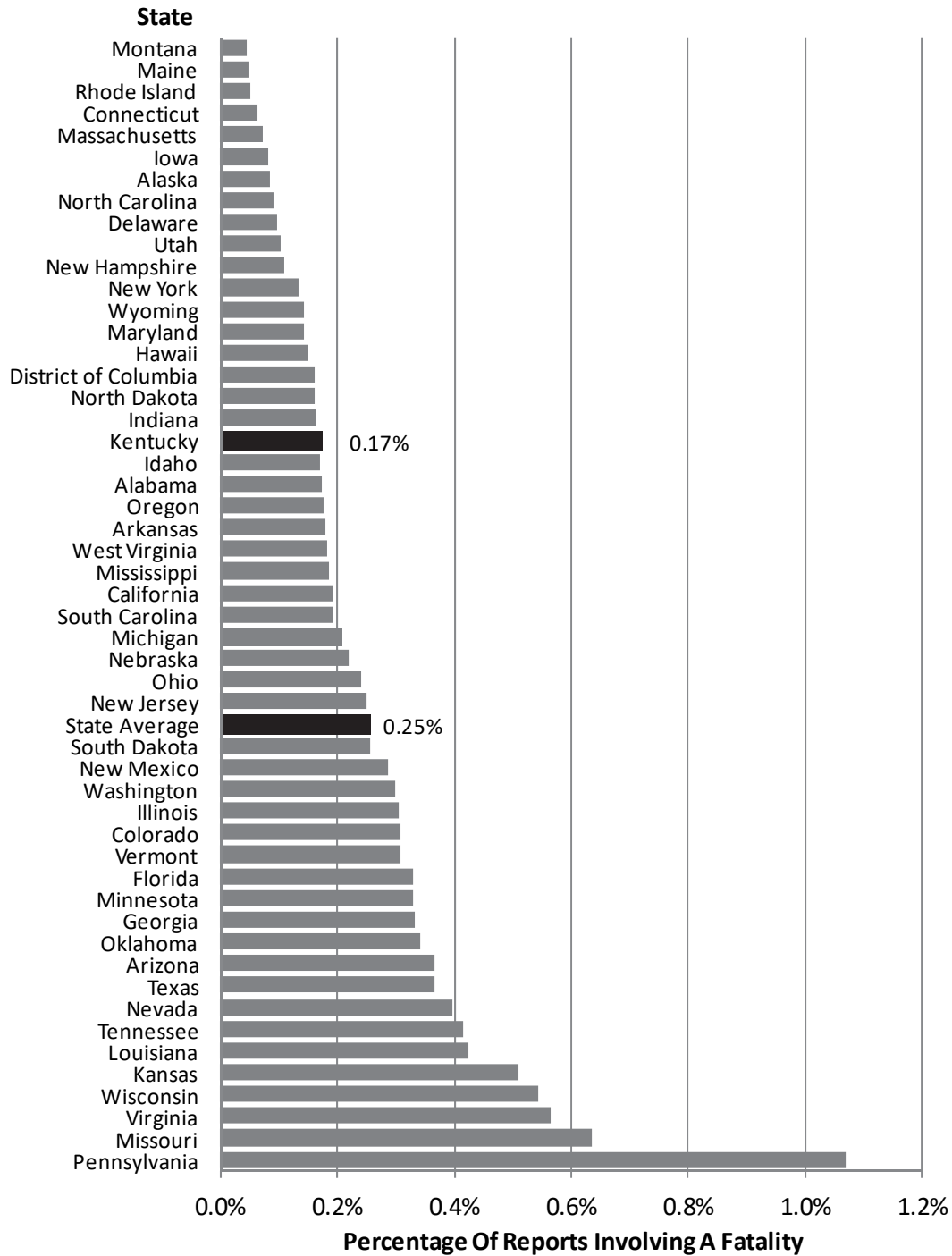
^f The 5-year average is used rather than fatalities for a specific year because the number of fatalities per state can vary significantly from year to year. For example, the changes in the number of fatalities in Indiana from one year to the next were a 47 percent increase, a 52 percent decrease, a 42 percent increase, and a 32 percent decrease.

Figure A
Average Annual Child Fatalities Due To Abuse And Neglect Per 100,000 Children
Fiscal Year 2008 To Fiscal Year 2012



Note: Fiscal year is federal (Oct. 1 to Sept. 30). Fatality rates and child populations are annual averages. Kentucky has approximately 1 million children. Child populations in states categorized as similar to Kentucky range from 757,000 to 1.3 million. Massachusetts and North Carolina reported fatalities for 3 years. Idaho and Maine reported fatalities for 4 years. Source: Compiled from United States. Dept. of Health and Human Services. Children’s Bureau. *Child Maltreatment 2012*. Web. Jan. 24, 2012.

Figure B
Percentage Of Reports Of Child Abuse And Neglect Involving A Fatality
Fiscal Year 2008 To Fiscal Year 2012



Note: Fiscal year is federal (Oct. 1 to Sept. 30). Fatalities and numbers of reports are annual averages. Massachusetts and North Carolina reported fatalities for 3 years. Idaho and Maine reported fatalities for 4 years. Source: Compiled from United States, Dept. of Health and Human Services, Children’s Bureau. *Child Maltreatment 2012*. Web. Jan. 24, 2012.

State Child Fatality Review Teams In Kentucky And Other States

Kentucky and seven other states were reviewed for other panel or team activities comparable to those of Kentucky's Child Fatality and Near Fatality External Review Panel.

Kentucky and seven other states were reviewed for other panel or team activities comparable to those of Kentucky's Child Fatality and Near Fatality External Review Panel. The seven other states are California, Colorado, Georgia, Indiana, Michigan, Missouri, and Tennessee. These states were chosen either because they are in the same region as Kentucky or because they represent, according to a national literature review, varied models for reviewing state child fatality cases and data.

Kentucky's external review panel appears to be distinctive. Only Colorado has a team with a similar mission and jurisdiction limited to cases involving abuse or neglect. Kentucky's panel appears to be unique in having no responsibilities related to local child review teams. The panel's attachment to a state department for administrative purposes only is also different from the other entities reviewed.

Kentucky's external review panel appears to be distinctive. Colorado has a team with a similar mission and jurisdiction limited to cases involving abuse or neglect. Kentucky's panel appears to be unique in having no responsibilities related to local child review teams. The panel's attachment to a state department for administrative purposes only is also different from the other entities reviewed. Enabling statutes for state review teams tend to provide for specific ways in which teams should provide information. Kentucky's enabling statute for its external review panel does not.

The Kentucky external review panel is similar to state-level panels in other states reviewed in that all enabling statutes specify who is to be represented on the panel. A difference is that for 9 of the 15 voting members of the Kentucky panel the appointing authority has to select from among nominees chosen by someone else.

Other States

Two states reviewed have no state-level child fatality review teams; two more are in the process of moving many of the state team's responsibilities to the local level. In California, the State Child Death Review Council was disbanded in 2008 because of budget cuts. Most California counties continue to maintain local child death review teams; they are formally authorized but not mandated in statute (Penal Code §11174.32). There are 50 to 55 local child death review teams active at any time. Most California local child death review teams review all sudden, traumatic, and unexpected child deaths including injury-related, natural, and undetermined deaths.

Missouri's child fatality review program is operated through local county or city child fatality review panels. The program is attached administratively to the Department of Social Services. Missouri

requires each of its 114 counties and the City of St Louis to have a multidisciplinary child fatality review panel.⁵⁴ A prosecuting attorney or circuit attorney must impanel a county or city child fatality review panel to investigate the deaths of children under the age of 18 years. The panel must operate according to the rules, guidelines, and protocols provided by the Department of Social Services.

Colorado has two state review teams. The State Child Fatality Prevention Review Team in the Department of Public Health and Environment conducts comprehensive reviews of preventable child deaths. The Child Fatality Review Team in the Department of Human Services reviews cases involving a suspicious incident of egregious abuse or neglect against a child or a child near fatality or fatality due to abuse or neglect. It submits an annual report by July 1.^g

Local public health agencies must establish multidisciplinary child fatality prevention review teams by January 1, 2015. At that time, all comprehensive reviews of preventable fatalities of children will shift from the Department of Public Health and Environment's State Child Fatality Prevention Review Team to the local review teams. The State Child Fatality Prevention Review Team will continue to conduct retrospective reviews of all child deaths.

Indiana began requiring child fatality review teams in each county in July 2013. Its Statewide Child Fatality Review Committee, whose members are appointed by the governor, serves mainly as a consulting body to assist the efforts of the local teams. The committee can assist with, or conduct, individual case reviews at the request of a local team. The state team is required to publish an annual report, based on reports provided by the local teams, which identifies trends and informs efforts to implement effective statewide prevention strategies.

Table 3 provides summary information on the state-level entities reviewed for this report. Appendix D has more information on the entities in selected other states.

^g Colorado statute defines an incident of egregious abuse or neglect as “an incident of suspected abuse or neglect involving significant violence, torture, use of cruel restraints, or other similar, aggravated circumstances ...” (CRSA 26-1-139(2)(a)).

Table 3
State-Level Entities In Kentucky And Five Selected States

Entity	Abuse And Neglect Cases Only	Reviews Near Fatalities	Coordinates With Local Teams	Statute Specifies Who Is Represented	Team Members
Kentucky Fatality and Near Fatality External Review Panel	√	√		√	20*
Kentucky State Child Fatality Review Team			√		31
Colorado Child Fatality Prevention Review Team			√	√	46
Colorado Child Fatality Review Team	√	√	√		18-20*
Georgia Child Fatality Review Panel			√	√	17
Indiana Statewide Child Fatality Review Committee			√	√	15
Michigan Child Death State Advisory Team			√	√	19
Tennessee Child Fatality Prevention Team			√	√	16

*Five members of the Kentucky External Fatality and Near Fatality Review Panel are nonvoting; two members of the Colorado Child Fatality Review Team are nonvoting.

Source: Compiled by Program Review staff.

Kentucky State Child Fatality Review Team

Kentucky also has a State Child Fatality Review Team. The 31-member team, established in 1996, is under the Kentucky Department for Public Health. The team analyzes data on all coroner case child deaths, not just those resulting from abuse and neglect. It does not conduct investigations; its purpose is to identify trends and patterns and to develop prevention strategies.

The Kentucky Department for Public Health established a State Child Fatality Review Team in 1996 under KRS 211.684, although such a state team is not mandatory. The state team

- facilitates the development of local child fatality review teams that may include training opportunities and technical assistance;
- develops and distributes model protocols for local child fatality review teams that investigate child fatalities;
- reviews and approves local protocols prepared and submitted by local teams;
- analyzes received data regarding child fatalities to identify trends, patterns, and risk factors;
- evaluates the effectiveness of adopted prevention and intervention strategies; and
- makes recommendations regarding state programs, legislation, administrative regulations, policies, budgets, and treatment and service standards that may facilitate

development of strategies for prevention and reduction of the number of child deaths.⁵⁵

KRS 211.684(1)(b) defines a “local child fatality response team”—also referred to as a local child fatality review team by the Department for Public Health—as a community team composed of representatives of agencies, offices, and institutions that investigate child deaths, including coroners, social service workers, medical professionals, law enforcement officials, and Commonwealth’s attorneys and county attorneys. The state team reviews information from the local teams to identify injury trends happening in multiple communities and develops strategies to help save children’s lives.⁵⁶

Under KRS 211.684(1)(a), “child fatality” means the death of a person under the age of 18 years. The state team analyzes data on all coroner case child deaths, not just those resulting from abuse and neglect. The state team does not conduct investigations of child deaths. Its purpose is to watch for trends and patterns and to develop prevention strategies based on the data it gathers.⁵⁷

The State Child Fatality Review Team has 31 members appointed by the commissioner of the Department for Public Health. Different members serve as the team’s chair at various times. Appendix E contains a list of team members for 2014.

The state team works with and provides guidance to local child fatality review teams but does not oversee their work.

Although the Kentucky state team works with and provides guidance to local child fatality review teams, it does not oversee their work. The state team does not analyze child near fatalities. The team reviews deaths only upon special request. State statutes and administrative regulations do not specifically address the question of whether information the state team obtains is subject to the Open Records Act or may be subject to subpoena or discovery, although a variety of protocols are in place.⁵⁸

The comprehensive reviews the Child Fatality and Near Fatality External Review Panel produces are likely to assist local child fatality review teams.

According to KRS 620.055(2)(n), the chair of the State Child Fatality Review Team (or designee) is a voting member of the Child Fatality and Near Fatality External Review Panel. Several panel members also serve as members of the state team. These include a representative from Prevent Child Abuse Kentucky and a child abuse pediatrician. The comprehensive reviews the panel produces are likely to assist local teams by providing expertise and better information to use in prevention planning.⁵⁹

Appendix A

How This Study Was Conducted

Program Review staff conducted a literature review and examined relevant statutes, audiotapes of legislative committee hearings, minutes of panel meetings, and other documents related to the history, creation, and codification of the Child Fatality and Near Fatality External Review Panel. Staff reviewed reports and other documents produced by a variety of Kentucky entities regarding the gathering of information on child fatalities and near fatalities. Program Review staff attended panel meetings and interviewed panel members and staff from other Kentucky agencies. Program Review staff analyzed statutes and documents of selected states and information from the National Center for the Review and Prevention of Child Deaths.

Statistics on cases reviewed by the panel were compiled by Program Review staff from data provided by the panel and staff of the Cabinet for Health and Family Services. National statistics on child fatalities were compiled by Program Review staff using data from the US Department of Health and Human Services' National Child Abuse and Neglect Data System.

Appendix B

Members Of Child Fatality And Near Fatality External Review Panel (As Of June 15, 2014)

Member	Title	Organization	Appointed By	Term	
				Starts	Ends
Roger Crittenden	Judge (ret.), panel chair	At large	Secretary of state	7/15/13	6/30/15
Rep. Tom Burch	Chair, House Health and Welfare Committee	General Assembly	Ex officio, position	6/26/13	
Kevin Calhoon	Detective	State Police	Attorney general	7/16/13	6/30/16
Tracey Corey, MD	Chief medical examiner	Ky. Office of Medical Examiner	Position	6/26/13	
Melissa Currie, MD	Child abuse pediatrician	Univ. of Louisville School of Medicine	Attorney general	7/16/13	6/30/15
Sharon Currens	Executive dir.	Ky. Domestic Violence Assn.	Exec. Dir., Ky. Domestic Violence Assn.	6/26/13	6/30/14
Sen. Julie Denton	Chair, Senate Health and Welfare Committee	General Assembly	Ex officio, position	6/26/13	
Andrea Goin*	Dir., Children's Advocacy Center of Green River	Ky. Court Appointed Special Advocates Assn.	Attorney general	7/16/13	6/30/16
Nathan Goins	State chair, Citizen Foster Care Review Board Executive Committee		Chief Justice, Supreme Court	6/26/13	6/30/15
Joel Griffith		Prevent Child Abuse Ky.	Attorney general	7/16/13	6/30/16
Brent Hall	Judge	Family Court, Elizabethtown	Chief Justice, Supreme Court	6/26/13	6/30/15
Teresa James	Commissioner	Dept. for Community Based Services	Ex officio Ex officio, position	6/26/13	
Stephanie Mayfield, MD (designee: Allyson Taylor)	Commissioner (Policy adviser)	Dept. for Public Health	Ex officio, position	6/26/13	

Member	Title	Organization	Appointed By	Term	
				Starts	Ends
Kimberly McClanahan**	CEO, Pathways Inc.	Ky. Assn. of Regional Mental Health and Mental Retardation	Attorney general	7/16/13	6/30/14
Jenny Oldham	County attorney	Hardin County	Attorney general	7/16/13	6/30/16
Jaime Pittenger Kirtley**	Child abuse pediatrician	Univ. of Ky. School of Medicine	Attorney general	7/16/13	6/30/14
Maxine Reid	Family Resource and Youth Services Center	Cabinet for Health and Family Services	Attorney general	7/16/13	6/30/16
Ruth Shepherd, MD	Chair, State Child Fatality Review Team	Dept. for Public Health	Position	7/16/13	`
Robert Walker***	Social worker, clinician	Board of Social Work	Attorney general	7/16/13	6/30/14
Carmella Yates, MD	Addiction counselor	Ky. Assn. of Addiction Professionals	Attorney general	7/16/13	6/30/15

*Member has asked to resign; new names are being submitted to the attorney general.

** Member has asked to be reappointed; names are being resubmitted to the attorney general for reappointment.

*** Member has asked not to be reappointed; new names are being submitted to the attorney general.

Source: Created by Program Review staff from information provided by staff of the Interim Joint Committee on Health and Welfare.

Appendix C

Draft Case Review Summary Form

The Child Fatality and Near Fatality External Review Panel has not formally adopted this document. This latest version created by panel members provides an idea of statistical data the panel will gather in a formalized fashion once panel staff are in place. This document or an earlier version is the first page of each case file in SharePoint.

EXTERNAL CHILD FATALITY AND NEAR FATALITY REVIEW PANEL										
Case Review Summary Form										
Year:	<input type="checkbox"/> F <input type="checkbox"/> NF <input type="checkbox"/> C <input type="checkbox"/> NC			Number				Version #5		
Case Identifier										
CHILD INFORMATION										
Child's Name:					DOB:					
Child's Gender:	<input type="checkbox"/> M	<input type="checkbox"/> F	Race:	<input type="text"/>	Date of Injury:					
			Ethnicity:	<input type="text"/>	Date of Death:					
Age at Injury:	years		months		County:	<input type="text"/>				
Synopsis of event:										
Agencies Involved:	<input type="checkbox"/> CPS		<input type="checkbox"/> Law Enforcement		<input type="checkbox"/> ER		<input type="checkbox"/> Medical Provider			
	<input type="checkbox"/> CAC		<input type="checkbox"/> Courts		<input type="checkbox"/> CMCH		<input type="checkbox"/> Other			
Child Risk Factors:	NICU/Premie <input type="checkbox"/> yes <input type="checkbox"/> no		Disability <input type="checkbox"/> yes <input type="checkbox"/> no		Neonatal Abstinence <input type="checkbox"/> yes <input type="checkbox"/> no					
Family/Household risks:	Substitute Caregiver at Time of Event <input type="checkbox"/> yes <input type="checkbox"/> no				Lack of child care <input type="checkbox"/> yes <input type="checkbox"/> no					
	Domestic Violence <input type="checkbox"/> yes <input type="checkbox"/> no				Criminal History <input type="checkbox"/> yes <input type="checkbox"/> no					
	Substance Abuse by any caregiver <input type="checkbox"/> yes <input type="checkbox"/> no									
FAMILY/HOUSEHOLD INFORMATION										
Case Members	Age	Name		DOB	Relation to Child		Comment (custody/perp/etc)			
PRIOR HISTORY WITH DCBS <input type="checkbox"/> NONE										
Referral Number	Date (most recent first)	Intake Determination			Result	Comment				
Type Involvement: <small>Prior Investigations; Resource linkage; referral not accepted; Current Open Case; Prior Open Case; Previous removal this child; previous removal sib/other child</small>										
PRIOR HISTORY WITH COURTS <input type="checkbox"/> NONE										
Date (most recent first)	Case member			Court Action Requested		Result	Comment			
if < 1 year:	Unsafe Sleep Environment		<input type="checkbox"/> yes <input type="checkbox"/> no		Unsafe Sleep with Impaired Caregiver		<input type="checkbox"/> yes <input type="checkbox"/> no			
	Hosp D/C appt with Ped		<input type="checkbox"/> yes <input type="checkbox"/> no		concern communicated to ped		<input type="checkbox"/> yes <input type="checkbox"/> no			
	AHT Education to Caregiver		<input type="checkbox"/> yes <input type="checkbox"/> no		Rec eived safe sleep info at birth		<input type="checkbox"/> yes <input type="checkbox"/> no			
Determinations/DX	<input type="checkbox"/> Physical Abuse		<input type="checkbox"/> Supervisory Neglect		<input type="checkbox"/> Other:					
	<input type="checkbox"/> AHT		<input type="checkbox"/> Medical Neglect		<input type="checkbox"/> Other:					
	<input type="checkbox"/> Sexual Abuse		<input type="checkbox"/> Deprivation of Needs		<input type="checkbox"/> Other:					
Notes and Recommendations:							Action Items/Follow-up:			

Appendix D

State Child Fatality Review Teams In Selected States

Colorado

Colorado has two state review teams. The State Child Fatality Prevention Review Team conducts comprehensive reviews of preventable child deaths. The Child Fatality Review Team assesses the records of cases involving a suspicious incident of egregious abuse or neglect against a child or a child near fatality or fatality due to abuse or neglect.

Colorado uses a public health approach to review all child fatalities for the purpose of prevention. This review process is not investigative. In September 2013, Colorado created a State Child Fatality Prevention Review Team in the Department of Public Health and Environment to conduct comprehensive reviews of preventable child deaths. The team does not review cases involving child near fatalities. The multidisciplinary and multiagency volunteer team reviews all preventable child fatalities. This process is conducted to identify trends across a variety of child fatality causes and make prevention recommendations.

Local public health agencies are required to establish local, multidisciplinary child fatality prevention review teams by January 1, 2015, at which time all comprehensive reviews of preventable fatalities of children will shift from the state review team to the local review teams. The state review team will continue to conduct retrospective reviews of all child deaths in Colorado.⁶⁰

The prevention review team has 34 voting members, including 18 appointed by the governor. The voting members may choose 12 nonvoting members. For most members, the statute specifies who is to be represented. For example, six gubernatorial appointees represent members of the medical profession who specialize in traumatic injury or children's health, including four physicians and two nurses.

The State Child Fatality Prevention Review Team must

- outline trends and patterns of child fatalities;
- identify and investigate risk factors that may lead to child fatalities;
- characterize groups of children who are at risk for a child fatality;
- evaluate the services offered and the system responses to children who are at risk of a child fatality and review recommendations of local or regional review teams;
- consider a review of all systemic child-related issues when evaluating services offered or system responses to children who are at risk of fatality;
- take steps to improve the quality and scope of data obtained through investigations and review of child fatalities;
- use a child fatalities data-collection system, using nationally developed public health guidelines, to ensure the proper identification of all potential child abuse or neglect fatalities;

- report annually to the governor and the state legislature recommendations for changes to any law, rule, or policy that the state review team has determined will promote the safety and well-being of children;
- provide an annual summary to the Department of Human Services outlining the trends and patterns of child abuse and neglect fatalities, including information regarding the findings from cases known and unknown to the county departments of social services;
- collaborate with the Department of Human Services Child Fatality Review Team to make joint recommendations for the prevention of child fatalities;
- administer money to county or district public health agencies to support local or regional review team activities;
- provide training and technical assistance to local or regional review teams regarding the facilitation of a child fatality review process, data collection, evidence-based prevention strategies, and the development of prevention recommendations;
- provide an annual data report to each local or regional review team, summarizing its local or regional review data entered into the Web-based data-collection system; and
- distribute information to the public concerning risks to children and recommendations for promoting the safety and well-being of children (CRS 25-20.5-407).

Colorado uses a review team approach to assess the records of cases involving a suspicious incident of egregious abuse or neglect against a child or a child near fatality or fatality due to abuse or neglect.^h The Child Fatality Review Team in the Department of Human Services conducts the assessments and submits an annual report containing its findings and recommendations by July 1 (CRSA 26-1-139). This review complements that of the Child Fatality Prevention Review Team. The Department of Human Services team has 16 to 18 voting members and two nonvoting members depending on the case reviewed, none appointed by the governor. Although three departments must be represented, the statute does not designate specific positions as voting team members (CRSA 26-1-139(6)).

The Child Fatality Review Team must

- review the circumstances around an incident of egregious abuse or neglect against a child, a near fatality, or a child fatality;
- review the services provided to the child, the child's family, and the perpetrator by the county department for any county with which the family has had involvement within 3 years prior to the incident;
- review records and interview individuals;
- review the county department's compliance with statutes, regulations, and relevant policies and procedures;
- identify strengths and best practices of service delivery to the child and the child's family;
- identify factors that may have contributed to conditions leading to the incident; and
- identify the quality and sufficiency of coordination between state and local agencies (CRSA 26-1-139(4)).

^h Colorado statute defines an incident of egregious abuse or neglect as an "incident of suspected abuse or neglect involving significant violence, torture, use of cruel restraints, or other similar, aggravated circumstances" (CRSA 26-1-139(2)(a)).

Georgia

The 17-member Georgia Child Fatality Review Panel is attached administratively to the Department of Human Resources. It oversees the county child fatality review process and recommends prevention measures based on the data. Panel members are appointed by the governor or lieutenant governor, or are ex officio members as state agency leaders. The state panel reviews selected case reports that have been completed by the local committees. State child fatality review staff review the accuracy and completeness of the case reports submitted by the local committees and ensure data quality. The panel does not review cases involving child near fatalities.⁶¹

The panel is composed of

- a district attorney appointed by the governor;
- a juvenile court judge appointed by the governor;
- two citizen members appointed by the governor, who are not employed by officers of the state or any political subdivision, one of whom must come from a statewide child abuse prevention organization and one of whom must come from a statewide childhood injury prevention organization;
- a forensic pathologist appointed by the governor;
- the chair of the Board of Human Resources;
- the director of the Division of Family and Children Services of the Department of Human Resources;
- the director of the Georgia Bureau of Investigation;
- the chair of the Criminal Justice Coordinating Council;
- a member of the Georgia Senate appointed by the lieutenant governor;
- a member of the Georgia House of Representatives appointed by the speaker of the House of Representatives;
- a local law enforcement official appointed by the governor;
- a superior court judge appointed by the governor;
- a coroner appointed by the governor;
- the Child Advocate for the Protection of Children;
- the director of the Division of Public Health of the Department of Human Resources; and
- the director of the Division of Mental Health, Developmental Disabilities, and Addictive Diseases of the Department of Human Resources.

The panel's purpose is to recommend measures to decrease the incidence of child death by undertaking the following duties:

- Identify factors which place a child at risk for death.
- Collect and share information among state agencies that provide services to children and families or investigate child deaths.
- Make suggestions and recommendations to appropriate participating agencies regarding improving coordination of services and investigations.
- Identify trends relevant to unexpected or unexplained child death.
- Investigate the relationship between child deaths and violence between past or present spouses, persons who are parents of the same child, parents and children, stepparents and

stepchildren, foster parents and foster children, or other persons living or formerly living in the same household.

- Review each report from local child fatality review committees.
- Provide training and written materials to the local review committees.
- Develop a protocol for child fatality investigations.
- Monitor the operations of local review committees to determine training needs and service gaps.
- If the panel determines that changes to any statute, regulation, or policy are needed to decrease the risk of child death, it must propose and recommend such changes in its annual report.

The panel must submit a report to the speaker of the House of Representatives regarding the prevalence and circumstances of child fatalities in the state, recommend measures to reduce such fatalities caused by other than natural causes, and address the following issues:

- Whether the deaths could have been prevented
- Whether the children were known to any state or local agency
- The actions, if any, taken by any state or local agency or court
- Whether agency or court intervention could have prevented their deaths
- Whether policy, procedural, regulatory, or statutory changes are called for as a result of these findings
- Whether any referral should have been made to a law enforcement agency but was not made

The panel must also establish procedures for the conduct of reviews by local review committees into deaths of children.

Information acquired by the panel and records the panel uses are not subject to the state open records law and are not subject to subpoena, discovery, or introduction into evidence in any civil or criminal proceeding (OCGA 19-15-4).

Indiana

In July 2013, Indiana law began requiring child fatality review teams in each county, with coordination and support for these teams to be provided by the Indiana Department of Health. The statute also requires that a coordinator position be created under the state Department of Health to help support and coordinate the local teams and the Statewide Child Fatality Review Committee, whose members are appointed by the governor.

The Statewide Child Fatality Review Committee serves as a consulting body to assist the efforts of the local teams. The committee can assist with or conduct individual case reviews at the request of a local team or the Indiana Department of Child Services ombudsman.

Local teams and the Statewide Child Fatality Review Committee are required by statute to complete an annual report. The local teams are required to provide an annual report to the Statewide Child Fatality Review Committee, which then identifies trends and informs efforts to implement effective statewide prevention strategies.⁶²

The state committee consists of the following members appointed by the governor:

- A coroner or deputy coroner
- A representative from the state Department of Health who is a licensed physician and specializes in injury prevention
- A representative of a local health department established or multiple county health department
- A pediatrician
- A representative of law enforcement who has experience in investigating child deaths
- A representative from an emergency medical services provider
- The director or a representative of the Department of Child Services
- A representative of a prosecuting attorney who has experience in prosecuting child abuse
- A pathologist who is certified by the American Board of Pathology in forensic pathology and licensed to practice medicine in Indiana
- A mental health provider
- A representative of a child abuse prevention program
- A representative of the Department of Education
- An epidemiologist
- The State Child Fatality Review coordinator
- At the discretion of the Department of Child Services, an ombudsman—a representative of the office of the Department of Child Services Ombudsman

The Statewide Child Fatality Review Committee must

- identify similarities, trends, and factual patterns concerning the deaths of children;
- create strategies and make recommendations for the prevention of injuries to and deaths of children;
- advise and educate the legislature, governor, and public on the status of child fatalities;
- review child mortality records and examine all other records relevant to child fatalities;
- compile and analyze data recorded by local child fatality review teams in reviewing child fatalities;
- assist efforts by local child fatality review teams by
 - overseeing the creation of standardized forms and protocols necessary for the review of child deaths;
 - providing expertise by answering questions related to a child's death that a local child fatality review team is reviewing;
 - establishing and sponsoring training programs for members of local child fatality review teams; and
 - providing, upon request of a local child fatality review team, expertise in creating local prevention strategies; and
- upon request by a local child fatality review team or the Department of Child Services ombudsman, assist in or conduct a review of the death of a child.

Records, information, documents, and reports acquired or produced by the committee are not subject to subpoena or discovery or admissible as evidence in any judicial or administrative proceeding (IC 16-49).

Michigan

The Michigan Child Death State Advisory Team has 19 members. It reviews the findings from 77 local child death review teams. The state team is charged with making recommendations on policy and statutory changes pertaining to child fatalities and with guiding statewide prevention, education, and training efforts. It is administratively attached to the Michigan Department of Human Services. Information the team receives is not subject to Michigan's Freedom of Information Act. The team does not review cases involving child near fatalities.⁶³

The director of the Department of Human Services chairs the state team's meetings and selects members. The team consists of

- two representatives of the Department of Human Services,
- two representatives of the Department of Community Health,
- one county medical examiner,
- one representative of law enforcement,
- one county prosecuting attorney, and
- the children's ombudsman.

Other members have also been appointed to add expertise on multiple causes of child death and prevention.⁶⁴

The Child Death State Advisory Team must publish an annual report on child fatalities to the governor and the legislature. The report must include

- the total number of child fatalities and the type or cause of each child fatality,
- the number of child fatalities that occurred while the child was in foster care,
- the number of cases in which the child's death occurred within 5 years after family preservation or family reunification, and
- trends in child fatalities.

The team must break down the information by county or by groups of counties (MCL 722.627b).

Tennessee

The State Child Fatality Prevention Team reviews the reports from local teams, and it analyzes statistics of the incidence and causes of child deaths. The state team is attached administratively to the Department of Health.⁶⁵

The state team is composed of

- the commissioner of the Department of Health, who chairs the state team;
- the attorney general and reporter;
- the commissioner of the Department of Children's Services;
- the director of the Tennessee Bureau of Investigation;
- a physician nominated by the state chapter of the American Medical Association;
- a physician appointed by the commissioner of the Department of Health who is credentialed in forensic pathology, preferably with experience in pediatric forensic pathology;
- the commissioner of the Department of Mental Health and Mental Retardation;

- a member of the judiciary selected from a list submitted by the chief justice of the Tennessee Supreme Court;
- the executive director of the Commission of Children and Youth;
- the president of the state professional society on the abuse of children;
- a team coordinator, to be appointed by the commissioner of the Department of Health;
- the chair of the Select Committee on Children and Youth;
- two members of the House of Representatives appointed by the speaker of the House, at least one of whom must be a member of the House Health and Human Resources Committee; and
- two senators appointed by the speaker of the Senate, at least one of whom must be a member of the Senate General Welfare, Health and Human Resources Committee.

The state team must

- review reports from the local child fatality review teams;
- report to the governor and the General Assembly concerning the state team's activities and its recommendations for changes to any law, rule, and policy that would promote the safety and well-being of children;
- undertake annual statistical studies of the incidence and causes of child fatalities in Tennessee. The studies must include an analysis of community and public and private agency involvement with the decedents and their families prior to and subsequent to the deaths;
- provide training and written materials to the local teams. Written materials may include model protocols for the operation of local teams;
- develop a protocol for collecting data regarding child deaths;
- upon request of a local team, provide technical assistance to the team, including the authorization of another medical or legal opinion on a particular death; and
- periodically assess the operations of child fatality prevention efforts and make recommendations for changes as needed (TOC 68-142).

Appendix E

Kentucky State Child Fatality Review Team Members (As Of 2014)

The Kentucky State Child Fatality Review Team is under the Department for Public Health and is separate from the Kentucky Child Fatality and Near Fatality External Review Panel.

Debbie Acker	DCBS, Protection and Permanency
Shelley Adams	Dept. for Public Health, Maternal and Child Health
Patti Clark	Dept. for Behavioral Health, Developmental and Intellectual Disabilities
Sandi Clark	Dept. for Public Health, Maternal and Child Health
Monica Clouse	Dept. for Public Health, Maternal and Child Health epidemiologist
Andrew Croley	Whitley County Coroner
Dr. Melissa Currie	Kosair Charities Forensic Pediatrics
Erica Davis	Dept. for Public Health
Torie Graham	Medical Examiner, Medical Examiner's Office—Central Kentucky
Joel Griffith	Prevent Child Abuse Kentucky
Lucy Heskins	DCBS, Protection and Advocacy
Darlene Hoover	DCBS, Child Care
Michael Hughes	Jessamine County coroner
Tracey Jewell	Dept. for Public Health, Maternal and Child Health epidemiologist
Sandy Kelly	Dept. for Public Health
Louan Martin	Metro Louisville Health Dept.
Richard Peddicord	State Fire Marshal's Office
Dr. Susan Pollack	University of Ky., Ky. Injury Prevention and Research
Sharon Rengers	Norton Healthcare/Kosair
Brian Ritchie	Ky. Coroner's Association
Sara Robeson	Dept. for Public Health, Ky. Injury Prevention and Research Center liaison
Joyce Robl	Dept. for Public Health, Maternal and Child Health epidemiologist
Morgan Scaggs	Kentucky Community and Technical College System, Emergency Medical Services/Technicians
Heidi Schissler	DCBS, Protection and Advocacy
Fred Scroggins	Kentucky State Police
Dr. Ruth Shepherd	Dept. for Public Health, Maternal and Child Health
Steve Sparrow	Univ. of Ky./ Ky. Safety and Prevention Alignment Network
Jan Ulrich	Dept. for Behavioral Health, Developmental and Intellectual Disabilities
Sabrina Walsh	Univ. of Ky./Ky. Violent Death Reporting System
Tina Webb	DCBS/Protection and Permanency
Melanie Tyner-Wilson	Univ. of Ky./Ky. Injury Prevention and Research Center

Note: DCBS is the Department for Community Based Services.

Source: Hagen, Colleen. Office of the Secretary, Cabinet for Health & Family Services. "State CFR Team." Message to Colleen Kennedy. June 13, 2014. Email.

Endnotes

¹ Brown, J. Michael, secretary. Tom Cannady. executive staff assistant. Marlene Mundine, legislative office program coordinator. Justice and Public Safety Cabinet; Judge Roger Crittenden, chair. Kentucky Child Fatality and Near Fatality External Review Panel; Detective Kevin Calhoun. State Police; Dr. Melissa Currie, chair. State Child Fatality Review Team; Joel Griffith. Prevent Child Abuse Kentucky. Personal interview. Feb. 14, 2014.

² Kentucky. Justice and Public Safety Cabinet. “Memorandum of Understanding Between the Justice and Public Safety Cabinet and the Child Fatality and Near Fatality Review Panel.” Sections 1 and 2.

³ Ibid. Section 2.

⁴ Ibid. Section 3.

⁵ Ibid.

⁶ Brown, J. Michael, secretary. Tom Cannady. executive staff assistant. Marlene Mundine, legislative office program coordinator. Justice and Public Safety Cabinet; Judge Roger Crittenden, chair. Kentucky Child Fatality and Near Fatality External Review Panel; Detective Kevin Calhoun. State Police; Dr. Melissa Currie, chair. State Child Fatality Review Team; Joel Griffith. Prevent Child Abuse Kentucky. Personal interview. Feb. 14, 2014; Audrey Tayse Haynes, secretary. Eric Friedlander, deputy secretary. Dana Nickles, policy adviser. Colleen Hagan, legislative director, Beth Jurek, executive director of Office of Policy and Budget; Teresa James, commissioner of Dept. for Community Based Services; Dr. Ruth Shepherd, director of Dept. for Public Health’s Division of Maternal and Child Health; Allyson Taylor, policy adviser. Dept. for Public Health. Cabinet for Health and Family Services. Personal interview. March 31, 2014.

⁷ Brown, J. Michael, secretary. Tom Cannady. executive staff assistant. Marlene Mundine, legislative office program coordinator. Justice and Public Safety Cabinet; Judge Roger Crittenden, chair. Kentucky Child Fatality and Near Fatality External Review Panel; Detective Kevin Calhoun. State Police; Dr. Melissa Currie, chair. State Child Fatality Review Team; Joel Griffith. Prevent Child Abuse Kentucky. Personal interview. Feb. 14, 2014.

⁸ Ibid.

⁹ Haynes, Audrey Tayse, secretary. Eric Friedlander, deputy secretary. Dana Nickles, policy adviser. Colleen Hagan, legislative director. Beth Jurek, executive director of Office of Policy and Budget; Teresa James, commissioner. Dept. for Community Based Services; Dr. Ruth Shepherd, director. Dept. for Public Health’s Division of Maternal and Child Health; Allyson Taylor, policy adviser. Dept. for Public Health. Cabinet for Health and Family Services. Personal interview. March 31, 2014.

¹⁰ Ibid.

¹¹ Cannady, Tom. “Staffing for Child Fatality Review Panel.” Message to Colleen Kennedy. June 16, 2014. Email.

¹² Kentucky. Child Fatality and Near Fatality External Review Panel. Approved Minutes. Web. June 18, 2014. Minutes. Jan. 13, 2014. Minutes. March 10, 2014; Cannady, Tom. “Adjusted dates for Panel meetings 2014.” Message to panel members. March 17, 2014. Email.

¹³ Kentucky. Child Fatality and Near Fatality External Review Panel. Approved Minutes. Web. June 18, 2014.

¹⁴ Cannady, Tom. Telephone interview. June 18, 2014.

¹⁵ Ibid.

¹⁶ KET: Kentucky Educational Television. Legislative Coverage Archives. Jan. 9—House Health and Welfare Committee 2014 Regular Session. Web. Jan. 23, 2014.

¹⁷ Cannady, Tom. “Questions for Program Review staff’s evaluation of the External Child Fatality and Near Fatality Review Panel.” Message to Colleen Kennedy. Feb. 24, 2014. Email.

¹⁸ Ibid.

¹⁹ Brown, J. Michael, secretary. Tom Cannady. executive staff assistant. Marlene Mundine, legislative office program coordinator. Justice and Public Safety Cabinet; Judge Roger Crittenden, chair. Kentucky Child Fatality and Near Fatality External Review Panel; Detective Kevin Calhoun. State Police; Dr. Melissa Currie, chair. State Child Fatality Review Team; Joel Griffith. Prevent Child Abuse Kentucky. Personal interview. Feb. 14, 2014.

²⁰ Cannady, Tom. Telephone interview. March 29, 2014.

²¹ Kentucky. Office of State Budget Director. *2014-2016 Executive Budget Recommendation: Operating Budget, Vol. 1, Part B*. P. 208. Web. June 17, 2014.

²² Brown, J. Michael, secretary. Tom Cannady. executive staff assistant. Marlene Mundine, legislative office program coordinator. Justice and Public Safety Cabinet; Judge Roger Crittenden, chair. Kentucky Child Fatality and Near Fatality External Review Panel; Detective Kevin Calhoun. State Police; Dr. Melissa Currie, chair. State Child Fatality Review Team; Joel Griffith. Prevent Child Abuse Kentucky. Personal interview. Feb. 14, 2014; KET:

Kentucky Educational Television. Legislative Coverage Archives. January 9—House Health and Welfare Committee 2014 Regular Session. Web. Jan. 23, 2014.

²³ Cannady, Tom. “SharePoint rated service.” Message to Colleen Kennedy. June 16, 2014. Email.

²⁴ Brown, J. Michael, secretary. Tom Cannady, executive staff assistant. Marlene Mundine, legislative office program coordinator. Justice and Public Safety Cabinet; Judge Roger Crittenden, chair. Kentucky Child Fatality and Near Fatality External Review Panel; Detective Kevin Calhoon. State Police; Dr. Melissa Currie, chair. State Child Fatality Review Team; Joel Griffith. Prevent Child Abuse Kentucky. Personal interview. Feb. 14, 2014.

²⁵ Kentucky. House Health and Welfare Committee. Child Fatality and Near Fatality External Review Panel Presentation of *2013 Annual Report*. Jan. 9, 2014. Web. Jan. 23, 2014.

²⁶ Brown, J. Michael, secretary. Tom Cannady, executive staff assistant. Marlene Mundine, legislative office program coordinator. Justice and Public Safety Cabinet; Judge Roger Crittenden, chair. Kentucky Child Fatality and Near Fatality External Review Panel; Detective Kevin Calhoon. State Police; Dr. Melissa Currie, chair. State Child Fatality Review Team; Joel Griffith. Prevent Child Abuse Kentucky. Personal interview. Feb. 14, 2014.

²⁷ Webb, Tina. “Copy of External Panel Total Cases.xlsx” and “CHFS Spreadsheets Sent to the External Child Fatality and Near Fatality Review Panel.” Message to Colleen Kennedy. June 18, 2014. Email.

²⁸ Brown, J. Michael, secretary. Tom Cannady, executive staff assistant. Marlene Mundine, legislative office program coordinator. Justice and Public Safety Cabinet; Judge Roger Crittenden, chair. Kentucky Child Fatality and Near Fatality External Review Panel; Detective Kevin Calhoon. State Police; Dr. Melissa Currie, chair. State Child Fatality Review Team; Joel Griffith. Prevent Child Abuse Kentucky. Personal interview. Feb. 14, 2014.

²⁹ Kentucky. Child Fatality and Near Fatality External Review Panel. “Summary of Child Fatality and Near Fatality External Review Panel meeting.” Nov. 2013. Web. June 19, 2014.

³⁰ Brown, J. Michael, secretary. Tom Cannady, executive staff assistant. Marlene Mundine, legislative office program coordinator. Justice and Public Safety Cabinet; Judge Roger Crittenden, chair. Kentucky Child Fatality and Near Fatality External Review Panel; Detective Kevin Calhoon. State Police; Dr. Melissa Currie, chair. State Child Fatality Review Team; Joel Griffith. Prevent Child Abuse Kentucky. Personal interview. Feb. 14, 2014; Audrey Tayse Haynes, secretary. Eric Friedlander, deputy secretary. Dana Nickles, policy adviser. Colleen Hagan, legislative director. Beth Jurek, executive director. Office of Policy and Budget; Teresa James, commissioner. Dept. for Community Based Services; Dr. Ruth Shepherd, director. Dept. for Public Health’s Division of Maternal and Child Health; Allyson Taylor, policy adviser. Dept. for Public Health. Cabinet for Health and Family Services. Personal interview. March 31, 2014.

³¹ Cannady, Tom. Personal interview. April 15, 2014.

³² Ibid.

³³ Kentucky. Cabinet for Health and Family Services. Dept. for Community Based Services. “Division of Protection and Permanency (DPP).” Web. June 18, 2014.

³⁴ Nickles, Dana. “Question for Program Review’s study of the Child Fatality & Near Fatality External Review Panel.” Message to Colleen Kennedy. April 7, 2014. Email.

³⁵ Haynes, Audrey Tayse, secretary. Eric Friedlander, deputy secretary. Dana Nickles, policy adviser. Colleen Hagan, legislative director. Beth Jurek, executive director. Office of Policy and Budget; Teresa James, commissioner. Dept. for Community Based Services; Dr. Ruth Shepherd, director. Dept. for Public Health’s Division of Maternal and Child Health; Allyson Taylor, policy adviser. Dept. for Public Health. Cabinet for Health and Family Services. Personal interview. March 31, 2014.

³⁶ Cannady, Tom. Personal interview. April 15, 2014.

³⁷ Haynes, Audrey Tayse, secretary. Eric Friedlander, deputy secretary. Dana Nickles, policy adviser. Colleen Hagan, legislative director. Beth Jurek, executive director. Office of Policy and Budget; Teresa James, commissioner. Dept. for Community Based Services; Dr. Ruth Shepherd, director. Dept. for Public Health’s Division of Maternal and Child Health; Allyson Taylor, policy adviser. Dept. for Public Health. Cabinet for Health and Family Services. Personal interview. March 31, 2014.

³⁸ Ibid.

³⁹ Cannady, Tom. Personal interview. April 15, 2014.

⁴⁰ Ibid.

⁴¹ Kentucky. Child Fatality and Near Fatality External Review Panel. Meeting Minutes. March 11, 2013. Web. June 17, 2014.

⁴² Shepherd, Dr. Ruth. Telephone interview. June 12, 2014.

⁴³ Haynes, Audrey Tayse, secretary. Eric Friedlander, deputy secretary. Dana Nickles, policy adviser. Colleen Hagan, legislative director. Beth Jurek, executive director. Office of Policy and Budget; Teresa James, commissioner. Dept. for Community Based Services; Dr. Ruth Shepherd, director. Dept. for Public Health’s

Division of Maternal and Child Health; Allyson Taylor, policy adviser. Dept. for Public Health. Cabinet for Health and Family Services. Personal interview. March 31, 2014.

⁴⁴ Kentucky. Child Fatality and Near Fatality External Review Panel. Meeting Minutes. May 13, 2013. Web. June 17, 2014.

⁴⁵ Kentucky. House Health and Welfare Committee. External Child Fatality and Near Fatality Review Panel Presentation of *2013 Annual Report*. Jan. 9, 2014. Web. Jan. 23, 2014.

⁴⁶ Kentucky. Child Fatality and Near Fatality External Review Panel. *2013 Annual Report*. P. 2. Web. June 19, 2014.

⁴⁷ Ibid. P. 4.

⁴⁸ Ibid. P. 5.

⁴⁹ Ibid. Pp. 5-7.

⁵⁰ Webb, Tina. "CHFS Spreadsheets Sent to the External Child Fatality and Near Fatality Review Panel." Message to Colleen Kennedy. June 18, 2014. Email.

⁵¹ Ibid.

⁵² Ibid.

⁵³ United States. Dept. of Health and Human Services. Children's Bureau. *Child Maltreatment 2012*. P. 2. Web. Jan. 24, 2014.

⁵⁴ National MCH Center for Child Death Review. "State Spotlight—Missouri." Web. June 15, 2014.

⁵⁵ Kentucky. Cabinet for Health and Family Services. Dept. for Public Health. *Public Health Child Fatality Review Program 2012 Annual Report*. P. 6. Web. Feb. 20, 2014.

⁵⁶ Ibid.

⁵⁷ Shepherd, Dr. Ruth. Telephone interview. June 12, 2014.

⁵⁸ National MCH Center for Child Death Review. "State Spotlight—Kentucky." Web. June 15, 2014.

⁵⁹ Brown, J. Michael, secretary. Tom Cannady, executive staff assistant. Marlene Mundine, legislative office program coordinator. Justice and Public Safety Cabinet; Judge Roger Crittenden, chair. Kentucky Child Fatality and Near Fatality External Review Panel; Detective Kevin Calhoon, State Police; Dr. Melissa Currie, chair. State Child Fatality Review Team; Joel Griffith. Prevent Child Abuse Kentucky. Personal interview. Feb. 14, 2014.

⁶⁰ National MCH Center for Child Death Review. "State Spotlight—Colorado." Web. June 15, 2014.

⁶¹ National MCH Center for Child Death Review. "State Spotlight—Georgia." Web. June 15, 2014.

⁶² National MCH Center for Child Death Review. "State Spotlight—Indiana." Web. June 15, 2014.

⁶³ National MCH Center for Child Death Review. "State Spotlight—Michigan." Web. June 15, 2014.

⁶⁴ Ibid.

⁶⁵ National MCH Center for Child Death Review. "State Spotlight—Tennessee." Web. June 15, 2014.

2015 Update On The Child Fatality And Near Fatality External Review Panel

Program Review And Investigations Committee

Sen. Danny Carroll, Co-chair
Rep. Martha Jane King, Co-chair

Sen. Tom Buford	Rep. Leslie Combs
Sen. Perry B. Clark	Rep. Tim Couch
Sen. Christian McDaniel	Rep. David Meade
Sen. Dorsey Ridley	Rep. Terry Mills
Sen. Dan “Malano” Seum	Rep. Ruth Ann Palumbo
Sen. Stephen West	Rep. Rick Rand
Sen. Whitney Westerfield	Rep. Arnold Simpson

Greg Hager, PhD
Committee Staff Administrator

Project Staff

Colleen Kennedy

Legislative Research Commission
Frankfort, Kentucky
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Adopted December 10, 2015

Abstract

The Child Fatality and Near Fatality External Review Panel conducts comprehensive reviews of child fatalities and near fatalities resulting from abuse or neglect. Statute requires that the Program Review and Investigations Committee annually monitor the panel's operations, procedures, and recommendations. Over the period covered in this report, the panel was in compliance with six of seven administrative requirements in statute and addressed all recommendations made in its 2014 annual report. The panel has determined that two of those recommendations would require action by the General Assembly.

Foreword

The Legislative Research Commission was established in 1948 to provide the staffing essential to the smooth and efficient operation of the Kentucky General Assembly. Over the course of the last 70 years, this organization has evolved into today's LRC: a multifaceted organization filling the many needs of a modern state legislature. As Kentuckians, we are fortunate to have hundreds of knowledgeable and dedicated professionals who provide high levels of analysis, legislative support, and customer service.

The staff of the Program Review and Investigations Committee perform the important work of monitoring and evaluating governmental programs throughout the Commonwealth. At the direction of the committee, they undertake a number of research reports every year, focusing on specific, well-defined questions of public policy.

Such work is done in collaboration with the community and within LRC. Program Review staff thank Judge Roger Crittenden, chair of the External Child Fatality and Near Fatality Review Panel, and all panel members for their cooperation and assistance. Staff thank Tom Cannady, the panel's executive assistant, for his valuable help. Among LRC staff, John McKee of the LRC Library was especially helpful.

Thank you for your interest in this publication and thank you to everyone who made this report possible.



David A. Byerman
Director

Legislative Research Commission
Frankfort, Kentucky
December 10, 2015

2015 Update On The Child Fatality And Near Fatality External Review Panel

According to KRS 6.922 and KRS 620.055(16), annually beginning in 2014 the Program Review and Investigations Committee shall “monitor the operations, procedures, and recommendations” of the Child Fatality and Near Fatality External Review Panel and report its findings to the General Assembly. The panel, which is attached administratively to the Justice and Public Safety Cabinet, conducts comprehensive reviews of child fatalities and near fatalities resulting from abuse or neglect.

The initial Program Review report on the panel, which was adopted in July 2014, covered in detail the panel’s organization, compliance with governing statutes, operations, and annual report. The Program Review report reviewed statistics on fatalities and near fatalities in Kentucky and other states and compared the organization of the Kentucky panel to that of its counterparts in other states. The panel was in compliance with its governing statutes. The report agreed with the panel that its need to aggregate trend data from a large volume of records and information was hampered by a lack of staff. The staffing concern was addressed through an appropriation by the 2014 General Assembly dedicated to the panel beginning July 1, 2014. This report reviews the panel’s activities from August 2014 to October 2015 and has one recommendation.

Conclusions

This report has three conclusions.

- The panel is in compliance with six of seven administrative requirements in statute.
- The panel has addressed all recommendations made in its 2014 annual report.
- The panel has determined that two of those recommendations would require action by the General Assembly.

Compliance With Statutes

Membership

KRS 620.055(2) requires that the panel have five ex officio nonvoting members and 15 voting members. Three of the voting members are panel members based on their position, 10 are appointed by the attorney general, one is appointed by the chief justice of the Supreme Court, and one is appointed by the secretary of state. Appointment procedures are detailed in statute. The panel's membership is in compliance.

Meeting Schedule

KRS 620.055(4) requires that the panel meet at least quarterly and may meet upon the call of the chair of the panel. The panel has met the requirement by meeting bimonthly.

Meeting Attendance

KRS 620.055(3)(d) requires that if a voting panel member is absent from two or more consecutive, regularly scheduled meetings, the member shall be considered to have resigned and shall be replaced. In practice, it is unclear how the three voting members who are on the panel based on their position could be replaced. For this report, only the other 12 voting members were considered. From the meeting of July 21, 2014, to the meeting of September 8, 2015, four appointed members had two consecutive absences from bimonthly meetings. One of the four's term ended June 30, 2015. The other three members remain on the panel.

Posting Updates

KRS 620.055(8) requires the panel to post updates after each meeting to the website of the Justice and Public Safety Cabinet regarding case reviews, findings, and recommendations. Minutes have been timely posted to the website for all meetings in 2014 and 2015.

Summary Reports

KRS 620.055(9) requires the panel chair, or other requested persons, to report a summary of the panel's discussions and proposed or actual recommendations to the Interim Joint Committee on Health and Welfare monthly or at the request of a committee co-chair. The committee has timely received a written summary of each panel meeting.

Annual Report

KRS 620.055(10) requires the panel to publish an annual report by December 1 consisting of case reviews, findings, and recommendations for system and process improvements to help prevent child fatalities and near fatalities that are due to abuse and neglect. The report shall be submitted to the governor, the secretary of the Cabinet for Health and Family Services, the chief justice of the Supreme Court, the attorney general, and the director of the Legislative Research Commission for distribution to the Health and Welfare Committee and the Judiciary Committee.

The panel published an annual report meeting the requirements on December 1, 2014. Copies were timely distributed to all members of the Interim Joint Committee on Health and Welfare at its December 17, 2014, meeting. The committee did not request an oral presentation of the report. The 2014 annual report was also timely submitted to the governor, the secretary of the Cabinet for Health and Family Services, the chief justice of the Kentucky Supreme Court, the attorney general, and the director of the Legislative Research Commission (LRC). The report was not distributed directly from the director's office to the Judiciary Committee, but it is available from a link on the LRC webpage.

Destruction Of Records

KRS 620.055(11) requires that all copies of information and records provided to the panel involving an individual case shall be destroyed by the Justice and Public Safety Cabinet at the conclusion of the panel's examinations. The panel's executive staff assistant takes all print case information to the state recycling center and witnesses the documents being shredded. He signs a document verifying that he witnessed the files being destroyed.

Electronic copies of cases in the panel's SharePoint online system have not yet been deleted. As time permits, contracted analysts will analyze all FY 2013 cases to extract data to use in trend identification. Once this is completed, the FY 2013 cases will be deleted. All data from the FY 2014 cases have been recorded by the analysts. The panel will maintain in SharePoint documents it has created for its own use, such as electronic discussions among panel members.

Recommendation

The panel may wish to create a formal policy for deleting cases stored in electronic form in SharePoint.

Action Of The Panel

During its first 2 years, the panel has worked to develop a methodology for reviewing cases and to create a staffing structure to implement the methodology. It has also begun to identify, encourage, and implement practices to reduce the number of child fatalities and near fatalities resulting from abuse or neglect. Although it is too soon to evaluate the panel's effect on those numbers, it has undertaken actions to address areas of special concern.

The panel's 2014 annual report included recommendations for panel, agency, legislative, and legal action. The table below summarizes how the recommendations have been addressed in 2015. The two recommendations that would require action by the General Assembly are

- developing a process for law enforcement to upload district and family court preventive and restrictive orders into the Law Information Network of Kentucky (LINK) and
- opening dependency cases in Kentucky courts.

Recommendations From The 2014 Annual Report And Actions Taken By The Panel Or State Agencies

Recommendation	Action
Develop and administer training conducted by medical professionals to family court and district court judges on abuse and neglect.	Meetings by panel with the Administrative Office of the Courts (AOC) have been conducted. A judicial presentation was held in Sept. 2015. Other training is being planned by AOC.
Develop, in collaboration with medical professionals, a statewide public awareness campaign highlighting the dangers of bed sharing and impaired bed sharing.	A campaign was launched by the Dept. for Public Health in October 2015.
Include information on the dangers of bed sharing and impaired bed sharing in any home visits with parents of infants.	Panel members are developing a tip sheet for Department for Community Based Services (DCBS) workers. The Dept. for Public Health and DCBS worked to include information on bed sharing during home visits.
Work to improve access to quality structured mental health assessments for caregivers of children in families found to be high risk.	The Affordable Care Act provides mental health coverage that allows access to Kentucky parents in need. The DCBS Assessment and Documentation Tool allows more targeted assessment.
Develop best practice guidelines for discharge of infants with neonatal abstinence syndrome and distribute them to all birthing hospitals.	Guidelines are in draft form for review and comment and were presented at a statewide meeting in Nov. 2015.
Develop a workforce study to look at workloads for DCBS workers.	The cost of such a study has been a barrier, but DCBS is working with the Cabinet for Health and Family Services (CHFS) leadership on the issue. DCBS has opened more management positions to help new workers.
Health care providers should discuss safe sleep with parents of newborns, including the dangers of bed sharing, particularly when the caregiver may be impaired by exhaustion or sedating substances.	This is included in a CHFS statewide awareness campaign.
Birthing hospitals should develop policies and practices to model safe sleep in their neonatal intensive care units.	A national certification program is now available. Three Kentucky hospitals have updated policies to model safe sleep.

Recommendation	Action
<p>Birthing hospitals should assure linkage of high-risk infants to a medical home and needed community services prior to discharge, make appointments for the newborn's follow-up with a medical home, identify and address any barriers to the family's attendance at that appointment, and establish communication protocol with the medical home so that if a high-risk infant does not show for follow-up, the office will notify the hospital social worker to make sure the infant is not in danger.</p>	<p>This is a recommended practice in the Dept. for Public Health's Kentucky Infants Safe and Strong hospital recognition program. However, it is an optional step. The practice was promoted at a statewide meeting.</p>
<p>Develop a protocol to administer across-the-board drug testing of caregivers in cases in which a child suffered an unexpected fatality.</p>	<p>Possible issues with across-the-board testing exist. The panel is considering a possible recommendation to encourage training of law enforcement.</p>
<p>*Develop a process for law enforcement to upload district and family court preventive and restrictive orders into the Law Information Network of Kentucky (LINK).</p>	<p>LINK system updates would be feasible only through legislation and funding.</p>
<p>Conduct scene investigations in cases in which a child suffered a fatality or near fatality and there is reasonable suspicion to believe the cause involved abuse or neglect.</p>	<p>The Department of Criminal Justice Training and Kentucky State Police are willing to address any unmet training need and will work with the panel.</p>
<p>*Consider authorizing legislation and Supreme Court rule change to open dependency, neglect, and abuse cases in Kentucky courts.</p>	<p>The panel continues to support the opening of dependency cases. Legislation is needed.</p>
<p>Develop and administer training conducted by medical professionals to county attorneys and staff on abuse and neglect.</p>	<p>Meetings with the AOC have been conducted. A training outline is in progress. A webinar is being discussed.</p>
<p>Develop education targeted to all professionals who work with children, as well as the community at large, about mandatory reporting requirements and recognition of early warning signs of child physical abuse, including specific education about bruising in infants.</p>	<p>Agencies represented on the panel have continued to provide and update training, including an update on Pediatric Abusive Head Trauma and the implementation of 2014 HB 157 and 2015 SB 119.</p>

Recommendation	Action
Not Included In The 2014 Annual Report But Included In The Panel's Action Plan For 2015	
<p>Develop multitiered prevention programming for abusive head trauma to be provided to parents by birth hospitals, health care providers and home-visiting programs that include the dangers of shaking an infant or young child, how to deal with infant crying including soothing techniques and permission for caregivers to step away and take a break when feeling frustrated, choosing safe caregivers for infants and young children, and having an action plan for caregivers in the event of escalating frustration.</p> <p>Two ideas were presented to the panel in 2015 that will need continued focus in 2016:</p> <ul style="list-style-type: none"> • Look into protocol for sharing information with DCBS during the investigatory process of child fatalities and near fatalities. • Consult existing statutes on sharing of information during child death investigations and ensure compliance. 	<p>A packet of information has been developed. A survey of birthing hospitals' practices is being implemented. A panel letter to all hospitals was sent in October 2015 to encourage them to develop evidence-informed prevention education to parents and caregivers.</p>

*Implementing the recommendation would require action by the General Assembly.

Sources: Kentucky. Child Fatality and Near Fatality External Review Panel. *2014 Annual Report*. Pp. 16-17; Cannady, Tom "Recommendations status spreadsheet." Message to Colleen Kennedy. Nov. 19, 2015. Email.

2016 Update On The Child Fatality And Near Fatality External Review Panel

Program Review and Investigations Committee

Sen. Danny Carroll, Co-chair
Rep. Terry Mills, Co-chair

Sen. Julie Raque Adams	Rep. Tim Couch
Sen. Tom Buford	Rep. David Meade
Sen. Perry B. Clark	Rep. Ruth Ann Palumbo
Sen. Dan “Malano” Seum	Rep. Rick Rand
Sen. Reginald Thomas	Rep. Arnold Simpson
Sen. Stephen West	Rep. Chuck Tackett
Sen. Whitney Westerfield	Rep. Jeff Taylor

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Adopted December 13, 2016

Paid for with state funds. Available in alternative format by request.

Abstract

KRS 620.055(16) requires an annual update by the Program Review and Investigations Committee on the Kentucky Child Fatality and Near Fatality External Review Panel. The panel is attached administratively to the Justice and Public Safety Cabinet and conducts comprehensive reviews of child fatalities and near fatalities resulting from abuse or neglect. Statute establishes panel requirements for filling membership vacancies, meeting at least quarterly, monitoring attendance of members, posting updates, issuing summary reports of meetings, publishing an annual report each December 1, and following records retention and destruction policies. The panel has timely complied with all statutory requirements except that the 2016 annual report was published on December 12. The panel had a direct effect on the outcome of one child abuse case during 2016. In previous fiscal years, a specified amount for the panel was included in the cabinet's budget. Beginning with FY 2017, funding for the panel is included in the cabinet's baseline budget. Recent information from the cabinet is that \$382,000 has been set aside for the panel. However, the panel's understanding has been that no set amount of funding was set aside for it in FY 2017.

Foreword

The Legislative Research Commission was established in 1948 to provide the staffing essential to the smooth and efficient operation of the Kentucky General Assembly. Over the course of the last 70 years, this organization has evolved into today's LRC: a multifaceted organization filling the many needs of a modern state legislature. As Kentuckians, we are fortunate to have hundreds of knowledgeable and dedicated professionals who provide high levels of analysis, legislative support, and customer service.

The staff of the Program Review and Investigations Committee perform the important work of monitoring and evaluating governmental programs throughout the commonwealth. At the direction of the committee, they undertake a number of research reports every year, focusing on specific, well-defined questions of public policy.

Such work is done in collaboration with the community and within LRC. Program Review staff thank Judge Roger Crittenden, Chair of the External Child Fatality and Near Fatality Review Panel; Lyn Bruckner, staff attorney; and Tim Havrilek, Justice and Public Safety Cabinet administrator, for their cooperation and assistance. Among LRC staff, Zachary Ireland, legislative fiscal analyst in Budget Review, and DeeAnn Wenk, committee staff administrator of the Interim Joint Committee on Health and Welfare, were especially helpful.

Thank you for your interest in this publication, and thank you to everyone who made this report possible.



David A. Byerman
Director

Legislative Research Commission
Frankfort, Kentucky
December 2016

2016 Update On The Child Fatality And Near Fatality External Review Panel

According to KRS 6.922 and KRS 620.055(16), annually beginning in 2014 the Program Review and Investigations Committee shall “monitor the operations, procedures, and recommendations” of the Child Fatality and Near Fatality External Review Panel and report its findings to the General Assembly. The panel, which is attached administratively to the Justice and Public Safety Cabinet, conducts comprehensive reviews of child fatalities and near fatalities resulting from abuse or neglect.

Relationship Of Panel To Justice and Public Safety Cabinet

KRS 620.055 says the panel shall be attached to the Justice and Public Safety Cabinet for staff and administrative purposes. A memorandum of understanding was signed in 2014 and is attached to this report. According to the memorandum,

- The Cabinet affirms the importance of the Panel’s work and that its work shall be carried out independently and without any interference by the Cabinet.
- The Cabinet pledges not to interfere in any way with the discretion, judgment, or operation of the Panel or its individual members in the conduct of their duties.¹

In 2016, the cabinet has examined panel procedures to ensure 100 percent compliance with state policy.

The panel operates on a calendar year basis. Cabinet staff review the panel’s uses of funds to ensure they are within the confines of statute.² The governor’s budget for 2014-2016 requested \$420,000 in each year of the biennium from the General Fund for five full-time positions and operating costs. During those years, the panel was creating a methodology and a data tool, and deciding on the necessary full-time staffing. Actual expenditures were \$219,528 in FY 2015 and \$296,186 in FY 2016. FY 2017 panel funding is part of the cabinet’s baseline funding, although recent information from a cabinet official is that \$382,000 has been set aside for the panel.³ However, the panel’s understanding has been that no specified amount of funding was set aside for it in FY 2017.

Compliance With Statutes

Composition Of Membership

KRS 620.055(2) requires that the panel have 5 ex officio nonvoting members and 15 voting members. Three of the voting members are panel members based on their position, 10 are appointed by the attorney general, and 1 is appointed by the chief justice of the Supreme Court. Appointment procedures are detailed in statute. The panel has complied, but there was one vacancy for part of the year. The term of the representative from a community mental health center expired on June 30, 2016. KRS 620.055(2)(r) specifies that three names must be submitted by the Kentucky Association of Regional Mental Health and Mental Retardation

Programs Inc. to the attorney general, who then appoints one as a panel member. Panel staff timely sent letters to the association and the attorney general notifying them of the upcoming vacancy. The replacement was named only in time for the panel's November 21, 2016, meeting.

The panel has added an ex officio expert under KRS 620.055(7). The appointee, who is with the University of Kentucky Department of Pediatrics, will be helpful on many of the cases the panel reviews.

Schedule Of Meetings

KRS 620.055(4) requires that the panel meet at least quarterly and may meet upon the call of the chair of the panel. The panel has met the requirement by meeting seven times in 2016, including a 3-day meeting.

Attendance At Meetings

KRS 620.055(3)(d) requires that if a voting panel member is absent from two or more consecutive, regularly scheduled meetings, the member shall be considered to have resigned and shall be replaced. In practice, it is unclear how the voting members who are on the panel based on their position could be replaced. For this report, only the 12 appointed voting members were considered. Exempted are excused absences, such as for illness or job emergencies. In 2016, the panel was in compliance.

Posting Of Updates

KRS 620.055(8) requires the panel to post updates after each meeting to the website of the Justice and Public Safety Cabinet regarding case reviews, findings, and recommendations. In 2016, updates have been timely posted. For 2016, the panel discontinued the practice of posting minutes on the website. At some point, the panel may wish to reconsider posting minutes to the website to enhance transparency.

Summary Reports

KRS 620.055(9) requires the panel chair, or other requested persons, to report a summary of the panel's discussions and proposed or actual recommendations to the Interim Joint Committee on Health and Welfare monthly or at the request of a committee co-chair. The committee co-chairs have timely received the minutes, case reviews, findings, and recommendations of each meeting via email.⁴ Beginning in October 2016, these summaries have also been emailed to the committee staff administrator of the committee.⁵

Annual Report

KRS 620.055(10) requires the panel to publish an annual report by December 1 of each year consisting of case reviews, findings, and recommendations for system and process improvements to help prevent child fatalities and near fatalities that are due to abuse and neglect. The report shall be submitted to the governor, the secretary of the Cabinet for Health and Family Services, the chief justice of the Supreme Court, the attorney general, and the director of the Legislative

Research Commission for distribution to the Interim Joint Committee on Health and Welfare and the Interim Joint Committee on the Judiciary. The panel published an annual report meeting the requirements on December 1, 2015. Copies were timely distributed to all members of the Interim Joint Committee on Health and Welfare.⁶ The Interim Committee on the Judiciary prefers to access the report from the Legislative Research Commission website as needed.⁷

The panel published its 2016 annual report on December 12, 2016.

Destruction Of Records

KRS 620.055(11) requires that at the conclusion of the panel's examinations, all copies of information and records provided to the panel involving an individual case shall be destroyed by the Justice and Public Safety Cabinet.

Program Review's 2015 report recommended that the panel may wish to create a formal policy for deleting cases stored in its SharePoint online system. The panel has done so. It has adopted a 5-year retention schedule in accordance with the practice of other Kentucky agencies tracking similar data and that of similar panels in other states as noted by panel members at its November 21, 2016, meeting. The panel will maintain in SharePoint documents it has created for its own use, such as panel member electronic discussions.

The panel continues its established policy of shredding paper documents. Panel staff schedule the state contractor for a special pickup of documents to be shredded. The courier signs an additional document attesting the pickup and shredding process.⁸

Panel Staffing

At present, the panel staff consists of

- a staff attorney, the panel's only full-time staff, whose salary is paid in full by the panel;
- an executive staff adviser who also handles a number of other duties for the Justice and Public Safety Cabinet and whose salary is 50 percent funded by the panel;
- a Justice and Public Safety Cabinet administrator; and
- an intern during the spring semester, who is paid a stipend through the Association of Independent Kentucky Colleges and Universities.

The panel also uses part-time contractors who review all case records and prepare case summaries and timelines to facilitate the panel review process. They are

- four medical case analysts under contract with the University of Louisville, and
- two social work case analysts with whom the panel contracts directly as personal service contractors.⁹

At its November 21, 2016, meeting, the panel expressed that it would like to have the following staff dedicated to the panel:

- a full-time director,

- a full-time program coordinator,
- a full-time data analyst,
- an intern, and
- contractors as needed.

A formal request has not been made based on the understanding that funding was unavailable.

Action Of The Panel

An example of the influence the panel may have on practices pertaining to child near fatalities is its finding of physical abuse in an incident at a public school for students with disabilities. The case involved staff use of prone or supine restraint to restrain an autistic minor that resulted in severe injuries. Investigations by police, state child protection officials, and school officials did not determine that abuse was involved. The panel, after reviewing all documents, concluded that physical abuse caused the injuries because staff used prone and supine restraint. As a result, the Kentucky commissioner of education sent a cease-and-desist letter to all public school superintendents, banning this practice. The letter made clear that the practice violates 704 KAR 7:160.¹⁰

The panel's 2015 annual report contained 10 recommendations. Two required legislative action. Of these, one has been implemented by legislation. Four recommendations involved the Department for Community Based Services, one involved law enforcement, one involved the courts, and two involved other state entities. The status of the recommendations is listed in the following table.

The panel's 2016 annual report includes two recommendations for 2017 that require legislative action:

- The Kentucky General Assembly should enact legislation creating easily accessible and low-cost access to background checks for parents considering utilization of unregulated child care providers.
- The General Assembly should consider enactment of enhanced penalties when a driver is convicted of driving under the influence with a minor in the vehicle.

Action On Panel's 2015 Recommendations

2015 Recommendation	2016 Implementation
<p>The General Assembly should implement legislation allowing dependency, neglect, and abuse court proceedings to be opened to the public for the purposes of transparency, accountability, and systems improvement.</p>	<p>General Assembly passed legislation codified at KRS 21A.190, which outlines a 4-year pilot project and requests that the Supreme Court of Kentucky institute it.</p>
<p>The General Assembly should pass legislation requiring hospitals and birthing centers to provide prevention of abusive head trauma training and safe sleep information to parents prior to an infant's discharge.</p>	<p>Panel continues to seek avenues for building support for this.</p>
<p>Drug court participants, youth who are involved with the Court Designated Worker Program, and any person who is a party to any family court proceeding should be required to receive education on prevention of abusive head trauma and safe sleep.</p>	<p>Panel sent letters to judges and provided a video on safe sleep to the Administrative Office of the Courts.</p>
<p>As required by KRS 72.410(3)(a), coroners should make timely notifications to and gather necessary information from law enforcement, the Department for Community Based Services (DCBS), and the local health department upon notification of the death of a child under 18 years of age.</p>	<p>Panel is searching for an efficient tool to capture the appropriate information. The panel is reviewing the new coroner brochure and its checklist and training on procedures.</p>
<p>Permit/require multidisciplinary teams on child sexual abuse, established by KRS 431.600 and 620.040, to also review physical abuse cases.</p>	<p>Panel staff has discussed with multidisciplinary teams. Panel is creating a survey of teams to determine which ones currently review physical abuse cases and criteria for selection of those cases.</p>
<p>Law enforcement should actively enhance enforcement of the provisions of KRS 189.125 that require infants and children to be properly secured in child restraint systems and booster seats during transport in a motor vehicle.</p>	<p>Panel is reviewing Motor Vehicle Commission report for better understanding of whether citations were issued for impaired driving and lack of restraint. Panel is also reviewing data collection.</p>

2015 Recommendation	2016 Implementation
<p>DCBS should consider inadequate restraint as an important indicator of neglect in an impaired driving incident or collision involving children, and include and weigh that information in its investigation and substantiation process.</p>	<p>DCBS is conducting discussions and meetings with regions and with panel members.</p>
<p>Ensure the DCBS internal review process of child fatality or near fatality as mandated in KRS 620.050(12) is conducted in a manner consistent with the statute and is part of a quality improvement process to address critical incidents within the child protection system. The review should include an examination of case best practice, policy compliance, staff training and experience, and a caseload analysis.</p>	<p>The DCBS process is becoming more formalized. A form has been drafted for use in internal reviews.</p>
<p>DCBS should implement quality improvement practices to increase the timely completion of investigations of fatalities and near fatalities. The annual report of child maltreatment fatalities and near fatalities that the department produces should specifically identify the number of incomplete investigations at the time of release of the report so the public is aware of these preliminary figures and knows that they may increase significantly.</p>	<p>The DCBS Director of Protection and Permanency has become more involved in the process.</p>
<p>DCBS should provide to the panel information regarding the caseload, training, and experience levels of staff serving families in which a fatal or near fatal incident has occurred.</p>	<p>The DCBS process is becoming more formalized. A form has been drafted for use in internal reviews. Department will provide the information as cases are referred to the panel.</p>

Source: Bruckner, Lyn. "2015 Recommendations May and July Update." Message to Colleen Kennedy. Nov. 22, 2016. Email.

Appendix

Memorandum Of Understanding Between The Justice And Public Safety Cabinet And The Child Fatality And Near Fatality Review Panel



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MEMORANDUM OF UNDERSTANDING BETWEEN THE JUSTICE AND PUBLIC SAFETY CABINET AND THE CHILD FATALITY AND NEAR FATALITY REVIEW PANEL

Pursuant to KRS 620.055, the Child Fatality and Near Fatality Review Panel (hereinafter “the Panel”) is an external panel made up of 20 members that conducts comprehensive reviews of child fatalities and near fatalities and issues case reviews, findings, and recommendations for improvement to help prevent child fatalities and near fatalities due to abuse and neglect. The Panel operates as an independent entity attached to the Justice and Public Safety Cabinet (hereinafter “the Cabinet”) solely “for staff and administrative purposes.” The Cabinet recognizes that in order to effectively perform its functions, the Panel must operate independently. This Memorandum of Understanding sets forth the formal agreement governing the manner in which potential conflicts of interest and other problems that could arise within this structure will be avoided.

1. The need for the Panel to be able to conduct closed sessions effectively

There are several agencies within the Justice and Public Safety Cabinet that may have had involvement in cases that are reviewed by the Panel. The Panel is permitted to conduct closed sessions pursuant to KRS 620.055(12) to review and discuss individual cases. Because of the amount of work necessary to prepare for and conduct Panel meetings, individuals employed by the Cabinet perform tasks for the Panel and may be asked to attend closed sessions. Similarly, some Panel members are employees of the Cabinet and may be a part of closed session discussions. The Cabinet and Panel agree that any discussions that occur during closed sessions will not be divulged by Cabinet employees who were present during closed sessions except as outlined in KRS 620.055(12).

2. The need for an independent review function and how independence will be maintained

The Panel was established to be external to the Justice and Public Safety Cabinet and independent of the executive branch. It was assigned the tasks of reviewing cases, issuing



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findings, and making recommendations for system and process improvements. The Panel's case reviews could involve scrutinizing the actions of employees of the Cabinet as well as other employees of state and local government. The Cabinet affirms the importance of the Panel's work and that its work shall be carried out independently and without any interference by the Cabinet.

The Panel's independence is guaranteed by KRS 620.055 and in the following ways:

- The Justice and Public Safety Cabinet affirms the importance of and guarantees the independence of the Panel's functions.
- The Panel is described in KRS 620.055 as "external" and "attached to the Justice and Public Safety Cabinet for staff and administrative purposes."
- The Panel is a multi-disciplinary group composed of individuals from each branch of state government, from local government, from private non-profits, from universities, and from the community, each of whom have experience in subject matter areas relevant and useful to the Panel.
- None of the Panel members are appointed by the Governor or Justice Cabinet Secretary, nor can they be removed by the Governor or Justice Cabinet Secretary.
- Neither the Panel nor its chairperson is made responsible to the Justice Cabinet Secretary in KRS 15A.020, 31.010, or 620.055. Rather, KRS 620.055 gives the Panel independent responsibilities and authority to carry out those responsibilities.
- The Cabinet pledges not to interfere in any way with the discretion, judgment, or operation of the Panel or its individual members in the conduct of their duties.
- Any employee of the Cabinet who is assigned to assist the Panel in carrying out its duties, whether that assignment is temporary or permanent, will perform his or her responsibilities relating to the Panel solely under the direction of the chair of the Panel. The Cabinet will not interfere in any way with the employee's performance of work for the Panel.
- The Panel will have control over its information technology equipment and use. The Panel will work directly with the Commonwealth Office of Technology to ensure that the Panel's information technology is in conformity with the requirements of state government. The Cabinet and the Panel will take all necessary steps to ensure that reasonable procedures are in place to maintain the confidentiality of all records that are confidential under state and federal law. The Cabinet will destroy all copies of information and records provided to the Panel in accordance with the requirements of KRS 620.055(11).
- The Cabinet will not require the use of letterhead that represents the Panel to be a part of the Cabinet. Rather, the Panel will use a suitable letterhead that reflects its position as an independent entity with independent authority and responsibilities.

3. Administrative relationship

The Panel is "attached to the Justice and Public Safety Cabinet for staff and administrative purposes." KRS 620.055(1). The Panel and Cabinet will work together to ensure a transparent, efficient, and accountable administrative process consistent with the provisions for confidentiality of case records pursuant to other state and federal law.

KRS 620.055 does not require the Panel to report to the Cabinet; however, the Cabinet and Panel agree that there is a need for administrative information to be provided to the Cabinet by the Panel. The Panel authorizes the Panel's Chair to keep the Cabinet Secretary or the Cabinet Secretary's designee sufficiently apprised of the Panel's administrative actions, including, but not limited to, budget requests and financial expenditures. Providing this information shall in no way be deemed to reduce the Panel's independence; rather, this reporting is necessary to allow the Cabinet to perform its fiscal responsibilities and other obligations owed to the citizens of the Commonwealth.

The Chair of the Panel will give advance notice to the Cabinet Secretary or the Cabinet Secretary's designee of any appearances by a representative of the Panel to testify before a legislative or other policy-creating body. The notice will be provided in a manner that will foster quick communication, but will not disturb the Panel's independence.


4. Budget matters

The Panel is attached to the Cabinet for staff and administrative purposes. The Panel's budget request will be provided to the Cabinet in the fall prior to the budget session of the General Assembly on a date and format to be required by the Cabinet. The Cabinet will operate as a pass-through and will submit the Panel's budget to the Office of State Budget Director without prioritization. The Cabinet recognizes that the Panel may have to demonstrate its budgetary needs to the executive branch and to members of the General Assembly.

5. The need to establish a good working relationship

The Cabinet recognizes the panel's need for independence and is fully dedicated to the mission of the Panel. The Panel members and Cabinet employees who are involved with or may appear before the panel agree to work together on various matters that may arise. At all times, efforts will be made to maintain a civil and professional working relationship between the Panel and the Cabinet.


J. Michael Brown 5/23/2014
Secretary Date
Justice and Public Safety Cabinet


Roger Crittenden 5/23/2014
Chair Date
Child Fatality and Near Fatality Review Panel

Endnotes

- ¹ Kentucky. Justice and Public Safety Cabinet. “Memorandum of Understanding Between the Justice and Public Safety Cabinet and the Child Fatality and Near Fatality Review Panel.” Message from Tom Cannady to Colleen Kennedy. May 16, 2014. Email.
- ² Ireland, Zach. “Funding for the Kentucky Child Fatality and Near Fatality External Review Panel.” Message to Colleen Kennedy. Sept. 7, 2016. Email.
- ³ Havrilek, Tim. “Letter to Program Review and Investigations Committee Staff.” Dec. 9, 2016. Message from Lyn Bruckner to Colleen Kennedy. Dec. 9, 2016. Email
- ⁴ Wenk, DeeAnn. “Info on Child Fatality and Near Fatality External Review Panel.” Message to Colleen Kennedy. Nov. 30, 2016. Email.
- ⁵ Bruckner, Lyn. “New Email for Minutes and Case Reviews.” Message to DeeAnn Wenk and Colleen Kennedy. Nov. 29, 2016. Email.
- ⁶ Rigsby, Gina. “Justice and Public Safety Cabinet Reports.” Message to Colleen Kennedy. Nov. 22, 2016. Email.
- ⁷ Comstock, Katie. Committee Staff Administrator, Interim Joint Committee on the Judiciary. Telephone interview. Dec. 1, 2016.
- ⁸ Bruckner, Lyn. “Responses to Questions.” Message to Colleen Kennedy. Nov. 22, 2016. Email.
- ⁹ Bruckner, Lyn. “KRS 620.055(9).” Message to Colleen Kennedy. Nov. 17, 2016. Email; Crittenden, Roger. “January 25 Panel Meeting.” Message to Colleen Kennedy. Jan. 26, 2016. Email; Bruckner, Lyn. “January 25 Panel Meeting.” Message to Colleen Kennedy. Jan. 26, 2016. Email.
- ¹⁰ Pruitt, Stephen. Commissioner, Kentucky Dept. of Education. “704 KAR 7:160, Use of Physical Restraint and Seclusion in Public Schools; Prohibition of Aikido Control Training (ACT); need reply by Tuesday, Aug. 9.” Message to all state superintendents. Aug. 2, 2016. Message from Tracy Herman to Colleen Kennedy. Dec. 2, 2016. Email.

2017 Update On The Child Fatality And Near Fatality External Review Panel

Program Review and Investigations Committee

Sen. Danny Carroll, Co-chair

Rep. Lynn Bechler, Co-chair

Sen. Tom Buford

Sen. Perry B. Clark

Sen. Dan “Malano” Seum

Sen. Wil Schroder

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Rep. Arnold Simpson

Rep. Walker Thomas

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Abstract

The Program Review and Investigations Committee is required by statute to annually monitor the operations, procedures, and recommendations of the Child Fatality and Near Fatality External Review Panel. The panel, attached administratively to the Justice and Public Safety Cabinet, conducts comprehensive reviews of child fatalities and near fatalities resulting from abuse or neglect. KRS 620.055 establishes requirements for filling membership vacancies, meeting at least quarterly, monitoring attendance of members, posting updates, issuing summary reports of meetings, publishing an annual report each December 1, and following records retention and destruction policies. The panel has timely complied with statutory requirements with two exceptions. Its 2017 annual report was published on December 8. A membership vacancy went unfilled after numerous attempts to contact the responsible, but possibly inactive, association. In an attempt to help resolve this problem, this report has one recommendation directed to the General Assembly regarding appointments. Three of the nine recommendations in the panel's 2016 annual report resulted in actions by the General Assembly, the Kentucky Hospital Association, or the Administrative Office of the Courts during 2017.

Foreword

The Legislative Research Commission was established in 1948 to provide the staffing essential to the smooth and efficient operation of the Kentucky General Assembly. Over the course of the last 70 years, this organization has evolved into today's LRC: a multifaceted organization filling the many needs of a modern state legislature. As Kentuckians, we are fortunate to have hundreds of knowledgeable and dedicated professionals who provide high levels of analysis, legislative support, and customer service.

The staff of the Program Review and Investigations Committee perform the important work of monitoring and evaluating governmental programs throughout the commonwealth. At the direction of the committee, they undertake a number of research reports every year, focusing on specific, well-defined questions of public policy.

Such work is done in collaboration with the community and within LRC. Program Review staff thank Judge Roger Crittenden, chair of the Child Fatality and Near Fatality External Review Panel, and executive staff adviser Elisha Mahoney. Among LRC staff, Katie Comstock, Miriam Fordham, Jake Fouts, Zach Ireland, Gina Rigsby, and DeeAnn Wenk were especially helpful.

Thank you for your interest in this publication, and thank you to everyone who made this report possible.



David A. Byerman
Director

Legislative Research Commission
Frankfort, Kentucky
August 2018

2017 Update On The Child Fatality And Near Fatality External Review Panel

According to KRS 620.055(16) and KRS 6.922, the Program Review and Investigations Committee shall annually “monitor the operations, procedures, and recommendations” of the Child Fatality and Near Fatality External Review Panel and report its findings to the General Assembly. The panel, which is attached administratively to the Justice and Public Safety Cabinet, conducts comprehensive reviews of child fatalities and near fatalities resulting from abuse or neglect.

In 2017, the panel reviewed 150 cases from fiscal year 2016, including three from the Department for Public Health. The cases comprised 59 fatalities and 91 near fatalities.¹

Conclusions

This report has two conclusions.

- The panel is in compliance with all but two of the statutory administrative requirements. First, the 2017 Annual Report was published on December 8 rather than December 1. Second, a panel seat has been vacant since June 30, 2017. Nominations must come from the Kentucky Association of Addiction Professionals, which has not responded to requests for nominations from the panel and the attorney general’s office.
- Three of the nine recommendations in the panel’s 2016 annual report resulted in actions by the General Assembly, the Kentucky Hospital Association, or the Administrative Office of the Courts during 2017.

Relationship Of Panel To Justice And Public Safety Cabinet

A 2014 memorandum of understanding describes the panel’s administrative attachment to the Justice and Public Safety Cabinet. A copy is in the *2016 Update* Appendix. According to the memorandum:

- The panel was established to be external to the Justice and Public Safety Cabinet and independent of the executive branch.
- The cabinet affirms the importance of the panel’s work and that its work shall be carried out independently and without any interference by the cabinet.
- The cabinet pledges not to interfere in any way with the discretion, judgment, or operation of the panel or its members in the conduct of their duties.
- The panel authorizes the panel’s chair to keep the cabinet secretary sufficiently apprised of the panel’s administrative actions, including, but not limited to, budget requests and financial expenditures.

Compliance With Statutes

Membership

KRS 620.055(2) requires that the panel have five ex officio nonvoting members and 15 voting members. Three of the voting members are panel members based on their position, 10 are appointed by the attorney general, one is appointed by the chief justice of the Supreme Court, and one is appointed by the secretary of state.

The panel's membership is in compliance with one exception. The addiction specialist's term ended June 30, 2017. As of December 2017, a replacement had not been appointed. Three nominations must come from the Kentucky Association of Addiction Professionals, with final appointment by the attorney general (KRS 620.055(2)(p) and (3)(b)). The association has not nominated anyone to fill the vacancy.

The panel and the attorney general's office attempted to contact association officials numerous times to notify them of the vacancy but received no response.² At its July 2018 meeting, the panel noted that the association may be inactive. The panel member from the Kentucky Association of Regional Mental Health and Mental Retardation Programs has volunteered to find recommendations to submit to the attorney general's office because professionals in those fields overlap. However, KRS 620.055(3)(b) does not include language allowing the appointing authority to fill appointments if no nominations are made by the entity specified in statute. KRS 620.055(7) does give the panel authority to "seek the advice of experts," which could allow for an addiction specialist to advise the panel. This is different from having such a person as a panel member. An adviser would not be a voting member and would not be covered under KRS 620.055(5), which allows panel members to be reimbursed for expenses.

The recommendation below covers appointments to the panel, but the General Assembly may wish to consider applying it to other statutes that provide for nominations or appointments to be made by entities specified in statute.

Recommendation

The General Assembly may wish to specify a procedure for filling the vacancy of a voting member when it cannot be filled in the same manner as the original appointment.

Meeting Schedule

KRS 620.055(4) requires the panel to meet at least quarterly. It may also meet upon the call of the panel chair. The panel met this requirement by meeting eight times in 2017, including a 3-day session in April and a 2-day session in November.

Meeting Attendance

KRS 620.055(3)(d) requires that if a voting panel member is absent from two or more consecutive, regularly scheduled meetings, the member shall be considered to have resigned and shall be replaced. In practice, it is unclear how the voting members who are on the panel based on their position could be replaced. For this report, only the 12 appointed voting members were considered. The panel exempts excused absences, such as for illness or emergency schedule conflicts. Given this panel policy, all appointed panel members were in compliance.

Posting Updates

KRS 620.055(8) requires the panel to post updates on the Justice and Public Safety Cabinet's website after each meeting. These must include case reviews, findings, and recommendations. The posting of minutes was discontinued in 2016. Although statute does not specifically require that minutes be posted, such posting provides further transparency.

The Program Review and Investigation Committee's *2016 Update* recommended that the panel reconsider posting all minutes to the website. In response, the panel has timely posted its 2016 and 2017 minutes.

Summary Reports

KRS 620.055(9) requires the panel to report a summary of its discussions, along with any proposed or actual recommendations, to the Interim Joint Committee on Health and Welfare and Family Services monthly or at least at the request of the committee co-chair. The committee co-chairs and the committee staff administrator have timely received reports via email when requested.³

Annual Report

KRS 620.055(10) requires the panel to publish an annual report by December 1 that recommends system and process improvements to help prevent child fatalities and near fatalities that are due to abuse or neglect. The report shall be submitted to the governor, the secretary of the Cabinet for Health and Family Services, the chief justice of the Supreme Court, the attorney general, and the director of the Legislative Research Commission for distribution to the Interim Joint Committee on Health and Welfare and Family Services and the Interim Joint Committee on Judiciary.^a The panel published its 2017 annual report on December 8, 2017. Copies were timely distributed, including to all members of the Interim Joint Committee on Health and Welfare and Family Services. The Interim Joint Committee on Judiciary prefers to access the report from the Legislative Research Commission website as needed.⁴

^a One of the committee names has changed. In the statute, it is the Interim Joint Committee on Health and Welfare.

Destruction Of Records

KRS 620.055(11) requires that, at the conclusion of the panel's examinations, all copies of information and records involving individual cases shall be destroyed by the Justice and Public Safety Cabinet.

The panel has adopted a 5-year retention schedule, which mirrors the practice of other Kentucky agencies tracking similar data and the practice of similar panels in other states. The panel maintains in its SharePoint site the documents it has created for its own use, such as panel member electronic discussions.

The panel continues its established policy of shredding paper documents. Panel staff schedule with the state contractor a special pickup of documents to be shredded. The courier signs a form attesting to the pickup and shredding process.

Panel Staffing

In FY 2017, panel staff were one full-time staff attorney and one part-time executive staff adviser, whose salaries were paid from the panel's budget. Beginning in FY 2018, panel staff was one full-time executive staff adviser, paid from the panel's budget. An intern during the 2017 spring semester was paid a stipend through the Association of Independent Kentucky Colleges and Universities.⁵ A part-time assistant position, funded by the Justice and Public Safety Cabinet, will be filled once the position's responsibilities are revised.

The panel also uses part-time analysts who review all case records and prepare summaries to facilitate the panel review process. The analysts are

- three forensic medical case analysts provided through a contract with the University of Louisville and
- two social work case analysts with whom the panel contracts directly as personal service contractors.

All contracts are paid through the Justice and Public Safety Cabinet's baseline funding.⁶

Funding And Expenditures

The panel receives its funding through the Justice and Public Safety Cabinet and does not have its own operating budget. Funding runs through the general fund baseline budget.⁷ The panel requested \$420,000 for FY 2017.⁸

The panel's expenditures were \$274,536.38 for FY 2017. Of this total, \$217,766—nearly 80 percent—was for compensation for panel staff, the case analysts provided through the University of Louisville contract, and the social work case analysts. The second largest expenditure, nearly \$41,000, was to the Commonwealth Office of Technology for development of the data tool described below.⁹

Case Review And Data Tool Categories

The panel's confidential, web-based SharePoint platform provides panel members access to case records and other relevant information. The Department for Community Based Services (DCBS) initiates case reviews by uploading its case records to the site. The panel's case analysts review the records and prepare case summaries.¹⁰ The analysts give oral case presentations at meetings, and the panel then conducts thorough discussions, using an evolving data tool that also facilitates data analysis. An overview of the data tool is in the Appendix to this update.

The panel determines specific findings for each case by designating the type of case, identifying the risk factors, and making a final determination of whether abuse or neglect was involved. The panel's case volume is large, and in the past it could not review the entirety of a fiscal year's case data. It instituted an expedited case review process in which panel members were divided into four groups. Each group reviews a set of cases, makes a decision on each, and then presents them to the entire panel for final review and vote. This process enabled the panel to enter complete data for an entire fiscal year.

Two federal representatives observed the panel's 3-day meeting in April 2017 as part of Kentucky's participation in a national initiative for the prevention of child fatalities. The representatives suggested modifying the list of risk factors in the panel's data tool by determining which family characteristics rise to the level of a risk.¹¹ The panel modified its list accordingly. The representatives commented that many of the best practices they advocate were already part of the panel's process.¹²

Action In 2017 On The Panel's 2016 Recommendations

The panel's 2016 annual report contained nine recommendations, shown in Table 1. Three resulted in action taken in 2017, including one action taken by the General Assembly. KRS 199.466 now allows a parent or legal guardian to obtain a background check of a potential caregiver from the Cabinet for Health and Family Services' child abuse and neglect registry records.

Table 1
Status Of Recommendations From Panel's 2016 Annual Report

2016 Recommendation	2017 Implementation
Implemented	
"Allow a parent or legal guardian to request background check of the child abuse and neglect registry records when employing a child care provider for a minor child."	KRS 199.466 allows a parent or legal guardian to obtain a background check from the Cabinet for Health and Family Services.
"Hospitals should be required/encouraged/incentivized to model safe sleep and provide face-to-face education regarding safe sleep and Abusive Head Trauma prevention education to parents of newborns."	The Kentucky Hospital Association (KHA) issued a letter to all Kentucky hospitals stating, "After thoughtful consideration the KHA Board of Trustees is proposing members review their current practices and implement the following recommendation. The Kentucky Hospital Association recommends Kentucky hospitals provide evidence informed education addressing abusive head trauma and safe sleep practices to the parents of newborns and recommends hospitals follow model safe sleep practices within birthing centers and NICU [neonatal intensive care] units."
"Judges who hear dependency, neglect and abuse (DNA) cases should use the Administrative Office of the Courts (AOC) mandated DNA series forms and should adhere to the statutory timeframes required in these cases. To the extent practicable, AOC should audit the judiciary's compliance in these cases and provide a reporting component to judges."	AOC has provided judges with additional training to encourage the use of the mandated DNA series forms.
Not Implemented	
"Enhanced penalties for driving under the influence (DUI) with a minor in the vehicle. The Kentucky Department of Transportation and the Kentucky State Police should collect data regarding the incidence of DUI with children in a vehicle and develop an awareness campaign regarding the outcomes and need for bystanders to intervene."	The panel is unaware of any steps taken related to these six recommendations.
"The Kentucky Hospital Association and Kentucky Chapter of the American Academy of Pediatrics should promote awareness and use of the two Pediatric Forensic Medicine centers within Kentucky."	

2016 Recommendation	2017 Implementation
Not Implemented	
"Law enforcement officers need to treat each child fatality/near fatality under the 'hypothesis' that the child may have been a victim of maltreatment and focus on preserving the scene."	
"Law enforcement should complete and/or submit a JC3 to DCBS in situations where child neglect, abuse and maltreatment are of concern, or should be of concern, to the officer."*	
"The Department of Criminal Justice Training and other Kentucky law enforcement training entities should assure all law enforcement officers are trained in best practices for safeguarding children."	
"Require Multidisciplinary Teams on Child Sexual Abuse (MDTs), established by KRS 431.600 and 620.040, to also review serious physical abuse cases."	

*A JC3 is a Justice and Public Safety Cabinet form used by law enforcement.

Source: Kentucky. Child Fatality and Near Fatality External Review Panel. *2017 Annual Report*. P. 19.

Panel's 2017 Annual Report Recommendations

The panel's 2017 annual report contains three recommendations, one of which has two subrecommendations:

- I. Address the substance abuse epidemic affecting families across the state.
 - A. ... vigorous enforcement (and clear sanctions) for all providers of MAT [Medication-Assisted Treatment] to ensure that the required counseling and behavioral therapy components are part of the treatment provided. ... MAT providers must be educated on monitoring and when and how to notify DCBS when they believe a child may be in danger. Further education must be disseminated regarding the grave effects of these medications in the hands of a small child.
 - B. ... full implementation of Family Court Drug Courts throughout Kentucky.
- II. Provide additional funding to the Department for Public Health.
- III. Provide additional funding for the Department for Community Based Services.¹³

Implementation of the above recommendations will be addressed in the panel's 2018 annual report.

Endnotes

- ¹ Kentucky. Child Fatality and Near Fatality External Review Panel. *2017 Annual Report*. P. 2.
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- ³ Lyn Bruckner. Email to Colleen Kennedy et al. April 20, 2017.
- ⁴ Katie Comstock. Email to Colleen Kennedy. June 7, 2018.
- ⁵ Elisha Mahoney. Email to Colleen Kennedy. June 13, 2018.
- ⁶ Ibid.
- ⁷ Miriam Fordham. Email to Colleen Kennedy. June 25, 2018.
- ⁸ Roger Crittenden. Email to Colleen Kennedy. May 21, 2018.
- ⁹ Elisha Mahoney. Email to Colleen Kennedy. July 11, 2018.
- ¹⁰ Kentucky. Child Fatality and Near Fatality External Review Panel. *2017 Annual Report*. P. 4.
- ¹¹ Kentucky. Child Fatality and Near Fatality External Review Panel. Minutes of April 25, 2017 meeting.
- ¹² Colleen Kennedy. Notes from April 25, 2017 meeting of the Child Fatality and Near Fatality External Review Panel; Kentucky. Child Fatality and Near Fatality External Review Panel. *2017 Annual Report*. P. 4.
- ¹³ Kentucky. Child Fatality and Near Fatality External Review Panel. *2017 Annual Report*. Pp. 5-8.

