Kentucky Child Fatality And Near Fatality External Review Panel 2024 Update

Research Report No. 489

Legislative Oversight And Investigations Committee

Kentucky Legislative Research Commission

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Kentucky Child Fatality And Near Fatality External Review Panel 2024 Update

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Research Report No. 489

Legislative Research Commission
Frankfort, Kentucky
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Adopted July 11, 2024

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

Abstract

KRS 6.922 requires the Legislative Oversight and Investigations Committee to conduct an annual evaluation of the Child Fatality and Near Fatality External Review Panel to monitor its operations, procedures, and recommendations. The panel, which has 17 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. It is also required to submit annual reports discussing case determinations, as well as findings and recommendations for system and process improvements. The panel addressed four of the five recommendations adopted by the Legislative Oversight and Investigations Committee in its 2023 panel update. The panel did not develop procedures to follow up with agencies that did not provide a timely response to recommendations. Generally, the panel complies with statutory requirements in that it exceeds the required number of meetings, posts required information, and delivers required reports. However, the panel membership for a practicing social work clinician has been vacant for nearly 4 years, which may deprive the panel of a valuable viewpoint. In addition, only 6 of 12 agencies responded in a timely manner to panel recommendations. Finally, the panel has not formally documented its policies and procedures. A lack of documented procedures can lead to issues with internal controls.

Foreword

Legislative Oversight and Investigations Committee staff appreciate all those who provided assistance with this report. The Kentucky Child Fatality and Near Fatality External Review Panel provided the benefit of its time. Among its staff, Elisha Mahoney, executive staff adviser, and Joel Griffith, social service clinician, provided valuable information.

Jay D. Hartz
Director

Legislative Research Commission
Frankfort, Kentucky
July 11, 2024

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Statute requires the Legislative Oversight and Investigations Committee (LOIC) to conduct an annual evaluation of the operations, procedures, and recommendations of the Child Fatality and Near Fatality External Review Panel. The panel conducts comprehensive reviews of child fatalities and near fatalities resulting from abuse or neglect. The panel is required to publish its annual report by February 1 of each year. These reports consist 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.

Major Objectives

The major objectives for this study were to review

- actions taken by the panel over the past year to address recommendations from LOIC's 2023 annual report;
- the panel's development of findings and recommendations to meet reporting and other requirements under KRS 620.055(10), as amended by Senate Bill 97 (Regular Session 2022); and
- the panel's operations and procedures.

Major Conclusions

- The panel addressed four of the five recommendations adopted by LOIC at its August 10, 2023, meeting. The panel did not develop procedures to follow up with agencies that did not respond to recommendations in a timely manner.
- Agencies responsible for responding to the panel's recommendations have not consistently fulfilled statutory requirements. As of May 20, 2024, 6 of 12 agencies responded to the panel. These responses addressed 9 of 25 recommendations in the panel's report.
- The panel is working with the Commonwealth Office of Technology to design and build a new case management system.
- Two positions on the panel are vacant. One position has been vacant for a relatively short period, but the position reserved for a practicing social work clinician has been vacant for nearly 4 years.
- The panel has met its statutory requirement to submit annual reports consisting of case reviews and findings and recommendations for system and process improvements.
- The panel's findings in its 2023 annual report were supported by analysis and data, and recommendations were linked to findings. Recommendations were targeted and actionable.
- The panel's operations and procedures have not been formalized into written standard operating procedures. A lack of written procedures can be a risk to internal controls and may prevent the panel from operating as intended or prevent panel members from providing feedback on operations.

Matter For Legislative Consideration And Recommendations

Statute does not allow either the panel or appointing authority to fill appointments if nominations are not made by the entity specified in statute. This stipulation can result in extended vacancies on the panel. The social work clinician position has been vacant for nearly 4 years. Such vacancies may cause the panel to be deprived of specialized knowledge or experience. KRS 620.055(7) allows the panel to "seek the advice of experts," but this is not the same as having a panel member with similar knowledge who is regularly engaged in panel discussions.

Legislative Consideration 3.A

The General Assembly may wish to specify a procedure for filling the vacancy of a voting member of the Child Fatality and Near Fatality External Review Panel when it cannot be filled in the manner mandated by KRS 620.055(2).

KRS 620.055(10) requires agencies to respond within 90 days of receiving a recommendation from the panel. The requirement has been in place for the panel's last two reports. Less than half of the 2022 and 2023 recommendations received a response by the deadline. The panel may be able to improve its notification system to increase agency response rates and compliance with KRS 620.055(10). For example, the panel does not have procedures for setting a response deadline and cannot determine when agencies physically received mailed recommendations. Establishing a policy regarding a deadline for responses would allow the panel to determine when responses are late, provide a specific date for responses in the notification letter, and establish when panel staff should follow up on notifications.

Recommendation 3.1

The panel should use a service such as certified mail or adopt policies determining the 90-day response deadline by which agencies are required to respond to panel recommendations.

In addition, the 2023 recommendation responses often did not include statutorily required elements such as a clear statement of intent to implement the recommendation and a timeline for implementation or a clear refusal to implement and an explanation of why the agency does not intend to do so. A standardized form could improve the quantity and quality of responses from agencies by reducing time to find recommendations and drafting responses. Including checkboxes for implementing or rejecting recommendations would prevent vague statements that do not clearly indicate actions. A section to indicate how recommendations will be implemented or why recommendations were rejected would make responses clearer.

Recommendation 3.2

The panel should update its notification letter format to include spaces for agencies to provide all of the required elements in their responses, such as clear intent to implement the recommendation, a timeline for implementation, and an explanation for declining to implement the recommendation.

Although statute establishes legislative expectations related to the panel, the panel has wide discretion in terms of its development of standard operating procedures. Although the panel has procedures, these procedures have not been formalized into written standard operating procedures. A lack of written procedures could be a threat to internal controls, and having written procedures would help in areas such as determining deadlines or determining how to follow up with agencies.

Recommendation 3.3

Panel staff should develop written procedures for review and approval by the panel chair and members. The written procedures should document the processes by which the panel obtains, stores, reviews, and analyzes cases; develops findings and recommendations; develops annual reports; and complies with the reporting requirements mandated by KRS 620.055(10).

Chapter 1

Kentucky Child Fatality And Near Fatality External Review Panel

Executive Order 2012-585 created the Child Fatality and Near Fatality External Review Panel, which was attached to the Justice and Public Safety Cabinet for administrative purposes.

In July 2012, Governor Steve Beshear issued an executive order creating the 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. The independent review panel was attached to the Justice and Public Safety Cabinet (JPSC) for staff and administrative purposes.[1]

KRS 620.055 mandates 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 General Assembly formally established the panel and its structure in 2013 with the passage of House Bill 290, codified as KRS 620.055. Per statute, the purpose of the panel is to conduct "comprehensive reviews of child fatalities and near fatalities, reported to the Cabinet for Health and Family Services [CHFS], suspected to be a result of abuse or neglect." The panel continues to be attached to the Justice and Public Safety Cabinet for staff and administrative purposes.[2]

During the 2022 Regular Session, the General Assembly passed Senate Bill 97, which amended KRS 620.055. The changes strengthened reporting controls with respect to how the panel makes annual recommendations to state agencies, as well as requirements for those agencies to implement the panel's recommendations. Additional requirements were enacted regarding the testing of caregivers suspected of being under the influence, adjustments to panel membership, coroner notifications, and the panel's annual reporting requirements.[3]

The panel is required to publish a report by February 1 of each year. The reports consist of case reviews, findings, and recommendations for system and process improvements.

The panel is required to publish its annual report by February 1 of each year. These reports consist 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.[4] The panel's annual report considers cases from the previous fiscal year regardless of whether investigations by the Department for Community Based Services (DCBS) substantiated allegations of abuse or neglect in each case.

The Legislative Oversight and Investigations Committee (LOIC) is statutorily required to conduct annual evaluations.

KRS 6.922 and KRS 620.055(17) require the Legislative Oversight and Investigations Committee (LOIC) to conduct annual evaluations of the Child Fatality and Near Fatality External Review Panel to monitor its "operations, procedures, and

recommendations." LOIC staff's first evaluation of the panel was adopted by the committee in July 2014 and focused on the panel's

- organization, membership, and independence;
- compliance with statute;
- confidentiality and transparency;
- budget and staff; and
- case review processes.

LOIC staff drafted and presented subsequent annual reports, which the committee adopted on December 10, 2015; December 13, 2016; August 9, 2018; and July 12, 2019. LOIC staff submitted a co-chair memorandum dated December 14, 2020, in lieu of a report for the 2020 evaluation. These evaluations continued the statutory compliance focus and a general description of various processes by which the panel receives and analyzes case information and drafts its annual reports.

The 2021 report, adopted on October 14, 2021, focused on the process the panel uses to request, receive, and analyze information to carry out its statutory responsibilities. It also focused on the process by which the panel requests and receives its funding. The 2022 and 2023 reports—adopted on November 10, 2022, and August 10, 2023, respectively—focused on the panel's implementation of the changes in Senate Bill 97 (2022 RS), the findings and recommendations in the panel's annual reports, updates to the panel's data tool and data dictionary, and the panel's budget procedures.

Major Objectives

This study had three major objectives.

The major objectives for this study were to review

- actions taken by the panel over the past year to address recommendations from LOIC's 2023 annual report;
- the panel's development of findings and recommendations to meet reporting and other requirements under KRS 620.055(10), as amended by Senate Bill 97 (Regular Session 2022); and
- the panel's operations and procedures.

Methodology

LOIC staff conducted the following research tasks:

- Observed monthly panel meetings and followed up on information as needed

- Reviewed and analyzed child fatality and near fatality case information and data from the panel's annual reports from 2014 to 2023
- Reviewed and analyzed the panel's historic expenditure data from eMARS
- Reviewed and analyzed the panel's historic contract information from eMARS
- Interviewed panel staff about the panel's operations, procedures, and recommendations

Major Conclusions

This study has seven major conclusions

This report has seven major conclusions.

- The panel addressed four of the five recommendations adopted by the Legislative Oversight and Investigations Committee at its August 10, 2023, meeting. The panel did not act on the recommendation to develop procedures to follow up with agencies that do not meet recommendation response requirements.

- Agencies responsible for responding to the recommendations in the panel's annual reports have not consistently fulfilled the requirements of KRS 620.055(10). As of May 20, 2024, 6 of 12 agencies responded to the panel. These responses addressed 9 of 25 recommendations in the panel's report.

- The 2024-2026 Budget of the Commonwealth included $200,000 for the panel in FY 2025 for the purchase of a new case management system. The panel is working with the Commonwealth Office of Technology (COT) to design and build a new system.

- Two positions on the panel are vacant. One position has been vacant for a relatively short period, but the position reserved for a practicing social work clinician has been vacant for nearly 4 years. Long vacancies can deprive the panel of useful viewpoints.

- The panel has met its statutory requirement to submit annual reports consisting of case reviews and findings and recommendations for system and process improvements. The reports include contextual information, and state and federal statistics, as well as case summaries and determinations.

- The panel's findings in its 2023 annual report were supported by analysis and data that were illustrated in the report, and recommendations were appropriately linked to the report's findings. The recommendations were targeted and actionable.

- The panel's operations and procedures have not been formalized into written standard operating procedures. A lack of written procedures can be a risk to internal controls and may prevent the panel from operating as intended or prevent panel members from providing feedback on operations.

Structure Of This Report

Chapter 2 provides statutory and background information related to the panel. It outlines statutory requirements, as well as administrative, budgetary, and staffing numbers. The chapter discusses case reporting, investigation, and referral; data collection and panel responsibilities to make case determinations and develop findings; and recommendations for system and process improvements.

Chapter 3 presents three major finding areas, one matter for legislative consideration, and three recommendations.

Chapter 2

Child Fatality And Near Fatality External Review Panel Background

KRS 620.055(1) created the Kentucky Child Fatality and Near Fatality External Review Panel. Statutory requirements are few and broadly stated, giving wide discretion to the panel.

KRS 620.055(1) requires that the panel conduct "comprehensive reviews of child fatalities and near fatalities, reported to the Cabinet for Health and Family Services [CHFS], suspected to be a result of abuse or neglect."

Statute requires the panel to

- 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" 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."[5]

Membership

The panel's membership is composed of 5 ex officio nonvoting members and 17 voting members. Panel memberships are assigned based on position or through appointments.

KRS 620.055(2) requires that the panel include 5 ex officio nonvoting members and 17 voting members. Four of the voting members serve because of their position, 11 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 member appointed by the secretary of state serves as chair of the panel. The names and affiliations of panel members are included in the panel's annuals reports and on the panel's webpage.[6]

Table 2.1 reflects the panel's membership as of May 28, 2024. There are currently two vacant panel positions and one panel member with an expired term. Panel members whose terms have expired typically continue serving on the panel as voting members until they are replaced or reappointed.[7] This practice is consistent with statute, which states that panel members serve until their term expires and thereafter "until successors are appointed and accept their appointments."[8]

Table 2.1
Membership Of The Child Fatality And Near Fatality External Review Panel
As Of May 28, 2024

Name	Title/Appointing Authority		Term Ends
Ex Officio (Nonvoting) Members (5)			
Sen. Danny Carroll	Member appointed by president of Senate		N/A
Rep. Samara Heavrin	Member appointed by speaker of House of Representatives		N/A
Lesa Dennis	Commissioner of Department for Community Based Services		N/A
Dr. Henrietta Bada	Commissioner of Department for Public Health		N/A
Judge Libby Messer	Family court judge appointed by chief justice of Kentucky Supreme Court		N/A
Voting Members (17)			
Benjamin Harrison	At-large representative who shall serve as chair	Secretary of state	4/15/2026
Dr. Christina Howard	Pediatrician from University of Kentucky Department of Pediatrics	Attorney general*	6/30/2024
Dr. Melissa Currie	Pediatrician from University of Louisville Department of Pediatrics**	Attorney general*	6/30/2025
Dr. William Ralston	State medical examiner or designee	Position	N/A
Vacant	Director of Court-Appointed Special Advocates	Attorney general*	N/A
Detective Jason Merlo	Peace officer***	Attorney general*	6/30/2024
Dr. Jaime Pittenger	Representative from Prevent Child Abuse Kentucky	Attorney general*	6/30/2024
Hon. Olivia McCollum	Practicing local prosecutor	Attorney general	6/30/2025
Olivia Spradlin	Proxy of executive director of ZeroV (formerly Kentucky Coalition Against Domestic Violence)	Position	N/A
Janice Bright, RN, BSN	Chair of State Child Fatality Review Team	Position	N/A
Vacant	Practicing social work clinician	Attorney general*	N/A
Geoff Wilson	Practicing addiction counselor	Attorney general*	6/30/2025
Heather McCarty	Representative from family resource and youth service centers	Attorney general*	6/30/2025
Steven Shannon	Representative of a community mental health center	Attorney general*	6/30/2024
Dr. Elizabeth Salt	Member of a citizen foster care review board	Chief justice of Kentucky Supreme Court	6/30/2023
Mark Hammond	President of Kentucky Coroner's Association	Position	N/A
Dr. Danielle Anderson	Practicing medication-assisted treatment provider	Attorney general*	6/30/2025

Note: N/A/ = not applicable.
*Attorney general selects appointee from a list of three names provided by entities specified in statute.
**The appointee must be licensed and experienced in forensic medicine relating to child abuse and neglect.
***The appointee must have experience investigating child abuse and neglect fatalities and near fatalities.
Source: KRS 620.055(2).

Meeting Requirements

Statute requires that the panel meet quarterly. The panel has met monthly since 2020 to complete its yearly case reviews.

Statute requires that the panel meet at least quarterly.[9] The panel has exceeded this requirement in every year since its inception in 2013.[10] The panel has met monthly since July 2020 due to increased caseloads.[11] Table 3.1 in Chapter 3 provides more information.

Budget And Expenditures

The panel is administratively attached to the Justice and Public Safety Cabinet.

The panel is attached to the Justice and Public Safety Cabinet for staffing and administrative purposes.[12] The panel does not have its own personnel and operating budgets, as its funding is included as part of the Office of the Secretary's baseline funding. In budget years when baseline funds were insufficient to meet the Office of the Secretary's needs, the panel's budget was also susceptible to cuts.[13]

A 2014 memorandum of understanding between the panel and the cabinet requires the panel to submit its budget requests to the cabinet prior to budget sessions.

According to a 2014 memorandum of understanding between the panel and the Justice and Public Safety Cabinet, the panel is required to provide its budget request during the fall prior to a budget session. The cabinet then operates as a pass-through to submit the panel's budget to the Office of State Budget Director without prioritization.[14]

The panel, through the cabinet, requested and received $420,000 annually in the 2014-2016 budget request. The 2022-2024 budget again allocated $420,000 for the panel.

The panel, through the cabinet, requested and received $420,000 annually in the 2014-2016 budget.[15] Subsequent budgets did not include specific appropriations or allotments for the panel. Rather, the panel's expenditures for the biennia covering 2016 through 2022 were included as part of the baseline funding for the Justice Administration appropriation unit, under the Office of the Secretary.[16]

The panel worked with Justice Cabinet budget staff and submitted a budget request in the fall of 2021.[17] The 2022-2024 Budget of the Commonwealth subsequently included $420,000 in the base budget of the Justice Administration budget for the panel.[18]

Panel expenses primarily consist of personnel costs. Operating expenses are relatively minimal and largely attributed to technology charges and rent for office space.

Table 2.3 details the panel's expenditures from FY 2015 through year-to-date FY 2024. Nearly 95 percent of the panel's expenses have been for personnel costs related to the compensation of full-time employees and contracted consultants/analysts. Operating expenses have typically been minimal and consist primarily of charges from the Commonwealth Office of Technology and, starting in FY 2023, rent for office space. Operating expenses related to food and travel have decreased since 2020 due to the panel's switch from in-person meetings to primarily virtual meetings.

Table 2.2
Kentucky Child Fatality And Near Fatality
External Review Panel Expenditures
FY 2015 To April 29, 2024

Fiscal Year	Personnel Expenditures	Operating Expenditures	Total
2015	$212,582	$6,946	$219,528
2016*	267,004	21,198	288,202
2017	213,259	56,289	269,547
2018	141,943	7,671	149,614
2019	185,345	3,611	188,955
2020	275,117	6,511	281,628
2021	245,261	2,206	247,467
2022	293,852	2,203	296,055
2023	320,547	13,269	333,816
2024**	272,326	14,907	287,233
Total	$2,427,236	$134,810	$2,562,045

Note: Operating expenditures do not sum to the total shown, due to rounding.
*An additional $7,983.75 was expended for part-time data consultants from Kentucky State University and the University of Louisville.
**Statewide accounting system data through April 29, 2024.
Source: eMARS, Expenditure Analysis Report-FAS Power BI.

Staffing

The panel's staff consists of an executive staff adviser, two analysts, and an administrative staff member shared with another Justice Cabinet unit. The panel also contracts with the Department for Public Health (DPH) for epidemiology services.

Panel staffing currently consists of one executive staff adviser, two social service clinicians II (case analysts), one contract pediatric forensic medical case analyst, and an administrative staff member who is shared with the Office of Drug Control Policy. Additionally, the panel has entered into an agreement with the Department for Public Health (DPH) for epidemiology services. The DPH epidemiologist assisted the panel with its 2023 annual report.[19]

Panel Funding In The 2024-2026 Budget

The panel's 2024-2026 budget allowed it to hire an additional analyst and procure a new case management system.

In its 2024-2026 budget request, the panel requested additional funding to hire additional full-time staff and for continued epidemiology support. The panel also requested one-time funding of $200,000 for FY 2025 for a new case management system.[20]

The 2024-2026 Budget of the Commonwealth increased the panel's annual allocation to $594,100 in FY 2025 and $592,900 in FY 2026. The panel received an additional $200,000 in FY 2025 for the procurement of a new case management system. The budget bill specified that the funds allocated to the panel for the purchase of the case management system will lapse to the Budget Reserve Trust Fund Account if not expended in FY 2025.[21]

The increase in funding has enabled the panel to hire an additional full-time case analyst.[22] The panel is in the process of developing and procuring a new case management system. It anticipates that the procurement process will be completed prior to the end of FY 2025, when the funds lapse.[23]

Case Referral

The Department for Community Based Services (DCBS) and, to a lesser extent, DPH refer cases to the panel for review.

The panel reviews cases referred from the Department for Community Based Services and, to a lesser extent, DPH.[24] Table 2.4 details the number of cases reported by each agency. From 2018 to 2023, total referrals increased 50.7 percent.

Table 2.3
Kentucky Child Fatality And Near Fatality External Review Panel
Case Referrals By Agency
2018 To 2023

Referring Agency	2018	2019	2020	2021	2022	2023
DCBS	126	121	140	173	207	196
DPH	8	15	42	27	8	6
Total	134	136	182	200	215	202

Note: DCBS = Department for Community Based Services; DPH = Department for Public Health.
Source: Kentucky Child Fatality and Near Fatality External Review Panel. 2018-2023 annual reports.

DCBS Referrals

If individuals or medical professionals believe a child is dependent, neglected, or abused, they are duty-bound to report.

KRS 620.030(1) and (2) require that individuals and medical professionals who know or have reasonable cause to believe that a child is dependent, neglected, or abused

> immediately cause an oral or written report to be made to a local law enforcement agency or to the Department of Kentucky State Police, the cabinet or its designated representative, the Commonwealth's attorney, or the county attorney by telephone or otherwise.

KRS 620.040(5)(e) requires law enforcement officers to request a test of blood, breath, or urine when a report includes a fatality or near fatality if the officer has reason to believe a caregiver was under the influence of drugs or alcohol at the time of the incident. If consent is not given for the test, a search warrant must be requested and may be issued by a judge. Also, KRS 72.410(a) requires that upon notification of the death of a child as defined in KRS 72.025 and 72.405, the coroner shall "immediately" contact DCBS and law enforcement agencies for information.

Once a report is received, DCBS screens acceptance criteria for the alleged maltreatment "where the alleged perpetrator is in a caretaking role."[25] DCBS then seeks to identify a link between the alleged maltreatment and a child's fatal or near fatal condition. According to DCBS, once a link is established, "centralized intake staff will designate the intake in TWIST as a fatality/near fatality."[26]

If a child's death has occurred, central intake personnel designate the occurrence as a fatality. Intake staff use a Near Fatality Tip Sheet "to decide if the child's condition meets criteria for the near fatality designation" in KRS 600.020(40) of a child in serious or critical condition as certified by a physician.[27]

If DCBS suspects that a child fatality occurred as a result of abuse or neglect, it investigates the case, which is ultimately referred to the panel.

If DCBS suspects that a child fatality occurred as a result of abuse or neglect, it investigates the case, which is ultimately referred to the panel for review. The same is true for cases involving a near fatality. However, if DCBS receives a report of abuse "other than a parent, guardian, or other person exercising control or supervision of the child," it notifies local or state law enforcement.[28]

DPH Referrals

DPH also refers cases to the panel from its local child fatality review teams.

DPH also refers cases to the panel from its local child fatality review teams.[29] Names, dates of birth, and dates of death are emailed to the panel by nurses from DPH's Division of Maternal and Child Health who support the local teams.[30] Upon receipt, panel staff send the list of DPH referrals to DCBS to request available case information. According to DCBS officials, frontline staff from DCBS regional offices also participate on the local teams and provide information as needed.[31]

If DCBS is not involved with the case, panel staff may send formal requests for information to local entities requesting medical, education, law enforcement, and other records. DCBS may choose to investigate the matter as well, if it is not familiar with the circumstances surrounding a child's death.[32]

Panel Reviews

Statute requires CHFS to provide information and records to the panel within 30 days upon request.

The panel uses information and records provided by the Cabinet for Health and Family Services to make its case determinations, as well as to support findings and recommendations for system and process improvement. KRS 620.055(6) requires CHFS to provide the panel, within 30 days, numerous types of information and

records in unredacted form. Appendix A summarizes the information to be provided to the panel.

Although statute authorizes the panel to request case records at any point, the panel has historically elected to wait until DCBS has finished its investigations before reviewing cases.[33] Panel staff state that it is easier to obtain information and records for closed cases.[34]

The amount of time required by DCBS to complete investigations has impeded the panel's ability to review cases in a timely manner. Investigations have an average completion time of nine months.

However, the significant amount of time required by DCBS to complete investigations has impeded the panel's ability to review cases in a timely manner. In its most recent annual report, the panel stated that the length of time from receipt of a fatality/near-fatality case to completion of the investigation ranges from 2½ months to 14 months, with a statewide average of just over 9 months.[35] Panel members and staff have discussed the issue with DCBS management, who have been "receptive to Panel concerns, open to suggestions, and willing to explore options."[36] The panel's recent hiring of a second full-time case analyst is expected to mitigate some of the issues caused by the delays in the completion of DCBS investigations.[37]

Review Process

Panel staff use a document management and storage platform called SharePoint to upload information from CHFS to a secure online location. Staff copy information and records into separate SharePoint folders for analysts and panel members to use when reviewing cases.[38]

Panel members elected to streamline the review process by having analysts provide case summaries during meetings. Each panel member is assigned four to five cases per meeting. Analyst findings and case summaries are provided a week before each meeting.

Due to the large number of records associated with each case, panel members elected to streamline the review process by having analysts provide panel members with case summaries and analysis.[39] Once CHFS uploads the case documents to SharePoint, panel analysts review the case information and document their findings and analyses into case summary and timeline templates, which are forwarded to panel members a week before each panel meeting. Each panel member is assigned four to five cases per meeting, depending on the number of cases and the number of panel members available for that month's meeting. Although each panel member is assigned only a portion of the month's cases, they all have access to all of the cases.[40]

The panel has a manual for analysts to reference while reviewing cases.

Analyst Binder. The panel has developed a manual called the Analyst Binder for analysts to reference when reviewing cases. It includes general instructions for accessing and using the two

software platforms used by the panel. SharePoint provides a secure location for storing case files where they can be accessed by panel members and analysts for review. DCBS and panel staff use the Research Electronic Data Capture application (REDCap) for entering case information to provide to the panel prior to meetings and to record panel determinations after meetings.

The binder includes a comprehensive, step-by-step instructions section for REDCap data entry. This section walks analysts through 22 screens where case specific information and context are entered into the application. Guidelines clarify what each prompt is asking for and what to enter in unusual scenarios. These guidelines also serve to ensure consistency between entries, such as date formatting, so multicase aggregate data analysis can be performed to produce the panel's annual reports. The binder's appendices define technical terms and acronyms for analyst reference. Instructions are also provided for requesting case documents from an agency or custodian of records if an analyst determines that additional information is required to complete a case review.

Analysts categorize cases based on a three-tier triage system. Triage 1 cases have several missed opportunities. Triage 2 cases have at least one missed opportunity. Triage 3 cases were accidental or did not involve missed opportunities and are not summarized for meetings.

The binder instructs analysts to categorize cases using a three-tier triage system based on their review of case files. Triage 1 cases are those in which analysts determine that there were several missed opportunities, Triage 2 cases involved at least one missed opportunity, and Triage 3 cases were accidental or did not involve any missed opportunities. The binder states that Triage 1 and Triage 2 cases require analysts to use included case summary and timeline templates to generate their written case analysis for panel members to review. These documents are filled out using data recorded through REDCap and stored on Sharepoint, and once completed, are uploaded to SharePoint and presented orally to panel members during meetings. Triage 3 cases are placed on meeting agendas for further questions from panel members and analysts.

Updates To Panel's Software Platforms. The panel received funding for a new case management system in the 2024-2026 Budget of the Commonwealth. The panel is working with the Commonwealth Office of Technology to develop a new software system that will incorporate elements of both SharePoint and REDCap.

Annual Reports And Recommendations

Since 2013, the panel has met statutory requirements to submit annual reports. Since 2017, the reports have summarized case information into a table.

Since 2013, the panel has met statutory requirements to submit annual reports consisting of child abuse and neglect case reviews, findings, and recommendations for system and process improvements. The reports include contextual information, state and federal statistics, and summaries and determinations of cases reviewed. Since 2017, the reports have included a table that summarizes case information based on four data fields from the data instrument:

- Categorization
- Family characteristics
- Other qualifiers
- Panel determination

The panel's 2023 annual report summarizes 202 cases reviewed from the previous fiscal year—July 1, 2021, through June 30, 2022. The 202 cases represented 68 fatalities and 134 near fatalities. DPH referred six fatality cases to the panel.[41] Table 2.4 shows the number of cases reviewed by the panel from the last six years.

Table 2.4
Cases And Recommendations
From Child Fatality And Near Fatality External Review Panel Reports
2018 To 2023

Action	2018	2019	2020	2021	2022	2023
Total cases reviewed	134	136	182	200	215	202
Fatalities reviewed	51	54	85	80	69	68
Near fatalities reviewed	83	82	97	120	146	134
Findings	18	32	6	20	14	25
Recommendations	18	32	6	22	21	25

Source: Child Fatality and Near Fatality External Review Panel annual reports.

Agency Responses To Recommendations

RS 2022 SB 97 required the panel to send recommendations to responsible agencies, and for the agencies to respond in 90 days.

During the 2022 Regular Session, the General Assembly passed Senate Bill 97, which amended KRS 620.055. The bill required the panel to send recommendations to the agency responsible for implementing the recommendations, and required the agency to respond within 90 days of receipt with an explanation of implementation or why it will not implement the recommendation. Additional requirements were enacted regarding the testing of caregivers suspected of being under the influence, adjustments to panel membership, notification by the coroners, and panel annual reporting requirements.[42]

Last year, only 10 of 21 recommendations were responded to within 90 days.

The panel's 2022 annual report included 21 recommendations, which were forwarded to recipient agencies on February 1, 2023, the report's publication date. Only 10 recommendations received appropriate agency responses within 90 days as required by statute.[43] The panel received responses to 6 additional recommendations in late-July from DPH and other entities within CHFS after the 90-day deadline.[44]

Chapter 3

Findings And Recommendations

This review produced three major finding areas, one matter for legislative consideration, and three recommendations.

This evaluation of the Kentucky Child Fatality and Near Fatality External Review Panel produced three major finding areas, one matter for legislative consideration, and three recommendations. The panel agreed with all recommendations.[45]

The Panel Has Acted On LOIC's 2023 Recommendations

The panel has acted on four of the five recommendations in LOIC's 2023 report.

On August 10, 2023, the Legislative Oversight and Investigations Committee adopted five recommendations related to the following areas:

- Funding and procurement of a new software platform for the panel to store, review, and analyze cases
- Budget and expenditure procedures
- Development of procedures to follow up with agencies that do not comply with KRS 620.055 (10)(c)
- Continued development of data-driven findings and actionable and targeted recommendations
- Organization of finding areas in the panel's annual reports[46]

In the year following the adoption of LOIC's report, panel members and staff addressed four of the five recommendations. The following section provides addition information related to each of the recommendations, with the original recommendation in italics.

Recommendations From LOIC's 2023 Panel Update

Panel staff have worked with Justice and Public Safety Cabinet and Commonwealth Office of Technology officials to fund and select a new case management system.

The Child Fatality and Near Fatality External Review Panel should continue to work with officials from the Commonwealth Office of Technology as well as Justice and Public Safety Cabinet budget staff to explore options that will allow the panel to use one platform for case storage, review, and analysis.

Panel staff have consulted with COT and JPSC staff for technical and financial support as it proceeds with the selection and procurement of a new case management system.[47] The panel collaborated with JPSC budget staff and included funding for a new case management system in its 2024-2026 budget request.[48] The panel's 2024-2026 budget request included additional funding of $200,000 for FY 2025 for the purchase of a new case

management system. Per the budget request, the panel is seeking a single software platform that will both store case information and provide data analysis.[49] House Bill 6 of the 2024 Regular Session, the 2024-2026 biennium executive branch budget bill, includes an additional $200,000 in funding in the panel's allocation for the new case management system. Per the bill, any portion of funding not expended by the end of FY 2025 will lapse to the Budget Reserve Trust fund.[50]

After consulting with COT and private vendors, the panel voted at its May 2024 meeting to have COT design and build a new case management system for the panel. The new system will be similar to the panel's existing case storage system, SharePoint, while integrating the panel's RedCap data tool. The panel anticipates that COT will be able to meet the deadline for expending the funds allocated for a new system.[51]

The panel and the Justice and Public Safety Cabinet finalized an update to the 2014 memorandum of understanding in June 2024.

The Child Fatality and Near Fatality External Review Panel and the Justice and Public Safety Cabinet should update the existing memorandum of understanding (MOU) to reflect current budgetary and expenditure procedures to reflect changes resulting from the recent direct appropriation and the establishment of expenditure budget authorities in eMARS, as well as increased staffing needs. The MOU has not been updated since it was drafted in 2014.

In June 2024, the panel and JPSC finalized an MOU "to further define the relationship between the parties."[52] The original 2014 MOU primarily served to establish the panel's independence from the cabinet and provide general administrative and budgetary guidance, but the 2024 MOU details the specific responsibilities of each party. The MOU will remain effective through June 30, 2026.[53]

The 2024 MOU specifies that JPSC is to "provide staff and administrative support to enable the Panel to carry out its statutory duties," including assigning cases, maintaining a case management system, generating financial reports, drafting annual reports, and interacting with "appropriate officials to address the staff and administrative needs of the Panel, including the Legislative Oversight & Investigations Committee." Additionally, JPSC is responsible for approving expenses incurred by the panel and consulting with COT regarding any technology needs identified by the panel.

The panel, in turn, is required to fulfill its statutory obligations as defined by KRS 620.055 and to communicate its staffing and administrative issues to JPSC via the panel's executive staff adviser, who is a JPSC employee. Further, the panel is required to provide JPSC advance notice of any media release or "any appearance by a representative of the Panel to testify before all legislative or policy-creating bodies."[54]

With regard to budgetary practices, the new MOU states that the panel is to provide its budget request to the panel's executive staff adviser "no later than August 15 in the odd-numbered year immediately preceding a regular session of the General Assembly." JPSC will then review the panel's budget request and include it, as appropriate, within the cabinet's budget request.[55]

A review of the panel's actions since 2022 related to funding and expenditures shows that the panel and JPSC have complied with the procedures outlined in the 2024 MOU. The panel has been proactive in budget matters over the past two budget sessions, working with JPSC budget staff to submit budget requests prior to the 2022 and 2024 General Sessions and requesting funding for additional staffing, general operational fees, and a new case management system.[56] Additionally, panel staff have presented quarterly financial updates to panel members since 2023.[57] JPSC budget staff have also appeared at panel meetings to provide financial and budget updates to panel members.[58]

The panel has not developed any procedures to follow up with agencies that do not respond to recommendations in its annual reports as directed by KRS 620.055(10)(c)(2).

The Child Fatality and Near Fatality External Review Panel should develop procedures to follow up with agencies that do not comply with KRS 620.055(10)(c)(2).

The panel has not developed any procedures to follow up with agencies that do not respond to the recommendations in its annual report as directed by statute. Panel staff have indicated that they could follow up with agencies only if the panel directs them to do so.[59] This issue is discussed in greater detail later in this chapter.

The panel has continued to ensure that its annual reports include findings based on data presented within the reports and recommendations that are actionable, targeted, and linked to the findings.

The Child Fatality and Near Fatality External Review Panel should continue its positive efforts to ensure that findings are based on data presented in the report and that recommendations are actionable, targeted, and directly related to findings.

All 15 findings in the panel's 2023 report are supported by evidence, data, or analysis identified within the report. Additionally, all 25 of the panel's recommendations are actionable and targeted, and all address the concerns expressed within their

corresponding findings. Appendix B provides an overview of the findings and recommendations in the panel's 2023 report.

The finding areas in the panel's most recent annual report clearly correspond to the associated recommendations.

The Child Fatality and Near Fatality External Review Panel should organize information in each finding area so that each finding is clearly articulated related to corresponding recommendations.

Although opportunities for improvement remain, the organization of the panel's 2023 report generally provides distinct finding areas that clearly correspond to associated recommendations.[60]

Statutory Compliance

Two Positions Are Vacant

The panel is in compliance with the membership appointment processes in statute, but two of its positions are vacant. The court-appointed special advocate program director membership was vacated on May 1, 2024.

The panel is in compliance with the appointment processes specified in KRS 620.055(2), as described in Chapter 2, but two positions are currently vacant. The panel membership reserved for a court-appointed special advocate program director was vacated on May 1, 2024, because the member accepted a case analyst position with the panel.[61] Panel staff emailed the attorney general's office requesting a new appointment in late April 2024.[62]

The practicing social work clinician position has been vacant for nearly 4 years. The attorney general's office requested nominations in May 2023.

Other than a period of 6 days in January 2023, the panel membership reserved for a practicing social work clinician has been vacant for nearly 4 years.[63] Per statute, the attorney general is required to select a practicing social work clinician from a list of three names submitted by the Kentucky Board of Social Work. Following the retirement of the incumbent panel appointee in June 2020, the board did not send any recommendations for membership to the attorney general until July 2022. An appointee was selected by the attorney general in January 2023 but immediately resigned due to professional obligations. The attorney general's office requested three nominations from the board in May 2023; however, the position is still vacant.[64]

Statute does not allow for an alternative process if nominations are not provided.

Statute does not include language allowing either the panel or the appointing authority to fill appointments if the entity specified in statute makes no nominations. This situation can result in extended panel vacancies that may deprive the panel of specialized knowledge or experience, such as the expertise of a social work clinician. KRS 620.055(7) allows the panel to "seek the advice of experts," but this is not the same as having a panel member with similar knowledge who is regularly engaged in panel discussions.

Matter For Legislative Consideration 3.A

Matter for Legislative Consideration 3.A

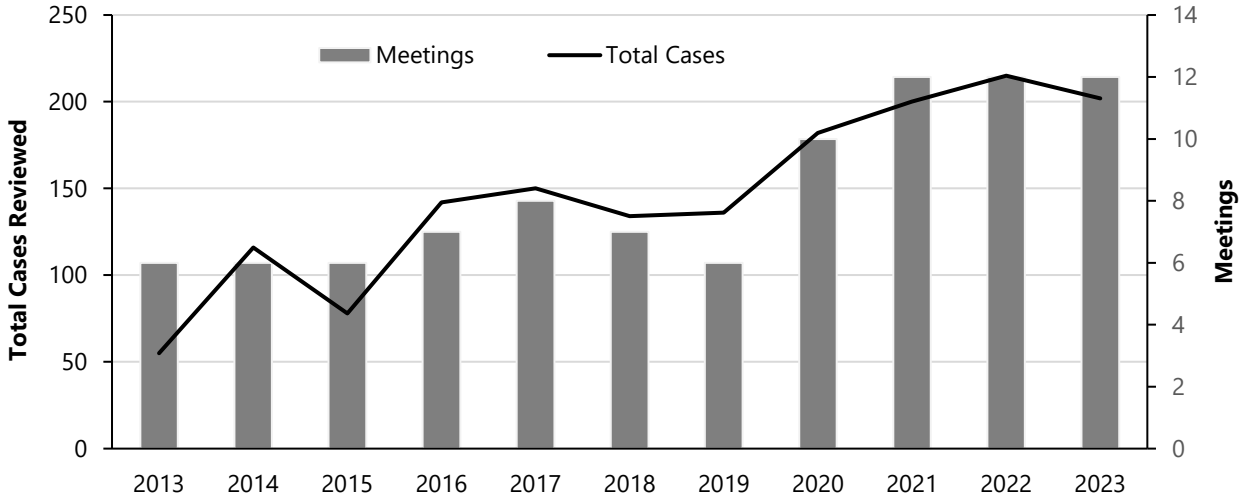
The General Assembly may wish to specify a procedure for filling the vacancy of a voting member of the Child Fatality and Near Fatality External Review Panel when it cannot be filled in the manner mandated by KRS 620.055(2).

Meeting Frequency Exceeds Requirements

The panel has met monthly since July 2020, exceeding statutory requirements.

KRS 620.055(4) requires the panel to meet at least quarterly. The panel has exceeded this requirement since its inception in 2013.[65] Due to increasing caseloads, the panel began meeting monthly in July 2020.[66] The panel has 12 meetings scheduled for calendar year 2024.[67] Figure 3.A shows that the increase in meetings has corresponded with an increase in total cases. Reviewed cases increased 267 percent, from 55 in 2013 to 202 in 2023.

Figure 3.A
Child Fatality And Near Fatality External Review Panel
Number Of Annual Meetings And Case Reviews
2013 To 2023



Source: Meeting and case review figures from the Kentucky Child Fatality and Near Fatality External Review Panel's 2013-2023 annual reports.

Panel Publicly Posts Required Information

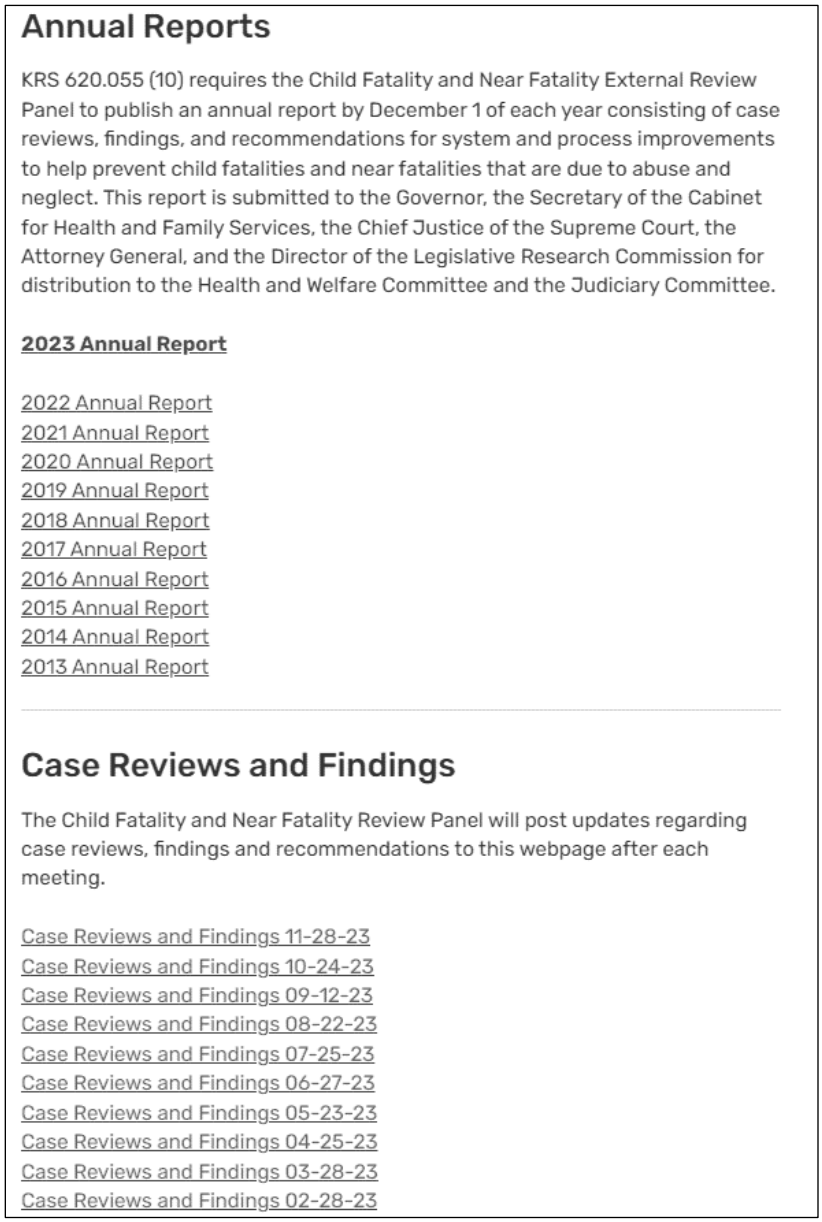
The panel posts case reviews and findings along with recommendations in its annual reports to the Justice and Public Safety Cabinet's website as specified by KRS 620.055(8).

KRS 620.055(8) requires the panel to post updates on the Justice and Public Safety Cabinet's website after each meeting. The updates must include case reviews, findings, and recommendations.

The panel posts case reviews and findings to the cabinet's website following each monthly meeting. Although not required by statute,

the panel also posts the minutes for its monthly meetings to the cabinet's website. The panel does not post its recommendations in a dedicated space on the website, but the panel's annual reports—which include the panel's recommendations—are posted to the website, fulfilling the requirement.[68] Figure 3.B demonstrates how the panel posts its required updates. The same page includes links to panel minutes.

Figure 3.B
Child Fatality And Near Fatality External Review Panel Website
Examples Of Annual Reports, Case Reviews, And Findings
April 18, 2024



Annual Reports

KRS 620.055 (10) requires the Child Fatality and Near Fatality External Review 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. This report is 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.

2023 Annual Report

2022 Annual Report
2021 Annual Report
2020 Annual Report
2019 Annual Report
2018 Annual Report
2017 Annual Report
2016 Annual Report
2015 Annual Report
2014 Annual Report
2013 Annual Report

Case Reviews and Findings

The Child Fatality and Near Fatality Review Panel will post updates regarding case reviews, findings and recommendations to this webpage after each meeting.

Case Reviews and Findings 11-28-23
Case Reviews and Findings 10-24-23
Case Reviews and Findings 09-12-23
Case Reviews and Findings 08-22-23
Case Reviews and Findings 07-25-23
Case Reviews and Findings 06-27-23
Case Reviews and Findings 05-23-23
Case Reviews and Findings 04-25-23
Case Reviews and Findings 03-28-23
Case Reviews and Findings 02-28-23

Source: Kentucky Justice and Public Safety Cabinet website.

Summary Reports Are Appropriately Delivered

The panel emails reports of its discussions, along with proposed or actual recommendations, to the Interim Joint Committee on Families and Children as required by statute.

The panel is complying with KRS 620.055(9), which requires it to report a summary of its discussions, along with any proposed or actual recommendations, to the Interim Joint Committee on Families and Children monthly or at the request of the committee co-chair. The panel sends its meeting minutes—which include discussions of any proposed or actual recommendations—via email to the co-chairs and committee staff administrator of the Interim Joint Committee on Families and Children on a monthly basis.[69] Additionally, the co-chairs of that committee are current ex officio nonvoting panel members and receive updates.[70]

The Panel Publishes Reports, But Not All Agencies Responded As Required

The panel met its statutory requirement to publish an annual report by February 1 consisting of case reviews, findings, and recommendations for system improvements to help prevent child fatalities and near fatalities that are due to abuse and neglect.

KRS 620.055(10)(a) requires the panel to publish an annual report by February 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. Statute requires that the panel submit the annual reports to

- the governor,
- the secretary of the Cabinet for Health and Family Services,
- the chief justice of the Supreme Court,
- the attorney general,
- the State Child Abuse and Neglect Prevention Board, and
- the director of the Legislative Research Commission for distribution to the Interim Joint Committee on Families and Children and the Interim Joint Committee on Judiciary.

The panel sent copies of its 2023 annual report to the parties specified by statute on January 31, 2024, thus fulfilling the requirements of the statute.[71] The report, along with all prior annual reports, is also posted to the Justice and Public Safety Cabinet website.[72]

All of the recommendations in the panel's 2023 report were actionable and targeted, and all addressed the concerns expressed within their corresponding findings.

Findings And Recommendations. In 2021, LOIC staff found that the findings in the panel's reports from 2014 to 2020 were often unsupported by evidence that could be identified within the report. Staff also found that recommendations in panel reports often failed to target a specific entity and did not address the concerns expressed within associated findings.[73] The panel's findings and recommendations have since improved.[74] All 15 findings in the panel's 2023 report are supported by evidence, data, or analysis identified within the report. Additionally, all 25 of the panel's

recommendations were actionable and targeted, and all addressed the concerns expressed within their corresponding findings. Appendix B provides an overview of the findings and recommendations in the panel's 2023 report.

The panel's 2023 report addressed 25 recommendations to 12 state entities. As of May 20, 2024, six agencies had responded in writing. These responses represent 9 of the 25 recommendations.

Agency Responses To Recommendations. KRS 620.055(10) requires the panel to determine which agency is responsible for implementing each recommendation and then forward the recommendation in writing to the responsible agency. The responsible agency is then required to respond within 90 days of receipt with

- written notice of intent to implement, an explanation of how it will do so, and an approximate time frame; or
- written notice that it does not intend to implement the recommendation, along with a detailed explanation.

The panel fulfilled its statutory notification requirement by mailing letters dated January 31 and February 1 to the 12 state entities, boards, commissions, and committees responsible for implementing the 25 recommendations in the panel's 2023 report. The following agencies received notifications:

- Administrative Office of the Courts
- Cabinet for Health and Family Services
- Department for Behavioral Health, Developmental and Intellectual Disabilities
- Department for Community Based Services
- Department for Public Health
- Governor's Office
- Interim Joint Committee on Families and Children
- Interim Joint Committee on Judiciary
- Kentucky Board of Medical Licensure
- Kentucky Board of Nursing
- Kentucky Multidisciplinary Commission on Child Sexual Abuse
- Office of the Attorney General[75]

Table 3.1 details the agency responses received as of May 20, 2024. Of the 12 agencies required to respond to the panel's recommendations, 6 had responded in writing, addressing 9 of the 25 recommendations (36 percent) in the panel's report. Three of the panel's recommendations were addressed to two agencies. Of those, there was one instance where only one of the responsible agencies responded.

Statute requires agencies to respond within 90 days of receipt. Of the six agencies that responded to recommendations, four

responded ahead of the 90-day deadline—which, based on an assumed postmark date of February 1, 2024, was assumed to be May 1, 2024. Two agencies—the Kentucky Multidisciplinary Commission on Child Sexual Abuse and Governor's Office—responded on May 2 and May 10. Those dates are outside the 90-day response window, but panel staff have indicated that it is unclear whether these responses are actually late, because the date the agencies received the notifications is unknown.[76] Recommendations are mailed to the agencies, but the panel does not receive notice when the agency receives the document and does not have policies for an allowance for delivery time.[77]

Table 3.1
Kentucky Child Fatality And Near Fatality External Review Panel
Agency Responses To Recommendations
2023 Annual Report

Panel Recommendation	Response	Responded Within 90 Days	Intent To Implement
The **Interim Joint Committee on Families and Children** (Families and Children) should convene a workgroup with the **Kentucky Board of Medical Licensure** to discuss amending KRS 311.601 to require at least 1 hour of mandatory training be dedicated to educating all professionals providing services in a medication-assisted treatment setting. The education should focus on safe storage practices, educating their clients with infants on safe sleep practices, and mandatory reporting duties when caregiver drug testing reveals a relapse.	Families: No KBML: Yes	Families: N/A KBML: Yes	Families: N/A KBML: Yes
The **Kentucky Board of Medical Licensure** should provide additional continuing medical education on their website regarding the signs and symptoms of opioid ingestions in children and the administration of naloxone.	Yes	Yes	Unclear
Kentucky Board of Medical Licensure should ensure proper training to medical marijuana prescribers regarding safe storage of medication and safe sleep practices.	Yes	Yes	No
The **Department for Community Based Services** should develop a training specific to providers of MAT regarding their intake criteria and required information for mandatory reporters.	No	N/A	N/A
The **Department for Public Health** should partner with Kentucky healthcare systems to integrate a screening for medication or illicit substance safe storage into the standard electronic health record intake for all pediatric encounters.	No	N/A	N/A
The **Department for Public Health** should do a public service campaign targeting retailers that distribute THC containing products or Kratom about safe storage and the dangers of co-sleeping while under the influence of these products.	No	N/A	N/A

Panel Recommendation	Response	Responded Within 90 Days	Intent To Implement
The **Department for Public Health** should amend 902 KAR 45:190, Hemp-derived cannabinoid products; packaging and labeling requirements, to ensure the FDA warnings regarding child ingestions are clearly visible to consumers.	No	N/A	N/A
The Panel recommends the **Kentucky Governor's Office** convene a task force with the goal of developing and implementing a robust Plan of Safe Care to address the needs of substance exposed infants and their caregivers across the Commonwealth. The task force should consist of House & Senate members, Executive Branch personnel, External Child Fatality and Near Fatality Review Panel members, and community stakeholders.	Yes	Yes*	Unclear
The **Cabinet for Health and Family Services**, in conjunction with the Kentucky Hospital Association, should identify barriers to reporting SEI/NAS cases to the Kentucky Public Health Neonatal Abstinence Syndrome (NAS) Reporting Registry and implement actionable steps to improve compliance by February 1st, 2025.	No	N/A	N/A
The **Kentucky Multidisciplinary Commission on Child Sexual Abuse** (KMCCSA) and the **Kentucky Attorney General's Office** (AG) should examine the feasibility and make a proposal to the Judiciary Committee to amend KRS 431.600 to require multidisciplinary teams to review all fatal or near fatal child physical abuse investigations.	Yes	KMCCSA: Yes* AG: Yes	Yes
The **Kentucky Multidisciplinary Commission on Child Sexual Abuse** shall amend their protocol to include all fatal and near fatal child physical abuse cases.	Yes	Yes*	Yes
The **Kentucky Board of Medical Licensure** (KBML) and **Kentucky Board of Nursing** (KBN) should encourage all primary care providers who care for children to complete an Intimate Partner Violence screening safely with their caregivers, to refer to resources for those with a positive screening, and to securely document those results.	Yes	KBML: Yes KBN: Yes	Yes
The **Cabinet for Health and Family Services, Equity and Determinants Health Branch** should create an educational handout for those individuals who screen positive for Intimate Partner Violence on the social determinants health screening. The information should include resources available throughout the Commonwealth and risk factors to children in the home.	No	N/A	N/A
The **Administrative Office of the Courts** should comply with the requirements of KRS 620.055(10)(c) and provide the Panel with an official response to the 2022 Annual Report recommendation.	Yes	Yes	Unclear
The Panel hereby requests the **Administrative Office of the Courts** to prepare and present information regarding any barriers identified in Kentucky which may prevent the full implementation of Family Recovery Courts.	Yes	Yes	Unclear

Panel Recommendation	Response	Responded Within 90 Days	Intent To Implement
Regarding the issue of screened out CPS referrals, the Panel recommends **DCBS** explore practice changes to ensure referrals from professional reporting sources, the age of victim, and prior CPS involvement be a weighted consideration in Central Intake decision making.	No	N/A	N/A
DCBS should continue to expand iTWIST improvements, as well as data collection efforts, to identify screened out CPS referrals which were ultimately accepted after further review and/or reports accepted within 60 days containing similar allegations. DCBS shall update the Panel on iTWIST changes and data collected.	No	N/A	N/A
DCBS should share information with the Panel regarding any data they currently have on wait times and potential improvement plans to address high volume call times.	No	N/A	N/A
DCBS should revise Central Intake practice to ensure referrals received after hours undergo a thorough supervisory review within the two-to-four-hour timeframe.	No	N/A	N/A
DCBS should implement a process to ensure the Systems Safety Staff receive timely notification of all fatal and near fatal referrals, regardless of the designation applied to the report.	No	N/A	N/A
DCBS should explore creating a specialized branch or other processes within Centralize Intake to focus on handling referrals made by a professional reporting source.	No	N/A	N/A
To better understand the drivers behind the quality casework related issues, it is recommended **DCBS** provide the Panel with county, team, and/or individual caseload information for the cases reviewed by the Panel in which concerns are identified.	No	N/A	N/A
The **Kentucky General Assembly**, through the Judiciary Committee, should research national legislative models pertaining to Child-Access Prevention and Safe Storage Laws with the goal of developing legislative action to encourage and support safe storage practices.	No	N/A	N/A
The Panel recommends if the **Department for Behavioral Health, Developmental and Intellectual Disabilities** does not believe they are the appropriate entity to implement the psychological autopsy, they should identify the recommended agency.	No	N/A	N/A
The Panel recommends the **Department for Behavioral Health, Developmental and Intellectual Disabilities**, complete the offered assessment of best practices in other states and present that information, along with any recommendations to the Panel by September 2024.	No	N/A	N/A

Note: MAT = medication-assisted treatment; THC = tetrahydrocannabinol; FDA = Food and Drug Administration; SEI/NAS = substance-exposed infant/neonatal abstinence syndrome; DCBS = Department for Community Based Services; CPS = child protective services.
* The panel received responses from Kentucky Multidisciplinary Commission on Child Sexual Abuse and Governor's Office on May 2 and May 10. Those dates are outside the 90-day response window, but panel staff have indicated that it is unclear whether these responses are actually late, because the date the agencies received the notifications is unknown.
Source: Staff analysis of information in the Kentucky Child Fatality and Near Fatality External Review Panel's 2023 Annual Report and Agency Responses.

Failure Of Agencies To Meet Response Requirements

Only 48 percent of recommendations from the 2022 report and 36 percent of recommendations from the 2023 report received a response by the 90-day deadline.

Agency notification and response requirements have existed for two of the panel's reports; for both reports, agencies have not consistently fulfilled statutory requirements to adequately respond to the panel's recommendations. Only 48 percent of recommendations from the panel's 2022 report received appropriate agency responses by the deadline. Only 36 percent of recommendations from the panel's 2023 report received a required agency response by the deadline. In addition, the 2023 recommendations that did receive responses often did not include statutorily required elements such as a clear statement of intent to implement the recommendation and a timeline for implementation or a clear refusal to implement and an explanation of why the agency does not intend to do so. Of the nine recommendations that received responses, only three received responses that included all elements required by statute. One of these recommendations received responses from two agencies, both of which were compliant.

The panel has complied with its notification requirements to the full extent of statutory language. As shown in the example provided in Figure 3.C, notification letters provide citations for the recommendations in the report that pertain to the receiving agency and state-required elements that must be provided in the agency response along with notice of the 90-day response deadline.

The panel does not have a policy determining when the 90-day window ends. The panel could use certified mail or base its policy off other existing policies.

The panel may be able to improve its notification system to increase agency response rates and statutory compliance. For example, because notification letters are mailed physically, there is no way for the panel to know when each agency received the notifications. Without that information, the panel cannot be certain of the date by which the "within 90 days of receipt" deadline falls for each recipient agency. The panel could use certified mail or a similar service that allows for documentation of when material is received. Alternatively, the panel could establish a policy regarding a deadline for responses to determine when responses are late, provide a specific date for responses in the notification letter, and establish when panel staff should follow up on notifications.

The panel could base a policy off similar rules. For example, the "mailbox rule" is a default rule in contracts law, in which an offer is considered to be accepted when the offeree mails a letter as opposed to once the offeror receives the letter.[78]

Figure 3.C
Child Fatality And Near Fatality External Review Panel Website
Example Of Letter To Agency Responsible For Recommendation Implementation

Child Fatality & Near Fatality External Review Panel
125 Holmes Street, 2nd Floor
Frankfort, Kentucky 40601
502-564-7554

January 31, 2024

Secretary Eric Friedlander
Cabinet for Health and Family Services
275 E. Main St., 5W-A
Frankfort, KY 40621

Dear Secretary Friedlander:

I'm pleased to present the 2023 Annual Report of the Child Fatality and Near Fatality External Review Panel. The Panel is statutorily required to conduct comprehensive reviews of all child fatalities and near fatalities suspected of abuse and neglect. Throughout 2023, the Panel reviewed 202 cases from across the Commonwealth. This report contains the findings and recommendations of the Panel based upon these case reviews.

In accordance with KRS 620.055(10), the Panel is required to determine which agency is responsible for implementing each recommendation within this report. The recipient of these recommendations shall respond to the Panel in ninety (90) days with a written notice of intent to implement, including how the recommendation will be implemented, and an approximate time frame *or* provide a detailed explanation of why the recommendation cannot be implemented. Recommendations regarding the Cabinet for Health and Family Services can be found here:

- DCBS, Page 5, Recommendations #4
- DPH, Page 5, Recommendations #5-7
- Page 9, Recommendations #2
- Page 11, Recommendations #4
- DCBS, Page 17, Recommendation #1-7
- DBHDID, Page 21, Recommendation #1 & #2

Please send your written response to the attention of Ms. Elisha Mahoney, Executive Staff Advisor, at the Justice & Public Safety Cabinet, address listed above. Please let me know if you have any questions about the report. We look forward to your response.

Sincerely,

Melissa Moore Murphy

Hon. Judge Melissa Moore Murphy, Chair

Hon. Melissa Moore Murphy
Chair

Panel Members:

Dr. Melissa Currie
Commissioner Lesa Dennis
Sen. Danny Carroll
Rep. Samara Heavrin
Detective Jason Merlo
Dr. Jaime Pittenger Kirtley
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Dr. Elizabeth Salt
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Dr. Henrietta Bada
Hon. Libby Messer
Lori Aldridge
Mark Hammond
Geoff Wilson
Heather McCarty
Olivia McCollum
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CC: Commissioner, Lesa Dennis
Commissioner, Steven J. Stack
Commissioner, Katherine Marks

Source: Elisha Mahoney, executive staff adviser, Child Fatality and Near Fatality External Review Panel. Email to Jeremy Skinner, March 6, 2024. Attachment: *Child Fatality And Near Fatality External Review Panel 2/21/2024 Question Set.*

The Kentucky Rules of Civil Procedure add a number of days after the document is sent. Rule 6.05 states that

> [w]henever a party has the right or is required to do some act or take some proceedings within a prescribed period after the service of a notice or other paper upon him and the notice or paper is served upon him by mail or electronic service, 3 days shall be added to the prescribed period.[79]

Response rate may be improved by sending a standardized notification that includes all the required elements of a response.

In addition, it may be beneficial to send a standardized notification to agencies that includes spaces for agencies to answer all of the elements required by statute. The current form references the pages of the recommendation without stating the recommendations. This form requires agencies to seek out the recommendation and create their own form. This requires additional time and effort from the agencies and results in a variety of responses from the agencies.

While it is the agency's responsibility to provide an adequate response, a standardized form could improve the quantity and quality of responses from agencies. Identifying the recommendations in the form would reduce the time needed to find the recommendations in the original report and not force the agency to develop its own template. The form should prompt the agency to indicate whether it will implement or reject recommendations. For example, including checkboxes for implementing or rejecting recommendations would prevent agencies from making vague statements that do not clearly indicate actions. Having a section to indicate how the agency will implement a recommendation or why it is rejecting the recommendation will make responses clearer, which will help the panel when it is considering how to draft future recommendations that will be more likely to be accepted.

Recommendation 3.1

Recommendation 3.1

The panel should use a service such as certified mail or adopt policies determining the 90-day response deadline by which agencies are required to respond to panel recommendations.

Recommendation 3.2

Recommendation 3.2

The panel should update its notification letter format to include spaces for agencies to provide all of the required elements in their responses, such as clear intent to implement the recommendation, a timeline for implementation, and an explanation for declining to implement the recommendation.

Internal Controls

The panel does not have written procedures for its operations. The panel's establishing statute does not require the panel to develop written procedures, but doing so could reduce internal control risks related to achieving panel objectives.

Although the statutory framework discussed in the previous finding area establishes legislative expectations related to the panel, the panel has wide discretion in developing its standard operating procedures. The panel set out to develop procedures for its operations soon after its inception and has since developed standard operating procedures related to its meetings; case referral, storage, and review; and annual reports and recommendations.[80] However, these procedures have not been formalized into written standard operating procedures.[81]

Although its establishing statute does not mandate that the panel develop written procedures, the development of procedures is implied by KRS 620.055(17), which states that

> [t]he Legislative Oversight and Investigations Committee of the Kentucky General Assembly shall conduct an annual evaluation of the external child fatality and near fatality review panel established pursuant to this section to monitor the operations, *procedures,* and recommendations of the panel and shall report its findings to the General Assembly [emphasis added].

Written, formal procedures can serve as internal controls for an entity. Internal controls address the risks related to achieving objectives.[82] *Risks* are any possibility that an event will occur and adversely affect the achievement of objectives.[83] The benefits of developing and maintaining written procedures include

- establishing and communicating the components of internal control execution to staff,
- retaining organizational knowledge and mitigating the risks associated with having organizational knowledge limited to a few personnel, and
- communicating organization knowledge as needed to external parties, such as external auditors.[84]

LOIC staff identified several areas during this year's review where the panel might benefit from having written policies and procedures, including

- protocols for determining the 90-day deadline for agencies responsible for responding to the panel's recommendations,
- procedures related to follow-ups with agencies that do not respond to panel recommendations in a timely manner,
- procedures related to follow-ups with agencies that do not clearly indicate whether they will implement a

recommendation or how they plan to implement a recommendation, and
- onboarding of new staff or panel members.

As discussed in Chapter 2, the panel has developed and maintained an Analyst Binder for analysts to reference while performing their case review duties. The binder includes general instructions for accessing and using the two software programs used by the panel, the completion of required case summary and timeline templates, and a dictionary of medical terminology. Although the Analyst Binder does include elements of policies and procedures, it is not comprehensive enough to be considered a standard operating procedures manual. For example, it does not discuss the responsibilities of the executive staff adviser, procedures for budget requests, or policies for communicating recommendations to agencies.

Recommendation 3.3

Recommendation 3.3

Panel staff should develop written procedures for review and approval by the panel chair and members. The written procedures should document the processes by which the panel obtains, stores, reviews, and analyzes cases; develops findings and recommendations; develops annual reports; and complies with the reporting requirements mandated by KRS 620.055(10).

Appendix A

Records Provided To Panel By Department For Community Based Services

KRS 620.055 (6) outlines all information that the Department for Community Based Services must provide to the panel within 30 days:

(a) Cabinet for Health and Family Services records and documentation regarding the deceased or injured child and his or her caregivers, residents of the home, and persons supervising the child at the time of the incident that include all records and documentation set out in this paragraph:
   1. All prior and ongoing investigations, services, or contacts;
   2. Any and all records of services to the family provided by agencies or individuals contracted by the Cabinet for Health and Family Services; and
   3. All documentation of actions taken as a result of child fatality internal reviews conducted pursuant to KRS 620.050(12)(b);

(b) Licensing reports from the Cabinet for Health and Family Services, Office of Inspector General, if an incident occurred in a licensed facility;

(c) All available records regarding protective services provided out of state;

(d) All records of services provided by the Department for Juvenile Justice 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;

(e) Autopsy reports;

(f) Emergency medical service, fire department, law enforcement, coroner, and other first responder reports, including but not limited to photos and interviews with family members and witnesses;

(g) Medical records regarding the deceased or injured child, including but not limited to all records and documentation set out in this paragraph:
   1. Primary care records, including progress notes; developmental milestones; growth charts that include head circumference; all laboratory and X-ray requests and results; and birth record that includes record of delivery type, complications, and initial physical exam of baby;
   2. In-home provider care notes about observations of the family, bonding, others in home, and concerns;
   3. Hospitalization and emergency department records;
   4. Dental records;
   5. Specialist records; and
   6. All photographs of injuries of the child that are available;

(h) Educational records of the deceased or injured child, or other children residing in the home where the incident occurred, including but not limited to the records and documents set out in this paragraph:
   1. Attendance records;
   2. Special education services;
   3. School-based health records; and
   4. Documentation of any interaction and services provided to the children and family.

The release of educational records shall be in compliance with the Family Educational Rights and Privacy Act, 20 U.S.C. sec. 1232g and its implementing regulations;

(i) Head Start records or records from any other child care or early child care provider;

(j) Records of any Family, Circuit, or District Court involvement with 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 that include but are not limited to the juvenile and family court records and orders set out in this paragraph, pursuant to KRS Chapters 199, 403, 405, 406, and 600 to 645:
   1. Petitions;
   2. Court reports by the Department for Community Based Services, guardian ad litem, court-appointed special advocate, and the Citizen Foster Care Review Board;
   3. All orders of the court, including temporary, dispositional, or adjudicatory; and
   4. Documentation of annual or any other review by the court;

(k) Home visit records from the Department for Public Health or other services;

(l) All information on prior allegations of abuse or neglect and deaths of children of adults residing in the household;

(m) 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; and

(n) 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.

Appendix B

2023 Panel Report Findings and Recommendations

Table B.1 contains the findings and associated recommendations, grouped by subject area, from the panel's 2023 report. As discussed in Chapter 3, all recommendations were supported by data and/or analysis. Multiple recommendations can be associated with a single finding.

Table B.1
2023 Panel Report Findings And Recommendations

Subject Area	Finding	Corresponding Recommendation
Overdose/Ingestion Cases	(P. 4) KRS 311.601 requires the Board of Medical Licensure to adopt administrative regulations regarding continuing medical education. 201 KAR 9:310 requires a licensee who is authorized to prescribe or dispense controlled substances complete at least four and half hours continuing education relating to the use of KASPER, pain management, addiction disorder, or a combination of two or more subjects. The Board currently has one approved continuing medical education course available on their website pertaining to Safe Medication Storage.	• (P. 5) The Interim Joint Committee on Families and Children should convene a workgroup with the Kentucky Board of Medical Licensure to discuss amending KRS 311.601 to require at least 1 hour of mandatory training be dedicated to educating all professionals providing services in a medication-assisted treatment setting. The education should focus on safe storage practices, educating their clients with infants on safe sleep practices, and mandatory reporting duties when caregiver drug testing reveals a relapse. • (P. 5) The Kentucky Board of Medical Licensure should provide additional continuing medical education on their website regarding the signs and symptoms of opioid ingestions in children and the administration of naloxone. • (P. 5) Kentucky Board of Medical Licensure should ensure proper training to medical marijuana prescribers regarding safe storage of medication and safe sleep practices.
Overdose/Ingestion Cases	(P. 4) During case discussions, the Panel identified cases where the caregivers were receiving MAT treatment but still testing positive for illicit drugs. Due to the Panel's limitations on obtaining access to MAT treatment records, we cannot always verify that the MAT provider made the appropriate referral to child protective services. Furthermore, providers have expressed frustration with referrals not being accepted by Centralized Intake.	(P. 5) The Department for Community Based Services should develop a training specific to providers of MAT regarding their intake criteria and required information for mandatory reporters.

Subject Area	Finding	Corresponding Recommendation
Overdose/Ingestion Cases	(P. 3) Overdose/ingestion cases continue to be one of the most common types of cases reviewed by the Panel. The Panel found the majority of these cases were unintentional ingestions which are potentially preventable with proper storage of dangerous substances in the home, particularly medications and illicit drugs.	(P. 5) The Department for Public Health should partner with Kentucky health care systems to integrate a screening for medication or illicit substance safe storage into the standard electronic health record intake for all pediatric encounters.
Overdose/Ingestion Cases	(P. 4) The American Academy of Pediatrics (AAP) published a recent study demonstrating a consistent increase in pediatric edible cannabis exposures over the last 5 years, with the potential for significant toxicity. Figure # 3 illustrates an alarming increase of cannabis or THC containing products ingested by children in Kentucky. Panel members, in their professional roles, have noted an increase in pediatric ingestions regarding delta-8 and other legal hemp-derived substances. The Panel reviewed at least two fatal cases where the child had ingested these substances. Not only have the Panel's ingestion cases substantially increased, but a paralleled trend was identified using emergency department data provided by KIPRC. Except for one Panel case, all cases shown in Figure #3 involved children four years or younger. … In 10% of the ingestion cases reviewed by the Panel, unsafe sleep was documented as a characteristic.	• (P. 5) The Department for Public Health should do a public service campaign targeting retailers that distribute THC containing products or Kratom about safe storage and the dangers of co-sleeping while under the influence of these products.* • (P. 5) The Department for Public Health should amend 902 KAR 45:190 Hemp-derived cannabinoid products; packaging and labeling requirements, to ensure the FDA warnings regarding child ingestions are clearly visible to consumers.
Plan of Safe Care	(P. 6) Year after year the Panel has documented that these children are at significant risk of serious maltreatment. The Panel has also made numerous recommendations aimed at enhancing the capacity to implement the Plan of Safe Care (POSC) as a tool to wrap services around SEIs, their parents, and caregivers. Regrettably, we now find ourselves facing little improvement in the case circumstances documented by the Panel or meaningful progress in the Commonwealth's capacity to address this complex issue.	(P. 9) The Panel recommends the Kentucky Governor's Office convene a task force with the goal of developing and implementing a robust Plan of Safe Care to address the needs of substance exposed infants and their caregivers across the Commonwealth. The task force should consist of House & Senate members, Executive Branch personnel, External Child Fatality and Near Fatality Review Panel members, and community stakeholders.

Subject Area	Finding	Corresponding Recommendation
Plan of Safe Care	(P. 6) According to data from the NAS Reporting Registry, 80% of NAS cases (679) were reported to DCBS in 2022. In CY 2022, 849 children were reported as diagnosed with NAS. An additional 787 children were identified as SEI, but without NAS symptoms. The rate of NAS in Kentucky is far above the national average. A wide variety of drugs were found within NAS cases. The NAS Reporting Data systems is limited by compliance issues among birthing hospitals which can negatively impact data quality.	(P. 9) The Cabinet for Health and Family Services, in conjunction with the Kentucky Hospital Association, should identify barriers to reporting SEI/NAS cases to the Kentucky Public Health Neonatal Abstinence Syndrome (NAS) Reporting Registry and implement actionable steps to improve compliance by February 1st, 2025.
Physical Abuse	(P. 10) KRS 620.040 requires multidisciplinary teams (MDTs) to review all child sexual abuse cases. Local MDTs review investigations, assess service delivery, and facilitate efficient and appropriate disposition of cases through the criminal justice system. The same need exists for all fatal and near fatal physical abuse cases. Reviewing all fatal and near fatal physical abuse cases would alleviate communication barriers agencies often face when handling these complex cases.	• (P. 11) The Kentucky Multidisciplinary Commission on Child Sexual Abuse and the Kentucky Attorney General's Office should examine the feasibility and make a proposal to the Judiciary Committee to amend KRS 431.600 to require multidisciplinary teams to review all fatal or near fatal child physical abuse investigations. • (P. 11) The Kentucky Multidisciplinary Commission on Child Sexual Abuse shall amend their protocol to include all fatal and near fatal child physical abuse cases.
Physical Abuse	(P. 10) The U.S. Preventive Services Task Force recommends screening all women of reproductive age for intimate partner violence (IPV) and provide or refer individuals who screen positive to ongoing support services. Medical providers have expressed concern that these screenings are often missing in the social history section of the child's medical record. Exposure to IPV is distressing to children and is associated with a host of mental health symptoms both in childhood and in later life.	• (P. 11) The Kentucky Board of Medical Licensure and Kentucky Board of Nursing should encourage all primary care providers who care for children to complete an Intimate Partner Violence screening safely with their caregivers, to refer to resources for those with a positive screening, and to securely document those results. • (P. 11) The Cabinet for Health and Family Services, Equity and Determinants Health Branch should create an educational handout for those individuals who screen positive for Intimate Partner Violence on the social determinants health screening. The information should include resources available throughout the Commonwealth and risk factors to children in the home.

Subject Area	Finding	Corresponding Recommendation
Family Recovery Court	(P. 11) In 2022, the Panel recommended the Administrative Office of the Courts develop a budgetary proposal to expand Family Recovery Courts throughout Kentucky. The budgetary proposal should be presented to the Interim Joint Committee on Appropriations and Revenue, Budget Review Subcommittee on Justice and Judiciary and the Kentucky Opioid Abatement Advisory Commission for appropriations. As previously mentioned, any agency that receives a recommendation from the Panel shall, within ninety (90) days respond with a written notice of whether they do or do not intend to implement the recommendation and provide explanation. Unfortunately, the Panel did not receive a written response from the Administrative Office of the Courts.	(P. 12) The Administrative Office of the Courts should comply with the requirements of KRS 620.055(10)(c) and provide the Panel with an official response to the 2022 Annual Report recommendation.
Family Recovery Court	(P. 12) Current research shows parents in Family Recovery Courts were 25%-35% more likely to complete treatment than in traditional dependency proceedings. Additionally, children spent 3-6 fewer months in out-of-home placement than traditional courts. It is apparent, domestic violence occurred at a higher rate in cases with prior court history. It appears there may exist communication barriers amongst judges due to how information is captured in the current CourtNet system.	(P. 12) The Panel hereby requests the Administrative Office of the Courts to prepare and present information regarding any barriers identified in Kentucky which may prevent the full implementation of Family Recovery Courts.
Department for Community Based Services	(P. 15) Despite these encouraging steps, the issue of screening out CPS reports remains of significant concern. This concern has been reinforced beyond the data and case examples provided in this report. Panel members have discussed their own difficulties in getting reports accepted by DCBS Central Intake, sometimes describing time consuming efforts to make a CPS report. Panel members making CPS referrals are professionals, often physicians and judges. During the Panel's June 2023 meeting, DCBS staff discussed improving their iTWIST system to track referrals that were originally screened out but ultimately accepted for investigation after a supervisory review. This data will be imperative to improve their current screening processes.	• (P. 17) Regarding the issue of screened out CPS referrals, the Panel recommends DCBS explore practice changes to ensure referrals from professional reporting sources, the age of victim, and prior CPS involvement be a weighted consideration in Central Intake decision making. • (P. 17) DCBS should continue to expand iTWIST improvements, as well as data collection efforts, to identify screened out CPS referrals which were ultimately accepted after further review and/or reports accepted within 60 days containing similar allegations. DCBS shall update the Panel on iTWIST changes and data collected. • (P. 17) DCBS should share information with the Panel regarding any data they currently have on wait times and potential improvement plans to address high volume call times.

Subject Area	Finding	Corresponding Recommendation
		• (P. 17) DCBS should revise Central Intake practice to ensure referrals received after hours undergo a thorough supervisory review within the two-to-four-hour timeframe. • (P. 17) DCBS should explore creating a specialized branch or other processes within Centralize Intake to focus on handling referrals made by a professional reporting source.
Department for Community Based Services	(P. 15) Related to the issue of screened out CPS reports, are concerns regarding the accurate designation of fatal or near fatal reports. In these situations, the reports (typically called into Central Intake) may be accepted for investigation but not designated as a fatality or near fatality. While certainly not the sole incident, Case Number F-059-22-PH is an example. If this case had not been referred by the State Sudden Unexpected Death in Infancy (SUDI) Team, it would have remained unknown to the Panel. This, and other similar cases, raises the concern that not all of these cases are being referred to the Panel.	(P. 17) DCBS should implement a process to ensure the Systems Safety Staff receive timely notification of all fatal and near fatal referrals, regardless of the designation applied to the report.
Department for Community Based Services	(P. 16) As previously noted, every issue identified in Figure #9 is not addressed in this narrative, however, it is important to note the Panel has attempted to address the root cause or "driver" behind many of these issues. It stands to reason, and is supported by anecdotal evidence, many of these issues (gaps in contact, untimely initiation, poor documentation, etc.) are a result of staffing issues such as vacancies, turnover, and burnout.	(P. 17) To better understand the drivers behind the quality casework related issues, it is recommended DCBS provide the Panel with county, team, and/or individual caseload information for the cases reviewed by the Panel in which concerns are identified.

Subject Area	Finding	Corresponding Recommendation
Child Access Prevention Laws	(P. 19) Safe storage of firearms is a crucial protective factor when examining youth suicide prevention efforts. This assertion is readily apparent in the Panel's case review data: in all suicide by firearm cases reviewed, the Panel identified unsafe access to firearms as a risk factor. Child-Access Prevention (CAP) laws, sometimes called safe storage laws, create penalties for individuals who fail to properly store a firearm in a manner that is not easily accessible to children. Safe Storage laws require firearm owners to secure and lock firearms. Most states have enacted some variation of CAP and/or safe storage legislation. There is evidence these efforts are effective.	(P. 19) The Kentucky General Assembly, through the Judiciary Committee, should research national legislative models pertaining to Child-Access Prevention and Safe Storage Laws with the goal of developing legislative action to encourage and support safe storage practices.
Youth Suicides	(P. 21) The written response to this recommendation described DBHDID as the "state mental health authority," outlined collaborative efforts made to address suicide, and acknowledged psychological autopsy would be a welcome addition to existing services. However, DBHDID did not agree it was the correct agency to administer such an effort. The department did offer to assess best practices in other states to develop an appropriate implementation proposal that identifies needed resources and expenditures, along with appropriate participating or administrating agencies. Further, DBHDID reported being unaware of any current grant solicitations regarding this recommendation but would integrate the issue into further planning efforts going forward. The Panel acknowledges the commendable work already accomplished by this department but still believes DBHDID is the appropriate agency to implement the psychological autopsies.	• (P. 21) The Panel recommends if the Department for Behavioral Health, Developmental and Intellectual Disabilities does not believe they are the appropriate entity to implement the psychological autopsy, they should identify the recommended agency. • (P. 21) The Panel recommends DBHDID, complete the offered assessment of best practices in other states and present that information, along with any recommendations to the Panel by September 2024.

Note: KASPER = Kentucky All Schedule Prescription Electronic Reporting; MAT = medication-assisted treatment; KIPRC = Kentucky Injury Prevention and Research Center; SEI = substance-exposed infant; NAS = neonatal abstinence syndrome; DCBS = Department for Community Based Services; CY = calendar year; CPS = child protective services; DBHDID = Department for Behavioral Health, Developmental and Intellectual Disabilities.
*****While all recommendations satisfied LOIC staff's criteria for being actionable, targeted, and addressing finding concerns, this recommendation discussed kratom despite there being no other mention of the substance in the report.
Source: Kentucky. Justice and Public Safety Cabinet. Child Fatality and Near Fatality External Review Panel. *2022 Annual Report*.

Endnotes

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[5] KRS 620.055(1); KRS 620.055(10).
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[20] Elisha Mahoney, executive staff adviser, Child Fatality and Near Fatality External Review Panel. Email to Jeremy Skinner. March 6, 2024.
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[29] KRS 211.686(1).

[30] Elisha Mahoney, executive staff adviser, Child Fatality and Near Fatality External Review Panel. Dec. 8, 2020. Interview.
[31] Sarah Cooper, staff assistant, Cabinet for Health and Family Services. Office of the Secretary. Email to Gerald Hoppmann, Feb. 19, 2021.
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[54] Kentucky. Justice and Public Safety Cabinet. *Justice And Public Safety Cabinet Office Of The Secretary, Memorandum Of Understanding.* June 10, 2024.
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[57] Kentucky. Child Fatality and Near Fatality External Review Panel. March 28, 2023. Meeting minutes.
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[63] Elisha Mahoney, executive staff adviser, Child Fatality and Near Fatality External Review Panel. Email to Jeremy Skinner, April 18, 2024.
[64] Kentucky. Child Fatality and Near Fatality External Review Panel. *2020 Annual Report*, p. 2; Kentucky. Child Fatality and Near Fatality External Review Panel. *2021 Annual Report*, p. 2; Elisha Mahoney, executive staff adviser, Child Fatality and Near Fatality External Review Panel. Email to Jeremy Skinner, April 17, 2024; Elisha Mahoney, executive staff adviser, Child Fatality and Near Fatality External Review Panel. Email to Jeremy Skinner, April 18, 2024.
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