

# **Kentucky Child Fatality And Near Fatality External Review Panel 2018 Update**

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## **Abstract**

The Program Review and Investigations Committee is required by statute to monitor annually the operations, procedures, and recommendations of the Child Fatality and Near Fatality External Review Panel. The panel, attached administratively to the Justice and Public Safety Cabinet, conducts comprehensive reviews of child fatalities and near fatalities resulting from abuse or neglect. Statute establishes requirements related to membership, meeting schedule and attendance, posting updates, issuing summary reports of meetings, retention and destruction of records, and publication of an annual report each December 1. The panel is in compliance with all requirements except that its 2018 report was issued February 1, 2019 because of delays in receiving case materials. The panel notified report recipients of the delay. This Program Review report also covers referral of cases to the panel, recommendations made by the panel, reporting requirements and fatality statistics of other states, and child fatality and near fatality review teams in selected states. The report has three recommendations: two directed to the panel regarding its procedures and one directed to the General Assembly regarding the due date of the panel's annual report.

## **Legislative Research Commission**

Frankfort, Kentucky  
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## **Acknowledgments**

Program Review staff thank the members of the Child Fatality and Near Fatality External Review Panel. Judge Roger Crittenden, panel chair, and Elisha Mahoney, executive staff advisor, were especially helpful and provided valuable information. Staff also acknowledge the assistance of deputy commissioner Elizabeth Caywood of the Department for Community Based Services and staff of the Department for Public Health's Division of Maternal and Child Health.



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## Summary

The Kentucky Child Fatality and Near Fatality External Review Panel conducts comprehensive reviews of child fatalities and near fatalities suspected to be a result of abuse or neglect that are reported to the Cabinet for Health and Family Services. The panel also accepts case referrals from other state and local agencies. The panel is independent but is attached to the Justice and Public Safety Cabinet for staff and administrative purposes. Statute requires that the Program Review and Investigations Committee monitor the panel annually.

By statute, the panel has five ex officio nonvoting members and 15 voting members. Three voting members are panel members based on their position, 10 are appointed by the attorney general, one is appointed by the chief justice of the Supreme Court, and one is appointed by the secretary of state.

### Statutory Requirements

The panel is in compliance with its statutory requirements related to membership, meeting schedule and attendance, posting updates, summary reports, and destruction of records. The panel's 2018 report was not issued on December 1 as required by statute because of delays in receiving case information. The panel notified report recipients that it would be published February 1, 2019, which it was.

#### Recommendation 1

**The General Assembly may wish to change the due date of the panel's annual report to February 1 to provide the panel with sufficient time to receive and review all cases of the previous fiscal year.**

Statute requires that, at the conclusion of the panel's examinations, all copies of information and records involving individual cases shall be destroyed by the Justice and Public Safety Cabinet. The panel maintains on its SharePoint site the documents it has created for its own use, such as electronic discussions among panel members. The panel's initial group of SharePoint documents will reach their 5-year retention date in 2019. The method for destruction of the SharePoint documents has yet to be established by the panel.

#### Recommendation 2

**The panel should establish a policy for the destruction of electronic documents stored in SharePoint.**

### **Staff And Funding**

The panel's current staff are an executive staff advisor who also handles other duties for the Justice and Public Safety Cabinet and a full-time social service clinician hired in December 2018 to do case analysis. The panel also uses part-time contractors who review all case records and prepare case summaries and timelines to facilitate the panel review process.

The panel receives its funding through the Justice and Public Safety Cabinet and does not have its own operating budget. For FY 2018, the panel's expenditures were \$156,149. Expenses will increase with the addition of the full-time social service clinician.

### **Referral Of Cases**

The primary source for panel cases is the Department for Community Based Services (DCBS). It provides comprehensive case material to the panel for review, but the significant amount of time it takes the department to complete its internal review process and then to upload case materials for the panel are impeding the panel's process. DCBS is working to address the issue.

The panel's position is that any state or local agency may refer cases to the panel as there is no statutory limitation on doing so. The panel expressed concern that its analysis of child fatalities and near fatalities due to maltreatment does not include all such cases occurring in the state. The Department for Public Health also forwards cases for review from its local child fatality review teams. However, not all localities have review teams and most existing teams are new and may not have a quality review process. The panel would like to see an increased awareness that law enforcement may refer cases to the panel.

### **State-Level Statistics**

Kentucky's average annual number of fatalities due to maltreatment per 100,000 children is nearly identical to the national average. The state's percentage of abuse reports that involve a fatality is below the national average. Both Kentucky numbers have been declining. As explained in the report, state comparisons and trends should be considered approximate though.

### **Child Fatality Review Teams In Kentucky And Other States**

In addition to Kentucky, 12 states and the District of Columbia include near fatalities of children in their review process. All have codified the definition of near fatality, with definitions nearly identical to Kentucky's.

The Department for Public Health's State Child Fatality Review Team reviews all child fatalities in Kentucky and works with local teams.

For this report, five other states were reviewed whose panel or team are comparable of the Kentucky's Child Fatality and Near Fatality External Review Panel: Colorado, Massachusetts, New Jersey, Oklahoma, and Tennessee.



### **Status Of The Panel's Recommendations**

Since 2014, the panel has made recommendations annually based on the cases it reviewed. This Program Review report covers the status of these recommendations. Recommendations are grouped into a general category and six topic-specific categories: Department for Community Based Services, substance abuse, medical providers, the courts, law enforcement, and coroners.

The panel's recommendations are in its annual reports. Typically, the report discusses an identified issue and then states the related recommendation. Sometimes, the wording of a recommendation is unclear. In some instances, it is unclear whether a recommendation is being made.

#### **Recommendation 3**

**Recommendations in the panel's annual reports should be easily identifiable and clearly stated.**



## Kentucky Child Fatality And Near Fatality External Review Panel 2018 Update

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**The Kentucky Child Fatality and Near Fatality Review Panel conducts comprehensive reviews of child fatalities and near fatalities suspected to be a result of abuse or neglect.**

The Kentucky Child Fatality and Near Fatality External Review Panel conducts comprehensive reviews of child fatalities and near fatalities suspected to be a result of abuse or neglect that are reported to the Cabinet for Health and Family Services (KRS 620.055(1)). The panel also accepts case referrals from other state and local agencies. Statute defines *near fatality* as an injury that, as certified by a physician, places a child in serious or critical condition (KRS 600.020(40)).

In July 2012, Governor Beshear issued an executive order creating the panel (E.O. 2012-585). In June 2013, the General Assembly codified the panel and its structure under HB 290. The panel is independent but is attached to the Justice and Public Safety Cabinet for staff and administrative purposes (KRS 620.055(1)). Appendix A of this report is the memorandum of understanding describing the panel's relationship with the cabinet.

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**Statute requires that the Program Review and Investigations Committee monitor the panel annually.**

According to KRS 6.922, annually beginning in 2014 the Program Review and Investigations Committee shall “monitor the operations, procedures, and recommendations” of the panel and report its findings to the General Assembly.<sup>a</sup>

In 2018, the panel reviewed 134 cases from fiscal year 2017: 51 fatalities and 83 near fatalities. All cases were referred by the Cabinet for Health and Family Services: 126 from the Department for Community Based Services (DCBS) and eight from the Department for Public Health.<sup>1</sup>

### Conclusions

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**This report has two conclusions.**

This report has two conclusions.

- The panel is in compliance with statute with the exception that its annual report was not published by the mandated time.
- The panel could receive additional case referrals to increase the likelihood that all relevant near fatalities and fatalities are reviewed.

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<sup>a</sup> The requirement is also in KRS 620.055(16).

## Recent Legislative Changes

In 2018, Kentucky and the federal government enacted significant child welfare legislation that, although it does not affect the panel directly, is relevant to its work.

### Kentucky

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**HB 1, enacted in 2018, changes Kentucky's adoption and foster care systems.**

HB 1, enacted in the 2018 Regular Session, changes the state's adoption and foster care systems. The bill enhances the Cabinet for Health and Family Services' ability to provide services before removing children from the home and imposes time frames to ensure that children find a permanent placement quickly. The legislation created 10 statutes and revised 15 statutory chapters. Major provisions include

- establishing the General Assembly's Child Welfare Oversight and Advisory Committee,
- setting caseload limits for DCBS workers,
- providing time frames for case reviews of children in foster care and for the consideration or termination for parental rights,
- adding neonatal abstinence syndrome as potential grounds for termination of parental rights,
- enabling the state to establish a kinship care program,
- improving notifications for foster families and child-caring agencies, and
- authorizing two study groups.

### Federal

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**The US Family First Prevention Act of 2018 allows federal funds to be used for supports and services intended to help prevent a child's removal from the home.**

The Family First Prevention Services Act of 2018 expands the use of specified federal funds to enable states to provide services for children at risk of entering the child welfare system.<sup>2</sup> States may now be reimbursed for prevention services such as mental health and substance use treatment and in-home parenting training. States may provide these services for up to 12 months and must maintain a prevention plan for the child to remain safely at home with a caregiver. The 12-month time period begins anew if a child is again identified by the state as a candidate for foster care.

The Act incentivizes states to reduce usage of group homes for children, requires that states implement an electronic case processing system to expedite the placement of children in foster care, and provides competitive grant funds to support recruitment and retention of high quality foster homes. Federal funds may also be used to establish kinship programs and to support evidence-based services to prevent substance-abuse-related child

maltreatment. The Act provides details on required data collection and service information. This includes a requirement that states develop a plan to prevent child abuse that details how the state will monitor and oversee the safety of children receiving services.

## **Panel's Compliance With Governing Statutes**

### **Membership**

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**The panel is in compliance with its statutory requirements related to membership, meeting schedule and attendance, posting updates, summary reports, and destruction of records.**

KRS 620.055(2) requires that the panel have five ex officio nonvoting members and 15 voting members. As shown in Table 1, three voting members are panel members based on their position, 10 are appointed by the attorney general, one is appointed by the chief justice of the Supreme Court, and one is appointed by the secretary of state. The panel's annual report lists panel members.

Program Review's 2017 report found that the panel was not in compliance with this requirement because of the absence of an addiction specialist. The Kentucky Association of Addiction Professionals had not made nominations for the position despite repeated requests from the panel and the attorney general's office. In November 2018, the association provided a list of nominees and the attorney general made the appointment. The appointee resigned in March 2019 due to scheduling conflicts. A subsequent nominee was appointed using the standard procedure. No explanation for the original delay was provided to the panel.<sup>3</sup>

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**In 2017, Program Review recommended that the General Assembly specify a procedure for filling a panel vacancy when it cannot be filled in the same manner as the original appointment.**

The 2017 Program Review report recommended that the General Assembly may wish to specify a procedure for filling the vacancy of a voting member when it cannot be filled in the same manner as the original appointment.

HB 89, introduced in the 2019 Regular Session, would have increased the number of nonvoting members to eight and the number of voting members to 16. The three additional nonvoting members are the House and Senate chairs of the Child Welfare Oversight and Advisory Committee and a policy advisor to be selected by the panel's chair. The additional voting member is the executive director of the Kentucky Association of Children's Advocacy Centers (or designee). The bill was not enacted, but the panel continues to support the bill's provisions.

**Table 1**  
**Membership Of The Child Fatality And Near Fatality External Review Panel**

<b>Ex Officio Members (5)</b>	
Chair of the Senate Health and Welfare Committee	
Chair of the House Health and Family Services Committee	
Commissioner of the Department for Community Based Services	
Commissioner of the Department for Public Health	
Family court judge appointed by the chief justice of the Kentucky Supreme Court	
<b>Voting Members (10)</b>	
<b>Title</b>	<b>Appointing Authority (Nominated By)</b>
At-large representative who shall serve as chairperson	Secretary of state
Pediatrician from Univ. of Kentucky Dept. of Pediatrics*	Attorney general** (dean of the Univ. of Kentucky School of Medicine)
Pediatrician from Univ. of Louisville Dept. of Pediatrics*	Attorney general** (dean of the Univ. of Louisville School of Medicine)
State medical examiner or designee	
Director of Court-appointed Special Advocate (CASA) program	Attorney general** (Kentucky CASA Assn.)
Peace officer***	Attorney general** (commissioner of State Police)
Representative from Prevent Child Abuse Kentucky Inc.	Attorney general** (president of board of directors of Prevent Child Abuse Kentucky Inc.)
Practicing local prosecutor	Attorney general
Executive director of Kentucky Domestic Violence Assn.	
Chairperson of State Child Fatality Review Team	
Practicing social work clinician	Attorney general** (Board of Social Work)
Practicing addiction counselor	Attorney general** (Kentucky Assn. of Addiction Professionals)
Representative from family resource and youth service centers	Attorney general** (Cabinet for Health and Family Services)
Representative of a community mental health center	Attorney general** (Kentucky Assn. of Regional Mental Health and Mental Retardation Programs Inc.)
Member of a citizen foster care review board	Chief justice of Kentucky Supreme Court

\*The appointee must be licensed and experienced in forensic medicine relating to child abuse and neglect.

\*\*Appointments are from a list of three nominees.

\*\*\*The appointee must have experience investigating child abuse and neglect fatalities and near fatalities.

Source: KRS 620.055(2).

## **Meeting Schedule**

KRS 620.055(4) requires the panel to meet at least quarterly. The panel may also meet upon the call of the panel chair. The panel fulfilled this requirement by meeting seven times in 2018, including a 2-day session in November.

## **Meeting Attendance**

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

## **Posting Updates**

KRS 620.055(8) requires the panel to post updates on the Justice and Public Safety Cabinet's website after each meeting. Updates must include case reviews, findings, and recommendations. Beginning in 2016, the panel also began voluntarily posting all minutes to the website. All minutes going back to 2012 and case reviews, findings, and recommendations going back to 2016 are available on the website.

## **Summary Reports**

KRS 620.055(10) requires the panel to report a summary of its discussions, along with any proposed or actual recommendations, to the Interim Joint Committee on Health and Welfare and Family Services monthly or at least at the request of the co-chairs. The panel reports monthly to the co-chairs via email and made a formal presentation at the September 2018 meeting of the committee.<sup>4</sup>

## **Annual Report**

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

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The panel's 2018 report was issued February 1, 2019 instead of December 1, 2018 because of delays in receiving cases. The panel notified report recipients of the delay.

general, and the director of the Legislative Research Commission for distribution to the Interim Joint Committee on Health and Welfare and Family Services and the Interim Joint Committee on Judiciary. In October 2018, the panel had 63 cases still pending review and determined the best course of action was to send a letter to the statutorily required recipients of the report to advise them the report would be published by February 1, 2019, which it was. HB 89 would have changed the due date of the annual report in statute to February 1.

### **Recommendation 1**

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**Recommendation 1**

**The General Assembly may wish to change the due date of the panel's annual report to February 1 to provide the panel with sufficient time to receive and review all cases of the previous fiscal year.**

### **Destruction Of Records**

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

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

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

The panel's initial group of SharePoint documents will reach their 5-year retention date in 2019. The panel has not established a policy for destruction of SharePoint documents.

### **Recommendation 2**

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**Recommendation 2**

**The panel should establish a policy for the destruction of electronic documents stored in SharePoint.**



## Administration And Procedures

### Staff

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**The panel has an executive staff advisor who also handles duties for the Justice and Public Safety Cabinet. In 2018, the panel hired a full-time social service clinician to analyze cases.**

The current staff are

- an executive staff advisor who also handles other duties for the Justice and Public Safety Cabinet and
- a full-time social service clinician hired in December 2018 to analyze cases.<sup>5</sup>

The panel also uses part-time contractors who review all case records and prepare case summaries and time lines to facilitate the panel's review process. The hiring of the social service clinician reduces the panel's need for contracted case analysts. As of 2019, the panel's only current contract is with University of Louisville Pediatric Forensic Medicine. The university has five medical analysts that it provides as needed to assist with case reviews. The contracts are paid through the Justice and Public Safety Cabinet's baseline funding.<sup>6</sup>

When asked about additional staffing needs, the panel responded that part-time administrative support would be beneficial.<sup>7</sup>

### Funding And Expenditures

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**The panel is included in the Justice and Public Safety Cabinet's baseline budget; it does not receive a line-item allocation.**

The panel receives its funding through the Justice and Public Safety Cabinet and does not have its own operating budget. The panel reports that it has no issues with receiving the support needed from the cabinet. The governor's budget for 2014-16 allocated \$420,000 to the panel. Since then, the panel has not received a line-item budget allocation but is included the cabinet's baseline budget.

For FY 2018, the panel's expenditures were \$156,149.<sup>8</sup> This is \$142,826 less than in the previous fiscal year's expenditures and reflects that the panel no longer has a full-time staff attorney or paid intern.<sup>9</sup> The panel's expenses will increase with the addition of the full-time social service clinician.

### Case Review And Data Tool

The panel continues to use an expedited case review process. The panel is divided into four groups, with each reviewing a set of cases, making a decision on each case, and then presenting to the entire panel for final review and discussion.

For each case it reviews, the panel uses a data tool to track different variables and case elements. The panel has revised the tool over the years. In 2017, the panel included risk factors recommended by federal representatives. In 2018, the panel included additional case characteristics such as coroner issues, environmental neglect, and medication-assisted treatment. The data tool now also provides space to detail pertinent additional information relating to DCBS involvement and medication-assisted treatment.<sup>10</sup> A summary of the current case review data tool is in Appendix B.

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**The lengthy times for DCBS' review process (10 months, on average) and subsequent uploading of case files (4 to 5 months) create delays in the panel's review of cases.**

The primary source for panel cases is DCBS. It provides comprehensive case materials to the panel for review, but the significant amount of time it takes the department to complete its internal review process and then to upload case materials for the panel are impeding the panel's process. These issues have been ongoing and led to the panel's delayed release of its 2018 report. During a June panel 2019 meeting, it was noted that, on average based on cases reviewed by the panel, 10 months pass from the incident until DCBS' completion of its review. After DCBS closes a case, it takes an additional 4 to 5 months to upload the case to SharePoint. The panel is unable to access a case for review until the case is uploaded and the delay is creating a data lag for the panel. DCBS is working to address the issue.

### Referral Of Cases

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**The panel expressed concern that its analysis does not include all child fatality and near fatality cases in the state.**

The panel expressed concern that its analysis of child fatalities and near fatalities due to maltreatment does not include all such cases occurring in the state. The panel mostly receives cases for review from DCBS. The Department for Public Health also forwards cases for review from its local child fatality review teams.<sup>11</sup> The panel's position is that any state or local agency may refer cases to the panel as there is no statutory limitation on doing so. The panel would like to see an increased awareness that law enforcement may refer cases to the panel.

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**Local child fatality teams may refer cases to the panel, but not all localities have teams, many existing teams may not have a quality review process, and some teams are new. If there are issues with the local review process, cases could be missed and not forwarded to the panel.**

Local child fatality teams may refer cases to the panel. However, not all localities have review teams, many existing teams may not have a quality review process, and some teams are new. According to Department for Public Health officials, Kentucky now has 104 local child fatality review teams.<sup>12</sup> This is an increase from the 78 counties with teams in 2017. However, a department assessment that year indicated that it appeared that most teams were only reporting deaths as required by statute and fewer than 10 counties had strong review.<sup>13</sup>

Teams must learn how to perform quality reviews that analyze the situation surrounding each child fatality. The local teams pass cases of child fatalities resulting from maltreatment to the state panel.<sup>14</sup> If there are issues with the local quality review process, cases of fatal child maltreatment could be missed and not forwarded for further review.

The Child Fatality and Near Fatality External Review Panel, DCBS, and the Department for Public Health have expressed concern that possible cases of child fatalities resulting from maltreatment are not reported to the panel because of jurisdictional issues. For example, an issue is which county the child's death is attributed to when the child dies in a different county than the child's county of residence.

### **Sudden Unexplained Death In Infancy Cases**

One of the causes of death that the panel consistently reviews is Sudden Unexplained Death in Infancy (SUDI), in which there is no obvious cause of the infant's death. Contributing factors include unsafe sleep conditions, illness, the mother smoking during pregnancy, smoking around an infant, and temperature of an infant.<sup>15</sup>

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**Only a small percentage of Sudden Unexplained Death in Infancy cases reported by the Department for Public Health are referred to the panel .**

There are discrepancies between the number of SUDI deaths the panel reviews each year and the number reported through the Office of Vital Statistics in the Department for Public Health. Nine of 10 SUDI deaths in Kentucky include unsafe sleep conditions as a contributing factor in the child's death.<sup>16</sup> Unsafe sleep conditions are repeatedly analyzed by the panel to determine whether maltreatment or neglect is present in the case. From 2 percent to 11 percent of SUDI cases are referred to the panel each year. In 2014, 89 of 94 SUDI deaths included unsafe sleep factors as a contributing element of the child's death.<sup>17</sup> The panel reviewed only two SUDI deaths in 2014.<sup>18</sup>

The Department for Public Health performs an extensive review of each SUDI case before deciding whether to refer the case to the panel for further review. If there is any suspicion of maltreatment or neglect, the department review teams will refer the case to the panel. For each child fatality case, including SUDI cases, the department is dependent on local teams to perform the initial review and gather information necessary to complete a comprehensive and quality review. This is challenging because most teams are new and experiencing turnover.<sup>19</sup>

## National Child Fatality Overview

### Reporting

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**According to a 2008 study, child fatalities resulting from maltreatment are underreported by 55 percent to 76 percent.**

Nationally, child fatalities arising from maltreatment are underreported.<sup>20</sup> For example, a 2008 study looked at three states' records for child fatalities resulting from maltreatment and found that child fatalities resulting from maltreatment were underreported by 55 percent to 76 percent.<sup>21</sup> A significant factor in underreporting is that states typically only report child fatalities arising from maltreatment that are known through the state's child protective services agency. Some children whose maltreatment results in a fatality may not be known to the agency. Some of the other agencies and departments that would commonly have record of child fatalities resulting from maltreatment are

- law enforcement,
- the medical examiner's office,
- the coroner's office,
- vital statistics, and
- state and local review teams.<sup>22</sup>

Many states utilize these agencies and departments to collect information on child fatalities arising from maltreatment for their review panels.

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**Some states mandate that specified state and local entities report child fatalities to the state's review panel.**

**Requirements.** Some states have mandatory requirements for state agencies to report child fatalities to the state review panel or include the state review panel in the child death review process. Examples of agencies that are required to report child fatalities to the panel are

- the Alaska medical examiner's office,
- the coroner's office in Georgia, and
- local child fatality review teams in Michigan.<sup>23</sup>

Examples of other departments and agencies that are often called upon, but not required, to report to the panels assist in reporting child fatalities and providing additional data needed to perform quality and comprehensive reviews are

- the Arkansas Department of Health;
- California Vital Statistics;
- law enforcement in Georgia;
- hospitals in North Carolina; and
- emergency management services, firefighters, chief juvenile probation officers, and child educators in Texas.<sup>24</sup>

## State Statistics

State-level statistics for child fatality or near fatality data are not directly comparable. States differ in their statutory definitions of child abuse and how and when child fatality data are reported. Another complication is that states may revise reported numbers, sometimes years later. Thus, child fatality comparisons are approximate across states and over time.

The data displayed in Figures A and B were collected from the National Child Abuse and Neglect Data System, which receives child abuse and neglect data submitted voluntarily by all 50 states, Puerto Rico, and Washington, DC.<sup>25</sup>

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**For the 10-year period ending in 2017, Kentucky averaged 2.2 fatalities due to abuse and neglect per 100,000 children annually, nearly identical to the national rate.**

Figure A shows the average annual number of fatalities per 100,000 children per state for the period covering federal fiscal years 2008 to 2017. Kentucky's average is 2.20 fatalities per 100,000 children, nearly identical to the national rate of 2.21. In the figure, the darker bars indicate the averages for Kentucky and for 13 states with similar numbers of children as Kentucky.

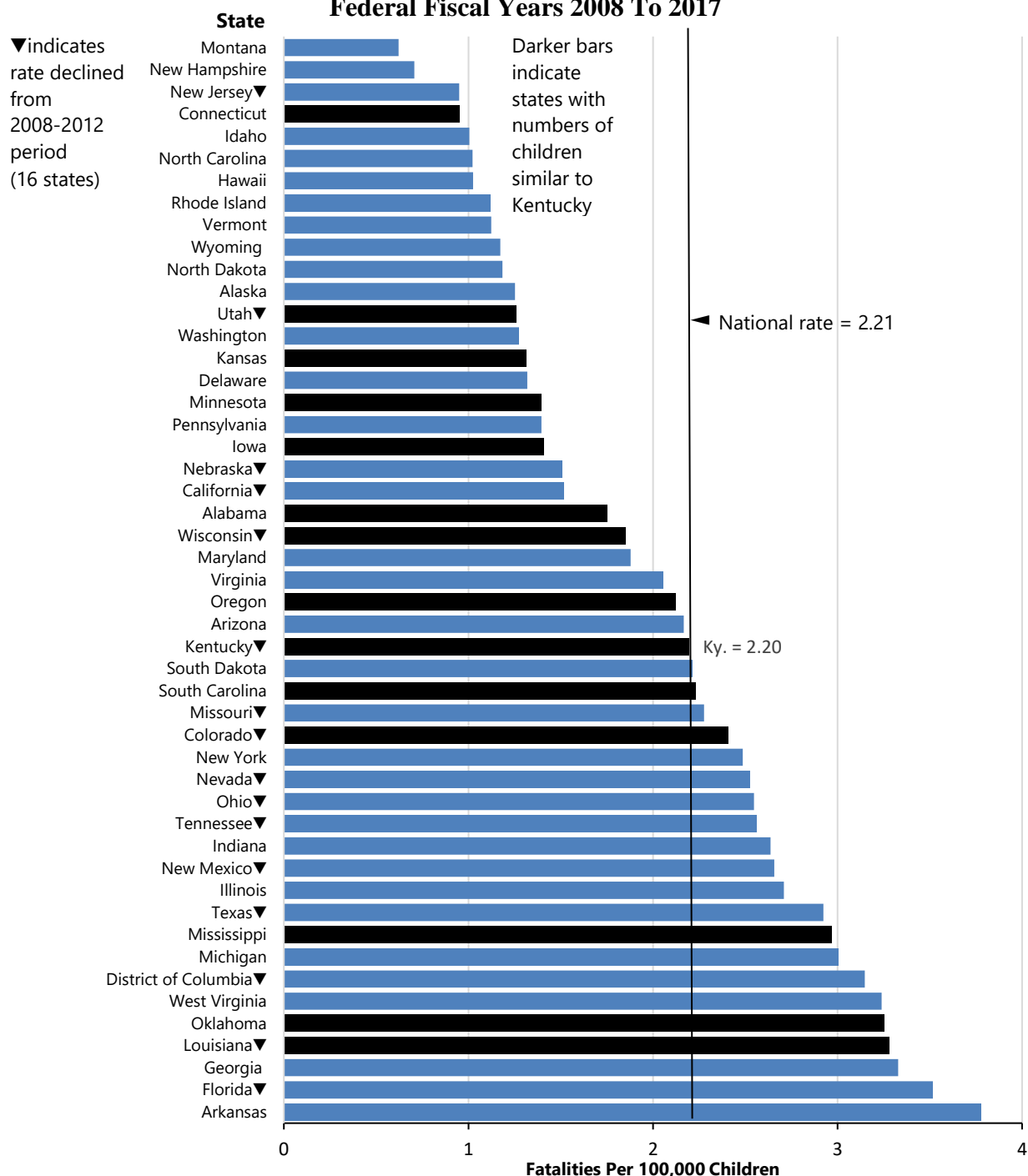
In the 2014 Program Review report on the Child Fatality and Near Fatality External Review panel, state child fatality statistics were shown for the 5-year period ending in federal fiscal year 2012. This report expands the period of analysis to 10 years. In Figure A, a downward arrow by a state's name means that the state's fatality rate is lower for the 10-year period, indicating a decline since 2012. The fatality rate declined for 16 states, including Kentucky, whose rate decreased from 2.83.

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**Kentucky averaged 18,094 abuse reports per year, of which 0.13 percent involved a fatality. This is lower than the 0.23 percent average annual national rate.**

Figure B shows the state percentages of reports of child abuse and neglect over the period of federal fiscal years 2008 to 2017. Kentucky averaged 18,094 abuse reports per year, of which 0.13 percent involved a fatality. This is lower than the 0.23 percent average annual national rate. As indicated by a downward arrow in the state names in the figure, the percentages were lower than in the earlier 5-year period for 20 states, including Kentucky, whose percentage decreased from 0.17.

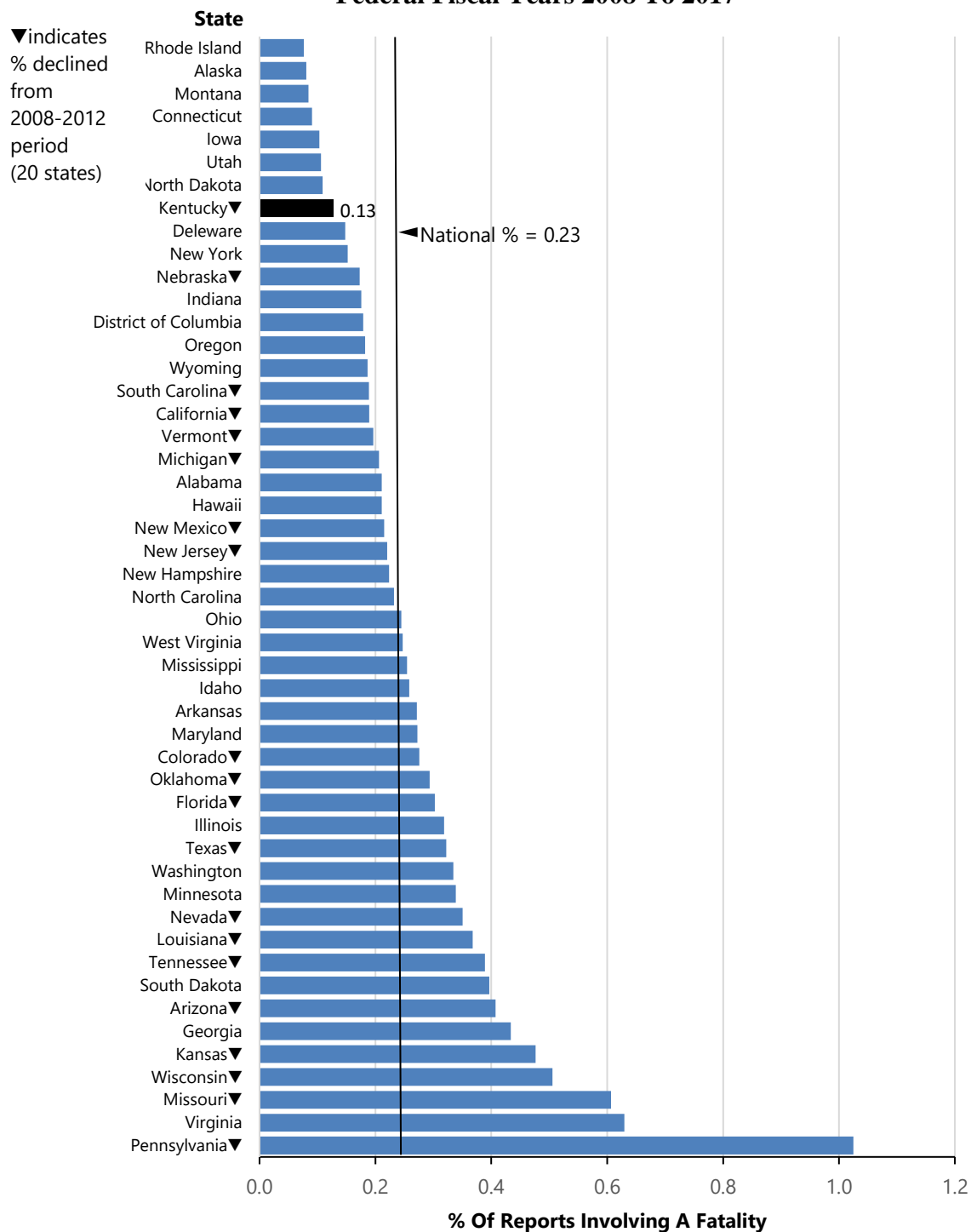
**Figure A**  
**Average Annual Child Fatalities Due To Abuse And Neglect Per 100,000 Children**  
**Federal Fiscal Years 2008 To 2017**



Note: Federal fiscal year is Oct. 1 to Sept. 30. Maine and Massachusetts had more than 3 years of missing data and are not included. States categorized as similar have plus or minus 300,000 children compared to Kentucky's 1 million.

Source: Compiled by Program Review Staff from United States, Dept. of Health and Human Services, Children's Bureau. *Child Maltreatment*, 2008 to 2017.

**Figure B**  
**Average Annual Percentage Of Reports Of Child Abuse And Neglect Involving A Fatality**  
**Federal Fiscal Years 2008 To 2017**



Note: Federal fiscal year is Oct. 1 to Sept. 30. Maine and Massachusetts had more than 3 years of missing data and are not included.

Sources: Compiled by Program Review staff from United States. Dept. of Health and Human Services. Children's Bureau. *Child Maltreatment*, 2008 to 2017.

The annual number of child fatalities in the National Child Abuse and Neglect Data System for Kentucky does not match the number of fatality cases reviewed by the Kentucky Child Fatality and Near Fatality External Review Panel. DCBS continually updates the numbers submitted to the national system, sometimes years later. Also, the submitted data cover only substantiated claims of fatalities resulting from maltreatment. The panel reviews substantiated and unsubstantiated cases of maltreatment. According to 922 KAR 1:330, sec. 16, a substantiated case is one in which there was an admission of the abuse by the perpetrator, a judicial finding of abuse, or a preponderance of the evidence that the abuse or neglect was committed. Preponderance of the evidence means that according to the facts gathered there is a greater than 50 percent chance that the claim of abuse or neglect by the perpetrator is true.<sup>26</sup>

### **Child Fatality Review Teams In Kentucky And Other States**

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**In addition to Kentucky, 12 states and the District of Columbia include near fatalities of children in their review process.**

In addition to Kentucky, 12 states and the District of Columbia include near fatalities of children in their review process.<sup>b</sup> All have codified the definition of *near fatality*, with definitions nearly identical to Kentucky's.

The Kentucky Child Fatality and Near Fatality External Review Panel differs from some states in that it does not directly correspond with local child fatality review teams. The only interaction the panel has with the local review team is if the team refers a case to the panel in which the local review team suspects maltreatment.<sup>27</sup>

The Department for Public Health's State Child Fatality Review Team reviews all child fatalities in Kentucky and works with local teams. The department has two nurses on staff who travel across the state to assist in the establishment of teams and to assist the existing 104 local teams in understanding how to perform a quality review of child fatality cases.<sup>28</sup>

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<sup>b</sup> The 12 states are Arkansas, Colorado, Delaware, Maine, Maryland, Massachusetts, Minnesota, New Jersey, Oklahoma, Pennsylvania, Rhode Island, and Texas.



For this report, five other states were reviewed whose panel or team are comparable to the Kentucky's Child Fatality and Near Fatality External Review Panel: Colorado, which has two teams; Massachusetts; New Jersey; Oklahoma; and Tennessee. The states were chosen because they are in the same region as Kentucky, have similar child populations, review near fatalities, or represent varied models for reviewing state child fatality cases and data.

The other states selected for review are housed administratively in multiple departments. In Colorado, the State Child Fatality Prevention Review Team is in the Department of Health and Environment. The team makes joint recommendations with the Child Fatality Review Team in the Department of Human Services. The Massachusetts state child fatality review team is within the Office of the Chief Medical Examiner. The New Jersey and Oklahoma state teams are in their Children and Family Services agencies. The Tennessee team is in the Department of Health.<sup>29</sup>

Each of the states selected for analysis has codified the make-up of its review team. The teams, which range from 13 to 34 voting members, are to have representatives from multiple disciplines. The Massachusetts team and the Colorado Child Fatality Review Team may appoint additional members for specific cases.

Table 2 provides a summary of the information on the state-level entities reviewed for this report. Appendix C has further information.

**Table 2**  
**State-Level Entities In Kentucky And Five Selected States**

Entity	Abuse And Neglect Cases Only	Reviews Near Fatalities	Coordinates With Local Teams	Statute Specifies Who Is Represented	Number Of Members	
					Voting	Nonvoting
Kentucky Child Fatality and Near Fatality External Review Panel	√	√		√	15	5
Kentucky State Child Fatality Review Team (Dept. for Public Health)			√	*	*	
Colorado <b>Child Fatality Review</b> Team	√	√		√	18 to 20**	
Colorado State Child Fatality Prevention Review Team			√	√	34	12
Massachusetts Child Fatality State Review Team		√	√	√	16**	
New Jersey Child Fatality and Near Fatality Review Board	√	√		√	13	
Oklahoma Child Death Review Board		√	√	√	27	
Tennessee State Child Fatality Review Team			√	√	17	

\* Representatives are not mandated. The team operates with volunteers in addition to the staff from the department's Division of Maternal and Child Health.

\*\* Additional members may be added for specific cases.

Sources: Colorado. C.R.S. 26-1-139, C.R.S. 25-20.5-407; Massachusetts. M.G.L. c. 38 § 2A(b); New Jersey. NJS § 9:6-8.89; Oklahoma. 10 OK Stat § 10-1150.3(A)(1); Tennessee. TN Code 68-142-105.

### Panel Recommendations, 2014 To 2018

Beginning with its 2014 report, the panel has made recommendations annually based on the cases it reviewed. This section reviews the status of these recommendations.

Recommendations are grouped into a general category and six topical categories: Department for Community Based Services, substance abuse, medical providers, the courts, law enforcement, and coroners. A full list of past recommendations and their status is in Appendix D.<sup>c</sup>

<sup>c</sup> At the time of its 2013 report, the panel was new and had reviewed a limited number of cases. Preliminary issues of concern were identified, but no formal recommendations were made in the report.

## Department For Community Based Services

As the state's child welfare agency and primary point of referral for cases before the panel, DCBS is a frequent subject of recommendations. The panel has been careful to recognize the constraints under which DCBS operates and frequently advocates for more financial support for the department.

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**The Department for Community Based Services (DCBS) is in the process of implementing state and federal legislation and a Culture of Safety model, which is an approach to internal review that focuses less on individual blame and more on system improvement.**

DCBS is in the process of implementing significant changes resulting from state and federal legislation and DCBS' new Culture of Safety model.<sup>30</sup> The model aims to shift the way child welfare systems view failure. The intent is to move DCBS towards an internal review format that focuses less on individual blame and more on recognizing possible systemic issues that contributed to the failure and learning from them as an organization.<sup>31</sup> DCBS is reviewing its internal processes and procedures including those recommended by the panel. The panel has recommended that the department review its internal review process for fatalities and near fatalities, consider caseworkers' caseloads and experience levels when reviewing a fatality or near fatality, and increase consistency throughout the state in how substantiation determinations are made.<sup>32</sup>

Given these ongoing changes, it is difficult to evaluate the response from DCBS to the panel's recommendations, particularly those that relate to DCBS' internal processes. Once changes are fully implemented, it may be productive for DCBS to discuss with the panel how its internal procedures have changed and what the panel should expect.

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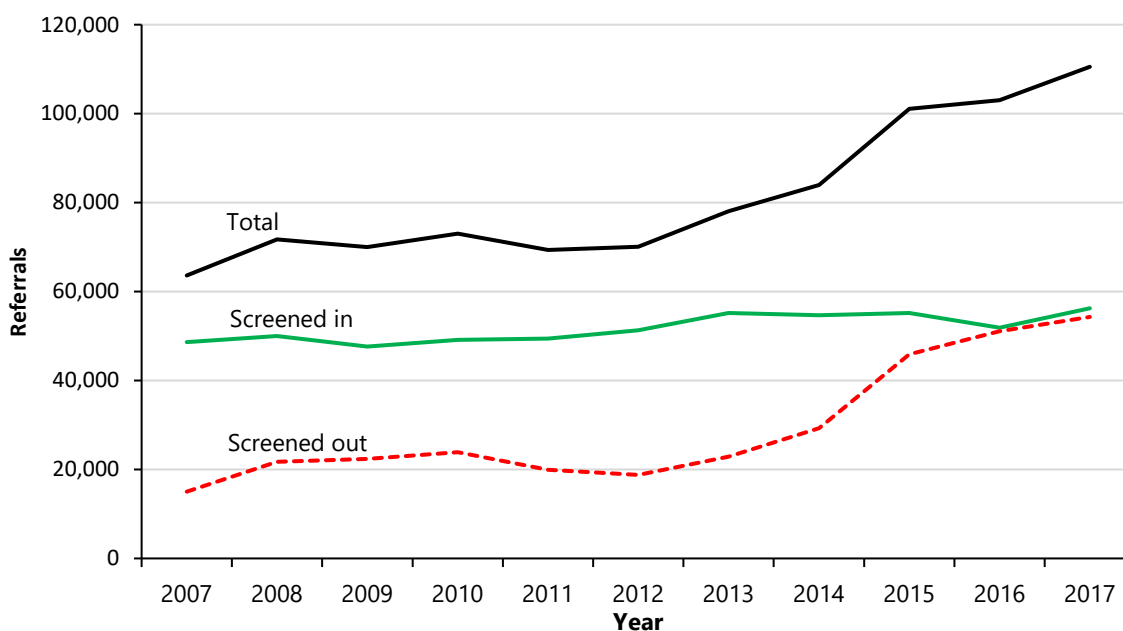
**DCBS disagrees with the panel's recommendation that the department review its protocols for screening out referrals. Screening out refers to when a referral for child maltreatment is determined to not meet the department's criteria for opening an investigation.**

**Screening Out Referrals.** One recommendation in particular, which may require additional discussion between DCBS and the panel, illustrates the panel's work and the complexity of child welfare.

In its 2018 report, the panel recommended that DCBS review its protocols for screening out referrals. Screening out refers to the process by which a child welfare agency determines whether a referral meets the criteria for acceptance for further investigation or response from the agency.<sup>33</sup> The report covered 27 cases—10 fatalities and 17 near fatalities—from FY 2017 with prior referrals that DCBS screened out.<sup>34</sup> DCBS disagrees with the panel's recommendation, arguing that more cases should be screened out.<sup>35</sup>

Nationally, in 2017, 42.4 percent of referrals were screened out, lower than Kentucky's rate of 49.1 percent. In the 23 states with a higher rate, the percentages screened out ranged from 49.4 percent to 84.4.<sup>36</sup> Figure C shows the total number of referrals made to DCBS and the numbers screened out and screened in from 2007 to 2017.

**Figure C**  
**Referrals To The Department For Community Based Services**  
**2007 to 2017**



Source: Compiled by Program Review Staff from United States. Dept. of Health and Human Services. Children's Bureau. *Child Maltreatment*, 2007 to 2017.

As the number of referrals has increased over recent years, the number of referrals screened out by DCBS has increased too, but the number of referrals screened in has remained relatively stable. Since 2013, referrals to DCBS have increased 29 percent, with more than 110,000 referrals made in 2017. The percentage of referrals screened out increased from 29.3 percent to 49.1 percent. The number of referrals screened in has not changed significantly, less than 1,100 more in 2017 than in 2013.

**From 2013 to 2017, the percentage of calls screened out by DCBS increased from 29 percent to 49 percent. The number of referrals screened in did not significantly change.**

Note that DCBS' capacity has not increased over the period. The number of screening, intake, investigation, and alternative response workers declined nearly 25 percent from 1,615 in 2007 to 1,215 in 2017.<sup>37</sup> If the rate of screening out is too high and the criteria for acceptance need to be adjusted, DCBS may require additional capacity and resources in order to provide a response to more referrals.

The panel's concern is that screened-out calls are a missed opportunity for early intervention, especially for children under the age of 4. In the panel's 2018 report, 81 percent of panel cases (fatalities and near fatalities) involved children under the age of 4, including 45 percent under 1 year of age.<sup>38</sup> Nationally, more than 70 percent of maltreatment and abuse fatalities reported in 2017 were children under the age of 3.<sup>39</sup>

Screening is important because it is often the first opportunity for child protective services to get involved. However, there is a dearth of research regarding the specific relationship between screened-out referrals and child fatalities.

In its report, the panel recommended that DCBS review its process and increase supervisory review of screened-out referrals when the child is younger than 4, has previous referrals, or is referred by a professional serving the child. It suggested that DCBS consider the National Commission to Eliminate Child Abuse and Neglect Fatalities' recommendation that states provide responses to all referrals of children under age 3 and repeat referrals.<sup>40</sup>

DCBS disagrees with the panel that its screening-out process needs to be adjusted and instead would like to increase the number of referrals screened out. The primary basis for this position is that DCBS does not have a true differential response and, under its current model, *risk of harm* is being interpreted too broadly, leading to too many cases being screened in.<sup>41</sup> A differential response system would allow a flexible response to referrals based on severity and risk factors. This would enable the department to provide an alternative response and implement services as appropriate instead of opening an investigation that is often considered adversarial.<sup>42</sup> As DCBS implements its Culture of Safety, it is reviewing these practices and its ability to develop a system that allows for a differential response. One possible option DCBS discussed is to divert low-risk cases to a private entity, allowing the department to focus its resources on moderate- to high-risk cases.<sup>43</sup>

### Substance Abuse

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**Kentucky has the 6<sup>th</sup> highest rate of illicit and prescription drug overdose deaths in the nation.**

Kentucky is one of the hardest hit states in the nation's growing drug epidemic. In 2017, Kentucky had 1,565 illicit and prescription drug overdose deaths, up more than 11 percent from 2016 and 25 percent from 2015.<sup>44</sup> Those numbers place Kentucky 5<sup>th</sup> in the nation with a rate of 37.2 overdose deaths per 100,000 residents.<sup>45</sup> Of those deaths, opioids continue to be a leading cause, with

heroin involved in 22 percent and fentanyl involved in 52 percent. In 2017, methamphetamine was detected in 29 percent of overdose deaths.<sup>d 46</sup>

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**Substance abuse by a caregiver was a factor in 46 percent of cases reviewed by the panel in 2017.**

The drug epidemic is increasingly affecting child welfare in the state. Data from 2017 indicate substance abuse was a contributing factor to maltreatment in 45 percent of all DCBS cases of abuse or neglect.<sup>47</sup> In cases before the panel in 2018, substance abuse by a caregiver was a factor in 46 percent of cases, up from 36 percent in 2017 and 37 percent in 2016.<sup>48</sup>

The panel has made multiple recommendations relating to substance abuse over the past 5 years. These include improved training and education for Medication-Assisted Treatment (MAT) providers, wraparound services and increased programming for infants diagnosed with Neonatal Abstinence Syndrome (NAS), and full implementation of family drug courts throughout Kentucky.

**Medication-Assisted Treatment.** MAT combines medication with behavioral therapy and counseling.<sup>49</sup> The panel sees MAT providers as an important line of defense for children living in homes with substance abuse. The panel recommended ensuring that MAT providers are providing the required counseling and therapy components of treatment and requiring family-oriented training for MAT providers that recognizes the increased safety risks present when children are in the home. The National Center on Substance Abuse and Child Welfare recognizes similar opportunities for increased awareness and collaboration between MAT providers and child welfare agencies and has recommended more research to understand how MAT can be effective in aiding family reunification and what additional services MAT may need to be successful for families.<sup>50</sup> The panel has been in contact with the Kentucky Office of Drug Control Policy to pursue these recommendations and is considering establishing subcommittees to develop training protocols.

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**In 2017, more than 1,100 Kentucky infants were diagnosed with Neonatal Abstinence Syndrome, more than 4 times the number in 2008.**

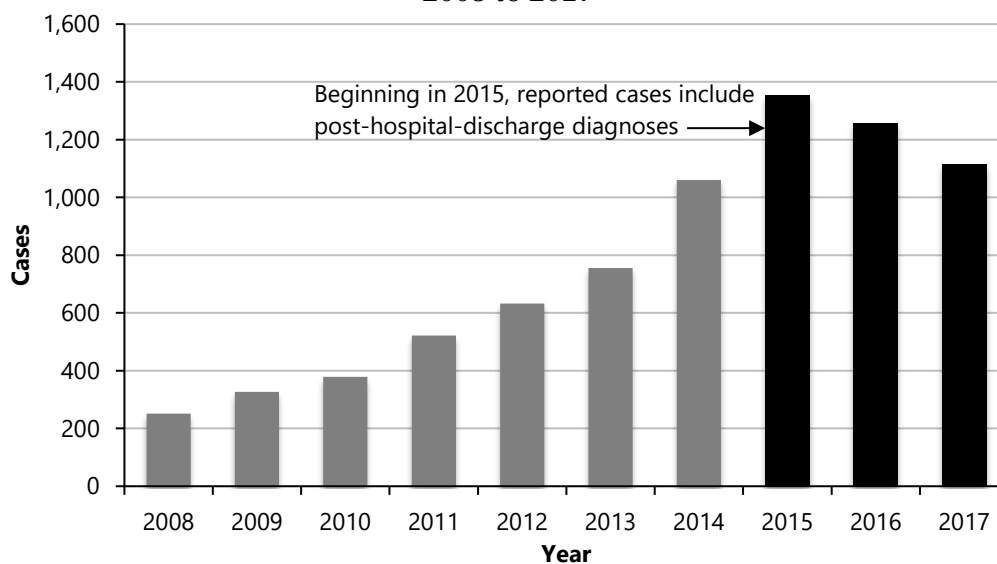
**Neonatal Abstinence Syndrome Services.** The increase in drug use has also meant an increase in the number of infants prenatally exposed to substances. Prenatal substance abuse can affect the fetus. The infant may experience withdrawal when the umbilical cord is cut at birth, ending the infant's drug exposure. Signs and symptoms of withdrawal include irritability, seizure, tremors, vomiting, fever, and poor feeding. Symptoms can develop as early as 24 hours after birth or as late as 5 to 10 days later. The

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<sup>d</sup> Multiple substances may be involved with a single overdose death.

symptoms of withdrawal are what lead to a diagnosis of NAS. Other drugs such as cocaine, amphetamines, and alcohol can cause NAS but, nationally, half of babies prenatally exposed to opiates are diagnosed with NAS.<sup>51</sup> Figure D shows the 10-year growth in NAS cases reported in Kentucky from 2008 to 2017, the last year of available data. Although the number of cases has declined in the past 2 years, more than 1,100 newborns were diagnosed with NAS in Kentucky in 2017, more than 4 times the number in 2008.

**Figure D**  
**Neonatal Abstinence Syndrome Cases in Kentucky**  
**2008 to 2017**



Source: Kentucky. Dept. for Public Health *Annual Report: Neonatal Abstinence Syndrome In Kentucky. 2007 to 2017.*

KRS 211.676 requires NAS cases to be reported to the Department for Public Health. As a participant in the federal Child Abuse and Prevention Act, the state is required to implement a plan of safe care to address the needs of the infant and caregiver.<sup>52</sup> However, the panel has found in its case reviews that the reporting of NAS is inconsistent and that there are insufficient resources to provide for the growing number of NAS cases. The panel has recommended increased resources to enable the department to better serve and protect children diagnosed with NAS.

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**The panel has repeatedly recommended implementation of family drug courts, pointing to improved participant outcomes including higher rates of family reunification and reduced time in foster care.**

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**The Jefferson Family Recovery Court began operations in October 2018 with funding from a nonprofit.**

**Family Drug Courts.** The panel's most frequent recommendation in relation to substance abuse is the full implementation of family drug courts. The panel points to improved outcomes of family drug court participants including higher rates of reunification and less time spent in foster care. Family drug courts are dependent on additional funding and no legislative action has been taken.

In 2018, Jefferson County reinstated its family drug court program with funding from a nonprofit. It had a family drug court program from 1999 to 2008 that ended due to lack of state funding.<sup>53</sup> A 2005 evaluation by the University of Kentucky's Center on Drug and Alcohol Research found the program to be successful: 90 percent of program graduates were successfully reunited with their children, 98 percent of urine screens were negative, and almost 90 percent of participants were employed at 6 months.<sup>54</sup> Now named the Jefferson Family Recovery Court, its multi-phase voluntary program aims to provide comprehensive treatment for parents with substance abuse issues who also have children involved in dependency cases.<sup>55</sup>

The program involves regular appearances before the judge, substance abuse treatment, counseling services, drug testing, regular attendance at Narcotics or Alcohol Anonymous meetings, and parenting classes. The court also provides vocational and educational assistance and housing and transportation services. Participation is expected to last approximately 12 months with two review dates following program completion. Clients' enrollment is voluntary and their involvement runs parallel to their case in dependency court.<sup>56</sup>

The court's first docket began in October 2018 under Judge Denise Brown and recently expanded to a second court. Based on preliminary information provided by Judge Brown, the court has 25 clients enrolled, serving 62 children. Fifteen of those clients are participating in substance use treatment; seven have successfully completed treatment.<sup>57</sup>

### **Medical Providers**

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**The panel has repeatedly recommended using hospitals and other providers as an important point of contact to provide education on abusive head trauma and safe sleep practices. The Kentucky Hospital Association and Prevent Child Abuse Kentucky developed a video on both issues that is being distributed to every birthing center in the state.**

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Panel recommendations affecting medical providers are largely focused on using hospitals and providers as a point of contact for families to learn about safe sleep practices and pediatric abusive head trauma. Of the 592 fatality and near fatality cases reviewed by the panel since 2014, 38 percent identified unsafe sleep or abusive head trauma as a cause, including 106 fatalities.<sup>58</sup> The Kentucky Hospital Association supports the panel's position and encouraged all hospitals to provide education on safe sleep and



abusive head trauma to parents of newborns. In May 2019, the association and Prevent Child Abuse Kentucky released a video educating caregivers on safe sleep practices and abusive head trauma. The video is being distributed to every birthing center in the state.<sup>59</sup> The panel, DCBS, and the Department for Public Health continue to promote awareness of these issues. The panel has also recommended the development of best practice guidelines for the discharge of NAS infants and the provision of wraparound services for high-risk infants before they leave the hospital. The panel continues to promote these recommendations, but implementing wraparound services requires additional funding.

### Courts

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**In 2016, the General Assembly authorized an open court pilot program. Open courts allow the public to attend dependency, neglect, and abuse proceedings. The pilot began in 2018.**

In 2014 and 2015, the panel expressed its support for allowing family courts to open their dependency, neglect, and abuse (DNA) proceedings to the public.<sup>60</sup>

SB 40, enacted in 2016, authorizes an open court pilot program to study the feasibility and desirability of opening DNA and termination of parental rights proceedings to the public. It was requested that the Supreme Court of Kentucky institute a 4-year pilot program, monitored and evaluated by the Administrative Office of the Courts (AOC), to study open court proceedings for DNA and termination proceedings, excluding cases relating to sexual abuse (KRS 21A.190-192). The pilot has two groups: three circuit courts that will open their DNA and termination proceedings and a control group with three similar circuit courts.

In September 2018, AOC released its initial report based on 3 months of the pilot's operation. According to the report, attendance and general court processes were similar between the pilot and closed courts.<sup>61</sup> The report also included results of surveys of professionals and family members associated with cases.<sup>e</sup> Survey results were mixed. Approximately one half of professionals in the open court cases disagreed with statements that having open cases was positive for children, other parties involved in cases, or others in attendance.<sup>f</sup> Nearly one-third strongly disagreed that positive effects can be anticipated for children or families when such proceedings are open to the public. However, a majority of professionals also disagreed that open proceeding made

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<sup>e</sup> Professionals included judges, attorneys, court staff, social workers, and the media.

<sup>f</sup> Typically, responses would be described as percentages who agreed. For these surveys, fewer respondents agreed or strongly agreed with many statements, with relatively high percentages saying they neither agreed nor disagreed.

the case take longer. More than 70 percent of family members agreed, most strongly agreeing, that the way the open case was handled was fair. But approximately 40 percent disagreed that having other people in the courtroom was positive for the child or helpful to the family member.<sup>62</sup>

The evaluation also included the results of three focus groups, one from each of the open circuit courts. According to the AOC report, the results “tended to suggest more support for opening the proceedings to the public, as long as there is judicial discretion.” There were some differences among the groups though. One group said there was no major difference in opening or closing proceedings, but that parties to cases and the public did not understand the difference between open and closed. One group said proceedings in open courts took longer. One group said dockets went quicker and fewer deputies were needed for open proceedings.<sup>63</sup>

The report advised that its findings cannot be generalized due to issues with the data collected including convenience sampling and AOC staff being present when surveys were completed. The report recommended continued study of the pilot project.<sup>64</sup>

## Law Enforcement

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**The panel has been working with the Department of Criminal Justice Training to provide child welfare related training to law enforcement. An initial training on child death scenes was provided and was well received. Additional trainings have been requested.**

The panel’s recommendations regarding law enforcement have centered primarily on education and training on child death scene investigations and standardized drug testing of caregivers when a child dies unexpectedly. The Department of Criminal Justice Training has been supportive of the panel’s training recommendations. The chief state medical examiner has provided training to law enforcement on child death scenes. Additional trainings have been requested. The panel has been holding discussions with the department’s legislative liaison regarding mandatory child death scene training.

The panel’s recommendation of standardized drug testing of caregivers at child death scenes is problematic because of the potential violation of the US Constitution’s Fourth Amendment prohibition against unreasonable searches and seizures. Law enforcement may perform blood or urine tests with voluntary consent, but requiring drug tests as standard practice without a warrant or probable cause would likely be a violation. The panel understands this and states that it would ideally like to see child death scene drug testing established as a best practice and incorporated into law enforcement child death scene protocols.

## Coroners

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**Coroners have improved reporting of child deaths to DCBS and other required agencies. Forms reporting Sudden Unexplained Infant Death investigations are submitted more frequently but are often incomplete.**

The panel has made three recommendations relating to coroners. Two were in the most recent report and accordingly, are yet to have a response. The previous recommendation, in 2015, encouraged coroners to make timely notifications of child deaths to DCBS, law enforcement, and the local health department. The panel has since seen significant improvement aided by the creation of pocket cards for coroners to use at the site of a child death scene.

In 2018, the panel noted that coroners' submission of the SUDI Reporting Form has increased, but according to the panel, the forms are often incomplete. The form collects information on sleep-related deaths and guides investigators through the steps of an investigation and assists in documenting their findings consistently. Law enforcement officers can also access the form in the State Police's report portal. The panel's second 2018 recommendation was that coroners, law enforcement, and DCBS conduct joint investigations into all child fatalities pursuant to KRS 211.686, which authorizes coroners to establish local child and maternal fatality response teams.

## General

Several panel recommendations are not specific to a given agency, profession, or issue. Among these are increased awareness of the state's two pediatric forensic medicine centers, expansion of the state's multidisciplinary teams on sexual abuse to review physical abuse, background checks on child care providers for parents, increased awareness of the dangers of bed sharing, and education on early warning signs of abuse for all professionals working with children.

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**Abusive head trauma education is now required by statute for pediatricians in Kentucky. Another statute requires the Kentucky Department of Education to provide child abuse and neglect training that is to be completed every 2 years.**

Three recommendations have been implemented. The Department for Public Health launched an ongoing campaign regarding the dangers of bed sharing. The General Assembly adopted legislation implementing two recommendations. KRS 199.466 allows a parent or legal guardian to request a background check on an individual caring for their child. DCBS will notify the individual who is the subject of the background check of whether or not there are substantiated findings of abuse and neglect. KRS 311.601(a) requires pediatricians and other medical practitioners to receive continuing medical education on pediatric abusive head trauma. KRS 156.095(8) mandates that Kentucky Department for

Education provide comprehensive training on child abuse and neglect. The mandatory training is to be completed every 2 years.

### **Presentation Of Recommendations In The Panel's Annual Reports**

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**Recommendations in the panel's annual reports are sometimes unclear.**

The panel's recommendations are in its annual reports. Typically, the report discusses an identified issue and then states the related recommendation. Sometimes, the wording of a recommendation is unclear. In some instances, it is unclear whether a recommendation is being made. For example, the panel's 2018 report explains coroners' use of the SUDI Reporting Form and indicated that while use of the form has increased, submitted forms are often incomplete. The report explains that the form is available on a website and is available to law enforcement officers throughout the state. Then, without having made a recommendation related to the form, the report states "The Panel *further recommends* [emphasis added] coroners, law enforcement, and DCBS conduct joint investigations in all child fatalities pursuant to KRS 211.686."<sup>65</sup>

In other instances, the recommendation lacks an action to be taken. The 2016 report recommends addressing the state's substance abuse epidemic and gives related recommendations included within that scope but the recommendations are statements and do not recommend a course of action. Two examples are provided below.

Hospital, Obstetricians, Pediatricians, Family Practice, and Nurse Practitioners need to know about the HANDS (Health Access Nurturing Development Services) program and make appropriate referrals.

In all of the mentioned strategies to address substance abuse issues, collaboration is again a critical feature. The family drug court model as well as other identified strategies, depend upon combined efforts from a team of professionals working in collaboration to meet the need of families and children.<sup>66</sup>

### **Recommendation 3**

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**Recommendation 3**

**Recommendations in the panel's annual reports should be easily identifiable and clearly stated.**

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<sup>1</sup> Kentucky. Child Fatality and Near Fatality External Review Panel. *2018 Annual Report*. 2019. P. 3,

<sup>2</sup> Family First Prevention Services Act. H.R. 1892, Division E, 115<sup>th</sup> Cong. (2018) (enacted).

<sup>3</sup> Elisha Mahoney, executive staff advisor. Justice and Public Safety Cabinet. Email to Susannah Stitzer. June 18, 2019.

<sup>4</sup> Judge Roger Crittenden, chair. Child Fatality and Near Fatality External Review Panel. Elisha Mahoney, executive staff advisor. Justice and Public Safety Cabinet. Interview. Feb. 5, 2019.

<sup>5</sup> Ibid.

<sup>6</sup> Elisha Mahoney, executive staff advisor. Justice and Public Safety Cabinet. Email to Susannah Stitzer. May 24, 2019.

<sup>7</sup> Elisha Mahoney, executive staff advisor. Justice and Public Safety Cabinet. Email to Susannah Stitzer. April 24, 2019.

<sup>8</sup> Ibid.

<sup>9</sup> Ibid.

<sup>10</sup> Elisha Mahoney, executive staff advisor. Justice and Public Safety Cabinet. Email to Susannah Stitzer. April 10, 2019.

<sup>11</sup> Andrew Waters, assistant dir., and Monica Clouse, epidemiologist. Dept. for Public Health. Division of Maternal and Child Health; Janice Bright, nurse service administrator. Dept. for Public Health. Division of Maternal and Child Health. Child and Family Health Improvement Branch; Sarah Cooper, legislative liaison, and Jim Musser, executive dir. Cabinet for Health and Family Services. Office of Legislative and Regulatory Affairs. Interview. May 24, 2019.

<sup>12</sup> Ibid.

<sup>13</sup> Kentucky. Dept. for Public Health. *Public Health Child Fatality Review Program 2017 Annual Report*. Nov. 2017. Web. July 10, 2019. P. 7; Kentucky. Cabinet for Health and Family Services. *Maternal And Child Health Services Title V Block Grant, Kentucky, FY 2019 Application/FY 2017 Annual Report*. July 2018. Web. July 10, 2019. P. 114.

<sup>14</sup> Andrew Waters, assistant dir., and Monica Clouse, epidemiologist. Dept. for Public Health. Division of Maternal and Child Health; Janice Bright, nurse service administrator. Dept. for Public Health. Division of Maternal and Child Health. Child and Family Health Improvement Branch; Sarah Cooper, legislative liaison, and Jim Musser, executive dir. Cabinet for Health and Family Services. Office of Legislative and Regulatory Affairs. Interview. May 24, 2019.

<sup>15</sup> Better Health Channel. "Sudden Unexpected Death In Infants (SUDI And SIDS)." Australia. Victoria. Dept. of Health & Human Services. Aug. 31, 2014. Web. May 22, 2019.

<sup>16</sup> Kentucky. Dept. for Public Health. "Unsafe Sleep In Kentucky." n.d. Web. June 6, 2019.

<sup>17</sup> Kentucky. Dept. for Public Health. Division of Maternal and Child Health. *Annual Report Public Health Child Fatality Review Program*. Nov. 2017. Web. June 6, 2019. P. 22.

<sup>18</sup> Kentucky. Child Fatality and Near Fatality External Review Panel. *2014 Annual Review*. P. 7.

<sup>19</sup> Andrew Waters, assistant dir., and Monica Clouse, epidemiologist. Dept. for Public Health. Division of Maternal and Child Health; Janice Bright, nurse service administrator. Dept. for Public Health. Division of Maternal and Child Health. Child and Family Health Improvement Branch; Sarah Cooper, legislative liaison, and Jim Musser, executive dir. Cabinet for Health and Family Services. Office of Legislative and Regulatory Affairs. Interview. May 24, 2019.

<sup>20</sup> United States. Government Accountability Office. *Child Maltreatment, Strengthening National Data On Child Fatalities Could Aid In Prevention*. July 2011. Web. April 9, 2019. P. 9.

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- <sup>21</sup> P. G. Schnitzer et al. “Public Health Surveillance Of Fatal Child Maltreatment: Analysis Of 3 State Programs,” *American Journal of Public Health* 98.2 (Feb. 2008). P. 300.
- <sup>22</sup> United States. Government Accountability Office. Child Maltreatment, Strengthening National Data On Child Fatalities Could Aid In Prevention. July 2011. Web. April 9, 2019. Pp. 9-11.
- <sup>23</sup> Alaska. AS 12.65.130; Georgia. O.C.G.A. § 19-15-3(h); Michigan. MCL 722.627b.
- <sup>24</sup> Arkansas. Code R. § 20-27-1705; California. Civ. Code § 11174.34; Georgia. O.C.G.A. § 19-15-3(h); North Carolina. N.C.G.S. § 143B-150.20; Texas. Dept. of State Health Services. Maternal & Child Health. Texas Child Fatality Review. *State Child Fatality Review Team Committee Child Fatality Review Team Operating Procedures*. July 2001. Web. May 29, 2019. P. 8.
- <sup>25</sup> United States. Dept. of Health and Human Services. Children’s Bureau. *Child Maltreatment 2017*. P. ii. Web. May 22, 2019.
- <sup>26</sup> Legal Information Institute. *Preponderance Of The Evidence*. Cornell. n.d. Web. May 30, 2019.
- <sup>27</sup> Andrew Waters, assistant dir., and Monica Clouse, epidemiologist. Dept. for Public Health. Division of Maternal and Child Health; Janice Bright, nurse service administrator. Dept. for Public Health. Division of Maternal and Child Health. Child and Family Health Improvement Branch; Sarah Cooper, legislative liaison, and Jim Musser, executive dir. Cabinet for Health and Family Services. Office of Legislative and Regulatory Affairs. Interview. May 24, 2019.
- <sup>28</sup> Ibid.
- <sup>29</sup> National MCH Center for Child Death Review. *State Spotlight—Colorado*. Web. May 22, 2019, *State Spotlight—Tennessee*. Web. May 22, 2019; New Jersey. Dept. of Children and Families. Child Fatality and Near Fatality Review Board. *Department Of Children And Families*. n.d. Web. March 27, 2019; Massachusetts. M.G.L. c. 38 § 2A(b); Oklahoma. 10 OK Stat § 10-1150.2(A).
- <sup>30</sup> Elizabeth Caywood, deputy commissioner. Dept. for Community Based Services. Interview. April 30, 2019.
- <sup>31</sup> Collaborative Safety, LLC. Safety Science Overview. n.d.
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## **Appendix A**

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



STEVEN L. BESHEAR  
GOVERNOR

COMMONWEALTH OF KENTUCKY  
**JUSTICE AND PUBLIC SAFETY CABINET**  
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J. MICHAEL BROWN  
SECRETARY

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

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

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

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

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

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



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

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

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

### **3. Administrative relationship**

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

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

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


#### **4. Budget matters**

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

#### **5. The need to establish a good working relationship**

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

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

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

## **Appendix B**

### **Case Review Form**

Printed, the case review form used by the Child Fatality and Near Fatality External Review Panel is 24 pages long. This appendix is an overview of the 22 items covered by the form. For many items, panel members choose one or more responses from a list. For example, for Item 5, 10 family/household risks are listed, of which examples are criminal history, domestic violence, and substance abuse.

1. Case Information
2. Child Information  
Includes name, gender, age, age at time in injury, date of injury and death, county of residence and injury
3. Prior History with DCBS [within past 60 months]
4. Case Review  
Includes suspected perpetrator, caregiver at time of event, agencies involved with the family within 60 months, child risk factors, substances that apply to the baby's toxicology screen, psychoactive/addictive substances that the mother has been exposed to according to maternal history
5. Family/Household Information  
Family/household risks
6. Healthcare Providers  
Includes date of last visit with a medical provider, whether a medical provider or hospital was involved in the event, healthcare issues prior to event
7. Birth Hospitals (applies to children 1 year and younger)  
Includes whether safe sleeping education was provided, whether education on the prevention of pediatric abusive head trauma was provided, family risk factors identified by the hospital, whether identified risks were addressed
8. Education/Child Care  
Child's usual site of care, child care issues
9. Law Enforcement/Military CIC [Children in Care]  
Law enforcement issues before or including event, family contact with law enforcement within 60 months, whether impairment was suspected in the event

10. Coroner  
Includes whether autopsy was authorized, whether a Sudden Unexplained Infant Death Investigation Reporting form was completed, notifications of relevant agencies
11. Department for Community Based Services  
Includes date investigation initiated and closed, issues (for example, investigation not coordinated with law enforcement)
12. Family Issues  
Whether concerns have been reported, if so, when and about what
13. Substance Abuse by Caregivers
14. Substance Abuse by Child
15. Mental Health of Caregiver
16. Mental Health of Child
17. Court System  
Includes prior history with courts, whether there have been drug charges or Family Court involvement
18. Overall Case Positives
19. Contributing Risks  
Checklist of 44 items. Examples: bystander issues, lack of regular child care, law enforcement issues
20. Categorization  
Checklist of 21 items. Examples: abusive head trauma, burn, drowning/near drowning, natural causes, physical abuse, undetermined
21. Other Qualifiers  
Response options: apparently accidental, manner undetermined/foul play not ruled out, potentially preventable
22. Panel Determination  
Checklist of 13 items: abusive head trauma, neglect (general), neglect (impaired caregiver), neglect (medical), neglect (inadequate/absent child restraint in motor vehicle), neglect (unsafe sleep), neglect due to unsafe access to deadly/potentially deadly means, no abuse or neglect, other, physical abuse, sexual abuse, supervisory neglect, torture  
  
Missed Opportunities (open response)

## **Appendix C**

### **State Child Fatality Review Teams In Selected States**

#### **Colorado**

Colorado uses a public health approach to review child fatalities for the purpose of prevention. The fatality review process is not investigative. Two state review teams collaborate to make joint recommendations for prevention of child fatalities.

The Child Fatality Review Team, created in 2011, reviews cases of egregious abuse or neglect of a child that results in a fatality or near fatality (C.R.S. 26-1-139(1)(b)). The state Child Fatality Review Team is to

- review circumstances around egregious abuse or neglect against a child, near fatality, or child fatality;
- review services the child, the child's family, and the perpetrator were receiving from the county department;
- review records related to the child, and interview individuals related to the incident;
- review the county department's compliance with statutes, regulations and relevant policies and procedures that directly related to the incident of egregious abuse or neglect against a child, near fatality, or fatality;
- identify strengths and best practices of delivering services to the family;
- identify factors that may have contributed to the incident;
- identify the quality and sufficiency of coordination between state and local agencies; and
- develop and distribute reports created by the prevention team (C.R.S. 26-1-139(3)(a)).

The team has 18 to 20 members.

- three from the Department of Human Services appointed by its executive director
- two from the Department of Public Health and Environment appointed by its executive director
- three representing county departments appointed by a statewide organization representing county commissioners
- Eight to 10 additional multidisciplinary members chosen by the eight department members listed above
- Two members of the General Assembly appointed by chamber majority leaders (if both are of the same party, the House minority leader makes the second appointment) (C.R.S. 26-1-139(6))

The eight members from departments may appoint additional members to participate in the review of a specific case to represent agencies involved with the child or the child's family.

The second state team, the Child Fatality Prevention Review Team, was created in 2013 to assess child fatality cases related to undetermined causes, unintentional injury, violence, motor vehicle incidents, abuse or neglect, sudden unexplained infant death, and suicide if a local or regional child fatality review team has not conducted a review. Local public health agencies are required

to establish local, multidisciplinary child fatality prevention review teams that perform all comprehensive reviews of preventable fatalities of children (C.R.S. 25-20.5-404). The state team conducts retrospective reviews of all child deaths in Colorado. The local and regional teams are responsible for entering the child fatality data into the National Center for Child Death Review Case Reporting System.

The Child Fatality Prevention Review Team is to

- outline trends and patterns of child fatalities;
- identify and investigate risk factors that may lead to child fatalities;
- characterize groups of children who are at risk for a child fatality;
- evaluate the services offered and the system responses to children who are at risk of a child fatality and review recommendations of local or regional review teams;
- consider a review of all systemic child-related issues when evaluating services offered or system responses to children who are at risk of fatality;
- take steps to improve the quality and scope of data obtained through investigations and review of child fatalities;
- use a child fatalities data-collection system, using nationally-developed public health guidelines, to ensure the proper identification of all potential child abuse or neglect fatalities;
- report annually to the governor and the state legislature recommendations for changes to any law, rule, or policy that the state review team has determined will promote the safety and well-being of children;
- provide an annual summary to the Department of Human Services outlining the trends and patterns of child abuse and neglect fatalities, including information regarding the findings from cases known and unknown to the county departments of social services;
- administer moneys to county or district public health agencies to support local or regional review team activities;
- provide training and technical assistance to local or regional review teams regarding the facilitation of a child fatality review process, data collection, evidence-based prevention strategies, and the development of prevention recommendations;
- provide an annual data report to each local or regional review team, summarizing its local or regional review data entered into the web-based data-collection system; and
- distribute information to the public concerning risks to children and recommendations for promoting the safety and well-being of children (CRS 25-20.5-407).

The team has 34 voting members.

- Eighteen appointed by the governor representing county sheriffs (2 members), coroners (2), peace officers who specialize in crimes against children (2), district attorneys (2), members of the medical profession who specialize in traumatic injury or children's health (6), local fire department employees (1), county attorneys who practice in the area of dependency and neglect (1), county commissioners (1), and a representative of the office of child protection ombudsman
- Six appointed by the executive director of the Department of Human Services (five representatives of specified entities in the department and a representative of the directors of county departments of social services)



- Eight appointed by the director of the Department of Public Health and Environment to represent the department, one of whom represents county or district public health agencies
- One appointed by the commissioner of the Department of Education to represent the department
- One by the executive director of the Department of Public Safety to represent the department (CRS 25-20.5-406)

The voting members select 12 nonvoting members to represent specified entities.

### **Massachusetts**

In 2001, Massachusetts established a Child Fatality Review Program that includes state and local teams. The state team reviews the reports and recommendations of the local teams, which review cases of child fatalities and near fatalities.<sup>8</sup> The state review team is housed in the Office of the Chief Medical Examiner (M.G.L. c. 38 § 2A(b)).

Each of the 11 districts has its own local team to review child fatalities and near fatalities. The local teams are required to meet at least 4 times a year. The chair of a local team is the district attorney of the county (M.G.L. c. 28 §2A(c)).

The 14 designated members of the state team are

- the chief medical examiner, chair;
- the attorney general or designee;
- the commissioner of children and families or a designee;
- the commissioner of public health or a designee;
- the commissioner of elementary and secondary education or a designee;
- a representative selected by the Massachusetts District Attorneys Association;
- a colonel of the state police or a designee;
- the commissioner of mental health or a designee;
- the commissioner of developmental services or a designee;
- the director of the Massachusetts Center for Sudden Infant Death Syndrome, located at the Boston Medical Center, or a designee;
- the commissioner of youth services or a designee;
- a representative selected by the Massachusetts chapter of the American Academy of Pediatrics who has experience diagnosing or treating child abuse and neglect;
- a representative selected by the Massachusetts Hospital Association;
- the chief justice of the juvenile division of the trial court or a designee;
- the president of the Massachusetts Chiefs of Police Association Incorporated or a designee; and
- a child advocate appointed under section 3 of chapter 18C or a designee.

The chair or a majority of the state team may add as a member anyone with expertise or information relevant to an individual case (M.G.L. c. 38 § 2A(b)).

The state child fatality review team is to

- develop a model investigative and data collection protocols for the local teams;
- provide information to local teams and law enforcement agencies for the purpose of protecting children;
- provide training and written materials to local teams to assist them in carrying out their duties;
- review reports from the local teams;
- study the incidence and causes of the child fatalities and near fatalities in the commonwealth;
- analyze community, public and private agency involvement with the children and families prior to and subsequent to fatalities or near fatalities;
- develop a protocol for the collection of data regarding fatalities and near fatalities and provide training to local teams on that protocol;
- develop and implement rules and procedures necessary to its own operation; and
- provide the governor, the general court, and the public with annual written reports, subject to confidentiality restrictions, which shall include, but not be limited to, the state team's findings and recommendations (M.G.L. c. 38 § 2A(b)(i-ix)).

### **New Jersey**

The Child Fatality and Near Fatality Review Board was established in 1997. It is included in the Department of Children and Families but operates independently.<sup>9</sup> The board reviews child fatalities and near fatalities of children who were involved with child protective services within 12 months of the fatality or near fatality. The board compiles an annual report of its findings, which is focused on the relationship of child fatalities and near fatalities to children placed in child protective services and to develop prevention measures to avoid similar situations in the future.<sup>10</sup>

The 13 board members are

- the commissioner of Human Services,
- the commissioner of Health and Senior Services,
- the director of the Division of Youth and Family Services in the Department of Human Services,
- the attorney general,
- the superintendent of the State Police or designee,
- the state medical examiner,
- the chairperson or executive director of the New Jersey Task Force on Child Abuse and Neglect,
- a representative of the New Jersey Prosecutors' Association appointed by the governor,
- a law guardian appointed by the governor,
- a pediatrician with expertise in child abuse and neglect appointed by the governor,
- a psychologist with expertise in child abuse and neglect appointed by the governor,
- a social work educator with experience and expertise in area of child abuse or a related field appointed by the governor, and
- a representative with experience in substance abuse appointed by the governor (NJS § 9:6-8.89).

## Oklahoma

Oklahoma's child death review process includes a state team and four regional teams (Eastern, Southwestern, Southeastern, and Tulsa). The state Child Death Review Board is in the Oklahoma Commission on Children and Youth. The board reviews fatalities and near fatalities of children under 18 years of age.<sup>11</sup> The board conducts reviews of cases in which abuse or neglect may be related to the fatality or near fatality of the child (10 OK Stat § 10-1150.2(A), (B)(2)).

The board has 27 members, each of whom can choose a designee:

- the chief medical examiner;
- the director of the Department of Human Services, or designee, provided the designee shall be a person assigned to the Child Welfare Division of the department;
- the state commissioner of health;
- the director of the Office of Child Abuse Prevention;
- the director of the Oklahoma Commission on Children and Youth;
- the chief child abuse medical examiner;
- the chief of Maternal and Child Health Services of the State Department of Health;
- the commissioner of Mental Health and Substance Abuse Services;
- the chair of the Child Protection Committee of the Children's Hospital of Oklahoma;
- the director of the Office of Juvenile Affairs;
- the chief of Injury Prevention Services of the State Department of Health;
- the state epidemiologist of the State Department of Health;
- the director of the State Bureau of Investigation;
- the chief executive officer of the Oklahoma Health Care Authority;
- a law enforcement officer selected from lists submitted by the executive boards of organizations representing sheriffs and peace officers in the state;
- an attorney licensed in this state who is in private practice selected from a list submitted by the executive board of the Oklahoma Bar Association;
- a district attorney selected from a list submitted by the District Attorney's Council;
- a physician selected from lists submitted by statewide organizations representing physicians in this state;
- a physician selected from lists submitted by statewide organizations representing osteopathic physicians in this state;
- a member of the State Post-Adjudication Review Advisory Board;
- a social worker selected from lists submitted by each organization representing social workers;
- an individual selected from lists submitted by Oklahoma court-appointed special advocate associations;
- a psychologist selected from lists submitted by Oklahoma psychological associations;
- a member of a Native American tribe involved in the area of protection of Native American children selected from a list submitted by the Oklahoma Indian Affairs Commission;
- an individual selected from lists submitted by Oklahoma coalitions or associations against domestic violence and sexual assault;

- a pediatric physician selected from lists submitted by organizations of pediatric physicians or osteopaths; and
- a member of an emergency medical technicians associations (10 OK Stat § 10-1150.3(A)(1)).

### **Tennessee**

The State Child Fatality Prevention Team reviews reports from local teams and analyzes statistics of the incidence and causes of child deaths. The team looks to the causes of child fatalities to develop preventive measures. The recommendations are sent to the governor and the General Assembly. The state team is attached administratively to the Department of Health.<sup>12</sup>

The 17 members of the team are

- the commissioner of Health, who chairs the state team;
- the attorney general and reporter;
- the commissioner of Children's Services;
- the director of the state Bureau of Investigation;
- a physician nominated by the state chapter of the American Medical Association;
- a physician to be appointed by the commissioner of Health who is credentialed in forensic pathology, preferably with experience in pediatric forensic pathology;
- the commissioner of Mental Health and substance abuse services;
- a member of the judiciary selected from a list submitted by the chief justice of the Tennessee Supreme Court;
- the executive director of the Commission of Children and Youth;
- a representative from a professional organization working to prevent child abuse in children;
- a team coordinator, to be appointed by the commissioner of Health;
- the commissioner of education or the commissioner's designee;
- the commissioner of intellectual and developmental disabilities;
- two members of the House of Representatives to be appointed by the speaker of the House, at least one of whom must be a member of the Health Committee; and
- two senators to be appointed by the speaker of the Senate, at least one of whom must be a member of the Health and Welfare Committee.

The state teams must

- review reports from local teams;
- report to the governor and the General Assembly concerning the state's teams activities and its recommendations for changes to any law, rule, and policy that would promote the safety and well-being of children;
- undertake annual statistical studies of the incidences and causes of child fatalities in the state;
- provide training and written materials to local teams;
- develop protocol for the collection of data regarding child deaths;
- upon request of a local team, provide technical assistance to the team; and
- periodically assess the operations of child fatality prevention efforts and make recommendations and changes as needed (TN Code 68-142-105).

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<sup>8</sup> Office of the Child Advocate. *Child Fatality Review Needs Assessment: Findings From The State Team*. Office Of The Child Advocate. March 2018. P.1. Web. May 22, 2019.

<sup>9</sup> New Jersey. Dept. of Children and Families. Child Fatality and Near Fatality Review Board. *Department of Children and Families*. n.d. Web. March 27, 2019.

<sup>10</sup> Natl. MCH Center for Child Death Review. *State Spotlight—New Jersey*. Web. March 27, 2019.

<sup>11</sup> Natl. MCH Center for Child Death Review. *State Spotlight—Oklahoma*. Web. May 22, 2019.

<sup>12</sup> Natl. MCH Center for Child Death Review. *State Spotlight—Tennessee*. Web. June 15, 2014.



## Appendix D

### Recommendations Of The Kentucky Child Fatality And Near Fatality External Review Panel 2014 To 2018

The wording of recommendations is verbatim from the panel's annual reports.

Year Recommended	Recommendation	Action Taken
<b>Department For Community Based Services (DCBS)</b>		
2018, 2016, 2015	The Department for Community Based Services should engage in critical review of existing practices and policies associated with accepting or screening out referrals of possible child maltreatment. Minimally these revisions should include increased supervisory review of any screened out if: 1) the child is age four or under, 2) has multiple previous referrals, or 3) the referral source is a professional serving the child or family. Additionally, intake training should enhance staff's capability to solicit information necessary to screen-in the call.	DCBS is implementing a new model for its internal operations, the Culture of Safety, and incorporating new state and federal legislation. As part of this process, the department is examining all its policies and procedures.
2018	The internal review is a critical opportunity for the agency to engage in a quality assurance and improvement process. Minimally, the internal reviews should address the statutorily required element of the process. Ideally, DCBS should engage in a process similar to recommendations made by JCAHO [Joint Commission on the Accreditation of Healthcare Organizations]. Further, based on Panel concerns regarding the screening-out of reports, it is recommended the Department expand the internal review criteria to include screened-out reports. The Cabinet should consider the death of any DCBS involved child as a sentinel event and conduct an internal review in cases in which performance concerns may have played a role.	Same as above

<b>Year</b>	<b>Recommended</b>	<b>Recommendation</b>	<b>Action Taken</b>
2018	The Panel has noted, however, inconsistency in the findings made by the Cabinet in unsafe sleep cases. An unsafe sleep death with an impaired caregiver may result in a substantiation of neglect in one region, while in another region a case with similar circumstances may not be substantiated. This issue seems to be exacerbated based on DCBS staff interpretation of the autopsy results that, absent obvious indicators, will list the cause of death as undetermined. DCBS has the latitude and authority to reach the investigative conclusion consistent with its own Standard Operating Procedure. The Panel recommends DCBS staff examine this issue and provide the appropriate training, guidance and oversight to support consistent practices statewide.		Same as above
2017	For the second consecutive year, the Panel strongly recommends additional resources be provided to the Department for Community Based Services during the next budget session. The Department of Community Based Services is the agency held accountable for the safety and well-being of Kentucky's children. However, it continues to be grossly underfunded, under-resourced, and under-staffed.		The panel is unaware of any steps taken related to this recommendation.
2015	Department for Community Based Services should likewise consider inadequate restraint as an important indicator of neglect in an impaired driving incident or collision involving children, and include and weigh that information in their investigation and substantiation process.		This is no longer a priority recommendation of the panel. DCBS informed the panel that implementing such a standard would overwhelm its offices.
2015	Ensure the Department for Community Based Services internal review process of child fatality or near fatality as mandated in KRS 620.050(12) is conducted in a manner consistent with the statute and it is part of a quality improvement process to address critical incidents within the child protection system. The review should include an examination of case best practice, policy compliance, staff training and experience, and a caseload analysis.		DCBS is implementing a new model for its internal operations, the Culture of Safety, and incorporating new state and federal legislation. As part of this process, the department is examining all its policies and procedures.
2015	The Department for Community Based Services should implement quality improvement practices to increase the timely completion of fatal and near fatal investigations. The annual report of child maltreatment fatalities and near fatalities that the DCBS produces should specifically identify the number of incomplete investigations at the time of release of the report so the public is aware of these preliminary figures and that they may increase significantly.		Same as above



<b>Year</b>	<b>Recommended</b>	<b>Recommendation</b>	<b>Action Taken</b>
2015		The Department for Community Based Services should provide to the Panel information regarding the caseload, training, and experience levels on staff serving families in which a fatal or near fatal incident has occurred.	DCBS now provides this information with the case materials sent to the panel.
2014		Include information on the dangers of bed sharing and impaired bed sharing in any home visits with parents of infants.	The Department for Public Health and DCBS continue to promote safe sleep practices and awareness.
2014		Work to improve access to quality structured mental health assessments for caregivers of children in families found to be high risk.	DCBS is implementing a new model for its internal operations, the Culture of Safety, and incorporating new state and federal legislation. As part of this process, the department is examining all its policies and procedures. New federal legislation may also enable increased provision of mental health assessments.
2014		Develop a workforce study to look at workloads for DCBS workers.	The cost of such a study is a barrier. KRS 199.461 implements caseload limits for workers and processes for when limits are exceeded.
<b>Substance Abuse</b>			
2018, 2017, 2016		For the third consecutive year, the Panel recommends the full implementation of Family Drug Court. Substance abuse by a caregiver was found to be a characteristic in 46% of the cases reviewed by the Panel. The Panel recommends the General Assembly allocate the funding in 2020 to implement Family Drug Courts across the Commonwealth. Family Drug Courts seek to provide safe environment for children, intensive judicial monitoring, and coordinated service provision to treat parents' substance use disorder and other co-occurring risk factors.	Funded by a nonprofit organization, Jefferson County reinstated its Family Drug Court in October 2018.
2018, 2017, 2016		(Re: Infants diagnosed with neonatal abstinence syndrome) The Panel recommends funding for the development of new programs and expansion of existing programs, to ensure every infant prenatally exposed to drugs or alcohol leaves the hospital with an appropriate Plan of Safe Care. These plans should be collaborative, based on individual child/family needs, and specifically identify the community agency responsible for monitoring and implementing the plan. Each program should include components addressing in-home service delivery, parent education, and compliance monitoring.	The panel is unaware of any steps taken related to this recommendation.

<b>Year</b>	<b>Recommendation</b>	<b>Action Taken</b>
<b>Recommended</b>		
2018	(Re: Medical Assisted Treatment (MAT)) The Panel strongly encourages the Cabinet for Health and Family Services, the Kentucky Board of Medical Licensure and the Office of Drug Control Policy to develop additional family-oriented protocol addressing the increased safety risks present in these families. Additional information must be disseminated regarding the grave effects of these medications in the hands of young children. Kentucky should develop, disseminate, and mandate additional education for each licensed provider.	The Office of Drug Control Policy has provided guidance regarding who the panel can work with to develop additional training for MAT providers. The panel is considering forming subcommittees to assist in developing training protocol.
2017	The panel recommends vigorous enforcement (and clear sanctions) for all providers of MAT to ensure that the required counseling and behavioral therapy components are part of the treatment provided... MAT providers must be educated on monitoring and when and how to notify DCBS when they believe a child may be in danger. Further education must be disseminated regarding the grave effects of these medications in the hands of a small child.	The panel has been assured that MAT providers are providing the required counseling but has no reasonable means to verify this.
<b>Medical Providers</b>		
2016, 2014	Hospitals should be required/encouraged/ incentivized to model safe sleep and provide face-to-face education regarding safe sleep and abusive head trauma prevention education to parents of newborns.	The Kentucky Hospital Assn (KHA) issued a letter to all Kentucky hospitals stating, "After thoughtful consideration the KHA Board of Trustees is proposing members review their current practices and implement the following recommendation. The Kentucky Hospital Association recommends Kentucky hospitals provide evidence informed education addressing abusive head trauma and safe sleep practices to the parents of newborns and recommends hospitals follow model safe sleep practices within birthing centers and NICU [neonatal intensive care] units."
2015	The General Assembly should pass legislation requiring hospitals and birthing centers to provide prevention of Abusive Head Trauma training and Safe Sleep information to parents prior to an infant's discharge.	The panel continues to seek avenues for building support for this.

<b>Year</b>	<b>Recommended</b>	<b>Recommendation</b>	<b>Action Taken</b>
2015		Develop best practice guidelines for discharge of infants with neonatal abstinence syndrome (NAS) and distribute them to all birthing hospitals.	The panel continues to make recommendations regarding the treatment of infants with NAS. This element is included with their recommendations regarding wrap-around services and a Plan of Safe Care for NAS infants. However, the recommendation is dependent on increased funding.
2014		Healthcare providers should discuss safe sleep with parents of newborns, including the dangers of bed sharing, particularly when the caregiver may be impaired by exhaustion or sedating substances.	This is included in a Cabinet for Health and Family Services statewide awareness campaign.
2014		Birthing hospitals should develop policies and practices to model safe sleep in their neonatal intensive care units.	A national certification program is now available. Three Kentucky hospitals have updated policies to model safe sleep.
2014		Birthing hospitals should assure linkage of high-risk infants to a medical home and needed community services prior to discharge. Make appointments for the newborn's follow-up with a medical home, identify and address any barriers to the family's attendance at that appointment, and establish communication protocol with the medical home so that if a high-risk infant does not show for follow-up, the office will notify the hospital social worker to make sure the infant is not in danger.	This is a recommended practice in the Department for Public Health's Kentucky Infants Safe and Strong hospital recognition program, but it is an optional step. The panel continues to support and recommend wraparound services for high-risk infants.
2014		Develop multi-tiered prevention programming for abusive head trauma to be provided to parents by birth hospitals healthcare providers and home-visiting programs that include: the dangers of shaking an infant or young child; how to deal with infant crying including soothing techniques and permission for caregivers to step away and take a break when feeling frustrated; choosing safe caregivers for infants and young children; and having an action plan for caregivers in the event of escalating frustration.	A packet of information has been developed. A survey of birthing hospitals' practices is being implemented. The panel sent a letter to all hospitals in October 2015 to encourage them to develop evidence-informed prevention education to parents and caregivers.  The panel continues to support abusive head trauma education and awareness across multiple disciplines.

<b>Year</b>	<b>Recommendation</b>	<b>Action Taken</b>
<b>Courts</b>		
2016	Judges who hear dependency, neglect and abuse (DNA) cases should use the Administrative Office of the Courts (AOC) mandated DNA series forms and should adhere to the statutory timeframes required in these cases. To the extent practicable, AOC should audit the judiciary's compliance in these cases and provide a reporting component to judges.	AOC has provided judges with additional training to encourage the use of the mandated DNA series forms. The panel is unaware whether further action has been taken in regard to this recommendation.
2015, 2014	The General Assembly should implement legislation allowing dependency, neglect, and abuse court proceedings to be opened to the public for the purposes of transparency, accountability, and systems improvement.	The General Assembly enacted legislation codified at KRS 21A.190, which outlines a 4-year pilot project and requests that the Supreme Court of Kentucky institute it. The pilot program began in 2018; an initial report was issued in September 2018.
2015	Drug court participants, youth who are involved with the Court Designated Worker Program, and any person who is a party to any family court proceedings should be required to receive education on prevention of Abusive Head Trauma and Safe Sleep.	The panel sent letters to judges and provided a video on safe sleep to AOC, which continues to provide the training materials. Training is also now provided to inmates on safe sleep and abusive head trauma.
2014	Develop and administer training conducted by medical professionals to family court and district court judges on abuse and neglect.	The panel has met with AOC. A judicial presentation was held in September 2015. AOC continues to offer training in dependency, neglect, and abuse to legal professionals.
<b>Law Enforcement</b>		
2018, 2016, 2014	The Panel continues to recommend law enforcement treat every child fatality and near fatality under the premise the child may have been a victim of abuse or neglect. Recently, the Department of Criminal Justice and Training held the Kentucky Criminalistics Academy Conference. During this conference, Kentucky's Chief Medical Examiner, Dr. William Ralston, conducted a training to various law enforcement officers from across the Commonwealth, regarding the importance of Child Death Scene Investigations. The Panel recommends expanding and mandating similar trainings to all law enforcement entities throughout the state.	The Department of Criminal Justice Training (DOCJT) and State Police are willing to address any unmet training need and will work with the panel. Trainings on child death scenes have been conducted and additional trainings have been requested. The panel is discussing with DOCJT's legislative liaison making child death scene training mandatory.

Year	Recommended	Recommendation	Action Taken
2018, 2014	The Panel further recommends the development of a protocol for standardized, universal administration of drug tests of the caregivers when a child dies unexpectedly. Currently, law enforcement may request voluntary consent to perform a blood or urine test, however, without consent, they must obtain a search warrant to secure biological testing. The Panel reviewed several cases in which law enforcement noted the caregivers appeared intoxicated but failed to request or administer drug testing.	Recognizing the possible constitutional issue with across-the-board testing, the panel's goal is to see administration of drug tests to caregivers established as a best practice.	
2016	Law enforcement should complete and/or submit a JC3 to DCBS in situations where child neglect, abuse and maltreatment are of concern, or should be of concern, to the officer.*	The panel reports that use of the JC3 from has improved significantly.	
2016	The Department of Criminal Justice Training and other Kentucky law enforcement training entities should assure all law enforcement officers are trained in best practices for safeguarding children.	The department is working with the panel to meet any unmet training needs.	
2015	Law enforcement should actively enhance enforcement of the provisions of KRS 189.125 which require infants and children to be properly secured in child restraining systems and booster seats during transport in a motor vehicle.	The panel continues to support enforcement of child restraint regulations.	
2014	Develop a process for law enforcement to upload district and family court preventive and restrictive orders into the Law Information Network of Kentucky (LINK).	LINK system updates would only be feasible through legislation and funding.	
Coroners			
2018	The Panel has noted coroners are more routinely utilizing the Sudden Unexplained Infant Death Investigation Reporting Form (SUIDIRF), however, often times the forms are not complete. The SUIDIRF is a standardized form that collects and may improve classification of sleep-related infant deaths. The form guides investigators through the steps involved in an investigation and allows them to document their findings consistently. This form produces information researchers can use to recognize new threats and risk factors for sudden unexpected infant death. The Panel recently worked with the Kentucky State Police to post the form on KyOps. KyOps is a website developed and maintained by the Kentucky State Police to serve as a portal into the state's repository for traffic collision, crime, and citation reports completed by law enforcement agencies. Law enforcement officers throughout the state may now utilize this invaluable tool.	The panel reports that use of the form is increasing.	

<b>Year</b>	<b>Recommendation</b>	<b>Action Taken</b>
<b>Recommended</b>		
2018	The Panel further recommends coroners, law enforcement, and DCBS conduct joint investigations in all child fatalities pursuant to KRS 211.686.	Coroners' involvement in child fatality investigation is steadily increasing across the state. This is particularly evident in the increase in local fatality review teams, which are under each county coroner's jurisdiction.
2015	As required by KRS 72.410(3)(a), coroners should make timely notifications to and gather necessary information from law enforcement, the Department for Community Based Services, and local health department upon notification of the death of a child under 18 years of age.	The panel reports improvements in the notification process. The panel continues to support and promote increased coroner involvement in the investigation of child fatalities.
<b>General</b>		
2018, 2016	The Panel continues to recommend the Kentucky Hospital Association and the Kentucky Chapter of the American Academy of Pediatrics promote awareness of the two Pediatric Forensic Medicine centers within Kentucky. UK HealthCare and UofL Kosair Charities Division of Pediatric Forensic Medicine both provide assessments and treatment of suspected child physical abuse and neglect. Pediatric Forensic Medicine divisions act as a liaison between the hospital staff, law enforcement and child welfare services. Both teams are available 24/7 for consultation and support.	The panel is discussing the best approach for promoting awareness of the two centers. Increased awareness among law enforcement is one of the avenues the panel thinks may be beneficial.
2018, 2016, 2015	The Panel further recommends the General Assembly and the Attorney General's Office analyze the practicability of amending KRS 431.600 to include Multidisciplinary Teams on Child Physical Abuse in addition to child sexual abuse.	The panel has approached current multidisciplinary teams about expanding their jurisdiction to physical abuse. The teams were receptive but indicated that they do not have the capacity for the increase in cases.
2016	Allow a parent or legal guardian to request background check of the child abuse and neglect registry records when employing a child care provider for a minor child.	KRS 199.466 allows a parent or legal guardian to obtain a background check from the Cabinet for Health and Family Services.
2016	Enhanced penalties for driving under the influence (DUI) with a minor in the vehicle. The Kentucky Department of Transportation and Kentucky State Police should collect data regarding the incidence of DUI with children in a vehicle and develop an awareness campaign regarding the outcomes and need for bystanders to intervene.	Panel staff report that this recommendation is no longer a priority. KRS 189A.010(11)(f) treats the presence of a child under age 12 as an aggravating circumstance resulting in increased penalties for the offender.

<b>Year</b>	<b>Recommended</b>	<b>Recommendation</b>	<b>Action Taken</b>
2014		Develop, in collaboration with medical professionals, a statewide public awareness campaign highlighting the dangers of bed sharing and impaired bed sharing.	The Department for Public Health launched a campaign in October 2015. The department continues to promote awareness on this issue.
2014		Develop education targeted to all professionals who work with children, as well as the community at large, about mandatory reporting requirements and recognition of early warning signs of child physical abuse, including specific education about bruising in infants.	KRS 311.601(a) requires pediatric abusive head trauma as an element of continuing medical education. Pediatricians and other certified medical practitioners are required to take at least one course on pediatric abusive head trauma. KRS 156.095(a) mandates that the Kentucky Department of Education provide comprehensive, evidence-informed training on child abuse and neglect. Training is mandatory and to be completed every 2 years.

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

Sources: Kentucky. Child Fatality and Near Fatality External Review Panel. *Annual Report*, 2014 to 2018.

