Kentucky Child Fatality And Near Fatality External Review Panel 2021 Update

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Legislative Oversight And Investigations Committee

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Abstract

KRS 6.922 requires that the Legislative Oversight and Investigations Committee conduct an annual evaluation of the Child Fatality and Near Fatality External Review Panel. The panel, which has 15 voting and 5 ex officio members, is attached administratively to the Justice and Public Safety Cabinet. The independent panel's charge is to conduct comprehensive reviews of child fatalities and near fatalities reported to the Cabinet for Health and Family Services that are suspected to be a result of abuse or neglect. It is also required to submit annual reports discussing case determinations, as well as findings and recommendations for system and process improvements. The panel uses SharePoint and a data tool to track various information and data related to child fatality and near fatality reports.

Foreword

Legislative Oversight and Investigations Committee staff appreciate all those who provided assistance with this report. The Kentucky Child Fatality and Near Fatality External Review Panel provided the benefit of its time, while its staff provided various data and other information. The Department for Community Based Services (DCBS) and Department for Public Health (DPH) also provided information and data. We will continue to work with DCBS and DPH to receive information and data that was not provided during the course of our review. The Justice and Public Safety Cabinet and the Office of State Budget Director provided budgetary and other information related to the panel's funding. Finally, the National Center for Fatality Review and Prevention provided assistance with other states' information and data requests.

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Summary

House Bill 6 from the 2021 Regular Session of the Kentucky General Assembly amended KRS 6.900 to change the name of the Program Review and Investigations Committee to the Legislative Oversight and Investigations Committee. The bill included an emergency clause, so the committee name change became effective on March 12, 2021, when the bill became law.

This report analyzes information presented in the Child Fatality and Near Fatality External Review Panel's annual reports related to dependency, neglect, and abuse (DNA) allegations. More specifically, the panel's annual reports discuss case determinations, findings, and recommendations for system and process improvements (KRS 620.055(1) and (10)).

KRS 620.055(6) grants the panel broad authority to request unredacted information related to DNA cases, including but not limited to medical records, autopsy reports, law enforcement reports, and educational records. This report analyzes the process by which the panel receives case information and how it uses that information to fulfill its statutory responsibilities.

This report discusses the panel's data tool, which is used with SharePoint to analyze and track various data points. The panel's data tool was compared with the data tool and data dictionary used by the National Center for Fatality Review and Prevention, which offers a web-based standardized case reporting tool to child death review teams and other state panels.

The panel is attached to the Justice and Public Safety Cabinet for staffing and administrative purposes (KRS 620.055(1)). As a result, the panel does not have its own personnel and operating budget. Funding for the panel is included as part of the Office of the Secretary's baseline funding. A May 2014 memorandum of understanding (MOU) between the panel and the Justice and Public Safety Cabinet established the panel's independence from the cabinet while maintaining the panel's administrative operations within the cabinet. This report discusses the panel's current budgetary and administrative practices and compares them to the administrative and budgetary processes outlined in the 2014 MOU.

Findings And Recommendations

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

However, staff analysis of panel reports found that its findings were often not supported by the analyses the panel performed and that the information needed to link the findings to data was not discussed in each report. Also, staff found that the panel's recommendations were not empirically linked to its findings. As a result, the reports are not as effective as possible, especially with respect to developing actionable and targeted recommendations.

Recommendation 3.1

The Child Fatality and Near Fatality External Review Panel should reevaluate how it uses SharePoint and its data tool to collect and analyze case data that are used to make case determinations, findings, and recommendations for system and process improvements. It should also consider contacting the National Center for Fatality Review and Prevention to discuss how best to develop recommendations related to its review of child fatalities and near fatalities where abuse or neglected is suspected.

The panel does not have a data dictionary that clearly defines the variables it collects from case files. Even though the panel amends its data tool periodically to capture additional data points, it has not formally evaluated the data tool since 2014. Because the data tool is the primary means by which the panel collects and analyzes data, it is important to continually review its overall effectiveness. Collecting and analyzing case data is essential not only for the panel to make its case determinations, but also to develop findings and actionable recommendations for system and process improvements.

Recommendation 3.2

The Child Fatality and Near Fatality External Review Panel should formally review its data tool to ensure that it is capturing relevant data needed to make case determinations and to develop findings and actionable recommendations.

Recommendation 3.3

The Child Fatality and Near Fatality External Review Panel should consider creating a data dictionary.

Recommendation 3.4

The Child Fatality and Near Fatality External Review Panel should consider requesting assistance from the National Center for Fatality Review and Prevention to understand how it designed its data tool and data dictionary. The center may also be able to assist with ideas about different types of data for the panel to capture related to the review of near fatality cases where abuse or neglect is suspected.

Although the panel is attached to the Justice and Public Safety Cabinet for staff and administrative purposes, it is not formally included as part of the cabinet's biennial budget process. Instead, the panel is included as part of baseline funding for Justice Administration.

The panel and the cabinet have not followed the budget procedures outlined in a May 2014 memorandum of understanding between the two parties requiring that the panel provide its budget request to the cabinet in the fall prior to each budget session on a "date and [in a] format to be required by the cabinet." Outside of the MOU, neither party has developed formal policies or guidelines to ensure meaningful communication between the panel chair and the cabinet secretary related to the panel's budget requests and financial expenditures. As a result, the

panel's autonomy to effectively address staff and workload issues through the budget process is diminished.

Recommendation 3.5

The Child Fatality and Near Fatality External Review Panel and the Justice and Public Safety Cabinet should develop processes to ensure that the panel submits a formal budget request to the cabinet in the fall prior to the budget session, as envisioned by the 2014 memorandum of understanding (section 4). Such a process should involve developing an appropriate format for the panel to use when preparing the budget and for the cabinet to use when submitting the budget to the Office of State Budget Director (OSBD). The process should include steps to ensure that the panel can formally present its personnel and operating requests to OSBD, as well as to the legislature.

Recommendation 3.6

The Child Fatality and Near Fatality External Review Panel and the Justice and Public Safety Cabinet should develop processes for meaningful communication between the panel chair and the cabinet secretary related to the panel's budgetary needs, as envisioned by the 2014 memorandum of understanding (section 3). Such processes should include steps by which panel expenditures are approved and staffing requests are formally considered, as well as the presentation of financial reports or updates to the panel.

Recommendation 3.7

The Child Fatality and Near Fatality External Review Panel and the Justice and Public Safety Cabinet should discuss with the Office of State Budget Director the possibility of establishing a separate appropriation allotment like those of other similarly funded programs under Justice Administration.

Chapter 1

Kentucky Child Fatality And Near Fatality External Review Panel

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

In July 2012, Governor Steve Beshear issued an executive order creating a Child Fatality and Near Fatality External Review Panel. The panel's purpose was to conduct comprehensive reviews of child fatalities and near fatalities determined to be due to child abuse or neglect. The independent review panel was attached to the Justice and Public Safety Cabinet for staff and administrative purposes.[1]

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

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

The panel is required to publish an annual report by December 1 that consists of case reviews, findings, and recommendations for system and process improvements to help prevent child fatalities and near fatalities that are due to abuse and neglect (KRS 620.055(10)). The panel has decided to base each annual report on an analysis of child fatality and near fatality cases from the previous fiscal year, regardless of whether investigations by the Department for Community Based Services (DCBS) substantiated allegations of abuse or neglect in each case.

The Legislative Oversight and Investigations Committee conducts an annual evaluation (KRS 6.922).

KRS 6.922 and 620.055(16) require that the Legislative Oversight and Investigations Committee conduct an annual evaluation of the Child Fatality and Near Fatality External Review Panel.

Legislative Oversight staff approached its initial work by completing a thorough first evaluation for the committee, which was adopted at the July 10, 2014, meeting. Although the evaluation did not make recommendations, it focused on the following areas:

- Panel organization, membership, and independence
- Compliance with statutes
- Confidentiality and transparency
- Budget and staff

- Case review using SharePoint
- Case statistics
- National statistics
- Other states

Staff drafted and presented subsequent annual reports, which the committee adopted on December 10, 2015 (2015 update); December 13, 2016 (2016 update); August 9, 2018 (2017 update); and July 12, 2019 (2018 update). These evaluations continued the statutory compliance focus and a general description of various processes by which the panel receives and analyzes case information and drafts its annual reports. Table 1.1 provides additional details.

Table 1.1
Legislative Oversight And Investigations Committee Staff Evaluations
2014 To 2019

Committee Adoption Date	Major Conclusions	Recommendations
7/10/14 (initial)	The Child Fatality and Near Fatality External Review Panel is complying with its governing statutes. The panel appears to be distinctive in terms of its organizational structure and mission. The $420,000 annual appropriation to the panel, to be used primarily for staff, should allow the panel to review cases and make recommendations more effectively.	None
12/10/15 (2015 update)	The panel is in compliance with six of seven administrative requirements in statute. The panel has addressed all recommendations made in its 2014 report. The panel has determined that two of those recommendations would require action by the General Assembly.	The panel may wish to create a formal policy for deleting cases stored in electronic form in SharePoint.
12/13/16 (2016 update)	The panel adopted a 5-year retention schedule in accordance with the practice of other Kentucky agencies tracking similar data and that of other states. The panel expressed that it would like to have dedicated staff as follows: full-time director; full-time program coordinator; full-time data analyst; an intern; and contractors as needed.	None

Committee Adoption Date	Major Conclusions	Recommendations
8/9/18 (2017 update)	The panel is in compliance with all but two of the statutory administrative requirements. First, the 2017 Annual Report was published on December 8 rather than December 1. Second, a panel seat has been vacant since June 30, 2017. Nominations must come from the Kentucky Association of Addiction Professionals, which has not responded to requests for nominations from the panel and the attorney general's office. Three of the nine recommendations in the panel's 2016 annual report resulted in actions by the General Assembly, the Kentucky Hospital Association, or the Administrative Office of the Courts during 2017.	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.
7/12/19 (2018 update)	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.	The General Assembly should consider changing 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. The panel should establish a policy for the destruction of electronic documents stored in SharePoint. Recommendations in the panel's annual reports should be easily identifiable and clearly stated.

Source: Legislative staff review of previous evaluations.

In December 2020, staff submitted a co-chair memorandum providing an update and additional detail on its initial and subsequent reports from 2014 to 2019, as well as identifying areas for further research in 2021. Generally, the areas suggested for additional review included the panel's operations, procedures, and recommendations.

Major Objectives

This study had five major objectives.

The major objectives for this study were to review

- the process by which the panel receives substantiated and unsubstantiated cases from the Cabinet for Health and Family Services;
- the process by which the panel requests, receives, and analyzes case information;
- the process by which the panel drafts and finalizes its annual report to meet its December reporting requirements (KRS 620.055(10));

- the panel's organizational placement within the Justice and Public Safety Cabinet; and
- best practices or other guidance from the National Center for Fatality Review and Prevention and from other states.

Methodology

This report focused on the processes the panel uses to request, receive, and analyze information to carry out its statutory responsibilities. It also focused on the process by which the panel requests and receives its funding. Staff conducted the following research tasks:

- Reviewed and analyzed panel members' committee testimony from 2015 to 2020
- Reviewed and analyzed committee meeting minutes from 2015 to 2021
- Reviewed and analyzed child fatality and near fatality case information and data from the panel's annual reports from 2014 to 2020
- Reviewed and analyzed the panel's historic expenditure data from eMARS
- Reviewed and analyzed the panel's historic contract information from eMARS
- Reviewed and analyzed the panel's operating budget reports and followed up with Office of State Budget Director officials for clarification
- Interviewed the panel's staff and chair about its budget, expenditures, and related processes
- Interviewed budget staff of the Justice and Public Safety Cabinet about the panel's budget, expenditures, and related processes
- Interviewed Cabinet for Health and Family Services officials about the process by which the Department for Community Based Services and the Department for Public Health (DPH) refer cases to the panel
- Analyzed a Department for Community Based Services data extract of 83,322 substantiated cases where abuse or neglect was suspected from 2017 to 2019
- Requested DPP-115 and investigative assessment reports related to a sample of 30 substantiated cases where abuse or neglect was suspected
- Requested Cabinet for Health and Family Services case referral documents (for example, DCBS Excel-115 forms and DPH emails) for 2017 to 2020
- Requested system analysis reports for 2017

- Requested Department for Community Based Services and Department for Public Health child fatality reports required pursuant to KRS 620.050(12)(c) and 211.684(4), respectively
- Interviewed officials from the National Center for Fatality Review and Prevention
- Reviewed similar panels in Arkansas, Delaware, Indiana, Minnesota, New Jersey, North Dakota, and Oklahoma

Data Limitation

The Cabinet for Health and Family Services' protocol for fulfilling legislative data requests caused prolonged delays in committee staff's receipt of the data needed to address the first objective: "Review the process by which the panel receives substantiated and unsubstantiated cases from the Cabinet for Health and Family Services."

The process by which the cabinet responds to legislative requests begins with a formal request to the legislative liaisons for both the cabinet and the appropriate department. The liaisons then work with agency personnel to answer questions, produce data, or conduct analyses. Once the requested information has been gathered, it is given to the liaisons for review and then sent to the Office of the Secretary for final approval. Only after these steps are complete is the information sent to the legislative staff who requested it. The process repeats itself if clarification is needed, which adds days or weeks to every interaction with the cabinet.

Committee staff followed this protocol for requesting 2017-2019 dependency, neglect, and abuse (DNA) data from the cabinet's data system, known as The Workers Information System (TWIST). As of the writing of this report, staff have received only part of the requested data: an initial extract of DNA cases reported to the cabinet from 2017 to 2019. However, other information and documents related to a sample of cases have not been provided. Over 4 months have passed since legislative oversight staff's initial requests.

Legislative oversight staff used the preliminary data from DCBS to document DNA reports from 2017 to 2019, the number of reports that were accepted for investigation, and the number of substantiated reports. However, for this report, staff were not able to review sampled case documentation to determine whether cases were processed according to standard operating procedures. This data limitation is being disclosed based on generally accepted auditing standards.[2]

Major Conclusions

This study has four major conclusions.

This report has four major conclusions:

- The panel has met its statutory requirements to submit annual reports consisting of case reviews, findings, and recommendations for system and process improvements. The reports include contextual information, state and federal statistics, and case summaries and determinations.
- The panel's findings in its annual reports were often not supported by the analyses performed, and the information needed to link findings to data was not discussed. Recommendations were not empirically linked to its findings, which contributes to challenges in developing actionable and targeted recommendations.
- The panel does not have a data dictionary to clearly define the variables it collects from case files. The data tool has not been evaluated since 2014. Collecting and analyzing case data is essential not only for the panel to make its case determinations, but also to develop findings and actionable recommendations for system and process improvements.
- The panel and the cabinet have not followed the requirements outlined in a May 2014 memorandum of understanding (MOU) between the two parties to ensure that the panel provides its budget request to the cabinet in the fall prior to each budget session. Outside the MOU, neither party has developed formal policies or guidelines to ensure meaningful communication between the panel chair and the cabinet secretary related to the panel's budget requests and financial expenditures. As a result, the panel's autonomy to effectively address staff and workload issues through the budget process is diminished.

Structure Of This Report

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

Chapter 3 presents major findings and seven recommendations.

[1] Kentucky, Governor Steve Beshear. Executive Order 2012-585, July 16, 2012. Secretary of State, Executive Journal.

[2] US. Government Accounting Office. *Government Auditing Standards, 2018 Revision,* pp. 197-198.

Chapter 2

Child Fatality And Near Fatality External Review Panel Background

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

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

Statute requires the panel to

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

Membership And Meeting Requirements

KRS 620.055(2) requires that the panel include 5 ex officio nonvoting members and 15 voting members. Table 2.1 shows that the voting members are 3 panel members based on their position, 10 appointed by the attorney general, 1 appointed by the chief justice of the Supreme Court, and 1 appointed by the secretary of state. Individual panel member names and affiliations are included in each annual report.

According to the panel's 2020 annual report, vacancies include one representative each from the Association of Addiction Professionals and the Board of Social Work.[1]

Table 2.1
Membership Of The Child Fatality And Near Fatality External Review Panel

Ex Officio Members (5)	
Chair of the House Health and Family Services Committee	
Chair of the Senate Health and Welfare 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	
Voting Members (10)	
Title	**Appointing Authority (Nominated By)**
At-large representative who shall serve as chairperson	Secretary of state
Pediatrician from University of Kentucky Department of Pediatrics*	Attorney general** (dean of the University of Kentucky School of Medicine)
Pediatrician from University of Louisville Department of Pediatrics*	Attorney general** (dean of the University of Louisville School of Medicine)
State medical examiner or designee	
Director of Court-Appointed Special Advocates (CASA)	Attorney general** (CASA)
Peace officer***	Attorney general** (commissioner of State Police)
Representative from Prevent Child Abuse Kentucky	Attorney general** (president of board of directors of Prevent Child Abuse Kentucky)
Practicing local prosecutor	Attorney general
Executive director of Kentucky Domestic Violence Association	
Chairperson of State Child Fatality Review Team	
Practicing social work clinician	Attorney general** (Board of Social Work)
Practicing addiction counselor	Attorney general** (Kentucky Association 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 Association of Regional Mental Health and Mental Retardation Programs)
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).

Meetings

The panel is required to meet at least quarterly (KRS 620.055(4)). However, according to its 2020 annual report, in July 2020 the panel began meeting monthly to complete yearly case reviews.[2] Since 2016, the panel has exceeded the requirement for quarterly meetings. Table 2.2 provides additional details.

Table 2.2
Panel Meeting Dates And Cases Reviewed
2016 To 2020

Year	2016	2017	2018	2019	2020	2021
Number of meetings	7	8	7	6	10	*12
Fatalities reviewed	47	59	51	54	85	**37
Near fatalities reviewed	95	91	83	82	97	**45

*Includes meetings scheduled for September 21, October 19, November 16, and December 21.
**As of June 15, 2021.
Source: Staff analysis of information in the Kentucky Child Fatality and Near Fatality External Review Panel's webpage and annual reports.

Administrative Attachment

The panel is attached to the Justice and Public Safety Cabinet for staffing and administrative purposes (KRS 620.055(1)). The panel does not have its own personnel and operating budgets, as its funding is included as part of the Office of the Secretary's baseline funding. In budget years when baseline funds were insufficient to meet the Office of the Secretary's needs, the panel's budget needs were also challenged.[3]

According to a memorandum of understanding between the panel and the Justice and Public Safety Cabinet, the panel is required to provide its budget request during the fall prior to a budget session. The cabinet then operates as a pass-through to submit the panel's budget to the Office of State Budget Director without prioritization.[4]

Initial Budget And Expenditures

The panel, through the cabinet, requested $420,000 annually in the 2014-2016 budget request.

The panel, through the cabinet, requested and received $420,000 annually in the 2014-2016 budget.[5] However, panel staff and members are not formally included as part of the cabinet's current biennial budget process.

The cabinet approves the panel's expenditures as part of baseline funding for the Justice Administration appropriation unit, under the Office of the Secretary.[6] The panel's annual personnel and operating expenditures have never totaled $420,000. Table 2.3 provides additional details.

Table 2.3
Kentucky Child Fatality And Near Fatality External Review Panel Expenditures

State Fiscal Year	Personnel Expenditures*	Operating Expenditures	Total
2015	$212,582.32	$6,946.05	$219,528.37
2016**	267,004.34	21,197.73	288,202.07
2017	213,258.51	56,288.95	269,547.46
2018	141,943.11	7,670.70	149,613.81
2019	185,344.55	3,610.57	188,955.12
2020	275,116.91	6,511.40	281,628.31
2021	245,260.94	2,205.67	247,466.61
Total	$1,540,510.68	$104,431.07	$1,644.941.75

*Staffing for the panel includes one executive staff adviser, one social service clinician II, and various contracts for a forensic nurse analyst and pediatric medical analyst.
**An additional $7,983.75 was expended for part-time data consultants from Kentucky State University and the University of Louisville.
Source: eMARS, Expenditure Analysis Report-FAS3.

Staffing

The panel has never been fully staffed as originally envisioned.

The panel has never been fully staffed as envisioned by the original *Kentucky Branch Budget, Additional Budget Request: Program Narrative/Documentation Record* (B-4 form). As the panel was established as an unfunded mandate, the cabinet requested sufficient funding to provide administrative and legal support. The funding would primarily be used to fund five full-time positions.

- Administrative coordinator
- Internal policy analyst III
- Staff attorney III
- Paralegal consultant
- Administrative specialist III[7]

In addition to administrative and legal support, staff resources were also needed to help review a high volume of cases, which involve analyzing hundreds of pages of information and records for each case. As of the writing of this report, staffing consists of one executive staff adviser, one social service clinician II, and one contract pediatric forensic medical case analyst.

Case Reporting, Investigation, And Referral

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

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

> immediately cause an oral or written report to be made to a local law enforcement agency or to the Department of

> Kentucky State Police, the cabinet or its designated representative, the Commonwealth's attorney, or the county attorney by telephone or otherwise.

Once a report is received, DCBS screens acceptance criteria for the alleged maltreatment "where the alleged perpetrator is in a caretaking role."[8] DCBS then seeks to identify a link between the alleged maltreatment and a child's fatal or near fatal condition. According to DCBS, once a link is established, "centralized intake staff will designate the intake in TWIST as a fatality/near fatality."[9]

If a child's death has occurred, central intake personnel will designate the occurrence as a fatality. Intake staff use a Near Fatality Tip Sheet "to decide if the child's condition meets criteria for the near fatality designation" in KRS 600.020(40) of a child in serious or critical condition as certified by a physician.[10]

If the Department for Community Based Services (DCBS) suspects that a child fatality occurred as a result of abuse or neglect, it investigates the case, which is ultimately referred to the panel.

If DCBS suspects that a child fatality occurred as a result of abuse or neglect, it investigates the case, which is ultimately referred to the panel for review. The same is true for cases involving a near fatality. However, if DCBS receives a report of abuse "other than a parent, guardian, or other person exercising control or supervision of the child," it will notify local or state law enforcement.[11]

Cases referred to the panel from DCBS are sent using an Excel form, which includes information from the Division of Protection and Permanency initial assessment (DPP-115). The DPP-115 includes the following information for each case:

- Calendar year
- Month
- State fiscal year
- Referral date (date DCBS received allegation)
- Approval date (regional DCBS date to send file to panel)
- Case number
- Last name of child
- First name of child
- Investigation finding (substantiated, unsubstantiated, pending)
- Upload date of case file to SharePoint for the panel (email is generated automatically to panel staff to notify that an upload has occurred)[12]

Table 2.4 provides additional details on total reports that DCBS received from 2017 to 2019. More specifically, it illustrates that 60 percent of reports met acceptance criteria for investigation. For the 3-year period, the panel reviewed 164 child fatality cases and 256 child near fatality cases.

Table 2.4
Reports Received And Investigated By Department For Community Based Services
2017 To 2019

Year	Reports	*Met Acceptance Criteria	Unsubstantiated	Substantiated
2017	160,628	102,378	74,799	27,579
2018	181,390	111,330	81,508	29,822
2019	180,600	102,436	76,515	25,921
Total	522,618	316,144	232,822	83,322

*Includes child fatality and near fatality cases. According to 2017-2019 annual reports, the panel reviewed a total of 164 child fatality cases and 256 child near-fatality cases for the 3-year period.
Source: Staff analysis of Department for Community Based Services TWIST (the Workers Information System) data for dependency, neglect, and abuse reports from 2017-2019.

The Department for Public Health also refers cases to the panel from its local child fatality review teams.

The Department for Public Health also refers cases to the panel from its local child fatality review teams (KRS 211.686(1)). Names, dates of birth, and dates of death are emailed to the panel by nurses from DPH's Division of Maternal and Child Health who support the local teams.[13] Upon receipt, panel staff send the list of DPH referrals to DCBS to request available case information. According to DCBS officials, frontline staff from DCBS regional offices participate on the local teams and provide information as needed.[14]

If DCBS is not involved with the case, panel staff send a formal request for information to local entities requesting medical, education, law enforcement, and other records. Once it is provided, panel staff will upload the information or records into the appropriate data field folder in SharePoint. DCBS may choose to investigate the matter as well, if it is not familiar with the circumstances surrounding a child's death.[15]

According to panel staff, DPH cases comprise 10 percent or less of the cases referred to the panel.[16]

Panel Review

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

For cases that the panel reviews, KRS 620.055(6) requires CHFS to provide the panel, within 30 days, numerous types of information and records in unredacted form. Requests may include items not in CHFS custody.

The panel uses information and records provided by CHFS to make its case determinations, as well as to support findings and recommendations for system and process improvement. The following excerpt of KRS 620.055(6) provides additional details:

(a) Cabinet for Health and Family Services records and documentation regarding the deceased or injured child and his or her caregivers, residents of the home, and persons supervising the child at the time of the incident that include all records and documentation set out in this paragraph:
   1. All prior and ongoing investigations, services, or contacts;
   2. Any and all records of services to the family provided by agencies or individuals contracted by the Cabinet for Health and Family Services; and
   3. All documentation of actions taken as a result of child fatality internal reviews conducted pursuant to KRS 620.050(12)(b);
(b) Licensing reports from the Cabinet for Health and Family Services, Office of Inspector General, if an incident occurred in a licensed facility;
(c) All available records regarding protective services provided out of state;
(d) All records of services provided by the Department for Juvenile Justice regarding the deceased or injured child and his or her caregivers, residents of the home, and persons involved with the child at the time of the incident;
(e) Autopsy reports;
(f) Emergency medical service, fire department, law enforcement, coroner, and other first responder reports, including but not limited to photos and interviews with family members and witnesses;
(g) Medical records regarding the deceased or injured child, including but not limited to all records and documentation set out in this paragraph:
   1. Primary care records, including progress notes; developmental milestones; growth charts that include head circumference; all laboratory and X-ray requests and results; and birth record that includes record of delivery type, complications, and initial physical exam of baby;
   2. In-home provider care notes about observations of the family, bonding, others in home, and concerns;
   3. Hospitalization and emergency department records;
   4. Dental records;
   5. Specialist records; and
   6. All photographs of injuries of the child that are available;
(h) Educational records of the deceased or injured child, or other children residing in the home where the incident occurred,

including but not limited to the records and documents set out in this paragraph:

1. Attendance records;
2. Special education services;
3. School-based health records; and
4. Documentation of any interaction and services provided to the children and family.

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

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

(j) Records of any Family, Circuit, or District Court involvement with the deceased or injured child and his or her caregivers, residents of the home and persons involved with the child at the time of the incident that include but are not limited to the juvenile and family court records and orders set out in this paragraph, pursuant to KRS Chapters 199, 403, 405, 406, and 600 to 645:

1. Petitions;
2. Court reports by the Department for Community Based Services, guardian ad litem, court-appointed special advocate, and the Citizen Foster Care Review Board;
3. All orders of the court, including temporary, dispositional, or adjudicatory; and
4. Documentation of annual or any other review by the court;

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

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

(m) All law enforcement records and documentation regarding the deceased or injured child and his or her caregivers, residents of the home, and persons involved with the child at the time of the incident; and

(n) Mental health records regarding the deceased or injured child and his or her caregivers, residents of the home, and persons involved with the child at the time of the incident.

SharePoint

Panel staff use SharePoint to upload information and records from CHFS to a secure online location.

Panel staff use SharePoint to upload information and records from CHFS to a secure online location. More specifically, staff copy information and records identified in Table 2.5 into separate folders for panel members to use when reviewing cases.

The case file is divided and scanned in sections in chronological order:

- Fatality and near fatality investigation (DPP-115, Investigative Assessment, Notification of Findings, Administrative Office of the Courts records, and Prevention Plans)
- Prior investigations
- Court records
- Medical records
- EMS records
- Autopsy records
- Law enforcement records
- Case plans and evaluations
- Service recordings
- Any other pertinent professional documents[17]

Panel members can also access case information through SharePoint outside of regularly scheduled meetings. After an annual report is published, hard and electronic copies of case information and records are destroyed. However, associated case review notes are maintained in SharePoint indefinitely.[18]

According to DCBS officials, regional offices provide agency records to the system safety review team for submission to the panel within 30 days of the fatality/near fatality investigative assessment approval. More specifically, the system safety review team is responsible for providing all records to the panel.[19]

Data Tool

The panel also uses a data tool, which includes 22 screens, 19 of which are populated by panel staff prior to and after each board meeting.

The panel uses a data tool in conjunction with SharePoint to record certain details about each case. The data tool includes 22 screens, 19 of which are populated by panel staff prior to and after each board meeting.

- Screens 1-2 are completed by DCBS staff or panel staff in order to create a case in SharePoint.
- Screens 3-18 are completed by the case analysts prior to their presentation to the panel.
- Screens 19-22 are completed by panel staff after the panel has discussed the cases and made their final determinations.

Table 2.5 provides additional details.

Table 2.5
Data Tool Screens

Number	Screen	Detail
1	Case information	Case year, case designation, case type, number, associated cases, and event synopsis
2	Child information	Name, date of birth, gender, sibling information, date of injury or death, race, ethnicity, county of residence, and county of injury
3	Prior history with Department for Community Based Services (DCBS)	Prior DCBS history and details, number of DCBS investigations prior to date of injury, parent DCBS history and details, and number of prior removals of index child and/or siblings
4	Case review	Suspected perpetrator, caregiver at time of event, involved agencies and child risk factors
5	Family/household information	Family/household risk factors
6	Health care providers	Date of last medical provider visit, involvement of medical provider in fatal or near fatal event, health care issues prior to event, and comments
7	Birth hospitals	Birth records not received, child information, treatment information, education provided, primary care physician, appointment for the baby, family risk factors identified and addressed, and whether verbally addressed
8	Education/child care	Site of care during child care, child care issues, and comments
9	Law enforcement/military children in care (CIC)	Law enforcement issues before or including fatal or near fatal event, impairment, testing, and comments
10	Coroner	Autopsy authorized, Sudden Unexpected Infant Death form completed, not applicable due to being a nonfatality, DCBS notification, law enforcement notification, public health notification, and performance of scene investigation
11	DCBS	DCBS investigation dates
12	Neighbor/bystander/family issues	Reported concerns and comments
13	Substance abuse by caregivers	Caregiver substance abuse information
14	Substance abuse by child	Child substance abuse information
15	Mental health of caregiver	Caregiver cognitive issue information
16	Mental health of child	Child mental health information
17	Court system	Court information, arrest information and details related to various charges
18	Overall case positives	Analyst requested to document positive features of the case
19	Family characteristics	Risk associated with the family such as substance abuse, unsafe sleep, unsafe access to deadly means, etc.
20	Categorization	Various case categories such as head trauma, blunt force trauma, etc.
21	Other qualifiers	Other information related to the case related to accidents, foul play, and prevention
22	Panel determination	Various categories of neglect and abuse an open response for missed opportunities

Source: Child Fatality and Near Fatality External Review Panel data tool.

Annual Reports

Since 2013, the panel has met its statutory requirements to submit annual reports consisting of case reviews, findings, and

recommendations for system and process improvements. The reports include contextual information, state and federal statistics, and summaries and determinations of cases reviewed.

Since 2017, the reports include a table that summarizes case information based on four data fields from the data instrument:

- Categorization
- Family characteristics
- Other qualifiers
- Panel determination

However, it is unclear from the reports how the panel uses these data fields to reach findings that are supported by data and used to develop recommendations that are targeted and actionable.

The panel's 2020 annual report summarizes cases reviewed from the previous state fiscal year (July 1, 2018 through June 30, 2019). It summarized information related to 182 cases, which included 85 fatalities and 97 near fatalities. A total of 33 fatality cases were referred to the panel from the Department for Public Health.[20] Table 2.6 provides additional information.

Table 2.6
Panel Reports
State Fiscal Years 2013 To 2020

	State Fiscal Year							
Action	**2013**	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**
Fatalities reviewed	0	43	31	47	59	51	54	85
Near fatalities reviewed	0	73	47	95	91	83	82	97
Findings	18	12	10	21	11	18	32	6
Recommendations	0	12	10	21	11	18	32	6

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

National Guidance And Other States

Legislative Oversight staff reviewed web-based information from the National Center for Fatality Review and Prevention (NCFRP). More specifically, staff identified downloadable forms related to the National Fatality Review Case Reporting System, which is used by 47 states that have a signed user agreement and upload their child fatality data to the system.[21] The downloadable information included case reporting forms and a data dictionary for system users.[22]

Staff also identified guidance related to how child death review teams should construct their report findings in a case-specific

manner using risk factors.[23] The NCFRP website includes a myriad of additional information such as webinars, written products, and training modules.

Staff reviewed seven states, which were identified in a United States Government Accountability Office report as defining a child near fatality in state law, statute, or policy.[24] The states that legislative staff contacted for additional information are Arkansas, Delaware, Indiana, Minnesota, New Jersey, North Dakota, and Oklahoma.

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[2] Ibid., p. 3.
[3] Kentucky. Office of State Budget Director. *2018-2020 Kentucky Branch Budget, Baseline Budget Request: Program Narrative/Documentation Record*. 2018, p. 44.
[4] Kentucky. Justice and Public Safety Cabinet. *Memorandum Of Understanding Between The Justice And Public Safety Cabinet And The Child Fatality And Near Fatality Review Panel*. May 23, 2014, pp. 3-4.
[5] Kentucky. Office of State Budget Director. *2014-2016 Budget Of The Commonwealth*. 2014, p. 214.
[6] Kentucky. Justice and Public Safety Cabinet. *Memorandum Of Understanding Between The Justice And Public Safety Cabinet And The Child Fatality And Near Fatality Review Panel*. May 23, 2014, pp. 3-4.
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[8] Kentucky. Cabinet for Health and Family Services. Department for Community Based Services. "2.3 Acceptance Criteria And Reports That Do Not Meet." *Standards Of Practice Online Manual*. January 14, 2020. Web.
[9] Kentucky. Cabinet for Health and Family Services. Department for Community Based Services. "2.14 Investigations Of Child Fatalities And Near Fatalities." *Standards Of Practice Online Manual.* June 29, 2020. Web.
[10] Ibid.
[11] Kentucky. Cabinet for Health and Family Services. Department for Community Based Services. "2.3 Acceptance Criteria and Reports That Do Not Meet." *Standards Of Practice Online Manual.* January 14, 2020. Web.
[12] Elisha Mahoney, executive staff adviser, Child Fatality and Near Fatality External Review Panel, March 29, 2021. Interview.
[13] Elisha Mahoney, executive staff adviser, Child Fatality and Near Fatality External Review Panel. December 8, 2020. Interview.
[14] Sarah Cooper, staff assistant, Cabinet for Health and Family Services. Office of the Secretary. Email to Gerald Hoppmann, February 19, 2021.
[15] Elisha Mahoney, executive staff adviser, Child Fatality and Near Fatality External Review Panel. January 13, 2021. Interview.
[16] Ibid.
[17] Ibid.
[18] Elisha Mahoney, executive staff adviser, Child Fatality and Near Fatality External Review Panel. August 25, 2021. Interview.

[19] Kentucky. Cabinet for Health and Family Services. Department for Community Based Services. "2.14 Investigations Of Child Fatalities And Near Fatalities." *Standards Of Practice Online Manual.* June 29, 2020. Web.
[20] Kentucky. Justice and Public Safety Cabinet. Child Fatality and Near External Review Panel. *2020 Annual Report*. 2020, pp. 35-42.
[21]Abby Collier, director, National Center for Fatality Review and Prevention. July 13, 2021. Interview.
[22] National Center for Fatality Review and Prevention. *CDR Report Form: National Fatality Review Case Reporting System, Version 5.1*. April 2020; National Center for Fatality Review and Prevention. *Data Dictionary: National Fatality Review Case Reporting System, Version 5.1.* September 7, 2021. Web.
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[24] US. Government Accountability Office. *Child Maltreatment, Strengthening National Data On Child Fatalities Could Aid In Prevention*. July 2011, p. 33.

Chapter 3

Findings And Recommendations

This review produced three major finding areas and seven recommendations.

This evaluation of the Kentucky Child Fatality and Near Fatality External Review Panel produced three major finding areas and seven recommendations.

Panel's Annual Reports Could Be More Effective

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

However, staff analysis of reports found that the panel's findings were often not supported by the analyses they performed and that the information needed to link their findings to data was not discussed in each report. Also, staff found that the panel's recommendations were not empirically linked to its findings. As a result, the reports are not as effective as possible, especially with respect to developing actionable and targeted recommendations.

Panel Uses Data To Fulfill Its Statutory Responsibilities

KRS 620.055(6) grants the panel broad authority to request information and records related to case reviews.

KRS 620.055(6) grants the panel broad authority to request information and records related to case reviews. This authority presumes that the panel will base its determinations, findings, and recommendations on an analysis of those data.

The panel recognized this in its 2013 annual report, where it stressed the importance of thorough case review and data analysis as prerequisites for "informed and effective recommendations for change." Further, the report stated that "diligent data collection, systematic analysis … will more likely lead to supportable recommendations that can be implemented by state and other agencies."[l] During a January 9, 2014, meeting of the House Health and Welfare Committee Panel, representatives also spoke about the importance of data and the need to place it into a standardized format.

The panel's 2014 annual report further discusses concrete and proactive steps it took to build on general observations in the first report. The panel received appropriations in the amount of $420,000 for FY 2014 and FY 2015 to "identify personnel priorities and plan for organized data collection."[2] The initial funding was consistent with a previous recommendation from the director of the National Center for Fatality Review and Prevention, who stressed the importance of "hiring dedicated staff to conduct data analysis and prepare case summaries, tying panel recommendations to specific cases, and creating a standard template of information for all cases."[3]

In its *Findings Guidance, National Center Guidance Report*, NCFRP stresses the importance of developing findings that are case-specific and based on risk factors, in order to support SMART recommendations.

- **S**pecific: Answers to "who, what, where, when, which, and why" as described.
- **M**easurable: A tangible plan for measuring impact is determined.
- **A**chievable: Decide how important this activity is to your end goal and if it is possible.
- **R**ealistic: Can this work be done with the resource available?
- **T**ime Sensitive: Identify a timeline and a due date.[4]

The panel's 2014 report stressed the importance of work completed by a subcommittee tasked with developing a data collection tool.

The panel's 2014 annual report noted the importance of work completed by a subcommittee tasked with developing a data collection tool that "could be applied to all cases reviewed by the Panel." The data tool, which evolved from a "summary sheet" to record demographic data for each case, was enhanced to work in conjunction with SharePoint. The enhancement allowed panel members access to uploaded case information and records, and it provided them the ability to capture data collected from case reviews for additional analysis when preparing their findings and recommendations.[5]

In its 2020 annual report, the panel pledged to focus on the developing strategic plans around "specific recommendations to better harness the commitment, skills, and partnerships of individual Panel members to move recommendations toward reality."[6]

Initial Framework Created

By using SharePoint to upload case information and records for the panel to review in conjunction with its data tool to store and analyze various risk factors, it has developed an initial framework from which to make its case determinations. For example, the panel may make its final determination with the benefit of information about risk factors related to the child, family, and caregivers gleaned from DCBS records, law enforcement reports, and the category and nature of injuries.

The framework may need improvement to better facilitate the development of data-supported findings and actionable recommendations.

However, the framework may need improvement to better facilitate the development of data-supported findings and actionable recommendations for system and process improvements.

Review Of Panel's Annual Reports

Legislative Oversight staff reviewed and analyzed 110 findings and 110 recommendations from the panel's 2014-2020 annual reports. Overall, staff found that 54 findings (49 percent) were based on some type of data analysis discussed in the report.

However, 16 findings (15 percent) did not appear to be based on data presented in the report. Staff also identified 40 findings (36 percent) where it was not clear from the report whether some type of data analysis was used. For example, there were multiple instances where the panel stated that it reviewed several cases with specific issues, but it did not provide additional analysis on these cases. Table 3.1 provides additional details.

Table 3.1
Supported Panel Findings
2014 To 2020

Report Year	Yes	No	Unsure	Findings
2020	3	0	3	6
2019	27	3	2	32
2018	13	0	5	18
2017	2	4	5	11
2016	4	6	11	21
2015	1	1	8	10
2014	4	2	6	12
Total	54	16	40	110
%	49	15	36	N/A

Source: Staff analysis of Child Fatality and Near Fatality External Review Panel annual reports, 2014 to 2020.

Overall, there were inconsistent links between the panel's recommendations and its findings. According to staff analysis, 27 recommendations (25 percent) addressed critical areas discussed in the findings. However, 79 recommendations (72 percent) were not explicitly linked to deficiencies that the panel identified in its findings. Report language was not clear whether the remaining 4 recommendations (4 percent) addressed a finding concern. Table 3.2 provides additional details.

Table 3.2
Panel's Recommendations Addressed Findings
2014 To 2020

Report Year	Did Recommendations Address Findings?			Number Of Recs.
	Yes	No	Unsure	
2020	0	6	0	6
2019	16	14	2	32
2018	3	15	0	18
2017	0	11	0	11
2016	1	19	1	21
2015	3	7	0	10
2014	4	7	1	12
Total	27	79	4	110
%	25	72	4	N/A

Note: Recs. = recommendations.
Source: Staff analysis of Child Fatality and Near Fatality External Review Panel annual reports, 2014 to 2020.

The result of not consistently basing findings on data, as well as ensuring recommendations specifically address findings, presents a challenge to development of targeted and actionable recommendations.

Not consistently basing findings on data, or ensuring that recommendations specifically address deficiencies identified in findings, presents a challenge to development of targeted and actionable recommendations. For example, staff identified only 40 recommendations (36 percent) that identified either an agency, the legislature, or a specific legislative committee to take some type of action. For the purposes of the analysis, staff identified these recommendations as actionable, even though the recommendations were often very broad.

Staff also identified 70 recommendations (64 percent) where no specific entity was identified. Rather, terms such as "law enforcement agencies," "regulatory authorities," "biennial budget," "medical providers," "the Commonwealth," and "birthing hospitals" were used. Some recommendations simply stated that general goals, such as enhanced funding, should occur. Table 3.3 provides additional information.

Table 3.3
Panel's Recommendations Are Targeted And Actionable
2014 To 2020

Annual Report Year	Recommendations Are Targeted And Actionable		Number Of Recs.
	Yes	No	
2020	4	2	6
2019	18	14	32
2018	1	17	18
2017	0	11	11
2016	7	14	21
2015	5	5	10
2014	5	7	12
Total	40	70	110
%	36	64	N/A

Note: Recs. = recommendations.
Source: Staff analysis of Child Fatality and Near Fatality External Review Panel annual reports.

Panel Challenges

Inconsistencies related to findings and recommendations could partly be due to the evolution of the panel's data tool and underdeveloped data tracking analysis.

The inconsistencies related to findings and recommendations discussed above could partly be due to the evolution of the panel's data tool and underdeveloped data tracking and analysis. This could be a result of not differentiating between methods of data analysis for each of the panel's statutory responsibilities. As a result, recommendations not linked to findings based on specific data and analysis cannot be consistently implemented.

The panel has also struggled with waiting until the end of each year to finalize recommendations, according to panel staff. More specifically, members have struggled with trying to prioritize and structure recommendations to make them easier to track. Panel staff and members are also pressed for time to review case information, as well as to finalize annual reports.[7]

Panel members have discussed the possibility of using a subcommittee structure to address how best to analyze data in order to draft actionable recommendations.

Panel staff recently discussed using existing criteria such as the number of missed opportunities to triage cases, but the panel would have to formally decide to adopt this or other criteria to prioritize its recommendations. Panel members have also discussed the possibility of using a subcommittee structure throughout the year to address how best to analyze data in order to draft more actionable recommendations.[8]

Recommendation 3.1

Recommendation 3.1

The Child Fatality and Near Fatality External Review Panel should reevaluate how it uses SharePoint and its data tool to collect and analyze case data that are used to make case determinations, findings, and recommendations for system and process improvements. It should also consider contacting the National Center for Fatality Review and Prevention to discuss how best to develop recommendations related to its review of child fatalities and near fatalities where abuse or neglected is suspected.

Data Dictionary Is Absent, And Data Tool Could Be Improved

The panel does not have a data dictionary to clearly define the variables it collects from case files.

The panel does not have a data dictionary that clearly defines the variables it collects from case files. Even though the panel amends its data tool periodically to capture additional data, it has not formally evaluated the data tool since 2014. Because the data tool is the primary means by which the panel collects and analyzes data, it is important to continually review its overall effectiveness. Collecting and analyzing case data is essential for the panel not only to make its case determinations, but also to develop findings and actionable recommendations for system and process improvements.

The panel showed considerable foresight in 2013 and 2014 when it recognized the importance of sound data analysis.

The panel showed considerable foresight in 2013 and 2014 when it recognized the importance of sound data analysis to make informed and effective recommendations for change. Panel members and staff also realized the importance of capturing consistent data to ensure that recommendations are implemented by state and other agencies. It appears the panel is amenable to continually improving the data tool. According to panel staff, since the data tool includes 5 years of information, now may be a good time to review the data tool to determine what can be done differently.[9]

Data Dictionary Purpose

The purpose of a data dictionary is to provide guidance when collecting and using data for various purposes. More specifically, it is essential to determine what the data means, how those data can be used, and each variable's relationship with other data. Data dictionaries also describe the purpose of certain data elements within programmatic areas. This type of guidance is also useful

because it helps avoid inconsistencies in the collection and use of data.

One essential component of an effective data tool is a data dictionary that defines each variable being captured, for example, from child fatality case records. Each definition should include an agreed-upon description of the variables and provide guidance on the interpretation and accepted meaning of each variable. Taking the time to create a well-conceived data dictionary can greatly decrease the risk of inconsistencies in the collection of case data.

There are multiple uses for data dictionaries, depending on the purpose and use of collected data. For the panel's purposes, a data dictionary can serve to provide structure and details for panel staff, panel members, and other stakeholders such as the Department for Community Based Services and the Department for Public Health.

Groups can benefit from a common vocabulary and definitions of certain data that can be used for various purposes such as case determinations and developing findings and recommendations.

These groups can benefit from a common vocabulary and definitions of certain data that can be used for various purposes such as case determinations and developing findings and recommendations for system and process improvements. In other words, the data dictionary ensures that the meaning, relevance, and quality of data elements are identical for these purposes. Lastly, a data dictionary can serve as the basis for revealing potential problems with data such as poor table organization, object naming, and use of narrative, which can limit the use of collected data for stated purposes.[10]

Panel's Data Tool

The panel's data tool seeks to capture information selected by the panel after each case review.

The panel's data tool seeks to capture information selected by the panel after each case review in the areas of family characteristics, injury categories, other variables, and final determinations. Without a data dictionary, it may be difficult for members to identify what factors to consistently consider prior to making their final decisions and how to use this information at the end of the year.

The reason that the panel has not formally reevaluated its data tool, including the creation of a data dictionary, is most likely related to lack of resources needed to continually review its data collection efforts. As discussed previously, the panel noted in 2013 and 2014 the need for dependable data to carry out its statutory functions. Although it envisioned additional staff, including a dedicated data analyst, funding for the panel has not been consistent since its initial appropriation of $420,000 during the first 2 years of its

existence. Panel staff stated that the panel is considering using a subcommittee structure to review data collection efforts and how it develops findings and recommendations.[11]

The panel's data tool is not supported by a data dictionary; however, it includes 22 categories, 98 questions, and an additional 242 data points.

Although the panel's data tool is not supported by a data dictionary, it includes 22 categories, 98 questions, and an additional 242 data points. Table 3.4 provides additional details.

Table 3.4
Data Tool Screens

Category	Description	Questions	Data Points
Case information	Case year, case designation, case type, number, associated cases, and event, synopsis	6	N/A
Child information	Name, date of birth, gender, sibling information, date of injury or death, race, ethnicity, county of residence, and county of injury	14	8
Prior history with Department for Community Based Services (DCBS)	Prior DCBS history and details, number of DCBS investigations prior to date of injury, parent DCBS history and details, and number of prior removals of index child and/or siblings	3	3
Case review	Suspected perpetrator, caregiver at time of event, involved agencies and child risk factors	4	32
Family/household information	Family/household risk factors	1	10
Healthcare providers	Date of last medical provider visit, involvement of medical provider in fatal or near fatal event, health care issues prior to event, and comments	4	11
Birth hospitals	Birth records not received, child information, treatment information, education provided, primary care physician, appointment for the baby, family risk factors identified and addressed, and whether verbally addressed	13	10
Education/child care	Site of care during child care, child care issues, and comments	3	16
Law enforcement/military children in care (CIC)	Law enforcement issues before or including fatal or near fatal event, impairment, testing, and comments	4	12
Coroner	Autopsy authorized, Sudden Unexplained Infant Death form completed, not applicable due to being a nonfatality, DCBS notification, law enforcement notification, public health notification, and performance of scene investigation	2	7
DCBS	DCBS investigation dates	7	7
Neighbor/bystander/family issues	Reported concerns and comments	3	2
Substance abuse by caregivers	Caregiver substance abuse information	3	6
Substance abuse by child	Child substance abuse information	3	4
Mental health of caregiver	Caregiver cognitive issue information	3	6
Mental health of child	Child mental health information	3	5
Court system	Court information, arrest information and details related to various charges	9	13
Overall case positives	Analyst requested to document positive features of the case	1	0

Category	Description	Questions	Data Points
Family characteristics	Risk associated with the family such as substance abuse, unsafe sleep, unsafe access to deadly means, etc.	1	51
Categorization	Various case categories such as head trauma, blunt force trauma, etc.	1	23
Other qualifiers	Other information related to the case related to accidents, foul play, and prevention	1	3
Panel determination	Various categories of neglect and abuse, and open response for missed opportunities	9	13
Total		98	242

Note: N/A = not applicable.
Source: Child Fatality and Near Fatality External Review Panel data tool.

National Center For Fatality Review And Prevention's Data Tool

The Center for Fatality and Prevention provides a good example of a complete and effective data dictionary.

In contrast, the National Center for Fatality Review and Prevention provides a web-based standardized case reporting system to states' review panels that can collect up to 17 data categories, 36 questions, and 606 primary data point for each case. This system is supported by a 135-page data dictionary that clearly defines each variable the system collects. For example, the definition for the question "Did child have supervision at time of incident leading to death?" considers multiple factors such as age, proximity of adults, and whether supervisors were asleep.[12]

Forty-seven states currently have a signed user agreement and upload their child fatality data to the National Center for Fatality Review and Prevention's system.

Forty-seven states currently have a signed user agreement and upload their child fatality data to NCFRP's system.[13] The types of child fatality cases reviewed and the data states entered into the system vary, ranging from states that are required to review all child deaths to those that enter only a statutorily specified subset of child fatality cases. According to NCFRP officials, while their data reporting system is designed to collect case information on all child fatalities and near fatalities, it can easily support and be just as useful for state panels that only look at DNA cases, such as Kentucky's external panel.[14] See Table 3.5 for additional details.

Table 3.5
National Center For Fatality Review And Prevention Data Dictionary Section Information

Category	Description	Questions	*Primary Data Points
Case number	Child information; complete for children over 1 year old; complete for all infants under 1 year; expanded infant/maternal questions; maternal interview	1	11
Child information	Child information for all ages	5	143
Biological parent information	Complete information for both biological parents	1	18

Category	Description	Questions	*Primary Data Points
Primary caregiver(s) information		1	19
Supervisor information		1	16
Incident information		1	13
Investigation information		1	16
Official manner and primary cause of death		1	6
Detailed information by cause of death	Motor vehicle and other transport; fire, burn, or electrocution; drowning; unintentional asphyxia; assault weapon, or person's body part; fall or crush; poisoning, overdose, or acute intoxication; medical condition; and other known injury cause	9	108
Other circumstances of incident	Sudden and unexpected death in the young; death related to sleeping or the sleeping environment; was death a consequence of a problem with a consumer product; did death occur during commission of another crime; child abuse, neglect, poor supervision, and exposure to hazards; suicide; life stressors; COVID-19 related deaths	8	184
Person responsible		1	20
Services to family and community as a result of the death		1	1
Findings identified during the review		1	5
Review meeting process		1	7
SUID and SDY case registry		1	11
Narrative	Issues summary: pre-, inter-, and post-conception care; medical: mother; family planning; substance use; prenatal care/delivery; medical: fetal/infant; pediatric care; environment; injuries; social support; partner/father of birth/caregivers; family transition; rental health/stress; family violence/neglect; culture; payment for care; service provided; transportation; documentation; other	1	20
Form completed by		1	8
Total		36	606

Note: SUID = sudden unexplained infant death; SDY = sudden death in the young.
*In addition to the 36 general data fields and 606 primary data points, the NCFRP data system includes hundreds of secondary and tertiary data points.
Source: Staff analysis of National Center for Fatality Review and Prevention, *Data Dictionary, National Fatality Review Case Reporting System, Version 5.0*.

Data Tool Comparison

The NCFRP data tool is used to collect consistent and comparable data with respect to child fatality cases. As seen in Tables 3.4 and 3.5, the NCFRP data tool is much more rigorous in the amount and

type of data it collects. Although Legislative Oversight staff did not complete an exhaustive comparison of the two, a general observation about the use of narratives to document case information and one comparative example about DCBS involvement may be helpful to illustrate how the NCFRP data tool is used to collect usable data.

Narrative boxes are used over 15 times throughout the panel's data tool.

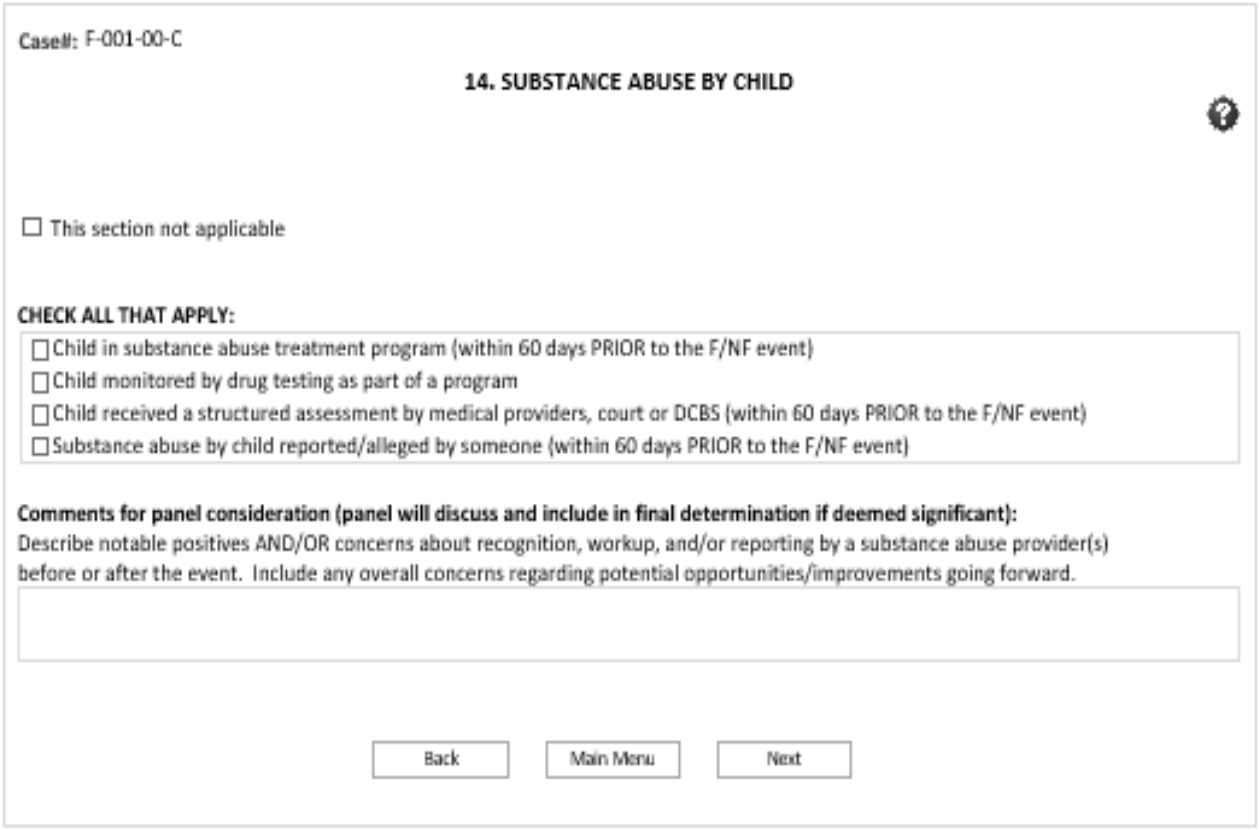
Narrative boxes are used over 15 times throughout the panel's data tool. While a well-designed data collection tool allows an analyst to code the case particulars (regardless of the data's original source or format), instances inevitably arise where the coding system does not capture a particular characteristic. It is circumstances such as this where providing the analyst the option of documenting such an anomaly in narrative form can be useful.

For example, after asking several questions about what procedures were performed during an autopsy, the NCFRP data tool provides a narrative space labeled "Describe any abnormalities or other significant findings noted in the autopsy."[15] Another example from the national tool where a narrative space is appropriate is where it asks, "Enter the following information exactly as written on the death certificate … immediate cause of death."[16]

However, the panel's data tool generally relies on narrative boxes to provide additional comments for the panel's consideration—more specifically, to describe the positives and/or concerns about recognition, workup, and/or reporting by various agencies.

Although this information can be useful to the panel, it may prove challenging to capture consistent information for each case to use at the end of the year when comparing across all cases. See Figure 3.A for such an example.

Figure 3.A
Panel Data Tool For Substance Abuse By Child


Case#: F-001-00-C

14. SUBSTANCE ABUSE BY CHILD

☐ This section not applicable

CHECK ALL THAT APPLY:

- ☐ Child in substance abuse treatment program (within 60 days PRIOR to the F/NF event)
- ☐ Child monitored by drug testing as part of a program
- ☐ Child received a structured assessment by medical providers, court or DCBS (within 60 days PRIOR to the F/NF event)
- ☐ Substance abuse by child reported/alleged by someone (within 60 days PRIOR to the F/NF event)

Comments for panel consideration (panel will discuss and include in final determination if deemed significant):
Describe notable positives AND/OR concerns about recognition, workup, and/or reporting by a substance abuse provider(s) before or after the event. Include any overall concerns regarding potential opportunities/improvements going forward.

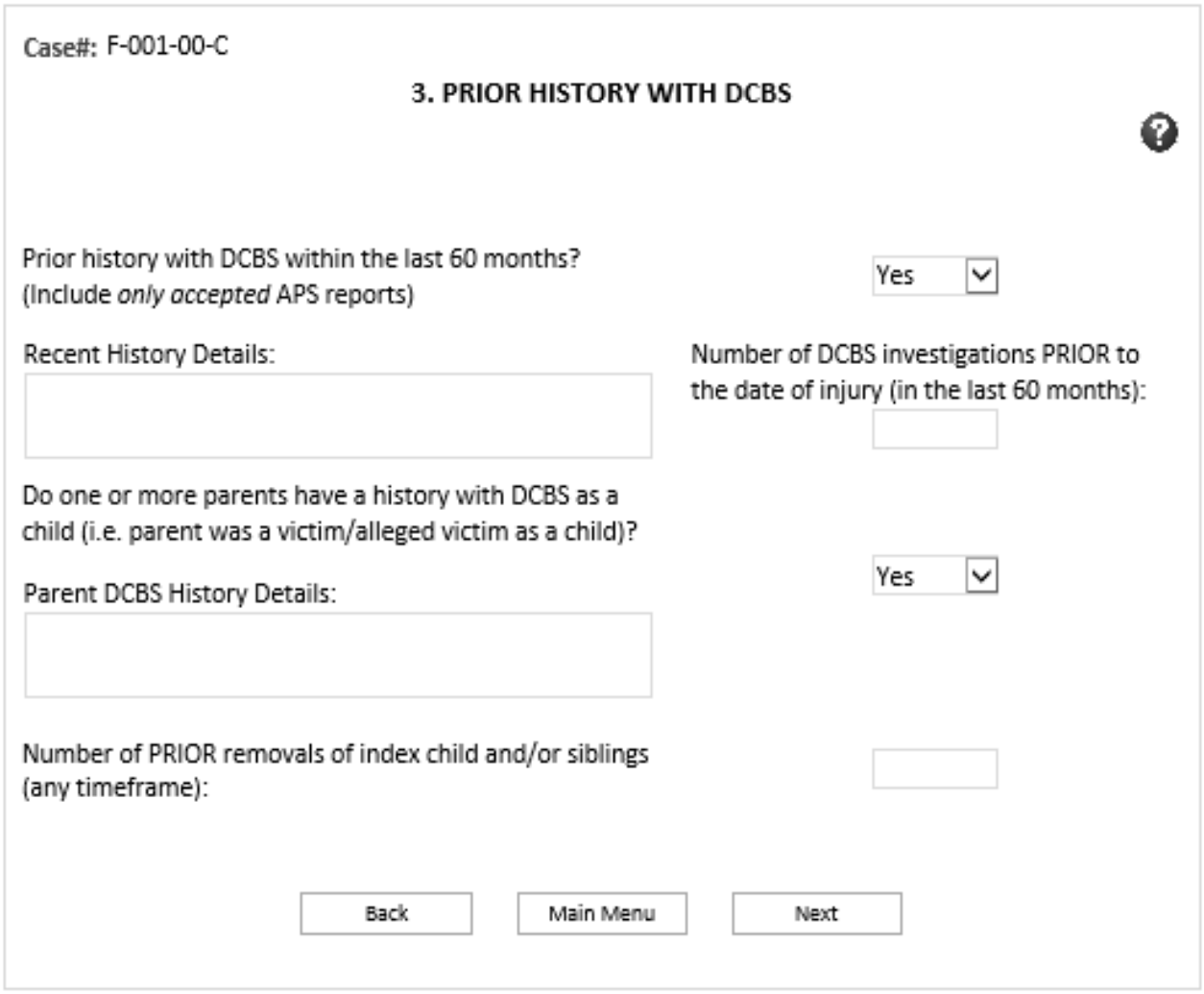
Back | Main Menu | Next

Source: Child Fatality and Near Fatality External Review Panel data tool, 14. Substance Abuse by Child.

In one instance, the panel's data tool seeks to document prior history with DCBS.

Also, in one instance, the panel's data tool seeks to document prior history with DCBS. It is important to collect and analyze any information recorded about a child or the child's family where there is a reasonable chance that DCBS documented an incident, initiated an action, or helped facilitate an action or service. However, most information is collected in narrative format, which may not allow an analyst to document the facts of each case in a consistent manner. See Figure 3.B for additional information.

Figure 3.B
Panel Data Tool For Prior History With Department For Community Based Services



Source: Kentucky Child Fatality and Near Fatality External Review Panel, data tool, 3. Prior History with DCBS.

The NCFRP data tool provides a suitable example of how the panel could code additional detail about DCBS interaction with a child or family.

In contrast, the NCFRP data tool provides a suitable example of how the panel could code additional detail about a child or family's interaction with DCBS in a manner that would allow the panel to compare such factors between all cases at the end of each year:[17]

Data Category A1: Child Information

- Tier 1 Question: Were any siblings placed outside of the home prior to this child's death? (A1.14)
  - Tier 2 Question: Number of times placed outside home? (A1.14.1)
- Tier 1 Question: Child had history of child maltreatment? (A1.22)

    - Tier 2 Questions: If yes, check all that apply as both victim and perpetrator (A1.22.*x*)
        - Physical
        - Neglect
        - Sexual
        - Emotional/psychological
        - # CPS referrals and # substantiations
        - # CPS referrals and # substantiations
        - How was history identified? (CPS or Other)
- Tier 1 Question: Was there an open CPS case with child at time of death? (A1.23)
- Tier 1 Question: Was child ever placed outside of the home prior to the death? (A1.24)

Data Category A2: Complete for children over one year old

- Tier 1 Question: Child had history of intimate partner violence? (A2.29)
    - Tier 2 Questions: If yes, ….(A2.29.*x*)
        1. As victim
        2. As perpetrator
- Tier 1 Question: Child had received prior mental health services? (A2.30)
- Tier 1 Question: Child was receiving mental health services? (A2.31)
- Tier 1 Question: Child on medication for mental health illness? (A2. 32)
- Tier 1 Question: Child had history of substance use or abuse? (A2.36)
    - Tier 2 Questions: If yes, ….(A2.36.*x*)
        1. Alcohol
        2. Cocaine
        3. Marijuana
        4. Methamphetamine
        5. Opioids
        6. Prescription drug
        7. Over-the-counter
        8. Other (specify)

Reviewing the NCFRP data dictionary to understand how it collects and uses data could assist the panel as it continues to operationalize the use of its data when making recommendations for system and process improvements.

Recommendation 3.2

Recommendation 3.2

The Child Fatality and Near Fatality External Review Panel should formally review its data tool to ensure that it is capturing relevant data needed to make case determinations and to develop findings and actionable recommendations.

Recommendation 3.3

Recommendation 3.3

The Child Fatality and Near Fatality External Review Panel should consider creating a data dictionary.

Recommendation 3.4

Recommendation 3.4

The Child Fatality and Near Fatality External Review Panel should consider requesting assistance from the National Center for Fatality Review and Prevention to understand how it designed its data tool and data dictionary. The center may also be able to assist with ideas about different types of data for the panel to capture related to the review of near fatality cases where abuse or neglect is suspected.

Panel Lacks Budget Autonomy

The panel is not formally included as part of the cabinet's biennial budget process.

The panel was originally attached to the Justice and Public Safety Cabinet as an unfunded mandate. An initial annual appropriation of $420,000 was included in the 2014-2016 Budget of the Commonwealth.[18] Panel funding was included in the overall appropriation for Justice Administration, specifically the Office of the Secretary. In subsequent budget years, panel funding has been included as part of the Office of the Secretary's baseline funding.

The panel and the cabinet have not followed the budget procedures outlined in the May 2014 memorandum of understanding requiring that the panel provide its budget request to the cabinet in the fall prior to each budget session on a "date and [in a] format to be required by the cabinet." Outside of the MOU, neither party has developed formal policies or guidelines to ensure meaningful communication between the panel chair and the cabinet secretary related to the panel's budget requests and financial expenditures.[19] As a result, the panel's autonomy to effectively address staff and workload issues through the budget process is diminished.

Legislative Priority

The panel, through the cabinet, requested $420,000 annually during the 2014-2016 biennium. The subsequent appropriation is reflected in the Budget of the Commonwealth 2014-2016. Since then, however, the panel's budget became part of the baseline budget for Justice Administration, specifically the Office of the Secretary.

The panel and cabinet showed significant foresight by requesting initial appropriations for the panel to provide sufficient staff to handle anticipated workloads.

The panel and cabinet showed significant foresight by requesting initial appropriations for the panel to provide sufficient staff to handle anticipated workloads related to case reviews and development of findings and recommendations. However, according to eMARS, annual expenditures have never totaled $420,000. This is especially salient for 2015 and 2016, given the direct appropriation from the legislature. See Table 3.6 for additional information.

Table 3.6
Child Fatality and Near Fatality External Review Panel Expenditures
2015 to 2021

Year	Personnel Expenditures*	Operating Expenditures	Total
2015	$212,582.32	$6,946.05	$219,528.37
2016**	267,004.34	21,197.73	288,202.07
2017	213,258.51	56,288.95	269,547.46
2018	141,943.11	7,670.70	149,613.81
2019***	185,344.55	3,610.57	188,955.12
2020***	275,116.91	6,511.40	281,628.31
2021	245,260.94	2,205.67	247,466.61
Total	$1,540,510.6868	$104,431.07	$1,644,941.75

*Staffing for the panel generally consists of one executive staff adviser, one social service clinician II, and contracts for a forensic nurse analyst and/or pediatric medical analyst.
**$7,983.75 was expended for part-time data consultants from Kentucky State University and the University of Louisville.
***For 2019 and 2020, baseline budget cuts of 6.25 percent were applied to 500A-Justice Administration. This calculates to $26,250 each year.
Source: Staff analysis of eMARS, Expenditure Analysis Report-FAS.

The panel may be consistently spending less than the $420,000 originally appropriated by the legislature because it does not have the opportunity to formally participate in the cabinet's budget process to present budgetary needs. This also includes not having an opportunity to participate in the cabinet's decision-making process related to expending the panel's past appropriations or establishing its allotments. This may be especially challenging when its expenditures are carved out from a separate appropriation allotment such as the Office of the Secretary. For example, the 2016-2018 Operating Budget Report (A-4) for the Office of the

Secretary shows a $420,000 request for baseline funding, but subsequent A-4s for 2018-2020 and 2020-2022 do not include specific requests.[20]

No appropriation allotment was created for the panel.

Although the panel's personnel and operating expenditures are tracked through a separate function code (AAD0) in eMARS under the Office of the Secretary, an appropriation allotment was not created as for other similarly funded programs under 500A-Justice Administration:

- 500J-Access to Justice ($639,800 of expenditures for 2020)
- 500M-Motorcycle Safety Training ($465,776 of expenditures for 2020)

Expenditures for both programs are tracked through separate function codes under 500-Justice-Office of the Secretary, similar to what is done for the panel's expenditures. Creating a separate allotment unit for the panel would provide additional transparency related to the panel's budget requests.

Lack Of Funding Impacts Original Staffing Numbers

Inconsistent funding compared to the amounts envisioned by the legislature prevents the panel from reaching desired staffing levels.

Inconsistent funding compared to the amounts envisioned by the legislature prevents the panel from reaching desired staffing levels. According to the 2014-2016 Operating Budget Report (B-4), the cabinet requested $420,000 to pay salaries and benefits for full-time staff to provide administrative and legal support to the panel. More specifically, it requested five full-time positions:

- Administrative coordinator
- Internal policy analyst III
- Staff attorney III
- Paralegal consultant
- Administrative specialist III[21]

The initial funding is consistent with a previous recommendation from the director of the National Center for Fatality Review and Prevention who stressed the importance of "hiring dedicated staff to conduct data analysis and prepare case summaries, tying panel recommendations to specific cases, and creating a standard template of information for all cases."[22] The panel in its 2014 annual report also stressed the importance of this initial funding in order to "identify personnel priorities and plan for organized data collection."[23]

However, panel staff has fluctuated over the years, typically consisting of two full-time employees and contract analysts. Prior to 2017, the panel staff included one full-time staff attorney, one

part-time executive staff assistant, one contract social work analyst, and one contract medical analyst (for instance, the University of Louisville contract mentioned above). According to panel staff, a contract data analyst was also hired in 2016. As of the writing of this report, staffing consists of one executive staff adviser, one social service clinician II, and one recently contracted pediatric forensic medical case analyst.[24]

Past Concerns

Some concerns have existed about the panel's budget.

Some concerns have existed about the panel's budget. For example, the staff attorney for the panel in 2016 reported difficulty focusing on legislation and following up on recommendations, due to inadequate staffing. In a telephone interview with legislative staff, the panel chair at the time also expressed frustration with cabinet officials after being told that the panel did not have a budget and therefore could not present a formal request for staff.[25] This statement by the cabinet is inconsistent with wording in the 2014 MOU, which requires the panel to submit a budget request.

The past chair also stated that other panel members shared his concerns related to budget issues, including the requirement to consult with the cabinet for expenditures. After speaking with panel staff as part of this evaluation, however, we understand that panel staff currently review and approve invoices related to travel, catering, contracting, and conference attendance. Once the invoices are approved, they are forwarded to the cabinet for processing in eMARS.[26]

Panel staff and members have limited knowledge of how budgeting decisions are made at the cabinet on behalf of the panel, as well as its available funds.

Panel staff and members said they have limited knowledge of how budgeting decisions are made at the cabinet on behalf of the panel, as well as its available funds.[27] Prior to 2017, panel staff obtained financial sheets from the cabinet and were able to provide a financial report during each panel meeting. Since 2017, however, similar reports have not been provided by the cabinet for discussion at panel meetings.[28]

A cabinet official indicated that the cabinet wants to be a productive participant in future reviews by the legislature. Although this particular official could not specifically speak to how the budgetary structure was established in prior years, he suggested that he is more than willing to delve deeper to ensure there is adequate transparency in the panel's financial needs and related decisions. He added that for the most recent and current budget, the cabinet has essentially used an incremental approach to ensure that expenditures carry forward from previous years.[29] As

illustrated in Table 3.6, however, this has not been the case with past budgets. He also said that future budget and expenditure numbers discussed in the annual reports will reconcile with eMARS.[30]

Recommendation 3.5

Recommendation 3.5

The Child Fatality and Near Fatality External Review Panel and the Justice and Public Safety Cabinet should develop processes to ensure that the panel submits a formal budget request to the cabinet in the fall prior to the budget session, as envisioned by the 2014 MOU (section 4). Such a process should involve developing an appropriate format for the panel to use when preparing the budget and for the cabinet to use when submitting the budget to the Office of State Budget Director (OSBD). The process should include steps to ensure that the panel can formally present its personnel and operating requests to OSBD, as well as to the legislature.

Recommendation 3.6

Recommendation 3.6

The Child Fatality and Near Fatality External Review Panel and the Justice and Public Safety Cabinet should develop processes for meaningful communication between the panel chair and the cabinet secretary or the cabinet secretary's designee related to the panel's budgetary needs, as envisioned by the 2014 MOU (section 3). Such processes should include steps by which panel expenditures are approved and staffing requests are formally considered, as well as the presentation of financial reports or updates to the panel.

Recommendation 3.7

Recommendation 3.7

The Child Fatality and Near Fatality External Review Panel and the Justice and Public Safety Cabinet should discuss with the Office of State Budget Director the possibility of establishing a separate appropriation allotment as is done for other similarly funded programs under Justice Administration.

[1] Kentucky. Justice and Public Safety Cabinet. Child Fatality and Near Fatality External Review Panel. *2013 Annual Report.* 2013, pp. 2 and 7.
[2] Kentucky. Justice and Public Safety Cabinet. Child Fatality and Near Fatality External Review Panel. *2014 Annual Report.* 2014, p. 3.
[3] Ibid., p. 4.
[4] National Center for Fatality Review and Prevention. *Findings Guidance, National Center Guidance Report.* May 2020, p. 11.

[5] Kentucky. Justice and Public Safety Cabinet. Child Fatality and Near Fatality External Review Panel. *2014 Annual Report.* 2014, pp. 3 and 5.
[6] Kentucky. Justice and Public Safety Cabinet. Child Fatality and Near Fatality External Review Panel. *2020 Annual Report*. 2020, p. 10.
[7] Elisha Mahoney, executive staff adviser, Child Fatality and Near Fatality External Review Panel. November 5, 2020. Interview.
[8] Ibid.
[9] Joel Griffith, social service clinician II, Child Fatality and Near Fatality External Review Panel. December 3, 2020. Interview.
[10] US Geological Survey "Data Dictionaries And Metadata." August 30, 2021. Web.
[11] Elisha Mahoney, executive staff adviser, Child Fatality and Near Fatality External Review Panel. November 5, 2020. Interview.
[12] National Center for Fatality Review and Prevention. *CDR Report Form: National Fatality Review Case Reporting System, Version 5.1*. April 2020.
[13]Abby Collier, director, National Center for Fatality Review and Prevention. July 13, 2021. Interview.
[14]Abby Collier, director, National Center for Fatality Review and Prevention, Email to Chris Hall, September 7, 2021.
[15] National Center for Fatality Review and Prevention. *CDR Report Form: National Fatality Review Case Reporting System, Version 5.1*. April 2020, p. 10.
[16] Ibid.
[17] Ibid, pp. 3-4.
[18] Kentucky. Office of State Budget Director, *2014-2016 Budget of the Commonwealth*. 2014, p. 214.
[19] Kentucky. Justice and Public Safety Cabinet. *Memorandum Of Understanding Between The Justice And Public Safety Cabinet And The Child Fatality And Near Fatality Review Panel*. May 23, 2014, pp. 3-4.
[20] Kentucky. Office of State Budget Director. *2018-2020 Kentucky Branch Budget, Baseline Budget Request: Program Narrative/Documentation Record*. 2018, p. 2; Kentucky. Office of State Budget Director. *2020-2022 Kentucky Branch Budget, Baseline Budget Request: Program Narrative/Documentation Record*. 2020, p. 2.
[21] Kentucky. Office of State Budget Director. *2014-2016 Kentucky Branch Budget, Additional Budget Request: Program Narrative/Documentation Record*. 2014, p. 54.
[22] Kentucky. Justice and Public Safety Cabinet. Child Fatality and Near Fatality External Review Panel. *2013 Annual Report*. 2013, p. 4.
[23] Kentucky. Justice and Public Safety Cabinet. Child Fatality and Near Fatality External Review Panel. *2014 Annual Report*. 2014, p. 3.
[24] Elisha Mahoney, executive staff adviser, Child Fatality and Near Fatality External Review Panel. November 5, 2020. Interview.
[25] Roger Crittenden, past chair, Child Fatality and Near Fatality External Review Panel. December 10, 2016. Interview.
[26] Elisha Mahoney, executive staff adviser, Child Fatality and Near Fatality External Review Panel. November 5, 2020. Interview.
[27] Ibid.
[28] Roger Crittenden, past chair, Child Fatality and Near Fatality External Review Panel. December 10, 2016. Interview.
[29] Jason Hamilton, assistant director, Justice and Public Safety Cabinet, Office of Financial Management. November 12, 2020. Interview.
[30] Ibid.

Appendix

Response To This Report By The Kentucky Child Fatality And Near Fatality External Review Panel