Kentucky Child Fatality And Near Fatality External Review Panel 2022 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 17 voting and 5 ex officio members, is attached administratively to the Justice and Public Safety Cabinet. The independent panel's charge is to conduct comprehensive reviews of child fatalities and near fatalities reported to the Cabinet for Health and Family Services that are suspected to be a result of abuse or neglect. It is also required to submit annual reports discussing case determinations, as well as findings and recommendations for system and process improvements. The panel uses SharePoint and a data tool to track various information and data related to child fatality and near fatality reports. Senate Bill 97, passed during the 2022 Regular Session, changed the panel's composition; its reporting requirements; and the privileged nature of panel proceedings, records, opinions, and deliberations. The bill also included changes to law enforcement testing requirements and coroner notifications. This report has nine recommendations related to the panel's implementation of the changes in Senate Bill 97, the findings and recommendations in the panel's annual reports, updates to the panel's data tool and data dictionary, and the panel's budget procedures.

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, and its staff provided various data and other information. The Department for Community Based Services and Department for Public Health also provided information and data. The Cabinet for Justice and Public Safety provided budgetary and other information related to the panel's operations and funding. Finally, Legislative Oversight and Investigations Committee staff used the National Center for Fatality Review and Prevention as an additional resource for assessing the panel's newly developed data tool and data dictionary.

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November 10, 2022

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Summary

The Legislative Oversight and Investigations Committee (LOIC) is required by statute to annually monitor the operations, procedures, and recommendations of the Child Fatality and Near Fatality External Review Panel. The panel conducts comprehensive reviews of child fatalities and near fatalities resulting from abuse or neglect.

In this year's report, LOIC staff address panel concerns related to the process by which the panel receives cases from the Cabinet for Health and Family Services. The report also reviews and analyzes the internal review process used by the Department for Community Based Services (DCBS) as required by KRS 620.050(12)(b). This analysis was intended for inclusion in staff's 2021 evaluation of the panel, but the requested information was not received in time for analysis. As a result, LOIC staff disclosed a "data limitation" in its 2021 report in order to comply with generally accepted auditing standards.

This year's report includes a summary of Senate Bill 97, which was passed during the 2022 Regular Session. The new law changes the panel's composition and reporting requirements, as well as the privileged nature of the panel's proceedings, records, options and deliberations. It also includes changes to law enforcement testing requirements and coroner notifications.

This report analyzes information presented in the panel's annual reports related to allegations of dependency, neglect, and abuse. More specifically, the panel's annual reports discuss case determinations, findings, and recommendations for system and process improvements.[1]

The panel recently updated the data tool that it uses to analyze and track various data points. Additionally, the panel created an analyst binder, which includes a data dictionary along with a directory of terms and abbreviations commonly found in medical records. This report includes an analysis of the updated data tool and data dictionary. The panel's new data tool and data dictionary are compared to the data tool and 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.[2] 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 provides a summary of the panel's 2022–2024 budget request and subsequent appropriation, historical expenses, and its adherence to the budgetary and expenditure procedures outlined in the 2014 MOU.

Findings And Recommendations

The Cabinet for Health and Family Services has provided a full and final response to a July 27, 2021, request from LOIC staff. In its review of documents related to a sample of 30 cases where incidents of abuse or neglect were substantiated, LOIC found that DCBS appears to be appropriately using an internal tip sheet to identify near fatalities. In its review of 118 system analysis reports, staff also found that DCBS completed internal reviews in accordance with KRS 620.050(12(b)) and its internal standards of practice/system safety manual.

Recommendation 3.1

The Child Fatality and Near Fatality External Review Panel should more formally address its concerns and ideas for improvement with the Department for Community Based Services (DCBS) through panel workgroups and/or annual report recommendations in the following areas: intake of reports filed by the medical community under KRS 620.030(2); DCBS's use of the Near-Fatality Criteria and Determination Flow Chart; training for the medical community related to reporting allegations of abuse and neglect; and DCBS's internal review process.

Recommendation 3.2

The Child Fatality and Near Fatality External Review Panel should formally discuss the possibility of online training modules with the Kentucky Board of Medical Licensure in the following areas: reports filed by the medical community pursuant to KRS 620.030(2) and documenting and reporting near fatalities as defined under KRS 600.020(40).

Recommendation 3.3

The Child Fatality and Near Fatality External Review Panel should contact the Department for Community Based Services and discuss the feasibility of using existing pediatric forensic medicine contracts to provide additional training to the medical community, which may require a contract modification to increase the number of hours available for training.

The panel is reviewing and developing processes related to SB 97 and its changes to the panel's membership and reporting requirements.

Recommendation 3.4

The Child Fatality and Near Fatality External Review Panel should follow through on its idea of holding a spring 2023 meeting to discuss Senate Bill 97 implementation and other issues if needed.

Recommendation 3.5

The Child Fatality and Near Fatality External Review Panel should proactively seek feedback from courts, law enforcement, the medical community, and coroners related to the following areas addressed in Senate Bill 97: law enforcement testing; treating panel proceedings, records, opinions, and deliberations as privileged; and coroners' contact with the Department for Community Based Services and others upon notification of the death of a child. Feedback related to these areas could help the panel develop recommendations for system and process improvements in its annual reports.

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.

The panel's findings in its 2021 annual report improved markedly from those of its previous reports. The findings were supported by analysis and data that were illustrated in the report, and recommendations were appropriately linked to the report's findings. The recommendations were targeted and actionable.

Recommendation 3.6

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

The panel has finalized a significant update of its data tool and the document it used to instruct users on each data element and related guidelines. The new data tool (REDCap survey) and analyst binder were finalized after significant discussion among panel members, staff, and epidemiologists from the Department of Public Health.

Recommendation 3.7

The Child Fatality and Near Fatality External Review Panel should continue to update its data tool and data dictionary, utilizing multidisciplinary workgroups and the National Center for Fatality Review and Prevention—for example, to address factors such as resuscitation, naloxone, and torture that contribute to child fatalities and near fatalities. The panel should also periodically review entries in "Other" and comment text boxes to identify common entries that may be beneficial to add in its multiple choice data field options.

The panel is updating budget processes after the passage of House Bill 1 of the 2022 Regular Session, which directly appropriated $420,000 for each year in FY 2023 and FY 2024. However, the 2014 memorandum of understanding between the panel and the Justice and Public Safety Cabinet has not been updated, nor has written guidance been established.

Recommendation 3.8

The Child Fatality and Near Fatality External Review Panel and the Justice and Public Safety Cabinet should update the existing memorandum of understanding to reflect current budgetary and expenditure procedures. The memorandum of understanding should include specific procedures related to the panel's biennial budget requests and expenditures.

Recommendation 3.9

Child Fatality and Near Fatality External Review Panel staff should present financial updates to panel members on a regular basis. The financial presentations should include updates on the panel's expenses and available funds, as well as information on the budget process.

Chapter 1

Kentucky Child Fatality And Near Fatality External Review Panel

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.[3]

KRS 620.055 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 June 2013, the General Assembly codified the panel and its structure under House Bill 290, codified as KRS 620.055. It formally established the panel to conduct "comprehensive reviews of child fatalities and near fatalities, reported to the Cabinet for Health and Family Services [CHFS], suspected to be a result of abuse or neglect." The panel continues to be attached to the Justice and Public Safety Cabinet for staff and administrative purposes.[4]

During the 2022 Regular Session, the General Assembly passed Senate Bill 97, which amended KRS 620.055. The changes strengthen reporting controls with respect to how the panel makes annual recommendations to state agencies, as well as requirements for those agencies to implement the panel's recommendations. Additional requirements were enacted regarding the testing of caregivers suspected of being under the influence, adjustments to panel membership, notification by coroners, and annual reporting requirements for the panel.[5]

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

The panel is required to publish its annual report by February 1 of each year. These reports consist of case reviews, findings, and recommendations for system and process improvements to help prevent child fatalities and near fatalities that are due to abuse and neglect.[6] The panel's annual report considers cases from the previous fiscal year regardless of whether investigations by the Department for Community Based Services (DCBS) substantiated allegations of abuse or neglect in each case.

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

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

LOIC 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. Staff's 2021 report, adopted on October 14, 2021, focused on the process the panel uses to request, receive, and analyze information to carry out its statutory responsibilities. It also focused on the process by which the panel request and receives its funding. Table 1.1 provides additional detail.

Table 1.1
Legislative Oversight And Investigations Committee Staff Evaluations
2014 To 2021

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.

Committee Adoption Date	Major Conclusions	Recommendations
12/13/16 (2016 update)	• The panel adopted a 5-year retention schedule in accordance with the practice of 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
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, except 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.
10/14/21 (2021 update)	• The panel has met its statutory requirements to submit annual reports. • The panel's findings in its annual reports were often not supported by the analyses performed. • The panel does not have a data dictionary to clearly define the variables it collects from case files. The data tool has not been updated since 2014. • The panel and the cabinet have not followed the requirements outlined in a May 2014 memorandum of understanding.	• The panel should reevaluate how it uses SharePoint and its data tool to collect and analyze case data. • The 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. • The panel should consider creating a data dictionary. • The 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.

Note: In December 2020, staff submitted a co-chair memorandum providing an update and additional detail on its initial and subsequent reports from 2015 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.
Source: Legislative staff review of previous evaluations.

Major Objectives

This study had seven major objectives.

The major objectives for this study were to review

- processes by which the panel receives substantiated and unsubstantiated cases from the Cabinet for Health and Family Services;
- the process by which the Department for Community Based Services completes its internal reviews pursuant to KRS 620.050(12)(b);
- the process by which the panel requests, receives, and analyzes case information;
- progress in developing findings and recommendations to meet reporting and other requirements under KRS 620.055(10), as amended by SB 97 from 2022;
- changes to the panel's data collection instrument (REDCap survey) and data analyst binder;
- changes to the panel's budget process to ensure it adequately communicates funding and personnel needs to the Justice and Public Safety Cabinet and the legislature; and
- best practices or other guidance from the National Center for Fatality Review and Prevention (NCFRP).

Methodology

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

- Observed monthly panel meetings and followed up on information as needed
- Tracked the progress of SB 97 and listened to related testimony
- Reviewed and analyzed child fatality and near fatality case information and data from the panel's annual reports from 2014 to 2021
- 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
- Interviewed the panel's staff and members about various budget, training, and reporting processes
- Interviewed budget staff from the Justice and Public Safety Cabinet about the panel's budget, expenditures, and related processes

- Interviewed CHFS officials about the process by which DCBS and the Department for Public Health (DPH) provide case information to the panel
- Analyzed DPP-115 and investigative assessment reports related to a sample of 30 substantiated cases where allegations of abuse or neglect were suspected from 2017 to 2020
- Analyzed DPH email case referrals to the panel for 2017 to 2020
- Analyzed system analysis reports (SARs) completed by DCBS for 2020
- Reviewed information from the National Center for Fatality Review and Prevention regarding other states' reporting, definitions of *torture*, and tracking the use of naloxone (generic name for Narcan) for federal reporting purposes

Major Conclusions

This study has six major conclusions.

This report has six major conclusions.

- The Cabinet for Health and Family Services has provided a full and final response to the July 27, 2021, request from LOIC staff. In its review of documents related to a sample of 30 cases in which incidents of abuse or neglect were substantiated, LOIC found that DCBS appears to be appropriately using an internal tip sheet to identify near fatalities. Staff also found in its review of 118 SARs that DCBS completed internal reviews in accordance with KRS 620.050(12)(b) and its internal standards of practice/system safety manual.

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

- The panel's findings in its 2021 annual report improved markedly from those of previous reports. The findings were supported by analysis and data that were illustrated in the report, and recommendations were appropriately linked to the report's findings. The recommendations were targeted and actionable.

- The panel has finalized a significant update of its data tool and the document it used to instruct users on each data element and

related guidelines. The new data tool (REDCap survey) and analyst binder were finalized after significant discussion among panel members, staff, and epidemiologists from the Department of Public Health.

- The panel is reviewing and developing processes related to SB 97's changes to the panel's membership and reporting requirements.

- The panel is updating budget processes after the passage of HB 1 (2022 Regular Session), which directly appropriated $420,000 for each year in FY 2023 and FY 2024, but the 2014 memorandum of understanding (MOU) between the panel and the Justice and Public Safety Cabinet has not been updated, nor has written guidance been established.

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 five major findings and nine recommendations.

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" 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."[7]

Membership And Meeting Requirements

KRS 620.055(2) requires that the panel include 5 ex officio nonvoting members and 17 voting members. Table 2.1 shows that the voting members are 4 panel members based on their position, 11 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.

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

Ex Officio Members (5)		Term Expires
Member appointed by the president of the Senate		Not filled
Member appointed by the speaker of the House of Representatives		Not filled
Commissioner of the Department for Community Based Services		No expiration
Commissioner of the Department for Public Health		No expiration
Family court judge appointed by the chief justice of the Kentucky Supreme Court		No expiration*
Voting Members (17)		**Term Expires**
Title	**Appointing Authority (Nominated By)**	
At-large representative who shall serve as chair	Secretary of state	6/30/2023
Pediatrician from University of Kentucky Department of Pediatrics**	Attorney general*** (three names provided by dean of University of Kentucky School of Medicine)	6/30/2024
Pediatrician from University of Louisville Department of Pediatrics**	Attorney general*** (three names provided by dean of University of Louisville School of Medicine)	6/30/2021
State medical examiner or designee	N/A	No expiration
Director of Court-Appointed Special Advocates (CASA)	Attorney general*** (three names provided by CASA)	6/30/2024
Peace officer†	Attorney general*** (three names provided by commissioner of state police)	6/30/2024
Representative from Prevent Child Abuse Kentucky	Attorney general*** (three names provided by president of board of directors of Prevent Child Abuse Kentucky)	6/30/2024
Practicing local prosecutor	Attorney general	Vacant
Executive director of Kentucky Domestic Violence Association	N/A	No expiration
Chair of State Child Fatality Review Team	N/A	No expiration
Practicing social work clinician	Attorney general*** (three names provided by Board of Social Work)	Vacant
Practicing addiction counselor	Attorney general*** (three names provided by Kentucky Association of Addiction Professionals)	Vacant
Representative from family resource and youth service centers	Attorney general*** (three names provided by Cabinet for Health and Family Services)	Vacant
Representative of a community mental health center	Attorney general*** (three names provided by Kentucky Association of Regional Mental Health and Mental Retardation Programs)	6/30/2024
Member of a citizen foster care review board	Chief justice of Kentucky Supreme Court	6/30/2023
President of Kentucky Coroners Association	N/A	No expiration
Practicing medication-assisted treatment provider	Attorney general*** (three names provided by Kentucky Board of Medical Licensure)	Vacant

Note: As of the writing of this report, the panel's membership has seven vacant positions. Two of the members are ex officio nonvoting members who are to be appointed by the Speaker of the House and President of the Senate. The remaining vacancies are voting members who have yet to be appointed by the Attorney General.

* No expiration unless decided by the current chief justice.

** 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.[8] However, according to its 2020 annual report, in July 2020 the panel began meeting monthly to complete yearly case reviews.[9] 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	2022
Number of meetings	7	8	7	6	10	12	12*
Fatalities reviewed	47	59	51	54	85	80	41**
Near fatalities reviewed	95	91	83	82	97	120	88**

* Includes meetings scheduled for October 18, November 15, and December 20.
** As of August 16, 2022.
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.[10] The panel does not have its own personnel and operating budgets, as its funding is included as part of the Office of the Secretary's baseline funding. In budget years when baseline funds were insufficient to meet the Office of the Secretary's needs, the panel's budget was susceptible to cuts.[11]

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.[12]

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.[13] However, panel staff and members historically have not participated in the cabinet's current biennial budget process.

The cabinet typically approves the panel's expenditures as part of baseline funding for the Justice Administration appropriation unit, under the Office of the Secretary.[14] The panel's annual personnel

and operating expenditures have never totaled $420,000, which was the panel's initial appropriation in 2015. From 2015 through 2021, the panel has expended only 58 percent of its appropriations.[a] Table 2.3 provides additional details.

Table 2.3
Kentucky Child Fatality And Near Fatality External Review Panel Expenditures
FY 2015 To FY 2022

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
2022	293,852.33	2,206.60	296,058.93
Total	$1,834,363.01	$106,637.67	$1,941,000.68

* 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.
*** 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: 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). After the panel was established, it 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[15]

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.

[a] $1,941,000.68/$3,360,000 = 0.578.

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.

KRS 620.040(5)(e) requires law enforcement officers to request a test of blood, breath, or urine when a report includes a fatality or near fatality if the officer has reason to believe a caregiver was under the influence of drugs or alcohol at the time of the incident. If consent is not given for the test, a search warrant must be requested and may be issued by a judge. Also, KRS 72.410(3)(a) requires that, upon notification of the death of a child as defined in KRS 72.405 and 72.025, the coroner shall "immediately" contact the Department for Community Based Services and law enforcement agencies for information.

Once a report is received, DCBS screens acceptance criteria for the alleged maltreatment "where the alleged perpetrator is in a caretaking role."[16] 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 designate the intake in TWIST as a fatality/near fatality."[17]

If a child's death has occurred, central intake personnel designate the occurrence as a fatality. Intake staff use a Near Fatality Tip Sheet "to decide if the child's condition meets criteria for the near fatality designation" in KRS 600.020(40) of a child in serious or critical condition as certified by a physician.[18]

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 notifies local or state law enforcement.[19]

After investigations are completed, the panel receives case files from DCBS via SharePoint, 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)[20]

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.[21] 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.[22] Upon receipt, panel staff send the list of DPH referrals to DCBS to request available case information. Panel staff also access DPH information via SharePoint. According to DCBS officials, frontline staff from DCBS regional offices also participate on the local teams and provide information as needed.[23]

If DCBS is not involved with the case, panel staff may send formal requests for information to local entities requesting medical, education, law enforcement, and other records. 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.[24]

According to panel staff, DPH cases comprise 10 percent or less of the cases referred to the panel.[25]

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 into separate SharePoint 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
- Emergency medical services records
- Autopsy records
- Law enforcement records
- Case plans and evaluations
- Service recordings
- Any other pertinent professional documents[26]

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.[27]

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. Specifically, the system safety review team is responsible for providing all records to the panel.[28]

Panel staff also use SharePoint to access DPH case information related to referrals.

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.[b]

- 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 case analysts prior to their presentation to the panel.

[b] The updated Research Electronic Data Capture application (REDCap) data tool uses the same 22 screens.

- Screens 19–22 are completed by panel staff after the panel has discussed the cases and made their final determinations.

Table 2.4 provides additional details.

Table 2.4
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	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 with 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 have included 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 that are used to develop targeted and actionable recommendations.

The panel's 2021 annual report summarizes cases reviewed from the previous state fiscal year (July 1, 2019, through June 30, 2020). It summarized information related to 182 cases, which included 80 fatalities and 120 near fatalities.[c] A total of 27 fatality cases were referred to the panel from the Department for Public Health.[29] Table 2.5 provides additional information.

Table 2.5
Panel Reports
State Fiscal Years 2013 To 2021

	State Fiscal Year								
Action	**2013**	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**
Fatalities reviewed	0	43	31	47	59	51	54	85	80
Near fatalities reviewed	0	73	47	95	91	83	82	97	120
Findings	18	12	10	21	11	18	32	6	20
Recommendations	0	12	10	21	11	18	32	6	22

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

National Guidance And Other States

LOIC staff reviewed web-based information from the National Center for Fatality Review and Prevention. 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

[c] Some cases included both a fatality and a near fatality.

to the system.[30] The downloadable information included case reporting forms and a data dictionary for system users.[31]

Staff also identified guidance related to how child death review teams should construct their report findings in a case-specific manner using risk factors.[32] The NCFRP website includes a myriad of additional information such as webinars, written products, and training modules.

Staff also reached out to NCFRP to discuss the following areas that are relevant for Kentucky:

- Best practices regarding notification and follow-up of findings and recommendations
- Defining and tracking child fatalities and near fatalities involving torture
- Tracking data related to the use of naloxone (brand name Narcan) as a life-saving measure

Chapter 3

Findings And Recommendations

This review produced five major finding areas and nine recommendations.

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

Cabinet Provided Response To Data Request

CHFS provided a full and final response to a July 2021 information request from the Legislative Oversight and Investigation Committee. The intent of the request was to address concerns raised by the panel.

The Cabinet for Health and Family Services has provided a full and final response to Legislative Oversight and Investigation Committee staff related to its July 27, 2021, request. The request was made by LOIC staff to address past panel concerns related to the following areas:

- Reports filed by the medical community pursuant to KRS 620.030(2)
- The definition of *near fatality* under KRS 600.020(40)
- Lack of training of medical professionals related to filing reports and designating near fatalities
- DCBS's Near-Fatality Criteria and Determination Flow Chart
- Internal reviews conducted by the Department for Community Based Services under KRS 620.050(12)(b)[33]

The responses came after LOIC issued a subpoena *duces tecum* on July 6, 2022, which was requested by CHFS's Office of Legal Services on September 23, 2021. On August 3, 2022, CHFS complied fully with the subpoena, and on August 23, 2022, it provided additional items related to LOIC's July 27, 2021 request.[a]

Intake, Investigative Assessments, And DPH Referrals

CHFS provided LOIC staff copies of DPP-115s and investigative assessments related to a sample of 30 substantiated child neglect and abuse cases investigated by DCBS from 2017 to 2019. In addition to documents related to the sample, CHFS provided copies of SARs for 2020, as well as emails between the Department for Public Health and the panel from 2017 to

[a] DCBS did provide other information and data through 2021 and 2022 at the request of LOIC staff but, due to CHFS' internal protocol for fulfilling legislative requests, not always in the most complete and timely manner, which at times impacted LOIC staff's ability to fully evaluate responses and formulate follow-up questions.

2020. These documents were requested in order to review DCBS' internal review process and the process by which DPH refers child fatalities to the panel from local child and maternal fatality response teams.[34]

Because LOIC staff did not receive the requested information in time for analysis in 2021, it disclosed a data limitation in its 2021 review of the panel, based on generally accepted auditing standards.[35] The 2022 report, however, provides the results of LOIC staff's review and analysis of information requested in 2021.

Cases identified as fatalities or near fatalities by DCBS are automatically uploaded for panel review. LOIC staff reviewed the DPP-115s and investigative assessments of 30 cases where incidents of abuse or neglect were substantiated, to determine whether any cases were not appropriately identified as near fatalities.

Sample Of 30 Substantiated Child Neglect And Abuse Cases. Cases designated as fatalities or near fatalities by DCBS are automatically uploaded to SharePoint for panel review.[36] Panel members have expressed concerns that there may be instances where incidents of abuse or neglect are not being appropriately identified as near fatalities and, thus, not being relayed to the panel.[37] KRS 600.020(40) defines *near fatality* as "an injury that, as certified by a physician, places a child in serious or critical condition."

LOIC staff reviewed the DPP-115 and investigative assessments for a sample of 30 cases where incidents of abuse or neglect were substantiated to determine whether any cases were not appropriately identified as near fatalities. In addition to thoroughly reading the DPP-115s and investigative assessments for each case, LOIC staff conducted a keyword search based on the Near-Fatality Criteria and Determination Flowchart used by DCBS staff. The keywords were divided into four categories: life-saving procedures, admittance (ICU/step-down unit), emergency transfer, and risk of death/other. Table 3.1 provides additional details.

Table 3.1
LOIC Staff Analysis Of DCBS Sample (Keywords)

Category	Keywords
Life-saving procedures	Lifesaving, life-saving, CPR, intubation, ventilator, Narcan, naloxone
Admittance (ICU, etc.)	Intensive care unit, ICU, pediatric intensive care unit, PICU, neonatal intensive care unit, NICU, step-down, step down, step-up, step up
Emergency transfer	Transfer, refer, referral, specialty, University of Kentucky, UK, University of Louisville, UL, Vanderbilt
Risk of death/other	Near-fatality, near fatality, fatality, NF, serious, critical, death, risk

Source: LOIC staff compilation of keywords indicative of a near-fatal incident based on the Near-Fatality Criteria and Determination Flowchart used by DCBS.

In nearly half (13) of the cases reviewed, there was no injury or accident; rather, the case was reported to DCBS because there was a "risk of harm" to the child in his or her current situation due to

medical neglect, inadequate supervision, etc. The remaining cases described some sort of physical injury or medical condition. In these remaining cases, there was no evidence in the DPP-115 and investigative assessments to suggest a near fatality.

After staff completed its review of the DPP-115 forms and investigative assessments, however, it identified two cases for additional follow-up—more specifically, to confirm whether the Child Fatality and Near Fatality External Review Panel reviewed the reports pursuant to KRS 620.055(1) regarding two cases:

- Child was transferred to a children's hospital after a CT scan revealed a skull fracture.
- Alleged victim did not sustain injuries, but another child discussed in the investigative assessment sustained a near-fatality injury, which ultimately resulted in a fatality.

Panel staff confirmed that it did not review the first case, since review of DCBS records indicated that the case did not receive a "near fatal" designation. For the second case, however, panel staff confirmed that it did review the case, which DCBS designated initially as a near fatality, and then as a fatality.

Panel staff indicated that medical professionals could benefit from training providing guidance on the importance of complete and accurate reports of suspected abuse and/or neglect.

As part of staff's discussions related to the above cases and medical reporting, panel staff mentioned that members believe that some type of training for medical professionals is needed. More specifically, training is needed to provide minimal guidance to medical professionals so reports of suspected abuse or neglect are complete and accurate. Online Kentucky state continuing medical education modules could be promoted through the Kentucky Board of Medical Licensure, as well as through statewide publications, notices from the board, and statewide emails or mailings.[38]

After a review of relevant DCBS contracts, LOIC staff identified a pediatric forensic medicine contract (PON2-736-2200002899) with Community Medical Associates Inc. (affiliated with the University of Louisville). The purpose of the contract is to "provide clinical/forensic evaluations and consultations regarding child victims of physical abuse to assist DCBS staff in completing and documenting Child Protective Services investigations and to provide court testimony, when required." The contract amount for FY 2023 and FY 2024 is $283,950 for each year. The contract is paid solely with federal funds. Contract language also allows for "up to twenty (20) hours of education about the recognition of maltreatment to DCBS staff or affiliated partners at no additional charge." This contract could be another vehicle by which training

is provided to the medical community related to reporting allegations of abuse and neglect.[b]

KRS 620.050(12)(b) requires CHFS to conduct internal reviews of cases "where child abuse or neglect has resulted in a child fatality or near fatality and the cabinet had prior involvement with the child or family."

System Analysis Reports. CHFS is statutorily required to conduct internal reviews of cases "where child abuse or neglect has resulted in a child fatality or near fatality and the cabinet had prior involvement with the child or family." KRS 620.050(12)(b) states that the cabinet is to prepare a summary that includes an account of

- The cabinet's actions and any policy or personnel changes taken or to be taken, including the results of appeals, as a result of the findings from the internal review; and
- Any cooperation, assistance, or information from any agency of the state or any other agency, institution, or facility providing services to the child or family that were requested and received by the cabinet during the investigation of the child fatality or near fatality.

KRS 620.050(12)(c) requires the cabinet to

> submit a report by September 1 of each year containing an analysis of all summaries of internal reviews occurring during the previous year and an analysis of historical trends to the Governor, the General Assembly, and the state child fatality review team created under KRS 211.684.

The panel's 2015 report was critical of the DCBS internal review process, stating that the reviews often lacked detail and did not address statutorily required elements.[39] The panel's 2016 and 2018 reports noted improvements in the DCBS internal review process but recommended continued improvement along with a "systemic analysis of events leading to the adverse event to identify 'causal and contributory' factors."[40]

In 2019, DCBS partnered with a private-sector company to create a new internal review process called the Culture of Safety, System Safety Review (SSR). The Division of Protection and Permanency oversees the SSR process and conducts a review of any death of a child with an active case and any child fatality and/or near fatality with prior DCBS involvement. The SSR process, which is documented in a form called the system analysis report, is as follows:

[b] According to the PON2 document, the contract is funded through the Children's Justice Grants to the States (CFDA #93.643), Social Services Block Grant (CFDA #93.667), and the Child Abuse and Neglect State Grants (CFDA #93.669).

- The SSR team/analyst completes an initial case review consisting of a review of circumstances of the fatal/near-fatal incident, allegations, details of prior investigations, and ongoing services (sections I and II of the SAR). A case review intended to identify features that may be recommended for further analysis is completed with 30 days of notification (section III).
- The case is then presented to the Multi-Disciplinary Team (MDT), which determines whether further analysis of the case is recommended (section IV).
- Those cases selected for further review undergo Learning Point and Human Factors Debriefing (section V), in which additional information is gathered, including an interview with key figures such as investigative workers, regional management personnel, law enforcement, health care providers, etc. The case then undergoes mapping (section VI) which "is intended to analyze the human factors data collected during the debriefing in order to develop a clear picture of systemic influences."
- All cases undergoing a system safety review—even those not selected for human factors debriefing and mapping—are then scored in section VII of the SAR.[41]

In its 2020 report, the panel stated that it had begun "receiving documents [system analysis reports] reflecting findings from the System Safety Review Process." The report did not indicate any concerns related to the new internal review process, but it stated that the panel would examine the SARs to determine whether the new internal review process is consistent with statute.[42] The panel's 2021 report again had no direct criticism of the DCBS internal review process and noted that the SSR process "involves reviewing case history and multidisciplinary reviews of selected cases to identify factors influencing staff decision making."[43]

LOIC staff reviewed all 118 SARs sent to the panel for FY 2020. The primary purpose of the review was to determine whether DCBS' internal review process complied with KRS 620.050(12)(b) and whether internal reviews were completed according to Chapter 2.14 of the DCBS Standards of Practice manual and the DCBS System Safety Review manual. During its review, LOIC staff also looked for indicators of thoroughness, such as mapping or other visuals, and checked to ensure that reviews were completed for substantiated and unsubstantiated cases. As stated previously, panel staff and/or members have expressed concerns about both areas in the past.

LOIC staff analysis of 118 DCBS system analysis reports (SARs) found that the forms generally met the requirements of KRS 620.050(12)(b).

Compliance With Statute. Staff analysis found that the SAR forms generally met the requirements of KRS 620.050(12)(b) by documenting the internal review of cases "where child abuse or neglect has resulted in a child fatality or near fatality and the cabinet had prior involvement with child or family."

The DCBS System Safety Review process reviews any death of a child on an active case and any child fatality or near fatality with prior DCBS involvement. Further, internal reviews are not limited to cases with substantiated allegations of abuse and/or neglect.

Among the 118 cases reviewed by LOIC staff, DCBS substantiated allegations of neglect and/or abuse in 70 cases, or 59 percent. The allegations in 42 cases (36 percent) were found to be unsubstantiated, and 6 cases were designated as "services needed." The statute limits the review requirement to those cases where the cabinet had prior involvement with either the child or the family. Note that 23 of the 118 SARs reviewed by LOIC staff documented cases where there was no prior DCBS involvement, indicating that DCBS is exceeding statutory requirements in terms of types of cases that must be reviewed. Table 3.2 provides additional detail.

Table 3.2
Investigation Findings, System Analysis Reports
FY 2020

Finding	Number Of Cases
Substantiated	70
Unsubstantiated	42
Services needed*	6
Total	118

* Per 922 KAR 1:330, "services needed" means a low-risk finding with no perpetrator that means a family needs to be linked to community services.
Source: LOIC staff analysis of DCBS System Analysis Reports for FY 2020.

KRS 620.050(12)(b) also requires the cabinet to prepare a summary that includes an account of

- The cabinet's actions and policy or personnel changes taken or to be taken, including the results of appeals, as a result of the findings from the internal review; and
- Any cooperation, assistance, or information from any agency of the state or any other agency, institution, or facility providing services to the child or family that were requested and received by the cabinet during the investigation of the child fatality or near fatality.

The SARs generally fulfill the statutory mandate of a summary documenting the cabinet's actions, personnel issues, relevant

appeals, and interactions with other agencies such as law enforcement and commonwealth's attorneys. Given that LOIC staff were limited to the SARs themselves and not the full breadth of records, however, it was not possible to quantify the number of requests for assistance, or the assistance provided.

Finally, it appears that CHFS is in compliance with the reporting requirements of KRS 620.050(12)(c), which calls for annual summaries. A review of the DCBS website—specifically the Child Protection Branch within the Division of Protection and Permanency (DPP)—shows that the DPP has released summary reports from 2017 to 2022. The DPP oversees the cabinet's system safety review process.

LOIC staff analysis showed that SARs met criteria in the DCBS Standards of Practice and System Safety Manual.

DCBS Standards Of Practice And System Safety Manual. The DCBS Standards of Practice and System Safety Manual outline the Culture of Safety, System Safety Review process. All cases undergoing a System Safety Review undergo an initial case review (sections I to III of the SAR), presentation to the multidisciplinary team (section IV), and scoring (section VII). Cases selected for further review also undergo human factors debriefing (section V) and mapping (section VI).

LOIC staff analysis shows that sections I to IV were completed on all 118 SARs sent to the panel in FY 2020, which means that all 118 underwent the internal case review process involving intake, DCBS history, and investigation. The reviews also document that summaries were presented to the MDT. Although it was not possible for LOIC staff to determine the quality of work by reviewing the entire case file, staff's review indicated that each section was completed in a relatively thorough fashion. The scoring section (section VII) was also completed for 117 of the 118 SARs reviewed.

Of the 118 cases reviewed, the MDT selected 40 (34 percent) for further review. Some of the factors identified by the MDT resulting in further analysis and mapping included

- court-ordered placement change,
- documentation issues,
- staffing issues,
- failure to interview parties relevant to investigation, and
- screening issues.

Of the 40 cases in the sample selected for further review by the MDT, all underwent mapping, and all but 1 received a human factors debriefing. It is unclear why one of the cases selected for

further review did not received a human factors debriefing, but the System Safety Review manual notes that the debriefing is not mandatory, and relevant parties reserved the right to not participate. Note that abuse and/or neglect was substantiated in 30 of the 40 cases selected for further review. Eight unsubstantiated and two "services needed" cases were also selected for review.

Local Child And Maternal Fatality Response Teams

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

The Department for Public Health refers cases to the panel from local child fatality review teams.[44] Names, dates of birth, and dates of death are emailed to the panel by DPH's Division of Maternal and Child Health, which supports the local teams.[45] In its review of 17 emails between DPH and panel staff, LOIC saw that DPH routinely refers the names, dates of birth, and dates of death related to child fatalities discussed at the local level to panel staff for review. Emails also showed panel staff formally requesting various information as discussed in KRS 620.055(6), including but not limited to DCBS investigations and other documents, autopsy reports, and medical records.

Currently, after an email is received that a DPH case has been referred to the panel for review, panel staff may request DPH information via SharePoint. Prior to the use of DPH's SharePoint, the panel had to upload requested information into the appropriate data field folder in its SharePoint application.[46] In one email, a DPH nurse manager described the excitement behind the new process now that all DPH files are electronic and can be viewed by panel staff. Note that part of the electronic process still includes a formal panel request for statutory information. Once the response is granted, panel staff can review any stored case records in SharePoint. According to panel staff, the panel is unaware of any challenges related to the DPH case referral process.[47]

Recommendation 3.1

Recommendation 3.1

The Child Fatality and Near Fatality External Review Panel should more formally address its concerns and ideas for improvement with the Department for Community Based Services (DCBS) through panel workgroups and/or annual report recommendations in the following areas: intake of reports filed by the medical community under KRS 620.030(2); DCBS's use of the Near-Fatality Criteria and Determination Flow Chart; training for the medical community related to reporting allegations of abuse and neglect, and DCBS's internal review process.

Recommendation 3.2

Recommendation 3.2

The Child Fatality and Near Fatality External Review Panel should formally discuss the possibility of online training modules with the Kentucky Board of Medical Licensure in the following areas: reports filed by the medical community pursuant to KRS 620.030(2) and documenting and reporting near fatalities as defined under KRS 600.020(40).

Recommendation 3.3

Recommendation 3.3

The Child Fatality and Near Fatality External Review Panel should contact the Department for Community Based Services and discuss the feasibility of using existing pediatric forensic medicine contracts to provide additional training to the medical community, which may require a contract modification to increase the number of hours available for training.

Implementation Of Senate Bill 97, 2022 Regular Session

The panel is implementing Senate Bill 97 (2022 Regular Session), including changes to the panel's composition; law enforcement testing requirements; the panel's reporting requirements; coroner notifications; and the privileged nature of panel proceedings, records, opinions, and deliberations.

The panel is in the process of implementing changes made by SB 97 of the 2022 Regular Session.[48] The bill amended sections of KRS Chapter 620 (Dependency, Neglect, And Abuse) and KRS Chapter 72 (Coroners, Inquests, and Medical Examinations). Specific changes were made regarding the panel's composition and reporting requirements; law enforcement testing requirements; and the privileged nature of panel proceedings, records, opinions, deliberations, and coroner notifications. The bill was passed as a result of findings and recommendations adopted by the committee, which are included in the LOIC staff report *Kentucky Child Fatality And Near Fatality External Review Panel 2021 Update,* Research Report No. 472.

As shown in Table 3.3, the panel has taken action to notify appointing agencies related to the panel's expanded membership. It is also developing a process by which the new reporting requirements will be implemented for use in calendar year 2024. The panel is considering holding a spring meeting dedicated to the topic. The panel indicated it has not taken action, however, related to law enforcement testing, proceedings of the panel considered privileged, or the coroners notification. Table 3.3 provides additional information.

Table 3.3
Statutory Amendments From 2022 Kentucky Acts Chapter 139

Statute Amended	Amendment	Panel Actions
KRS 72.410	Requires the coroner, upon notification of the death of a child that meets criteria defined in KRS 72.025 and 72.405, to immediately contact the local office of the Department for Community Based Services, law enforcement agencies with local jurisdiction, and the local health department to determine the existence of relevant information concerning the case. The language previously required the coroner to do so "as soon as practicable."	No action taken. The panel is unaware of any challenges or concerns to these amendments.
KRS 620.040(5)(e)	Requires law enforcement officers to request a test of blood, breath, or urine when a report includes a child fatality or near fatality and the officer has reason to believe the child's supervisor was under the influence of drugs or alcohol at the time of the incident. If the individual does not consent, a search warrant must be requested and may be issued by a judge to the officer. Tests must be conducted pursuant to KRS 189.103.	No action taken. The panel is unaware of any challenges or concerns to these amendments.
KRS 620.055(2)	Expanded panel membership to 17 voting members, adding the president of the Kentucky Coroners Association and a practicing medication-assisted treatment provider selected by the attorney general from a list of three names provided by the Kentucky Board of Medical Licensure. The chair of the House Health and Welfare Committee and the chair of the Senate Health and Welfare Committee were removed as ex officio nonvoting members. Two new members appointed by the president of the Senate and the speaker of the House of Representatives were added as ex officio nonvoting members.	Notified appointing agencies
KRS 620.055(10)(a)	Changed the publication date of the panel's required annual report from December 1 to February 1.	N/A
KRS 620.055(10)(b)	Introduced a new requirement for the panel to determine which agency is responsible for implementing each recommendation it makes in its annual report, and to forward that recommendation in writing to the appropriate agency.	In process of determining the best approach to review cases in calendar year 2024. Considering a spring 2023 special meeting to discuss.
KRS 620.055(10)(c)	Recipient agencies must respond within 90 days with written notice of intent to implement, an explanation of how they will do so, and an approximate time frame, or with written notice that the agency does not intend to implement the recommendation along with a detailed explanation of why this cannot be done.	In process of determining the best approach to review cases in calendar year 2024. Considering a spring 2023 special meeting to discuss.
KRS 620.055(16)	States that proceedings, records, opinions, and deliberations of the panel are privileged and cannot be subject to discovery or subpoena, or used as evidence in any civil or criminal actions in a manner that would identify specific persons or cases reviewed by the panel.	No action taken. The panel is unaware of any challenges or concerns to these amendments

Source: LOIC staff compilation of responses provided by the Kentucky Child Fatality and Near Fatality External Review Panel, 2021 Update, Sept. 1, 2022.

Recommendation 3.4

Recommendation 3.4

The Child Fatality and Near Fatality External Review Panel should follow through on its idea of holding a spring 2023 meeting to discuss Senate Bill 97 implementation and other issues if needed.

Recommendation 3.5

Recommendation 3.5

The Child Fatality and Near Fatality External Review Panel should proactively seek feedback from courts, law enforcement, the medical community, and coroners related to the following areas addressed in Senate Bill 97: law enforcement testing; treating panel proceedings, records, opinions, and deliberations as privileged; and coroners' contact with the Department for Community Based Services and others upon notification of the death of a child. Feedback related to these areas could help the panel develop recommendations for system and process improvements in its annual reports.

The Panel Is Meeting Its Statutory Requirements To Submit Annual Reports

LOIC staff found that the panel met its statutory requirement to submit annual reports consisting of case reviews, findings, and recommendations for system and process improvements.

In LOIC's 2021 evaluation of the Kentucky Child Fatality and Near Fatality External Review Panel, staff found that the panel met its statutory requirement to submit annual reports consisting of case reviews, findings, and recommendations for system and process improvements. It also found that the panel's reports included case summaries, determinations, contextual information, and state and federal statistics.

However, LOIC staff also found that the panel's findings were often not supported by the analyses they performed and that information needed to link findings to data was not always discussed in the reports. Staff also found that the panel's recommendations were not directly linked to its findings, nor were they consistently targeted, actionable, or addressing finding concerns.[49]

LOIC staff analysis found that 19 of the 20 findings in the panel's 2021 report were based on data/analysis identified in the report.

A review of the panel's most recent report, from 2021, indicated that improvements have been made in these areas. Of 20 findings in the panel's 2021 report, 19 were based on data/analysis identified in the report. The remaining finding disclosed an issue often discussed during panel meetings regarding gaps in

jurisdiction between local review teams, but the finding was not supported by data to show the number of cases not reviewed by local review teams.[50] Finally, all of the recommendations in the panel's 2021 report addressed the concerns identified in findings and were both targeted and actionable.

Previous Annual Report Analysis

Table 3.4 provides a historical overview of panel findings and whether they were based on data and/or data analysis.

Table 3.4
Panel's Findings Based On Case Data/Analysis In The Report
2014 To 2021

	Based On Case Data/Analysis?			
Annual Report Year	Yes	No	Unsure	Annual Total
2021	19	1	0	20
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	73	17	40	130

Source: Staff analysis of information in the Kentucky Child Fatality and Near Fatality External Review Panel's annual reports

The marked improvement is emphasized by LOIC's previous analysis, which determined that, in the panel's reports from 2014 to 2020, 49 percent of the 110 findings presented cited specific case data or analysis. Over that same period, 36 percent of the explanations explicitly mentioned case reviews but did not provide specific data or analysis. The remaining 15 percent of the finding explanations did not appear to link to any case data/analysis. These designations were determined by whether the relevant data/analysis could be identified within the report. In some cases where "yes" was indicated, the finding summary provided did not immediately include data/analysis, but relevant data/analysis was present in other parts of the report, such as appendices.[51]

Targeted And Actionable Recommendations Addressing Findings. Table 3.5 provides a historical overview of panel recommendations and whether they addressed finding concerns.

Table 3.5
Panel's Recommendations Addressed Findings
2014 To 2021

	Based On Case Data/Analysis?			
Annual Report Year	Yes	No	Unsure	Annual Total
2021	22	0	0	22
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	49	79	4	132

Source: Staff analysis of information in the Kentucky Child Fatality and Near Fatality External Review Panel's annual reports

The marked improvement is emphasized by LOIC's previous analysis, which determined that 25 percent of recommendations addressed corresponding findings. Nearly 72 percent of the panel's recommendations did not address finding concerns.[52]

LOIC staff analysis found that all of the recommendations in the panel's 2021 report addressed finding concerns and were actionable and targeted.

For the 2021 annual report, however, all 22 recommendations were actionable and targeted, a significant improvement. *Actionable* indicates that the recommendation is realistic and tangible and includes exactly what should be accomplished to satisfy the recommendation. *Targeted* means the recommendation specifies the entity that would carry out the recommendation. These terms are based on principles found in guidance from the National Center for Fatality Review and Prevention and represent best practices for developing recommendations.[53]

Recommendation 3.6

Recommendation 3.6

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

The Panel Updated Its Data Tool And Data Dictionary

LOIC's 2021 report noted that the panel's data tool had not been formally evaluated since 2014 and that it relied heavily on narrative text boxes.

LOIC staff's 2021 evaluation of the panel identified important issues regarding the panel's data tool and its lack of a data dictionary. The report noted that the panel's data tool had not

been formally evaluated since 2014 and that it relied heavily on narrative text boxes.

Further, the panel did not have a data dictionary that clearly defined the many variables collected from case files.

Further, the panel did not have a data dictionary that clearly defined the many variables collected from case files.

On October 14, 2021, LOIC adopted four recommendations to remedy the issues that LOIC staff identified in its 2021 evaluation of the panel.[54] In the year following the adoption of the report, the panel addressed all four recommendations by updating its data tool and creating an analyst binder with a data dictionary. Table 3.6 provides additional detail.

Table 3.6
Recommendations Related To Budget And Expenditures,
Legislative Oversight And Investigations Committee
2021 Update On The Kentucky Child Fatality And Near Fatality External Review Panel

Recommendation	Text	Addressed?
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.	Yes
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.	Yes
3.3	The Child Fatality and Near Fatality External Review Panel should consider creating a data dictionary.	Yes
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.	Yes

Source: Kentucky. Legislative Research Commission. *Kentucky Child Fatality And Near Fatality External Review Panel 2021 Update*, Research Report No. 472, pp. 24, 33.

Data Tool Improvement

The panel revised its data tool using web-based Research Electronic Data Capture (REDCap).

In LOIC's 2021 report, staff recommended that the panel 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.[55] In response to the recommendation, the panel revised its data tool using the web-based Research Electronic Data Capture (REDCap) application.[56] Panel staff, members, and epidemiologists with the Department for Public

Health met on several occasions to evaluate the current data tool and implement a survey in REDCap. During this process, staff also created an analyst binder, which now serves as the data dictionary. The analyst binder and REDCap survey were adopted by the panel during the January 2022 meeting.[57]

Although 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 in circumstances such as this that providing the option of documenting such an anomaly in narrative form can be useful. However, the panel's old data tool generally relied 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.[58]

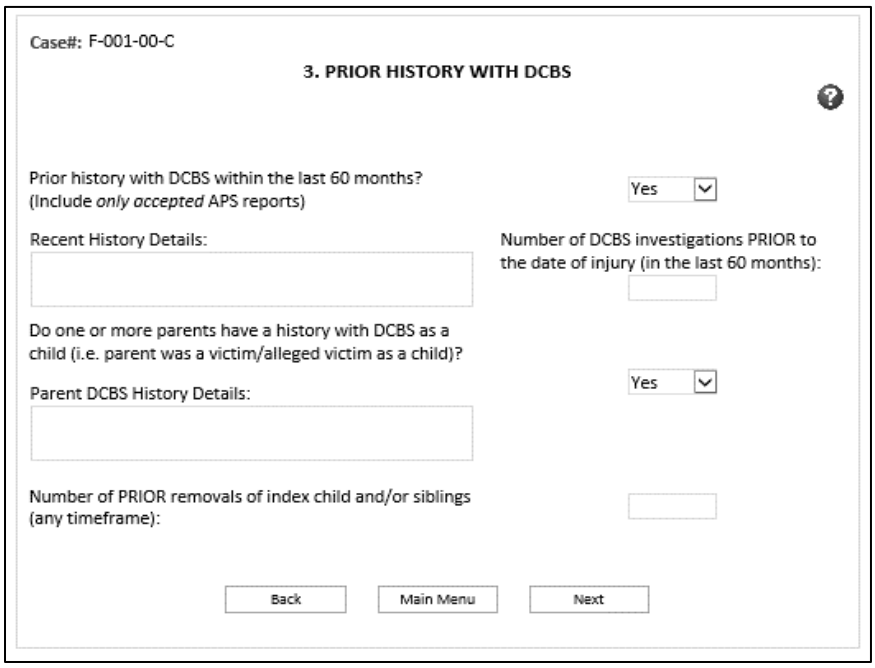
In the panel's new data tool, narrative text boxes were replaced with more analysis-friendly options such as multiple choice formats.

In the panel's new data tool, narrative text boxes were replaced with more analysis-friendly options such as multiple choice formats. The only functions of narrative boxes are to provide an "Other" space to input an option that is not already listed as a choice or to provide additional information. By eliminating imperfect narrative boxes when possible, the data tool utilizes different entry options that are more conducive to data analysis. Most commonly, multiple choice selection is used in the new data tool.[59]

Of the 22 sections in the old data tool, 16 included a narrative text box of some kind. Excluding those narrative boxes, the total number of data fields (or questions) in the 16 sections totaled 54. Those same sections in the new data tool contain 73 data fields (or questions).[60] Now, each data field can contain from two to hundreds of additional pieces of information, which can be used by the panel for further analysis. The improvements in the data tool appear to coincide with an improvement in quality of the panel's findings and recommendations made in its 2021 report.[61]

Figure 3.A shows that the panel's previous data tool for "Section 3. Prior History with DCBS" included two text boxes for additional information regarding prior DCBS history (child and parent). It also included two yes/no options.

Figure 3.A
DCBS Previous Data Tool:
Field 3. Prior History With DCBS



Source: Kentucky. Legislative Research Commission. *Kentucky Child Fatality And Near Fatality External Review Panel 2021 Update,* Research Report No. 472, Oct. 14, 2021, p. 31.

In contrast, Table 3.7 shows how the new data tool includes non-narrative box data fields in sections that previously contained narrative boxes. This example illustrates how the panel completely replaced narrative boxes with more analysis-friendly multiple choice options. This one example includes seven yes/no questions with 13 multiple choice options containing 36 additional data points.[62]

Table 3.7
Updated Data Tool (REDCap Survey): Field 3. Prior History With DCBS

Question	Multiple Choice Options	Additional Data Points
1. Prior history with DCBS within the last 60 months?	1. Result of involvement. 2. Number of substantiated cases. 3. Number of unsubstantiated cases. 4. Number of FINSA/in need of services. 5. Number of screened-out. 6. Number of DCBS investigations prior to date of injury.	1. Substantiated (1-10+) 2. Unsubstantiated (1-10+) 3. FINSA/in need of services (1-10+) 4. Screened out (1-10+) 5. DCBS investigations prior to date of energy (1-10+)

Question	Multiple Choice Options	Additional Data Points
2. Does mother have a history with DCBS as a child?	7. DCBS history details.	6. Parent identified as a child victim in CPS investigation 7. Parent removal from household 8. Parent identified in a screened out referral 9. Parent in substantiated case was in household of CPS investigation 10. Unknown
3. Does father have a history with DCBS as a child?	8. DCBS history details.	11. Parent identified as a child victim in CPS investigation 12. Parent removal from household 13. Parent identified in a screened out referral 14. Parent in substantiated case was in household of CPS investigation 15. Unknown
4. Does stepparent (mother's) have a history with DCBS as a child?	9. DCBS history details.	16. Parent identified as a child victim in CPS investigation 17. Parent removal from household 18. Parent identified in a screened out referral 19. Parent in substantiated case was in household of CPS investigation 20. Unknown
5. Does stepparent (father's) have a history with DCBS as a child?	10. DCBS history details.	21. Parent identified as a child victim in CPS investigation 22. Parent removal from household 23. Parent identified in a screened out referral 24. Parent in substantiated case was in household of CPS investigation 25. Unknown
6. Does paramour (mother's) have a history with DCBS as a child?	11. DCBS history details.	26. Parent identified as a child victim in CPS investigation 27. Parent removal from household 28. Parent identified in a screened out referral 29. Parent in substantiated case was in household of CPS investigation 30. Unknown
7. Does paramour (father's) have a history with DCBS as a child?	12. DCBS history details. 13. Number of prior removals of index child and/or siblings.	31. Parent identified as a child victim in CPS investigation 32. Parent removal from household 33. Parent identified in a screened out referral 34. Parent in substantiated case was in household of CPS investigation 35. Unknown 36. Number of prior removals of index child and/or siblings

Note: DCBS = Department for Community Based Services; FINSA = families in need of services assessment; CPS = Child Protective Services.
Source: LOIC staff analysis of REDCap provided by the Kentucky Child Fatality and Near Fatality External Review Panel.

Panel Considering Additional Updates. In the past, the panel has discussed whether the administration of the opioid overdose resuscitation drug Narcan (naloxone) should always qualify as a near fatality.[63] The National Center for Fatality Review and

Prevention data tool includes data fields for whether resuscitation was attempted, what kind of resuscitation was attempted, and what medication was used to do so.[64] Given that DCBS recognizes administration of Narcan as a life-saving procedure to assist with the identification of near fatalities under KRS 600.020(40), the panel may wish to include a similar data field in its data tool. If the panel were to gather this information, it could be able to arrive at an informed answer to its discussion about qualifying a near fatality.

Also, panel members had discussions regarding the current panel definition of *torture* at its meetings over the past year. In response, the panel formed a work group to develop a "transdisciplinary definition of torture" that would replace the panel's operational definition. The current definition states that *torture* means

> at least two physical assaults (occurring over at least two incidents) or one extended assault which would cause prolonged physical pain, emotional distress, bodily injury or death, and when in the presence of two or more forms psychological maltreatment (such as isolation, intimidation, emotional/psychological maltreatment, terrorizing, spurning or deprivation).[65]

The panel may wish to include a data field in future revisions of the data tool related to torture, if it determines that tracking this additional information would be beneficial.

Data Dictionary Improvement

LOIC staff recommended that the panel consider creating a data dictionary using guidance from the National Center for Fatality Review and Prevention. In response, the panel developed and now utilizes a data dictionary within its analyst binder that can be referenced when inputting or interpreting data.

LOIC's 2021 evaluation found that the panel did not have a suitable data dictionary that clearly defines the variables it collects from case files. In its formal response, the panel agreed that a data dictionary "would be of great benefit to the newly developed data tool instrument." It also stated that it previously used a document that, though not a data dictionary per se, "instructs users on each data element, including guidelines for how best to complete the data elements in the current tool."[66]

LOIC staff recommended that the panel consider creating a data dictionary using guidance from the National Center for Fatality Review and Prevention.[67] In response, the panel developed and now utilizes a data dictionary within its analyst binder that can be referenced when inputting or interpreting data.[68] LOIC staff analyzed the panel's new data dictionary and referenced the data dictionary used by the NCFRP to identify any large differences.

The data dictionaries used by the NCFRP and the panel have comparable structures that serve as step-by-step reference guides for those inputting data. Both expand on data fields/questions to ensure that data is consistently understood both on the input end and the aggregate analysis end. Both include definitions for terms used by the data tool, but the panel's dictionary presents definitions in an appendix whereas the NCFRP dictionary provides definitions of terms upon their use throughout its guide. Each document is presented as an instruction manual for the input side of the data system, but they both can also be used as reference material when analyzing and interpreting aggregate data.[69]

Both the NCFRP dictionary and the analyst binder walk through the exact sequence that someone entering case data would follow and provide clarification for each step to ensure consistent understanding of what each entry field is asking and how resulting data should be interpreted.

The most obvious difference is in the length of the two documents, which is understandable, considering that NCFRP collects significantly more data points and therefore expounds on more fields of entry. The amount of data collected by NCFRP relative to the panel may be due to differing purposes for the data. The panel is broadly tasked with reviewing cases and making recommendations for system and process improvements in Kentucky. The NCFRP's purpose is to provide a maximally comprehensive data tool for use by entities with various goals. Broadly speaking, all data fields collected by the panel's data tool are also comparably collected by the NCFRP, with inconsequential differences such as questions including Kentucky-specific terms such as "DCBS."[70]

Recommendation 3.7

Recommendation 3.7

The Child Fatality and Near Fatality External Review Panel should continue to update its data tool and data dictionary, utilizing multidisciplinary workgroups and the National Center for Fatality Review and Prevention—for example, to address factors such as resuscitation, naloxone, and torture that contribute to child fatalities and near fatalities. The panel should also periodically review entries in "Other" and comment text boxes to identify common entries that may be beneficial to add in its multiple choice data field options.

Panel Budget And Expenditure Procedures

Addressing The Panel's Appropriations And Budget Concerns

LOIC staff's 2021 evaluation made three recommendations related to the panel's lack of budget autonomy and its budget and expenditure processes.

The LOIC 2021 evaluation of the Child Fatality and Near Fatality External Review Panel identified critical issues regarding the panel's lack of budget autonomy, legislative priority, and impact on staffing. It also found that the panel and the Justice and Public Safety 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." Also, neither party could provide documentation outside of the MOU to indicate a formal process to ensure meaningful communication between the panel chair and the cabinet secretary related to the panel's budget requests and financial expenditures.[71]

On October 14, 2021, the committee adopted three recommendations to remedy the critical issues that LOIC staff identified in its 2021 evaluation of the panel.[72] Subsequently, the panel and the cabinet addressed one of the recommendations and partially addressed the other two recommendations. Table 3.8 provides more detailed information.

Table 3.8
LOIC Panel Evaluation Recommendations Related To Budgeting
2021

Recommendation	Text	Addressed?
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.	Partially
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.	Partially
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.	Yes

Source: Kentucky. Legislative Research Commission. *Kentucky Child Fatality And Near Fatality External Review Panel 2021 Update*, Research Report No. 472, Oct. 14, 2021, p. 37.

Budget Autonomy

The panel submitted a budget request in the fall of 2021. The panel and the Justice Cabinet have not historically followed the budget procedures in the 2014 memorandum of understanding.

The panel and cabinet partially implemented Recommendation 3.5: that both parties develop processes to ensure that the panel submits a formal budget request prior to each budget session. The panel proactively worked with the cabinet to submit budget requests for the 2014 and 2022 biennia, but there is no indication that the panel submitted budget requests in other years. Also, LOIC staff did not identify written guidance to ensure that the panel will actively participate in the budget process in a consistent manner.

According to the 2014 MOU between the panel and the cabinet, the panel is required to provide its budget request during the fall prior to a budget session. The cabinet is then to operate as a pass-through and submit the panel's budget to the Office of State Budget Director without prioritization.[73] As outlined in LOIC's 2021 report, neither the panel nor the cabinet followed the budget procedures outlined in the MOU after its initial appropriation in 2014. Also, neither party had developed written guidance to ensure meaningful communication between the panel and cabinet related to the panel's budget requests and financial expenditures. As a

result, it appears the panel had very little formal input into biennial budget requests.

In the years following the initial appropriation to the panel, the cabinet essentially used an incremental approach for the panel's budget to ensure that expenditures carry forward from previous years. In budget years when baseline funds were insufficient to meet the Office of the Secretary's needs, the panel's budget was also susceptible to cuts.[74] Further, panel members and staff indicated having only limited knowledge of the panel's budget and its available funds.[75]

Expenditures

Although communication between the panel and the Justice Cabinet regarding the panel's budgetary matters has improved over the past year, no written guidance has been established.

The panel and the cabinet partially addressed Recommendation 3.6: that both parties develop processes for meaningful communication related to budgetary needs. Although it does appear that communication between the panel and the cabinet has improved over the past year, no written guidance has been established. The cabinet sends expenses reports to the panel detailing the panel's expenses, budgeted funds, and remaining funds, but the expense reports are not presented to the panel members.

The cabinet typically approves the panel's expenditures as part of baseline funding for the Justice Administration appropriation unit, under the Office of the Secretary.[76] Panel expenses—such as salaries and fringe benefits, contract employee costs, and operating expenses—post to the panel's chart of accounts. Note that the panel's annual personnel and operating expenditures have never totaled $420,000, which was the panel's initial appropriation in 2015. From 2015 through 2021, the panel has expended only 58 percent of its appropriations.[c] Table 3.9 provides additional information.

[c] The percentage is based on the panel's actual total expenditures from 2015 through 2022 divided by 8 full years of annual appropriations of $420,000.

Table 3.9
Kentucky Child Fatality And Near Fatality External Review Panel Expenditures
FY 2015 To FY 2022

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
2022	293,852.33	2,206.60	296,058.93
Total	$1,834,363.01	$106,637.67	$1,941,000.68

* 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.
*** 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: eMARS, Expenditure Analysis Report-FAS3.

Staffing

Panel staffing has historically consisted of one executive staff adviser, a social service clinician II, and a contract pediatric forensic medical case analyst.

The panel has never been staffed to the level envisioned by its initial request for funding in 2014, which included five full-time positions: administrative coordinator, internal policy analyst III, staff attorney III, paralegal consultant, and administrative specialist III.[77] In addition to administrative and legal support, staff resources were also needed to help review a high volume of cases, which involved analyzing hundreds of pages of information and records for each case. There have been periodic fluctuations over the past several years, but staffing has historically consisted of one executive staff adviser, one social service clinician II, and one contract pediatric forensic medical case analyst.[78]

The panel's 2022–2024 budget request asked for two full-time positions: a social service clinician II and epidemiologist.

The panel's 2022–2024 budget request included a request for funding for two full-time positions: a social service clinician II and an epidemiologist I.[79] In its justification for additional funding, the panel indicated that increased caseloads had resulted from its recent collaboration with the Department for Public Health to encourage local child fatality review teams to refer cases suspected to result from abuse or neglect. Further increases in caseloads are expected due to continued collaboration with DPH, along with a plan to have coroners, law enforcement agencies, and hospitals directly refer cases to the panel. Further, the panel is reevaluating and changing its data tool, which may require the addition of new data fields that will increase workload for staff. The panel also

expressed the need for an epidemiologist for data analysis and quality assurance.[80]

The panel was appropriated $420,000 in the 2022–2024 Budget of the Commonwealth, which is a considerable increase from the panel's historical expenditures. However, it may not be sufficient to allow the panel to hire two new additional full-time staff members. The panel did receive a $50,000 transfer from the Kentucky Agency for Substance Abuse Policy, which it will use to hire a part-time contract epidemiologist. Given that the panel's historical expenditures have never exceeded $300,000, it appears that the panel would have sufficient funds to hire a full-time data analyst, if it chooses to do so.

Legislative Priority

The legislature appropriated $420,000 for each fiscal year in the 2022–2024 biennium.

Related to the establishment of a separate appropriation allotment for the panel discussed in Recommendation 3.7, the 2022–2024 Budget of the Commonwealth included a $420,000 appropriation for each fiscal year in the base budget of the Justice Administration budget for the panel.[81] This appropriation is consistent with the initial annual appropriation of $420,000 in the 2014–2016 Budget of the Commonwealth, which appears to illustrate the legislature's intent to fully fund the panel each year.[82]

Subsequently, LOIC staff identified in eMARS budgeted amounts of $450,000 for personnel costs and $20,000 for operating costs; as of the writing of this report, $78,276.03 and $1,073.68, respectively, have been expended for FY 2023. Although a separate budget allotment was not created in eMARS, establishing annual expenditure budget amounts is another way to ensure the panel is able to expend its full appropriation.[d]

It is clear that panel members and staff have interacted with the cabinet's fiscal staff and, in the fall of 2021, submitted a budget request that included funding for two additional full-time staff members. Although the panel proactively worked with the cabinet and submitted a budget request in the fall of 2021, there is no indication that written guidance has been developed to ensure that the panel will actively participate in the budget process in a consistent manner. At a minimum, the panel and cabinet should

[d] Using the Financial Accounting System (eMARS-FAS3) LOIC staff confirmed that, for FY 2023, expenditure authorities were established under 54-Justice & Public Safety Cabinet-500-Office of the Secretary-AADO-Child Fatality/Near Fatality Review Board Fund in the following amounts: $450,000 for personnel costs and $20,000 for operating expenses, for a total of $470,000.

review the 2014 MOU and update it to reflect changes resulting from the recent direct appropriation and the establishment of expenditure budget authorities in eMARS, as well as increased staffing needs to handle direct referrals from coroners, law enforcement agencies, and hospitals, as mentioned in the panel's most recent budget request.

Recommendation 3.8

Recommendation 3.8

The Child Fatality and Near Fatality External Review Panel and the Justice and Public Safety Cabinet should update the existing memorandum of understanding to reflect current budgetary and expenditure procedures. The memorandum of understanding should include specific procedures related to the panel's biennial budget requests and expenditures.

Recommendation 3.9

Recommendation 3.9

Child Fatality and Near Fatality External Review Panel staff should present financial updates to panel members on a regular basis. The financial presentations should include updates on the panel's expenses and available funds, as well as information on the budget process.

Endnotes

[1] KRS 620.055(1) and 620.055(10).
[2] KRS 620.055(1).
[3] Kentucky. Governor Steven L. Beshear. Executive Order 2012-585, July 16, 2012. Secretary of State, Executive Journal.
[4] KRS 620.055(1).
[5] Kentucky. General Assembly. *Acts Of The 2022 Regular Session,* ch. 139.
[6] KRS 620.055(10).
[7] KRS 620.055(1); KRS 620.055(10).
[8] KRS 620.055(4).
[9] Kentucky. Justice and Public Safety Cabinet. Child Fatality and Near Fatality External Review Panel. *2020 Annual Report*, 2020, p. 3.
[10] KRS 620.055(1).
[11] Kentucky. Office of State Budget Director. *2018–2020 Kentucky Branch Budget, Baseline Budget Request: Program Narrative/Documentation Record*, 2018, p. 44.
[12] 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.
[13] Kentucky. Office of State Budget Director. *2014–2016 Budget Of The Commonwealth*, 2014, p. 214.
[14] 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.
[15] Kentucky. Office of State Budget Director. *2014–2016 Kentucky Branch Budget, Additional Budget Request: Program Narrative/Documentation Record*, 2014, p. 54.
[16] 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*, Jan. 14, 2020. Web.
[17] 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.
[18] Ibid.
[19] 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*, Jan. 14, 2020. Web.
[20] Elisha Mahoney, executive staff adviser, Child Fatality and Near Fatality External Review Panel. March 29, 2021. Interview.
[21] KRS 211.686(1).
[22] Elisha Mahoney, executive staff adviser, Child Fatality and Near Fatality External Review Panel. Dec. 8, 2020. Interview.
[23] Sarah Cooper, staff assistant, Cabinet for Health and Family Services, Office of the Secretary. Email to Gerald Hoppmann, Feb. 19, 2021.
[24] Elisha Mahoney, executive staff adviser, Child Fatality and Near Fatality External Review Panel. Jan. 13, 2021. Interview.
[25] Ibid.
[26] Ibid.
[27] Elisha Mahoney, executive staff adviser, Child Fatality and Near Fatality External Review Panel. Aug. 25, 2021. Interview.
[28] 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.
[29] Kentucky. Justice and Public Safety Cabinet. Child Fatality and Near External Review Panel. *2020 Annual Report*, pp. 35–42.
[30]Abby Collier, director, National Center for Fatality Review and Prevention. July 13, 2021. Interview.
[31] 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*, Sept. 7, 2021. Web.
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